Bundle LCHG Board Meeting in Public Session 1 July 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
Group Chair

2.1 Ward Accreditation
Bronze Accreditation - Louth Theatre

3 Apologies for Absence
Group Chair

4 Declarations of Interest
Group Chair

5 Minutes of the meeting held on 6th May 2025
Group Chair
- Item 5.1 Public Board Minutes May 25

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

6 Group Chief Executive Report to the Board
Group Chief Executive
- Item 6 Group CEO update public board July 2025 Final v2

6.1 Group Model Workstream Progress Briefing
Group Chief Executive
- Item 6.1 LCHG Progress Report to Group Board 1 July 2025
- Item 6.1 Group Development Programme Plan Update as at June 2025

7 Patient/Staff Story

7.1 Celebrating Group Success

7.2 BREAK

8 Strategic Aim 1 - Patients

8.1 Assurance and Risk Report from the Quality Committee
Chair, Quality Committee
- Item 8.1 Quality Committee Upward Report May 2025v1
- Item 8.1Quality Committee Upward Report June 2025v1
- Item 8.1 Appendix 1.0 - Perinatal Assurance report May V1.1 19052025
- Item 8.1 Appendix 1.3- CNST MIS Year 7-Update Report May
- Item 8.1 Appendix 1.5.6 - PMRT Q4 Jan -March 25 (none identifiable data)
- Item 8.1 Appendix 1.9 - Claims Scorecard Q4 '24-25
- Item 8.1 Appendix 1.11 - Bi-annual staffing report May 2025 V1.1
- Item 8.1 Appendix 1.13 - QIS paper Q4 May 2025

8.2 2024/25 Quality Account
Group Chief Clinical Governance Officer
- Item 8.2 Quality Accounts 2024-2025 Front Sheet
- LCHS Quality Account 2024-25 V4
- ULTH Quality Account 2024-25 v5

8.3 Urgent and Emergency Care Plan 2025/26
Group Chief Integration Officer
- Item 8.3 July Board UEC Front sheet
- Item 8.3 Urgent and emergency care plan

Item 8.3 UEC Plan v2

8.4 Assurance and Risk Report from the Finance and Performance Committee
Chair, Finance and Performance Committee
To include the 2024/25 Emergency Preparedness Annual Report and EPRR Core Standards
Item 8.4 Finance Committee Upward Report May 2025v1
Item 8.4 Finance Committee Upward Report June 2025v1
Item 8.4 LCHS EPRR Annual Report FPC 2024-25
Item 8.4 ULTH EPRR Annual Report FPC 2024-2025

8.5 Finance Briefing
Group Chief Finance Officer
Item 8.5 Finance Briefing Front Sheet
Item 8.5 Finance Briefing Trust Board M2

9 Strategic Aim 2 - People

9.1 Assurance and Risk Report from the People Committee
Chair, People Committee
Item 9.1 People Committee Upward Report May 2025v1
Item 9.1 People Committee Upward Report June 2025 (002)

10 Strategic Aim 3 - Population

10.1 Assurance and Risk Report from the Integration Committee
Chair, Integration Committee
Item 10.1 Integration Committee Upward Report May 2025v1
Item 10.1 Integration Committee Upward Report June 2025
10.1 Appendix A - One digital Strategy 25-28 v5 May 25

11 Integrated Performance Report - ULTH/LCHS
Group Chief Integration Officer
Item 11 ULTH Front Sheet Trust Board - IPR
Item 11 ULTH IPR Trust Board June 2025
Item 11 LCHS IPR Front sheet - May
Item 11 LCHG Integrated Performance Report - May (002)

12 Risk and Assurance

12.1 Group Risk Management Report
Group Chief Clinical Governance Officer
Item 12.1 LCHG Group Board Risk Report July 2025
Item 12.1 Appendix A LCHS Risk Report
Item 12.1 Appendix B - ULTH Group Board Risk Report Very High and High rated risks June 2025

12.1.1 Risk Appetite Statement 2025/26
Group Chief Clinical Governance
Item 12.1.1 LCHG Group Board Risk Appetite Statement 2025-2026

12.2 Board Assurance Framework
Group Director of Corporate Affairs
Item 12. 2 BAF Group Board Front Sheet 1 July 2025
Item 12.2 LCHG Group BAF as at June 2025

12.3 Assurance and Risk Report from the Audit Committee
Chair, Audit Committee
Item 12.3 Audit Committee Upward Report - May 2025

12.4 Board Forward Planer
Information item

Item 12.4 MASTER Board Work Programme 2025-26

13 Any Other Notified Items of Urgent Business

14 The next meeting will be held on Tuesday 2nd September 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 6 May 2025

Via MS Teams Live Stream

Present

LCHS
Voting Members:
Mrs Elaine Baylis, Group Chair
Mrs Rebecca Brown, Deputy Chair/Non-Executive Director
Miss Gail Shadlock, Non-Executive Director, LCHS
Ms Dani Cecchini, Non-Executive Director
Mr Neil Herbert, 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
Mr Paul Antunes Goncalves, Group Chief Finance Officer

LCHS
Non-Voting Members:
Mr Ian Orrell, Associate Non-Executive Director
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, Deputy Chair/Non-Executive Director
Ms Dani Cecchini, Non-Executive Director
Mr Neil Herbert, Non-Executive Director
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
Mr Paul Antunes Goncalves, Group Chief Finance Officer

ULHT
Non-Voting Members:
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

Professor 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, Board Administration, LCHS (minutes)
Rebecca Cook, Sister/Charge Nurse, ICU ULTH
Heather Baker, Advanced Clinical Practitioner, ICU ULTH
Paula Brown, Radiography Manager, ULTH (item 7.1)

Apologies:
Professor Duncan French, Non-Executive Director
Mr Jim Connolly, Non-Executive Director

171/25	**Item 1 Introduction** The Group Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream.
172/25	The Group Chair took the opportunity to welcome Mr Paul Antunes Goncalves, to his first Board meeting since securing the substantive Group Chief Finance Officer position and Ms Caroline Landon who had also been successful in securing the Group Chief Operating Officer position.
173/25	The Group Chair also thanked Professor Philip Baker, who had now left his role of Non-Executive Director, for the different direction he had brought to the Board in his role of Chair of the People Committee, for sharing his passion for research and innovation and for the work he had undertaken in supporting the organisation's application for Teaching Hospital status.
174/25	**Item 2 Public Questions** **Q1 Received from Vi King** Please can I ask if pre ops are still being carried out on all sites, for people having operations?
176/25	The Group Chief Operating Officer responded that a full pre-op service continued to run from the Pilgrim, Lincoln and Grantham Hospital sites. She explained that discussions were taking place to relocate the Pilgrim pre-op service to an alternative area of the Hospital, as this had been affected by the Pilgrim ED build, however there would be no change for now and a full service remained in place.

177/25	**Item 3 Apologies for Absence** Apologies for absence were received from Professor Duncan French and Mr Jim Connolly, Non-Executive Directors.
178/25	**Item 4 Declarations of Interest** There were no additional Declarations of Interest made.
179/25	**Item 5 Minutes of the meetings held on 4th March 2025** The minutes of the meeting held on Tuesday 4th March 2025 were approved as an accurate record.
180/25	**Item 5.1 Matters Arising from the previous meeting/log** There were no outstanding matters arising.
181/25	**Item 6 Group Chief Executive's Report to the Board** The Group Chief Executive presented the report to the Board, paying tribute to those staff members who had worked tirelessly over recent weeks, including during the recent Bank Holidays to ensure patients remained cared for and treated in a timely manner. The Group Chief Executive also took the opportunity to thank Executive colleagues in supporting the close down position of the 2025/26 System Operational Plan which had now been agreed with NHS England (NHSE).
182/25	The Group Chief Executive explained that in recent weeks there had been much domination of the headlines following the national announcements of organisational change, including a 50% reduction in running and programme costs for Integrated Care Boards (ICB), 50% reduction in staffing costs within NHSE and the abolition of NHSE which would be absorbed by the Department of Health and Social Care, and a 50% reduction in corporate cost growth in provider organisations. The Group Chief Executive advised that further information was continuing to be received associated with this and would be offering further communication into the Group as more detail was known.
183/25	The Group Chief Executive advised that the top team of NHSE had also recently changed following the appointment of Sir Jim Mackey as Chief Executive. The coming months were expected to be challenging both nationally, within Lincolnshire and across the Group.
184/25	The HSJ Independent Healthcare Provider and HSJ Partnerships Awards had taken place in March, where the partnership between United Lincolnshire Teaching Hospitals NHS Trust, Lincolnshire ICB, Lincolnshire Elective Activity Coordination Hub and DMC Healthcare had been successful in winning Best Elective Care Recovery Initiative and Best Insourcing Initiative, both of which recognised the project aimed at reducing the dermatology patient waiting list following the Covid-19

	pandemic and improving the overall patient experience. The awards recognised the tremendous achievement and showed the close working within the Lincolnshire system and other partners.
185/25	On 16th April 2025, the Supreme Court delivered a landmark ruling on gender identity. The Group Chief Executive explained that there were currently many details to be worked through on a national level as to how this would impact the Group. Communications had been shared with colleagues making it clear that they were welcomed, regardless of gender identity, and the organisations would continue to create a safe and working environment for all.
186/25	The Group had recently released communications to gauge levels of interest in a Mutually Agreed Resignation Scheme (MARS) and to date there had been several expressions of interest from colleagues across the Group.
187/25	The Group Chief Executive explained that 9th March 2025 marked five years since the beginning of the Covid-19 pandemic. The Group arranged a series of reflection services to allow colleagues to mark the anniversary and to honour those affected, as well as recognising the huge contribution the NHS made during the pandemic.
188/25	United Lincolnshire Teaching Hospital NHS Trust (ULTH) had been considering the future plans of the old buildings on the front of Grantham Hospitals. To help develop the plans, the Trust recently ran a public engagement exercise inviting views and ideas from residents, to ensure that the plans are of benefit to the local community. A report on the outcome of this engagement exercise would be shared soon.
189/25	The Group Chief Executive outlined some good performance since the commencement of the Group, specifically across the UEC pathway indicators, and the organisation had shown the most improvement within the East Midlands region and was in the top ten in the country. Progress has also been seen within planned care on 65 week waits and further work would continue in earnest across the elective and UEC pathways across the Group to further improve performance.
190/25	From a digital perspective, Ministerial approval had now been received to continue with the Electronic Patient Record and the Group recently hosted the National Director of Transformation and his team who had been impressed with the case submitted and they were keen to support the digital agenda moving forward.
191/25	The 2024/25 National Staff Survey results had been received for the Group, which had seen an improvement in all the people promise indicators, with particular improvement in the acute side of the Group.
192/25	Mrs Buik offered that it was encouraging to see the improvements in the Staff Survey results, particularly at a time of uncertainty for staff members and asked if there was any indication that colleagues were now feeling less anxious. The Group Chief Executive responded that there had been mixed feedback, some teams had

	embraced Group working and could see the advantages and there were others not touched by Group working yet, however had anxiety in respect of the future of their teams and from an individual perspective. The Group Chief Executive offered that the Group Leadership Team (GLT) would shortly be commencing a series of roadshows across the County where discussions would take place in respect of the national agenda, and the intent and purpose of the Group which she hoped would settle anxieties for individuals.
193/25	The Group Chair acknowledged the significant changes nationally and explained that guidance had been issued today in respect of the ICB Operating Model moving forward and work would be undertaken to understand the detail of the report prior to any further communications being released. The impacts of this would continue to be assessed moving forward.
194/25	The Group Chair took the opportunity to congratulate colleagues on the HSJ awards and commended partnership working that could deliver such transformation and change procedures that helped to deliver services.
195/25	In respect of the financial year end position, the Group Chair endorsed the point made on the excellent work that had been undertaken within the system and Group to get to the final position for 2025/26 planning. The Board: • **Received the report and noted the significant assurance provided**
196/25	**Item 6.1 Group Model Workstream Progress Briefing** The Group Chief Executive presented the report to the Board explaining that this was a high-level briefing in respect of progress against Group developments and key milestones. She explained that there had been some understandable slippage more recently, however some key documents would be discussed during today's meeting which would continue to move the Group forward.
197/25	Mrs Brown offered that considering the work that had been undertaken over the last 12 months, the Board should not challenge itself on any slippage. Mrs Brown expressed a view that this may have been ambitious as it was developed, however this had been the right thing to do at the time.
198/25	Mrs Brown requested an update on the health and wellbeing area which was red rated. The Group Chief Executive responded that in bringing the two organisations together, culture and health and wellbeing underpinned this. There was a focus on the key milestones by the Executive team on a weekly basis and the Human Resources team and engagement team were understanding from colleagues what improvements could be made and in time there would be adaptation across the Group.
199/25	The Group Chief People Officer explained that there were good relationships with Staffside colleagues and the Group Chief Executive and herself were meeting with

	colleagues weekly to receive feedback on how staff were feeling and how they could be supported further. It was anticipated that the GLT roadshows would also be a good source of information and would provide an opportunity for staff to provide feedback directly to senior leaders.
200/25	The Group Chair offered that the red rating related specifically to the future of the menopause service rather than the whole area and suggested that this may need to be revisited. The Board: • **Received the report**
201/25	**Item 6.2 Board and Board Committee Governance** The Group Director of Corporate Affairs presented a suite of papers to Board members which referenced back to the Group Development Plan and some of the key actions to be undertaken. The Joint Working Principles Framework would provide clarity on how the Board and assurance Committees would make decisions across the Group, the assurance map outlined which Committee would provide oversight on several documents and the updated Terms of Reference (ToR) and workplans for each Committee were also presented.
202/25	The Group Director of Corporate Affairs outlined that all the documents would continue to be reviewed and updated moving forward, adding that the Integration Committee was still in development. Next steps would include the development of new templates for reporting into the Committees and upward reporting templates and this would tie into a Board Development Session with NHS Providers in the coming weeks.
203/25	The Group Chair and the Group Director of Corporate Affairs took the opportunity to thank Corporate Governance colleagues for their hard work in developing these documents.
204/25	Mr Herbert commented that Information Governance and cyber security currently sat under the Audit Committee, however those areas had been delegated to the Finance and Performance Committee and he asked that this be made clearer on the document and through the ToR of both Committees. **Action: Group Director of Corporate Affairs, 1st July 2025** The Board: • **Received the report and approved the updated Terms of Reference and workplans** • **Noted the position on the assurance map** • **Approved the Joint Working Principles Framework**

205/25	**Item 6.3 Performance Management and Accountability Framework** The Group Chief Integration Officer presented the Performance Management and Accountability Framework which described how performance and improvement would be measured, managed, monitored and reported including how the Group would utilise improved information management to understand trends and drive better performance at all levels of the organisation.
206/25	The Group Chief Integration Officer outlined the approach that was being taken in respect of Performance Review Meetings (PRMs) for each Division and for Corporate areas and how this detail would be reported to GLT, Committees and the Board.
207/25	Mrs Brown welcomed the framework and asked what support would be available if areas were unable to meet their actions, adding that it would be interesting to see what changes had occurred within the next 12 months.
208/25	Ms Cecchini commented that it was good to see how the Committees would receive assurance and asked if there was any intention to report the ratings to Board or through a sub-Committee, depending on the issue reducing the rating.
209/25	The Group Chief Integration Officer responded that the upward report would have the ratings set out under three components: the rating and phasing, areas for celebration and success and areas for escalation. The Finance and Performance Committee would receive a monthly highlight report.
210/25	Mrs Wells commented on the responsibilities of corporate directors and teams and staff under section 3.8 and 3.9 of the framework and asked if it would be possible to highlight the responsibilities of middle leaders in this section and to be more explicit on responsibilities through the organisations. Section 3.10 referred to members of the public being able to attend Board meetings, and Mrs Wells expressed a view that this should state members of the public were invited to attend Board meetings. The Group Chief Integration Officer agreed with this comment.
211/25	Mr Orrell asked how this had been received by middle managers so far. The Group Chief Integration Officer responded that engagement had been good, and this had been embraced by GLT members. The first round of meetings had been held during February 2025 and Divisions were developing the process and owning it as the process evolved, adding that there was still one area of focus in respect of strategic analytics which was the next phase of engagement.
212/25	The Group Chief Integration Officer offered that in terms of escalation and developments, the Shadow Bord would help to support the day to day rhythm of the organisations, including the early warning mechanisms in respect of cultural changes or resistance. The Group Chair offered that this was about stronger ownership and being able to hold people to account.
213/25	Miss Shadlock liked section 5.2 relating to accountability and autonomy and expressed a view that there needed to be greater autonomy from a cultural perspective.

	The Board: • **Approved the Performance Management and Accountability Framework**
214/25	**Item 7 Patient/Staff Story** The Group Chair welcomed Becky Cook, Sister/Charge Nurse and Heather Baker Advanced Clinical Practitioner (ACP) to the meeting to present the patient story which documented improving patient experiences within the Intensive Care Unit (ICU) at Lincoln County Hospital. Patients often suffered side effects of being in ICU including psychological problems, suffering from memory gaps and loss of time. The team had listened to feedback and had introduced an ICU Support Group who met every three months and patient diaries at the bedside where anyone could make an entry, so that patients could see various milestones they had missed.
215/25	John and Christine shared their story of when John suffered a cardiac arrest at the gym and was taken to Lincoln ICU. John expressed a view that the Support Group had helped him in his recovery and explained how it had been interesting to hear the stories of other patients at these sessions.
216/25	Sister Cook explained that she had been proud of the changes made and that the feedback received was positive. Patients chatting at the Support Group had aided recovery and had made a real difference.
217/25	The Group Chair thanked Sister Cook and ACP Baker for sharing this story and said they were right to feel proud for addressing these issues in such a straightforward way by introducing the diaries for patients.
218/25	The Group Chief Medical Officer commented that this was a good story, and it was something that would have a huge impact on patients and their families. The long-standing psychological impacts of a patient going through significant illness took a lot of work and the Group Chief Medical Officer expressed a view that this was an excellent initiative.
219/25	The Group Chief Executive had met with the team several months ago where this had been shared, along with other work being undertaken within the ICU and added that it was good to see that the staff members had listened to the feedback received from patients and their families in introducing these initiatives. The Group Chief Executive asked if this story was being shared wider across the organisation. ACP Baker responded an audit would be completed of what patients were experiencing and feeling which it was hoped would be published soon.
220/25	Mrs Wells asked if the use of diaries could be implemented across other Wards. ACP Baker responded that this would be useful, however a patients experience within a Ward could often be different to that of ICU and there was a lack of understanding of post ICU syndromes. It would be good to develop this further.
221/25	The Group Chief Clinical Governance Officer advised that clinical audit week was approaching, and the organisation ran a competition where the best audit shared received a prize and encouraged ACP Baker to submit a nomination.

222/25	ACP Baker informed Board members that she was now the lead ACP at Pilgrim Hospital, Boston and had also introduced a Support Group there along with face to face follow up clinics.
223/25	The Group Chair thanked Sister Cook and ACP Baker for attending the meeting and for offering such good leadership and to John and Christine for sharing their story. The Board: • **Received the Patient/Staff Story**
224/25	**Item 7.1 Celebrating Group Success – Radiology Service** The Group Chair welcomed Paula Jones, Radiology Manager to the meeting who provided a presentation on new and innovative approaches for head and neck treatments, including the use of face masks increasing patient comfort and in some cases could offer mask free treatments for more simple cases, which saved time and resource. Longer term the Radiology Manager explained that it was hoped to go mask free for head and neck patients
225/25	The Radiology Manager informed those present that staff members had benefitted from this innovation in many ways, including standardisation, progression and peace of mind.
226/25	The Group Chair thanked the Radiology Manager for bringing this initiative alive, making the service offered modern and relevant and for being able to offer something different to patients. The Group Chair recognised the compassion for the patients throughout the presentation relating to patient experience and asked how the radiology team worked with consultants and specialties to put the patients best interests at heart. The Radiology Manager responded that the team worked collaboratively with Oncologists who were keen to make the treatments the best they could be in terms of the outcomes and by utilising the technology available to the best of their ability, whilst attempting to reduce waiting times to see and treat more patients.
227/25	The Group Chief Finance Officer asked if the technology was easy to learn and adaptable to get people up to speed quickly. The Radiology Manager confirmed this was the case. The Group Chief Finance Officer asked if there were any other area the team were interesting in expanding in terms of outcomes and impacts for patients. The Radiology Manager responded that there were currently elements of the system that were not used, which the team would like to, specifically in relation to being mask free to further improve patient experiences for head and neck patients, and a module which reduced patient breathing rates however this was expensive. The Group Chief Finance Officer offered the services of members of his team to assist in developing a business case for this equipment.
228/25	The Group Chief Medical Officer described his lived experiences and expressed a view that it should not be underestimated how much this would be revolutionary for patients and he looked forward to seeing future innovations which would be important for patients who were going through arduous treatments.

229/25	The Group Chair thanked the Radiology Manager for attending the meeting and for sharing this innovative work which had a lot of potential for the future. The Board: • **Received the presentation**
	Item 8 Strategic Aim 1 Patients
230/25	**Item 8.1 Assurance and Risk Report Quality Committee in Common and 2024/25 Annual Report** The Deputy-Chair of the Quality Committee in Common, Mrs Brown, presented the Committee reports following the meetings held during March and April 2025 and the reports were taken as read with no formal escalations made to the Board from either meeting.
231/25	The Quality Committee had received the first iteration of the patient safety investigation report, providing learning from incidents and Mrs Brown recommended this to the Board for approval. The Group Chief Clinical Governance Officer offered that this report had been in development alongside colleagues both internally and outside of the Group to bring together a Group Patient Safety Response plan, which was a good step forward. This was based on evidence and data identifying key patient safety priorities for the coming year which were outlined within the Plan. The Group Chief Clinical Governance Officer explained that there would be 28 PSIIs in the next calendar year, 18 from learning from death priorities, 5 for never events and 5 locally defined projects based on data to drive down transfers of care, deteriorating patients for sepsis, deteriorating patients fluid management and speech and language therapy and transfer of medication. This provided assurance that this process had been developed widely using local colleagues and was based on data available.
232/25	The Group Chief Nurse offered that this would strengthen assurance from the plan and there would be oversight in respect of how patients were seeing the organisations, and that feedback would be utilised to triangulate data and to share response planning through the framework.
233/25	Mrs Brown offered that there had been a continued focus on infection prevention and control by the Committee and a further external visit had been undertaken which highlighted some key areas of improvement. This would be a key focus for the Quality Committee in the coming months and the Group Chief Nurse had provided assurance in respect of several areas. An update had been received at the meeting relating to several MRSA cases within maternity which an investigation had found had not been connected and the Infection Prevention and Control team had been supporting the Maternity team to look at areas of improvement. A detailed plan had been developed which was being discussed at the Maternity and Neonatal Oversight Group (MNOG) and would be submitted to a future Quality Committee meeting.
234/25	The Maternity team had achieved CNST year six, despite some complications however this was a good achievement for the team who were already working on achieving year seven. Several documents had been received by the Committee from MNOG based on CNST requirements.

235/25	Mrs Brown informed those present that a detailed discussion had taken place regarding clinical harm and further detail had been requested in respect of having the correct levels of process to capture clinical harm, specifically within LCHS as the report received had focussed upon ULTH.
236/25	Improvements had been seen within the Children in Care Service which were expected to continue for the month ahead.
237/25	Mrs Brown also offered that HMSR and SHIMY remained within expected levels.
238/25	The Group Chair thanked Mrs Brown for the report and commented on the focus around clinical harm and infection prevention and control. Congratulations were offered to the maternity team in respect of the CNST achievements and the Children in Care position was noted, following previous escalations to the Board. The Board: • **Received the assurance reports, noting there were no escalations** • **Accepted the recommendation to adopt the response plan for Patient Safety Incident Investigations** • **Received the 2024/25 Quality Committee Annual Report**
239/25	**Item 8.2 Assurance and Risk Report Quality Committee in Common and 2024/25 Annual Report** The Chair of the Finance and Performance Committee, Ms Cecchini, presented the Committee reports following the meetings held during March and April 2025. The reports were taken as read with the following highlights being made to the Board from the April meeting.
240/25	Ms Cecchini drew attention to page two of the report stating there were zero 52 week waits, this was a typographical error and show have read zero for 78 week waits and she acknowledged that 65 week performance was better than trajectory. There had also been a reduction in performance for the faster diagnosis cancer standard however the organisation was still delivering well ahead of the standard.
241/25	The Group Performance Report had been received by the Committee and the community waiting list position had started to be reported; it was noted there was work to do on the performance metrics for the community side of the Group due to some targets being set with ambitious levels.
242/25	In respect of the financial outturn position, the position had been agreed with NHSE achieving a more challenging position.
243/25	Ms Cecchini offered that it had been satisfactory to see the cost improvement plans (CIP) for 2024/25 had been delivered across the Group, due to a level of non-recurrent funding supporting the position.
244/25	There had been improvements in the Better Payment Practice Code (BPPC) however due to the cash position in 2024/25 performance had reduced.

245/25	A productivity improvement planning update had been received and further progress would be received by the Committee in due course along with the development of the Transformation and Delivery Oversight Group.
246/25	A 2025/26 CIP target £79.3m, which included a system gap of £23m which had been accepted by the Group. Ms Cecchini expressed some concern in the delivery of that on behalf of the Finance and Performance Committee and would require scrutiny.
247/25	From an estates perspective, there had been limited assurance largely relating to the community estate, including an issue relating to a fire enforcement notice for Johnson Hospital, Spalding and mitigations had been discussed to ensure patients and staff were being kept safe.
248/25	The Group Health and Safety Committee had also met during May and the Finance and Performance Committee looked forward to receiving a joint upward report in due course.
249/25	The Group Chair acknowledged the comments made in respect of the CIP delivery and that greater assurance was required in relation to community estates. The Board: • **Received the assurance reports** • **Received the 2024/25 Finance and Performance Committee Annual Report**
250/25	**Item 8.3 Finance Briefing** The Group Chief Finance Officer offered a summary of performance on the 2024/25 financial position, reminding colleagues that the Group started the year with a system breakeven plan and the Group had been set a challenging financial plan in support of that, with several mitigations being undertaken to support the financial position.
251/25	In terms of the pay position, there had been growth relating to new developments, for example the Community Diagnostic Centres and the vacancy position supported by international nurse recruitment and vacancy control measures had been supported by robust Quality Impact Assessments (QIAs) or put in place to ensure the correct decisions stabilised the workforce position in 20/24/25. The band two to band three job evaluation position had also been resolved and had been backdated as part of a settlement in year resulting in a £5.1m adverse variance on the pay position which have been including within the 2025/26 financial plan.
252/25	Inroads had been made in supporting the efficiency programme delivering £47m efficiencies in year and there had been a significant effort across teams reducing premium pay, and procurement savings on consumables and estates. The Group had delivered several efficiencies in a non-recurrent manner and the focus for 2025/26 would be converting that to transformational savings. 2024/25 had ended at an £18.2m deficit position for the Group which was £11.3m adverse to plan.

253/25	The Group Chief Finance Officer advised that a cash position of £93.4m capital spend in 2024/2025 had been achieved and he took the opportunity to thank teams across the Group for their hard work in achieving this. Improvements made included the estate, digital infrastructure and new developments including the opening of two new CDC's in Skegness and Lincoln to deliver state-of-the-art care closer to patients homes. Charitable Funds had also provided additional extras which was a good enhancement to the environment for patients. £18.9m had also been spent on improving the core estate infrastructure including a £20m spend on the new Emergency Department at Pilgrim Hospital which would be opening later this year.
254/25	The Group Chair thanked the Group Chief Finance Officer for the summary and drew attention to the achievements in respect of the 2024/25 capital programme and expressed a view that the building work currently ongoing would be revolutionary to the way in which the organisations provided services for patients. The Group Chair added that in visiting several areas of the Group recently, it was noticed that there was a different feel relating to environment and thanked the estates team for all their hard work. The Board: • **Noted the contents of the Finance report in respect of Revenue, Capital, Cash and CIP positions.** • **Noted the Group had delivered a deficit for 2024/25 of £18.2m, although this was adverse to plan, it is in line with agreed outturn position with the regulator.** • **Noted the Group delivered its capital programme for 2024/25, utilising £93.3m of available funding.** • **Noted that the Group did not achieve its planned cash position for 2024/25 however managed a very challenging cash position to minimise the impact of this upon supplier payments.** • **Noted that the Group delivered its CIP target for 2024/25, however there was a significant reliance on non-recurrent CIP and in year mitigations to support this position.**
	Item 9 Strategic Aim 2 People
255/25	**Item 9.1 Assurance and Risk Report People Committee and 2024/25 Annual Report** Mrs Wells provided the assurances received by the People Committee, at the meetings held during March and April 2025 and the reports were taken as read. The March meeting had been Professor Baker's last meeting as Chair, and Mrs Wells highlighted the 2024/25 National Staff Survey results which had been referred to the Quality Committee to ensure there was triangulation with the quality and safety data.
256/25	At the April meeting, a positive report had been received from the Education Oversight Group, focussing on continued improvements in statutory and mandatory training uptake across the Group and there had also been assurance in respect of medical and clinical education. Assurance had also been received on safer staffing for nursing and AHPs and the level of transparency provided had been welcomed by the Committee.

257/25	Mrs Wells outlined some work in progress reviewing increases in sickness levels in some areas and work had also been undertaken around the recent identification of relatively junior skill mix within community teams to ensure there was an adequate skill mix.
258/25	The medical safer staffing report had been received, along with a welcome report on bank and agency staffing demonstrating that temporary medical staffing was reducing, however remained high at this stage.
259/25	The Workforce Strategy Group report highlighted deep dive work on absence management and return to work compliance.
260/25	The first joint Freedom to Speak Up report had been received by the Committee which provided assurance and actions that were particularly important across the Group in respect of ensuring leadership visibility and Mrs Wells referenced the significance of the upcoming GLT roadshows as an opportunity to connect with staff members.
261/25	The Guardian Safe Working report had also been received and rest spaces had been raised as an issue across both organisations and this was being addressed by the Estates team.
262/25	Mrs Wells also drew attention to the Equality Diversity and Inclusion objectives, which had been shared for information.
263/25	An update had been received from the Group Chief Estates and Facilities Officer regarding year on year improvements across teams which also highlighted some of the challenges in high turnover of staff in that area and actions were being taken to ensure there was stability.
264/25	A deep dive relating to risk was being undertaken soon, where areas would be revisited to ensure mitigating actions remained appropriate.
265/25	The Group Chair thanked Mrs Wells for the comprehensive report and acknowledged that the Committee Annual Report demonstrated the progress made over the last year. The Board: • **Received the assurance reports** • **Received the 2024/25 Annual Report**
266/25	**Item 9.2 2024/25 National Staff Survey Results** The Group Chief People Officer presented the National Staff Survey (NSS) results to the Board and advised that across LCHG a total of 12,293 colleagues were invited to complete the 2024 NSS, resulting in return rates of 55% (1,231 colleagues) for Lincolnshire Community Health Services (LCHS) and 36% (3,570 colleagues) for United Lincolnshire Teaching Hospitals NHS Trust (ULTH).

267/25	Both response rates had reduced from the previous year, with LCHS seeing a 1% reduction and ULTH an 8% reduction. For LCHS out of the 7 people promise elements, 5 areas had decreased, with 2 areas remaining the same and for ULTH, 5 areas had increased, with 2 areas remaining the same.
268/25	The Group Chief People Officer offered that work was underway with teams to devise local actions plans, with a focus on those areas where scores had reduced.
269/25	Mr Orrell commented that there was a lot of good detail included within the report and asked about the decrease in response rates from the previous year and if there were any areas where there had been a greater reduction than others. The Group Chief People Officer responded that a breakdown of percentage by area and division/team was forming part of the local action plans. It was suggested that there was more that could be done to promote completion of the survey, and this would also be a focus of the action plans.
270/25	Miss Shadlock suggested keeping a close eye on the LCHS response rates as there was an awareness of some nervousness from colleagues in respect of the forming of the Group. However overall, Miss Shadlock expressed a view that the results for both organisations were good, despite going through major change. Time would be required to absorb the change and to ensure there was empowerment and autonomy, and the results would follow. The Group Chair agreed that both organisations were going through large transformational change, and it was inevitable that individuals would feel disorientated, and expressed a view that the middle managers across the Group would have a significant role to play in this. The Board: • **Received the 2024/25 National Staff Survey Results**
271/25	**Item 9.3 Board Member Appraisals** The Group Chief People Officer advised that during April 2025, NHSE had released new Board Member Appraisal Framework for Chairs, Chief Executives, Non-Executives and Executive Directors which had been produced in accordance with the Messenger review. There were now six domains of leadership and competency which aligned with the Fit and Proper Persons paperwork.
272/25	The Group Director of Corporate Affairs outlined the timescales for completion of appraisals and submission dates.
273/25	In seeking feedback from individuals in readiness for appraisals, the Group Chair requested that colleagues were not overloaded with requests and that feedback was only requested where it was relevant to the roles performed. The Board: • **Received the report and would comply with national guidance**

	Item 10 Strategic Aim 3 Population
274/25	**Item 10.1 Assurance and Risk Report from the Integration Committee** Mrs Brown provided the assurances received by the Committee at the meeting held in March and April 2025.
275/25	An estates and facilities upward report had detailed the newly formed Space Utilisation Group which would look at the best use of the current space and potential for alternative ways of working moving forward.
276/25	An update had been received from East Midlands Acute Provider (EMAP) network, which was hosted for the East Midlands by ULTH, requesting an increase in funding provided to the region wide initiative which was in line with budget controls and had been approved by the Committee. Mrs Brown offered that EMAP had not provided the organisation with the levels of achievement expected, however this was an important way of working as a region and would provide good opportunities moving forward.
277/25	The Alliance Steering Group had four clear areas of work; planning and unplanned care, left shift redesign, integration and health inequalities and each area was gathering momentum. A Digital Oversight report focussed on four main project areas; NHS net migration, where a lessons learned exercise was being undertaken, two EPR projects which were progressing to timescales and EDMS which the team would like to bring forward recognising this was a good enabler for other programmes and could enable additional efficiencies moving forward.
278/25	The Committee had received an update from the AGEM Digital Innovation Group who were undertaking due diligence currently to ensure there was no additional pressure on the Group, which would be monitored closely going forward.
279/25	A verbal update had been received on the intermediate care support proposal which was being undertaken in partnership with the ICB and would provide efficiencies and integration moving forward.
280/25	A Research and Innovation report was also received and there would be a Lincolnshire Wide Expo in May and Mrs Brown would be meeting with chairs and research leads to look at building on success and extending this wider within the Group.
281/25	In respect of the University Hospitals status Mrs Brown commented that a key area was to drive the joint academic posts, however acknowledged that this would be challenging due to the financial position and that there would need to be some creativity in respect of additional posts or utilising vacancies differently.
282/25	The performance dashboard has been received in draft and provided an opportunity for a deep dive if required to provide improved detail on pathways where there were any issues or concerns. The Board: • **Received the assurance reports**

283/25	**Item 10.2 2025 – 2030 Group Strategy** The Group Chief Integration Officer presented the 2025 – 2030 Group Strategy advising that the Strategy had been developed over the last 12 months and was a product of collective work between the Board and senior leadership team.
284/25	The core components of the document included the movement of secondary care into neighbourhood teams, which would be coproduced in due course. This was also aligned with the national picture and saw three shifts of hospital to community, sickness to prevention and analogue to digital.
285/25	The Group Chief Integration Officer explained that there would be three core star areas, patients, people and population delivering better care opportunities and better health and the strategic aims/objectives would be where Committees and the Board would seek assurances.
286/25	A roadmap was presented which was inclusive and outlined how the Strategy would change the Group and how it worked with staff and how they adopted new ways of working and resident personas.
287/25	There had been commitment, as part of the delivery and communication to socialise this via an engagement plan.
288/25	Mrs Buik commented that this was a good document and thanked the teams who had worked hard in producing this. In terms of the socialisation plan, due to shift work and remote working, Mrs Buik asked about a feedback mechanism to ensure people had heard about this directly, rather than online.
289/25	The Group Chief Integration Officer responded that this would be socialised alongside the vision and values through the GLT roadshow, and a feedback loop would be included as part of that. It was agreed that the remoteness of some sites was challenging, and that continuous engagement would be required.
290/25	The Group Chair offered that this was an excellent piece of work that set out the ambitions of the Group and enabled items to be discharged with a strong focus on the forward ambition. This was noted as aligning to the national direction of travel and acknowledged that this had been coproduced with senior leaders. The Group Chair therefore commended approval of the Strategy to the Board. The Board: • **Approved the 2025 – 2030 Group Strategy**
291/25	**Item 10.3 Operating Model** The Group Chief Integration Officer presented the Operating Model explained that this was a key enabler for LCHG to support delivery of the Department of Health ‘Road to Recover’ initiatives focussed on moving care from hospital to community, sickness to prevention and analogue to digital. This would be a common, organisational-agnostic space that identified and took forward opportunities to collaborate at scale across a range of partners and included the design/redesign of

	clinical pathways of care, using population health management datasets, service models and delivery vehicles to enable care to be delivered closer to people's homes and communities, enabled by digital solutions.
292/25	The Alliance would consist of three core areas (i) a partnership space, working with key partners in an innovative way to drive 'left shift' (ii) left shift transformation programmes, key services to be delivered within community settings which did not need to delivered on an acute site (iii) as part of LCHG coming together, the restructure of our care groups to create an alliance care group which would host all of the clinical support services with the exception of outpatients and cancer services.
293/25	The Group Chief Integration Officer advised that the PCN Alliance were ready to work with the Group in respect of neighbourhood working.
294/25	The Group Chair commented that this document was clear and well set out and was offered a significant change in terms of the way the Group currently worked. There was optimism in respect of the opportunity to provide services in a different way that would benefit the population of Lincolnshire. The Board: • **Received the report and endorsed the direction of travel**
295/25	**Item 11 Integrated Performance Reports** The Integrated Performance Reports were taken as read with the Board noting that the reports had been received and reviewed in depth by the Committees. The Group Chief Integration Officer described further work that was required in respect of reducing the average length of stay in community beds to 10 days. The Urgent Community Response figures were acceptable, however unsustainable given the current operating model and the team were reviewing this to increase the volume, including bringing home visiting in line with that.
296/25	The Group Chief People Officer explained that there had been an increase in vacancy rates to 6.91% which reflected the control processes currently in place and advised that increases were likely to be seen month on month moving forward.
297/25	In respect of pressure ulcers, the Group Chief Nurse offered that work was ongoing within the community where there were several pressure ulcers and actions were being taken to ensure new leaders were being supported to embed the actions. The LCHG action plan for pressure ulcers had been revisited and new targets would be reported on via the Quality Committee. The Board: • **Received the Integrated Performance Reports noting the moderate assurance**

	Item 12 Risk and Assurance
298/25	**Item 12.1 Group Risk Management Report** The Group Chief Clinical Governance Officer presented the risk report to the Board noting there had been a reduction of one very high risk within LCHS, following completion of some work and the risk score had reduced. There were several very high risks within ULTH which remained stable.
299/25	Following a Board Development Session on Risk Appetite, work was underway to implement the outputs and going forward the Group Chief Clinical Governance Officer would report on risks against the risk appetite as agreed by the Board. The Board: • **Accepted the risks as presented noting the significant assurance**
300/25	**Item 12.2 Board Assurance Framework** The Group Director of Corporate Affairs presented the final 2024/25 report and a 2025/26 Framework which had been developed by the Corporate Governance Team and Executive Directors and had been considered by Committees in April with the exception of the People Committee, due to a timing issue.
301/25	The Group Director of Corporate Affairs offered that the risk position had been built in, so this could be seen within one document, and this remained work in progress. The document had been considered by the Audit Committee and had been shared with internal and external audit colleagues for comments.
302/25	The Group Director of Corporate Affairs took the opportunity to thank members of the Corporate Governance team who had been instrumental in the development of the document. The Board: • **Accepted the 2024/25 Board Assurance Framework** • **Accepted the 2025/26 Board Assurance Framework**
303/25	**Item 12.3 Assurance Report from the Audit Committee** Mr Herbert provided the key highlights from the Audit Committee meeting held in April 2025, taking the report as read.
304/25	The Auditors confirmed that a draft set of accounts had been submitted for both organisations by the due dates. It was recognised that the detailed planning which had been produced for the two organisations for 2025/26 was significant, however the year remained a significant challenge.
305/25	The Committee received reports assuring on the lessons which had been learned from the interim audit and the actions which were being taken to deliver the year end process internally.

306/25	From an internal audit perspective, several reports had been received since the last Audit Committee meeting and it was noted further reports were in the final stages of completion.
307/25	It was recognised that the evidence could not be offered to demonstrate the completion of an NHS Providers self-assessment in the previous financial year for LCHS, however management responses had been offered to the audit findings and one of the papers being offered to the Committee addressed one of the outstanding actions.
308/25	There had been some concern on the lack of agreement of the findings of an estate management audit and a meeting would be held with the Chair of the Finance and Performance Committee and Internal Audit to understand this further.
309/25	The 2025/26 Internal Audit Plan required work ahead of the Internal Audit opinion being offered, there had been concerns raised relating to audits on absence management and vacancy controls where the management response had been outstanding, however had now been completed.
310/25	The Committee had reviewed the 2025/26 proposed schedule of Internal Audits and approved the first quarter of requested work to identify efficiencies within the plan across the Group to make more time available for other areas.
311/25	In terms of outstanding policies, the position remained poor in terms of numbers, however Committee Chairs were seeing traction within their areas and work was being undertaken, reducing some risk ratings.
312/25	The Group Chair noted the position in respect of the LCHS NHS Provider Licence for 2024/25 and outstanding policies. The Board: • **Received the Assurance Report**
313/25	**Item 12.4 NHS Provider Licence Self Certification** The Group Director of Corporate Affairs presented the Self Certifications for ULTH and LCHS which had been approved by the Audit Committee and closed down an outstanding action. The self-certifications declared both organisations compliant against conditions G5 and NHS2 of the Provider Licence and oversight would be provided to the Audit Committee through quarterly compliance reports. The Board: • **Noted the NHS Providers Self-Certifications**
314/25	**Item 13 Board and Board Development Forward Planners** The Group Director of Corporate Affairs presented the Forward Planner for Board and Board Development Sessions, for information. The Board:

	• **Received the Board and Board Development Forward Planner**
315/25 316/25	**Item 14 Any Other Notified Items of Urgent Business** As this would be Miss Shadlock's last Public Board meeting due to the end of her tenure, the Group Chair took the opportunity to thank her for all of her hard work across both LCHS and ULTH and for her contributions, passion and commitment to the Group. The Group Chair particularly thanked Miss Shadlock for chairing the Charitable Funds Committee and for her input into all of the other Committees at various times during her tenure. The Group Chair offered that Miss Shadlock had been a friend and colleague and a great ambassador for the residents of Lincolnshire during her time on the Board. In response, Miss Shadlock offered that it had been a pleasure working with all members of the Board and with the people and teams within LCHS and more latterly ULTH. She added that it would be good to retire as a member of the public knowing that she would be confident to use any of the services available within the Group.
317/25	The next scheduled meeting will be held on Tuesday 1st July 2025 via MS Teams live stream.

Voting Members	**6 May 2025**											
ULHT/LCHS												
Elaine Baylis	X											
Rebecca Brown	X											
Neil Herbert	X											
Dani Cecchini	X											
Jim Connolly	A											
Karen Dunderdale	X											
Daren Fradgley	X											
Nerea Odongo	X											
Colin Farquharson	X											
Paul Antunes Goncalves	X											
LCHS												
Gail Shadlock	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	*1st July 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 on the key points from May and June 2025.*

System Overview

a) All parts of Lincolnshire health and care system remain busy, but good work continues to cope with the ongoing operational pressures. Over the May bank holiday, the Group experienced operational pressures driven by the increased demand in Urgent and Emergency Care.

b) The Model ICB Blueprint, developed in collaboration with NHS England and ICB Leaders, was published in May 2025 and outlines the strategic redesign of Integrated Care Boards to enhance their role as strategic commissioners. This initiative supports ICBs to produce plans to reduce their running costs by 50%. NHS Lincolnshire has submitted their plans and are waiting for the final outcome.

c) On 1st May 2025, the inaugural election for the Mayor of Greater Lincolnshire Combined County Authority was held where Dame Andrea Jenkyns of Reform UK was elected as the first Mayor. This marks a significant milestone in regional governance, establishing a new leadership role with devolved powers across Lincolnshire County Council, North Lincolnshire Council and North East Lincolnshire County Council. At the same time local elections took place, with significant changes in local authorities, including a move of Lincolnshire County Council to become a Reform UK-led council.

d) NHS England launched the Urgent and Emergency Care (UEC) Plan, which sets out a roadmap for rapid and sustained improvement, focusing on the changes that will make the biggest difference to patients and staff. The plan

emphasises a whole system approach to support UEC pressures and includes examples of best practice across the country. The plan also introduces ambitious targets to significantly improve services this winter, focusing on reducing hospital stays, improving patient flow and enhancing ambulance response times. Across Lincolnshire we are now working to develop plans, which include a number of high priority actions, to enable these to be tested and implemented prior to winter.

e) The Secretary of State for Health and NHS England Chief Executive have recently written to all provider and Integrated Care Board Chief Executives to reiterate the expectation, as outlined in the NHS Planning Guidance, that systems must reduce their agency spent by at least 30% within the next financial year. The Lincolnshire system is currently undertaking a review to understand the position in relation to the national workforce plan and to assess the implications for meeting this target.

f) NHS Lincolnshire ICB appointed Clair Raybould as their interim CEO from 18 June 2025, following the retirement of John Turner.

Group overview

a) At month 2, ULTH's YTD financial position is a £7.1deficit, in line with plan

b) LCHS's YTD financial position is a 1.0m deficit, £0.1m favourable to plan.

c) The ULTH CIP YTD has delivered savings of £5.3m, in line with plan. LCHS CIP YTD has delivered 0.7m, which is £0.2 favourable to plan.

d) On 1st April 2025, following information presented to the NHS Resolution Collaborate Advisory Group, ULTH received formal confirmation of achieving full compliance with year six of the Maternity Incentive Scheme (MIS). This demonstrates the significant work undertaken by the maternity and corporate teams and the Trust will be entitled to receive the full MIS rebate. The funds will be used to support maternity and neonatal safety whilst continuing to improve services.

e) The first phase of the Emergency Department at Pilgrim Hospital, Boston opened to patients on 7th May 2025, which marked a significant milestone in the provision of urgent and emergency care. The work has been completed following £21.3m funding announced during a visit by the then Prime Minister Boris Johnson in August 2019. Additional funding to complete the transformation will come from the Lincolnshire NHS System and the expected final cost will be approximately £45m. Work will now focus on transforming the existing department and to join both phases together in 2026.

f) Pilgrim Hospital, Boston has recently been awarded £23m in funding through the Public Sector Decarbonisation Scheme. This investment will be used to implement a series of energy infrastructure improvements aimed at reducing the hospital's dependence on fossil fuels and enhancing the resilience of its critical systems. The planned upgrades will contribute significantly to the hospital's sustainability goals and long-term operational efficiency. The scheme is being delivered by Salix on behalf of the Department for Energy Security and Net Zero.

g) The Full Business Case for the United Lincolnshire Teaching Hospitals Trust Electronic Patient Record programme received Cabinet approval in May 2025. With this milestone achieved, the Trust will enter the planning phase of the project in July, in preparation for implementation commencing in September 2025.

h) In January 2024 ULTH were invited to lead a pilot study into the prevalence of Obstructive Sleep Apnoea (OSA) in breast cancer patients across Lincolnshire, as part of the East Midlands Cancer Alliance. As part of the pilot, screening tools were integrated into the breast cancer pathway to identify patients at higher risk of OSA. The team were recently invited to present their findings at the House of Lords during an all-party parliamentary group on OSA. The team will continue with their work to ensure there are better outcomes for patients living with OSA.

i) On 14th May 2025 I attended the Education and Skills Garden Party at Buckingham palace, alongside Elaine Baylis our Chair, Claire Low our Chief People Officer and Claire Flavell our Talent Academy Strategic Lead and members of her team from the Lincolnshire Talent Academy. The invitation was in recognition of the academy's outstanding contribution in the field of education and skills development. Established in 2015, the Lincolnshire Talent Academy was created to bring together health and care organisations from across the county with a shared commitment to develop a strong, skilled and suitable workforce. Over the past 10 years the academy has engaged with over 137,000 young people, delivered more than 5,700 work experience placement and supported more than 1,000 colleagues into apprenticeships.

j) Throughout May and June 2025, a series of staff engagement roadshows have taken place across the Group involving the Group Leadership Team, providing colleagues with the opportunity to discuss the Group's values, vision and strategy. The key themes from the roadshows include culture, communication, inclusivity and group identity. These insights will inform the development of 'Our values in action' which is the behavioural framework to bring the group values to life. This framework will support a consistent and values led culture across all teams and services.

k) We continue to demonstrate the strength of collaborative working across the Lincolnshire health and care system to deliver person-centred integrated care. Lancaster Ward at Lincoln County Hospital was recently transformed to provide step-down intermediate, time limited care. Now operating as a community rehabilitation and reablement ward in an acute setting, Lancaster Ward supports patients in their recovery before they transition to the next stage of their care journey.

l) As part of Volunteers Week in June, the Group proudly celebrated and recognised the invaluable contributions of our dedicated volunteers. The Group currently has 329 volunteers who generously contributed 46,069 hours of their time over the last financial year to support our work. Their compassion, time, and commitment play a vital role in enhancing patient care and supporting staff.

m) The University of Lincoln recently received confirmation that following the GMC submission, Lincoln Medical School can progress to recruitment of students for two new medical courses. The school can now proceed with a Gateway Year course from September 2025 and the new five-year independent medical programme from September 2026. An introductory meeting took place with the GMC in mid-June and marks a critical milestone in the journey to train the next generation of doctors in Lincolnshire.

NHS
Lincolnshire Community and Hospitals NHS Group

Group Model Workstream Progress Briefing - June 2025

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*1 July 2025*
Item Number	*6.1*

Group Model Workstream Progress Briefing
June 2025

Accountable Director	*Professor Karen Dunderdale, Group Chief Executive*
Presented by	*Professor Karen Dunderdale, Group Chief Executive & Work Stream SROs*
Author(s)	*Professor Karen Dunderdale, Group Chief Executive* *Wendy Booth, Interim Governance Advisor*
Recommendations/ Decision Required	*The Group Board is asked to:* • *review progress with delivery of the group development programme plan* • *agree the need for any additional actions or assurances at this stage*

How the report supports the delivery of the LCHG strategic aims & objectives	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings	*X*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	*X*
2b: Empower our people to continuously improve and innovate	*X*
2c: Nurture compassionate and diverse leadership	*X*
2d: Recognising our people through thanks and celebration	*X*
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*X*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	*X*
3c: Enhance our digital, research & innovation capability	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	*X*

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, there has been continued good progress on delivery of the agreed programme milestones. In the main, slippage on agreed timescales remains as previously reported although slippage is being reported within the June 2025 update in respect of the agreement of some group strategies e.g. finance and estates & facilities due to interdependencies with other work streams or the need for staff engagement.

It should also be noted that additional actions have also been added to Work stream 8: Estates & Facilities, in respect of backlog maintenance and planned preventative maintenance.

Other issues for escalation:

- work to align the IPR and finalise the group KPIs remains outstanding;
- there is a need to agree improvement trajectories for bringing out of date policies into compliance;
- work to finalise and agree strengthened board committee and reporting group upward reports and report templates & associated guidance needs to be concluded as a priority. This work is underway and new draft templates will be shared with board members shortly.

Group Board Action Required:

The Group Board is asked to:

- review progress on delivery of the group development programme plan;
- agree the need for any additional actions or assurances at this stage.

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 issued for initial cohort but outstanding for recent substantive appointments. Where roles remain interim, substantive appointments to be made over the period March – August 2025. Testing of FPPT compliance within 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. Schedule recently 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)** **30 June 2025 (embedded)**	Operating model socialised through the re-launched Group Leadership Team (GLT) and implementation plan developed Final operating model approved by the board in May 2025 and being embedded	
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 and embed the new operating model and leadership structure, Performance Management & Accountability Framework and associated governance arrangements	1 April 2025 **(implementation)** 30 June 2025 **(embedded)**	As above. PRMs are now in their sixth cycle and are scored as per the Performance Management & Accountability Framework.	
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 complete – Comms cascade has been completed through GLT roadshows. Comms in respect of the Alliance will be issued shortly	

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 Performance Management & Accountability 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 – now in sixth cycle Performance Management & Accountability Framework drafted (including a clear process and ratings for escalation / intervention) and approved by GLT on Friday, 4 April 2025 and the Group Board on Tuesday, 6 May 2025 Aligned IPR and KPIs / metrics for 2025 / 26 remain outstanding	
Review the BI resource across the group to ensure this remains effective in support of the Performance Management & Accountability 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)** 30 April 2025 **(approval of structure)**	Director of Digital in post from 1 April 2025. Director of Performance Intelligence to go out to advert imminently. New performance information system now developed and being deployed (RACH). Next step is to deploy RACH to support PRMs and the IPR for board	

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. Terms of Reference for Well Led Assessment drafted and assessment commenced	
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)**	**Complete:** Board business cycle for 2025/26 approved by Group Board 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 refreshed to reflect the new group strategic aims & objectives and approved by the Group Board in May 2025 (together with the 'Assurance Map', 'Board & Board Committee Principles Framework) 'Assurance ratings within the BAF have been reviewed and wording updated. Assurance ratings used within reports to the board and board committees being aligned as part of the strengthening of the board & board committee templates Review of reporting sub-groups is almost complete	
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)**	**Complete:** 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 the need for embedding of all joint board committees	
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)	**Complete:** 'Board & committee principles framework' drafted and approved by the Group Board in May 2025	
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 template being strengthened to ensure consistency of approach and to ensure it supports and prompts 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 template also being strengthened. Report writing guidance drafted and report front sheet amended. Slippage due to alignment of this work with the board development programme and the session held on 3 June 2025 on board reporting and assurance	

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 NHSE approval also received for the appointment of an additional NED who is now in post. Additional NED is 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	
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	**Complete & ongoing:** Board Development sessions being undertaken with NHS Providers support Formal programme for 2025/26 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) Programme shared with the Group Board in May 2025	
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, which is being undertaken by NHS Providers, commenced in June 2025 and is expected to last 3 months	

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 complete – final iteration submitted to ELT on Thursday, 6 June 2025. Final amendments to be made and structure to be socialised through GLT	
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 are finalised	

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)**	**Complete:** Strategic aims & objectives for 2025/26, a revised BAF format and BAF review cycle agreed by the Group Board. BAF is now operating in new format through board committees and Group Board. Work to further refine the BAF will continue over the coming months Underpinning risks on the ULTH and LCHS risk registers have been aligned to the relevant strategic risks within the BAF. Very high and high risks were included within the BAF initially but all underpinning risks to be included from June 2025 onwards	
Agree the group risk appetite and ensure this is appropriately referenced within the BAF for each strategic objective	18 March 2025 **(Group Board workshop)**	**Complete:** Group risk appetite agreed by the Group Board and incorporated within the BAF	
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 considered to be a consistent approach to risk management across the group, however, scope being drafted for NHS Provider to review & test the approach. Routine testing of the effectiveness of these arrangements will continue to be undertaken as part of the annual internal audit review of risk management which informs the Annual Governance Statement and as part of the planned Well Led Assessment Risk Register – Confirm & Challenge Group terms of reference and membership refreshed to ensure executive input	
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	**Complete:** 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 **(policy in place)** 31 June 2025 **(embedded)**	A combined document control policy and process is in place although is not yet fully embedded. A recent internal audit of these arrangements recognised that the group is still in transition. The move to a single Intranet will enable policies to be in retained in one place. Some historical backlogs remain – improvement trajectories to be agreed for bringing out of date policies back into compliance	
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 • Performance Management & 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	25 July 2025 **(Audit Committee)** 2 September 2025 **(Group Board approval)**	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 Division of Responsibilities Schedule drafted and shared with Group Chair & Group Chief Executive. Schedule to be appended to Standing Orders and approved by the Group Board A joint Fit & Proper Persons Policy is in place for the group but will need to be refreshed to ensure alignment with the newly published Board Member Appraisal Framework Performance Management & Accountability Framework drafted and approved by GLT on 4 April 2025 and by the Group Board on 6 May 2025 Final amendments to the Standing Orders, Standing Financial Instructions and Scheme of Delegation cannot be undertaken until other work stream actions are complete	
Review and update relevant policies, documentation and templates to reflect the move to group and the group brand	As above	As above	

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	2 September 2025	This action cannot be completed until other work stream actions are complete	
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	2 September 2025	As above	
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	2 September 2025	As above	

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	1 July 2025	Strategy drafted and currently being reviewed. Group Board approval scheduled for 1 July 2025	
Develop the Group visual ID / brand ensuring adherence to the NHS Identity Guidelines specifically in respect of partnership branding	21 April 2025	**Complete:** Group visual ID / brand approved and rolled-out on 21 April 2025	
Develop guidelines and supporting suite of templates for the use of the Group visual ID / brand (how and when it should be used including in respect of signage, document design, correspondence etc.)	As above	**Complete:** Guidelines and templates developed and implemented	
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 March 2025	Confirmation received from relevant social media platforms that due to Meta rules this proposal is not feasible. Action to be closed and removed from the plan	N/A
Merge the staff closed Facebook group	28 February 2025 **(consideration by GLT)** 8 April 2025 **(enacted)**	**Complete:** Proposal considered by GLT in February 2025 and agreed that the Facebook group would not be merged but that each organisation's page could be viewed by staff from the other. This has now been enacted	
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)**	**Complete:** Communication channels have been merged – 'Group Bulletin' was the final one and become one newsletter on 23 April 2025	
Develop and implement a communication & engagement toolkit aimed at ensuring wider awareness of service changes & developments across the group	31 March 2025	**Complete:** Toolkit developed in conjunction with the Patient Experience Team. Communication & Engagement Team working with the Improvement & Integration Team to embed the toolkit in to use as part of the service change process	
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	**Complete:** Ongoing process is BAU as part of consultation and included in new group policy	
Develop a package of individual support for staff who will be affected by the change of the move to group	Ongoing	**Complete:** range of options in place including a team-wide and individual offering together with an e-learning programme. A 3rd tier is ready to launch to support managers to lead during change from both a process and behavioural perspective	
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	Priority policies have been harmonised and formally ratified. The only remaining contractual policy awaiting ratification is the Managing Attendance Policy which is due to be discussed with the Staff Side on 25 June 2025. The next cohort of policies to be reviewed and harmonised relate to leave	
Harmonise T&Cs – *linked to policy work*	As above	**Complete:** Harmonised Change Management Policy for the group approved	
Harmonise Reward & Recognition including the development of a group Reward & Recognition Policy	31 December 2024	**Complete:** Arrangements harmonised and policy developed and approved. Comms issued June 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 30 June 2025	**Complete:** group face to face and video inductions in place. Following staff feedback, joint virtual induction option to be launched in June 2025. Alternative induction venues also being explored across the county	
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)**	**Complete:** Ongoing & monitored through Workforce Strategy Group	
Ensure portability of staff for cross-site working	1 November 2024 **(interim solution)** 1 April 2025 **(long term solution)**	**Complete:** Staff in both Trusts can access vacancies across the group now, with a link provided on the respective intranet sites and the recruitment teams at each Trust are working in partnership to facilitate transfers across the group	

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	**Complete & Ongoing:** Engagement 'Tube Map' and Change Workshops in place & ongoing **(Appendix C refers).** Additional staff / GLT engagement roadshows held during May & June 2025	
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 'LCHG Way' which includes leadership development	
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)**	**Complete:** New group values – Compassionate, Collaborative and Innovative – approved by the Group Board and implemented w/c 14 April 2025. Underpinning behavioural framework for each value ('Our Values in Action') currently in development with staff as part of staff / GLT roadshows	
Continue to develop the staff health & well-being offer across the group including the introduction of menopause support	31 May 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 to determine what funding can be identified to offer the service across the group. This will be resolved as part of the People Directorate restructure	

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	Strategy considered by the Integration Committee in June 2025 and due to be approved by the Group Board on 1 July 2025	
• 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)** 30 June 2025 **(Group Intranet)**	Mapping complete and plan developed. • EDMS initiation in progress • LCHS Datix moved to cloud and linked to NHS net login. ULTH already in cloud and moving to NHS net login • Group Intranet remains on track for deadline • Other systems continue to be aligned, where possible. Some limitations due to existing contracts and sovereignty requirements e.g. finance, ESR	
• move to a single Microsoft 365 teams platform with the migration of ULTH to the national tenancy	31 March 2025	**Complete & ongoing** – work continues to optimise and standardise processes	
• move to a single domain / directory login process	31 March 2025 **(Implementation Plan)** 31 October 2025 **(Full Implementation)**	Underway – part of expanded AGEM service transition to LCHG • Phase 1 due to handover to LCHG June 2025 • Work underway to plan next steps as part of AGEM contract transition to LCHG	
• 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 • Procurement contract team has been formed and LCHG project manager assigned	

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 – based on expanded scope. Some risk based on increased complexity • New governance arrangements introduced, ICB CDIO leading programme board • Some risk around delivery of technical elements (AGEM delivery) – work underway to agree mitigating actions • TUPE / due diligence process underway. Group Deputy Director of People supporting process • Review of plan underway	
• create a common identity for the Digital Team (linked to the group brand & associated actions)	31 October 2025 (due to merger of LCHS and GPIT teams)	Full system digital alignment plan in place and underway	
• 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 Performance Management & Accountability Framework and the accurate, effective and timely reporting on performance	31 March 2025 30 April 2025 **(agreement of structure)**	Director of Digital in post from 1 April 2025. Director of Performance Intelligence to go out to advert imminently.. New performance information system developed and being deployed (RACH)	
• move to aligned telecoms	30 May 2026 **(Secured single contract for Telephony Services)**	Underway: • Single team lead in place, new group contract in place for 12 months • Plan to move LCHS to current ULTH system to deliver saving • Procurement of required group level services planned during 2025/26 into 2026/7 • Finalisation of roles as part of integration of LCHS and ULTH digital teams being planned as part of structure	
• data hosting	31 October 2025	Underway – on track: • As at the end of June 2025, all but 6 of the 101 servers have been migrated. Remaining systems remain outstanding due to significant technical difficulties and third party dependency. LCHG teams continue to work with AGEM. Whilst this does not pose a risk to transition a plan is being developed	

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)**	Underway although completion dependent on finalisation of the clinical service strategy and also likely to be impacted by the decision on the future model for the provision of EFM services – *see next action. Approval not expected until 31 March 2026*	
• 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	30 September 2025	Assessment of options undertaken and currently being evaluated. Further guidance awaited from NHSE on legal requirements in respect of wholly owned subsidiary option. Date for approval of agreed option to be confirmed	
• 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. This work to be undertaken in line with "left shift" proposals	30 June 2025	Underway. External support to undertake the review being sourced at an estimated cost of £22.5k. Procurement process commenced. 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 – although some difficulties have been experienced in obtaining information on leases and licences under the previous shared service arrangements. Dialogue now underway with relevant landlords	
• 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 2024/25 EFM transformation projects and EFM improvement plans	31 March 2025	**Complete:** Plan and projects delivered for 2024/25. Plan in development for 2025/26	

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 August 2025	Deferred further to August 2025 due to lack of HR capacity to support the process. Also likely to be impacted by the decision on the future model for the provision of EFM services Some gaps in the senior management team currently which is a risk	
Equality & Inclusion			
Continue to promote equality & inclusion and reduce workforce inequalities within EFM:	30 September 2025	Linked to future model for the provision of EFM services	
• develop a single approach to the movement of EFM staff across the group	30 September 2025	As above	
• commission a cultural review of estates services and continue to deliver the improvement actions identified in the facilities services cultural review	30 September 2025	As above	
• align and improve the processes for staff development, on boarding etc. across EFM	30 September 2025	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 – EFM Head of Compliance recruited. Also linked to future EFM model. Full group PPM audit – specification developed and company being sourced to undertake work	
• 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 8: Estates & Facilities (cont'd) – new actions added since April 2025

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
EFM Digital Strategy			
Review the EFM service functions on a service-by-service basis, identify all opportunities to digitalise the process to improve reliability and productivity	30 September 2025	Ongoing – each service to develop a digital strategy project plan – linked future EFM model	
Backlog Maintenance			
Continue to review the findings of the six-facet survey and identify critical estate infrastructure risks (CIR) across the group	Ongoing	Ongoing	
• using the results of the six-facet survey prioritise the high & significant CIR risks and submit funding bid to the ICB	31 March 2026	£7.1m ICB monies received. £2.9m allocated internally. Funding being used to address priority areas: fire alarm and HV system at Pilgrim Hospital.	
• ensure CIR risks are addressed in respect of any new developments across the sites	Ongoing	Capital design team to ensure backlog maintenance items are included as part of the brief in any new build capital developments	
• provide regular backlog maintenance progress reports to the Finance & Performance Committee and Capital & Revenue Investment Group	Ongoing	In place and ongoing	
• ensure all CIR risks are recorded on the trusts' risk registers	30 September 2025	Ongoing	
Group Asset Register & Planned Preventative Maintenance (PPM) Review			
Review the group assets and ensure a comprehensive and accurate asset register is created	31 March 2026	Brief & scope of work presently being developed (estimated costs c£150k)	
• ensure all assets are barcoded and linked to an industry standard maintenance management system	31 March 2026	Review use of SFG20 (maintenance worksheet system) – estimated cost c£30k	
• carry out a review of PPM across the group to improve compliance and productivity	31 March 2026	External audit support required	

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	**Complete:** Strategic aims & objectives finalised. Further work undertaken through the board development session on 1 April 2025 on finalising the programme and projects required to deliver the strategy. Final strategy approved by the Group Board in May 2025	
Harmonise the underpinning strategies e.g. clinical, quality, people, digital etc.	30 June 2025	In progress – 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	**Complete:** Operational & financial plan developed, approved & submitted. Final triangulated plan expected by 30 April 2025	
Develop transformation and improvement programmes to facilitate the delivery of the strategy	31 March 2025	**Complete:** new Productivity & Transformation Framework developed and approved by GLT on Friday, 4 April 2024. Productivity, Improvement & Transformation Group set up and reporting to GLT but with reporting from an assurance perspective to the Finance Committee (Productivity) and the Integration Committee (Improvement). Care Groups outlined their key transformation & improvement programmes at GLT on Friday, 4 April 2024. Work complete to allocate resources from the strategy, improvement and design teams to support the Care Groups to work up and deliver their programmes	
Develop a common Project Management Office (PMO) approach to enable accurate reporting aligned to the new governance arrangements across the group	31 March 2025	**Complete:** PMO approach in place	

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 Group Quality Improvement (QI) strategy and commence implementation of the Quality Management System (QMS) as a key enabler to delivery of our productivity and transformation programme. QI strategy to focus on culture/shared purpose/leadership behaviours and a dosing model for building improvement capacity	31 March 2025 (QI Strategy) 31 October 2025 (QMS)	QI approved by Integration Committee and GLT.. QMS being developed	
Develop a proposal for primary, community and acute care collaboration (Alliance Model) and a spectrum of integration	31 March 2025 31 August 2025 (Phase 2)	Alliance Model and programme confirmed and approved via Integration Committee. Communications plan in development for internal awareness. Approach to external stakeholder engagement and attendance at new Alliance Steering Group to be agreed. Proposed timescale for next phase of work – 31 August 2025	
Develop a Partnership Strategy for the group	31 May 2025 30 June 2025	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. Proposed revised timescale – 30 June 2025	
Support development of the Group Sustainability & Green Plan - Phase 1	31 March 2025 (Phase 1) 1 July 2025 (board approval)	Phase 1 - Refreshed Green Plans drafted using the national template and are scheduled for review by the Integration Committee in June 2025 and approval by the Group Board on 1 July 2025 Work remains ongoing with the ICB to support the system sustainability agenda. The sustainability agenda is being embedded in the new LCHG strategy and the SRO for the programme is the Group Director of Estates & Facilities	
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	

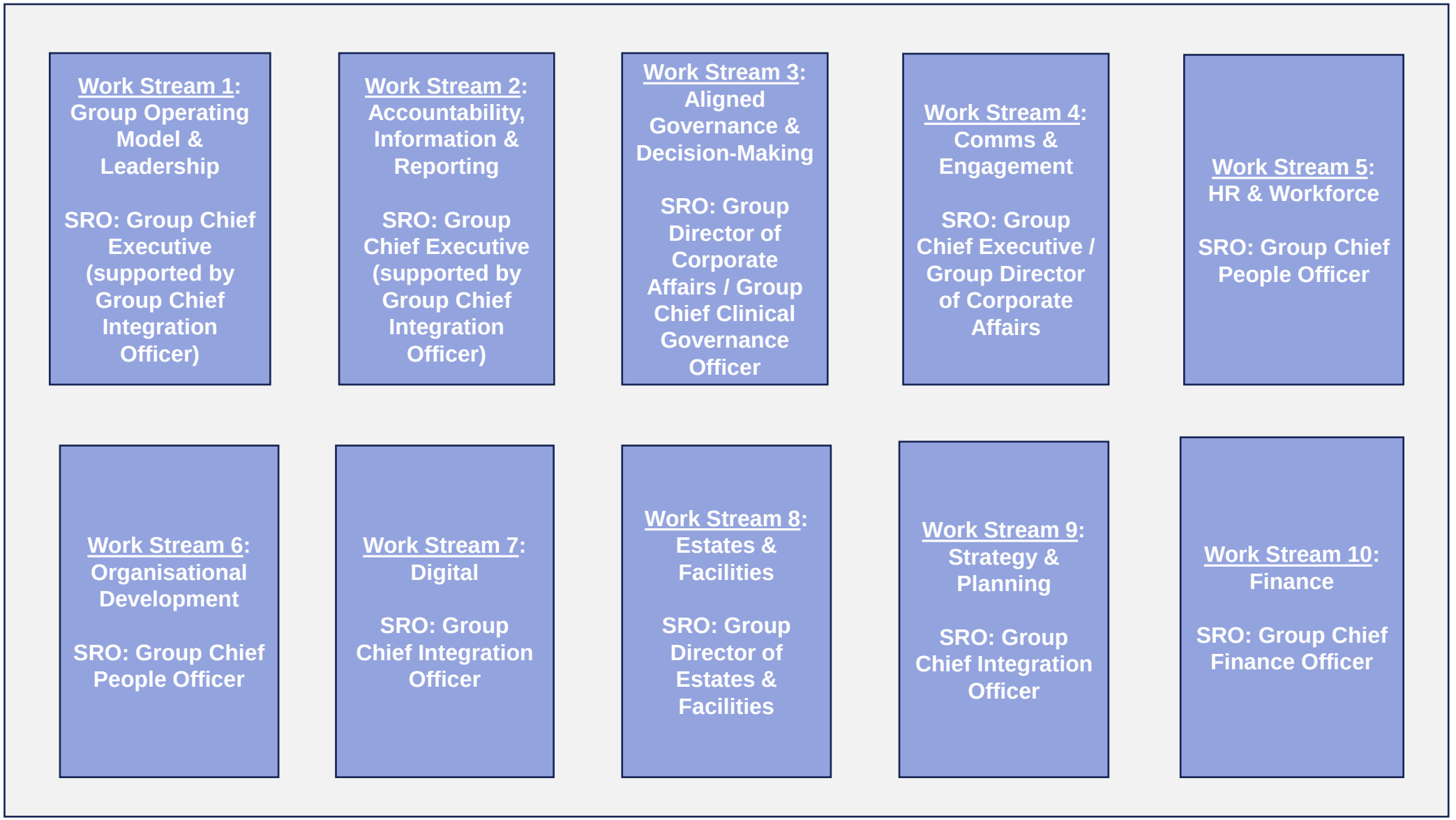
Work Stream 10: Finance

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)**	Proposal to delay timescale to allow increased engagement. Finance away day planned for 26 June 2025. Draft to be developed in July 2025 with engagement with care groups and committees and approval in October 2025	
Harmonise the financial planning & budget setting processes across the group	31 January 2025	Planning assumptions and budget setting processes aligned but need embedding. Budget setting complete for 2025/26	
• produce and roll-out a revised budget holder manual	28 February 2025	Single budget holder manual developed and published	
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)**	Operational & financial plan developed, approved and submitted	
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	Financial reporting is now consistent across the group. Work to further strengthen information dashboard is ongoing Bottom up review of budgets complete	
Harmonise the business case development, review and approval process ensuring a consistent approach and methodology	31 July 2025	Underway. Capital, Revenue & Investment Group (CRIG) being reviewed and strengthened	
As part 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	Performance Management & Accountability Framework approved Aligned IPR and final KPIs / metrics for 2025 / 26 still being worked up Consistent approach adopted to PRMs from January 2025. Oversight of delivery of agreed financial priorities and improvements will be undertaken through the new Productivity, Improvement & Transformation Group	

Work Stream 10: Finance

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
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	25 July 2025 **(Audit Committee)** 2 September 2025 **(Group Board approval)**	Underway with corporate governance team: this action cannot be completed until other work stream actions are complete	
Harmonise the financial policies and processes across the group	31 December 2025	Underway – on track. Current financial policies all up to date. Mapping exercise to be undertake to identify those still to be aligned and to agree timescales. Oversees Visitors & Private Patients policy aligned and approved	
Align the Internal Audit arrangements	31 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	30 June 2025	Underway – on track. First finance roadshow training event held in February 2025. Budget holder refresher training held during February & March 2025. Training available on learning module	

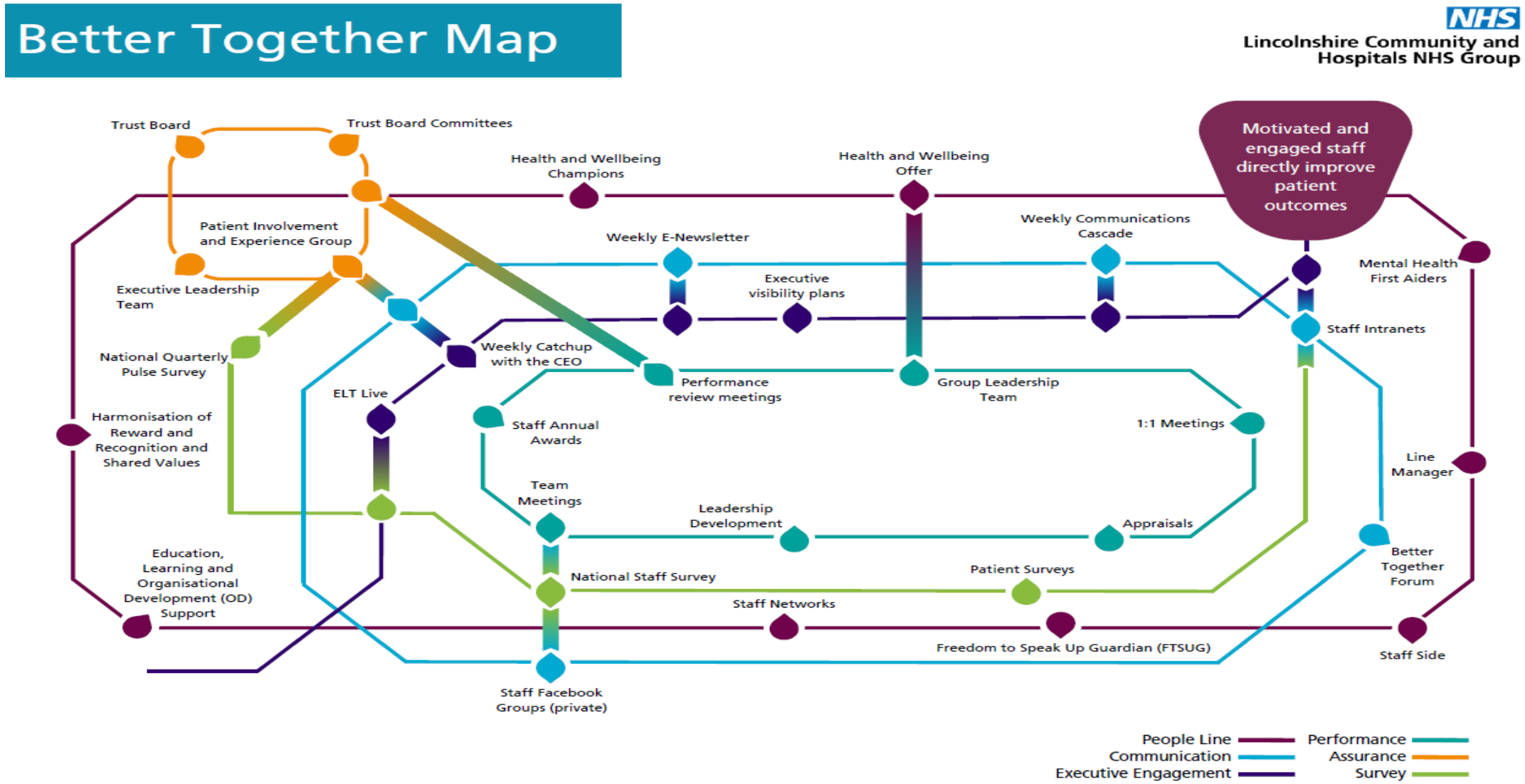
Appendix A: Group Development Programme: Work Streams & SROs



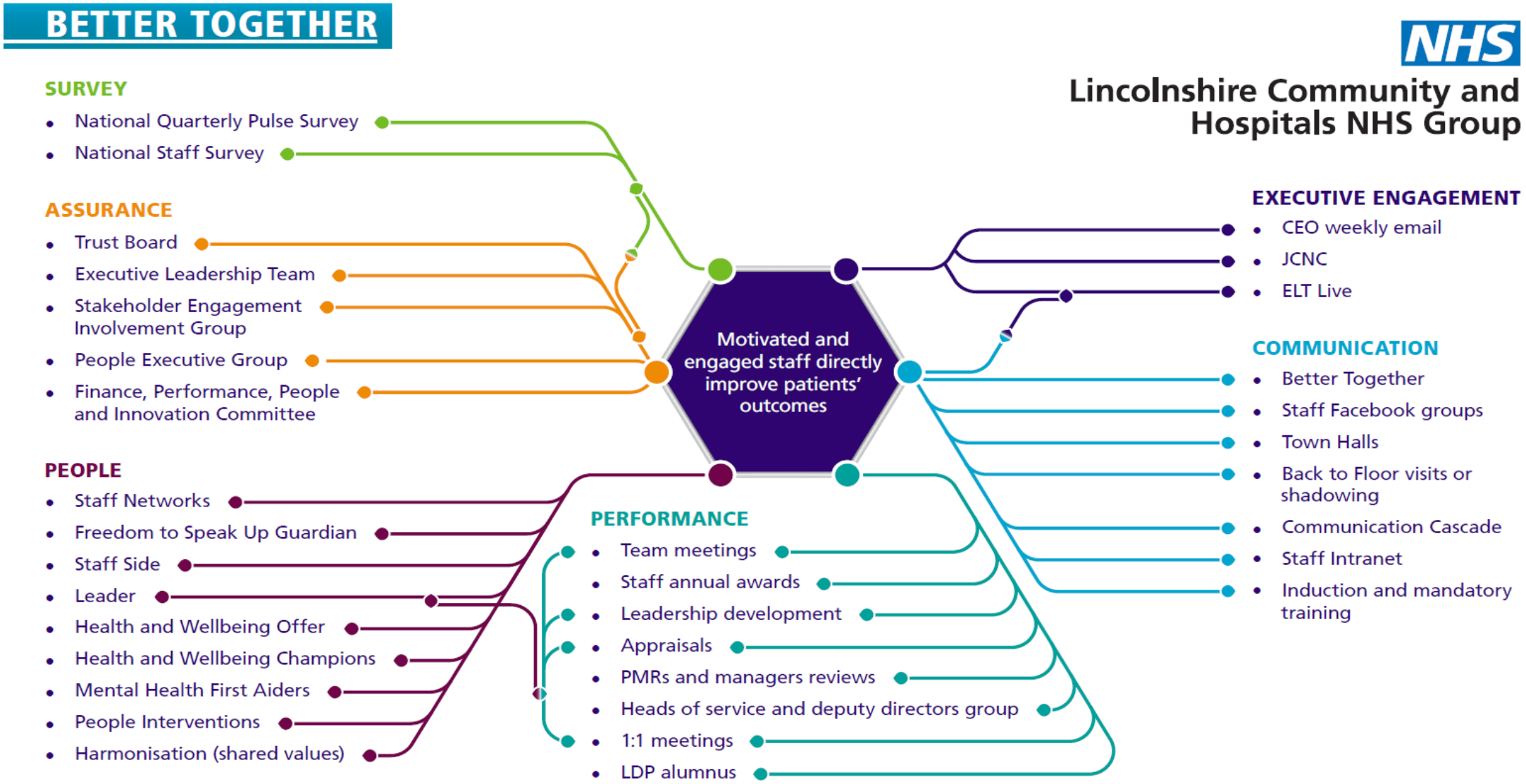
Appendix B: Group Development Programme Delivery RAG Rating

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

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	*1 July 2025*
Item Number	*8.1*

Quality Committee Upward Report of the meeting held on 20 May 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 2025/26 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 – Improve patient safety, patient experience and deliver clinically effective care

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
- High Profile Cases Report
- Children and Young People Oversight Group Upward Report inc ToR and Paediatric Cardiology update
- Update on Pressure Ulcers
- Focussed Discussion – End of Life Care
- Patient Experience and Involvement Group Upward Report
- Safeguarding and Vulnerabilities Oversight Group Upward Report
- Clinical Effectiveness Upward Report

- Antibiotic Usage

The Committee was pleased to note that Central Alert System (CAS) position with 1 open CAS alert and a reduction achieved in Field Safety Notices (FSNs) and no escalation offered from the group. The Q4 safety triangulation report indicated that treatment delays, communication, deteriorating patients and pressure ulcers were continued themes that the Committee was sighted on.

The IPC report was received, and the fundamentals of practice had been identified as areas for improvement through the NHS England and Integrated Care Board (ICB) visits with actions being taken to address concerns.

The Children and Young People Oversight Group provided significant updates on areas of risk including paediatric cardiology, audiology, ENT and diabetes services with the Committee recognising the fragility of some of these services with mitigations in place. It was noted that whilst there were ongoing performance issues in a number of areas this was not resulting in serious harm to patients. The Committee noted the need to ensure reporting extended to community services to provide full oversight.

The update in respect of Pressure Ulcers identified the ongoing actions being taken to improve the position within LCHS with a focus on education and training for staff with the initiation of an assurance programme supporting the improvements. Progress was also noted in respect of ULTH in pressure ulcer performance with a further update requested by the Committee in 6-months.

The Committee requested a focused discussion on End-of-Life care fowling receipt of a number of patient and staff stories which had highlighted poor experiences. The focussed discussion held by the Committee demonstrated the significant work being undertaken. This work has the potential to improve the experience across the system pathway. Development of a high-level dashboard for end-of-life care would support the understanding of service delivery.

The upward report from the Patient Experience and Involvement Group identified the significant number of hours offered by volunteers across the Group with 328 volunteers providing support. The Committee recognised the need for the People Committee to be sighted on this area of the workforce due to the significant contribution being made.

The Committee was delighted to note the improvement in looked after children however recognised the ongoing fragility of the service and the impact of this noting the ongoing work to address and resolve the position.

The Clinical Effectiveness Group upward report highlighted concern around the governance arrangements in respect of Get It Right First Time (GIRFT) however ongoing discussions were taking place to ensure this was strengthened.

Both Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) remained within expected levels for ULTH.

The antibiotic usage update offered the Committee oversight as to the current position with a recognition of the need to address the culture and ownership of this across the Group. The plan on the page was noted and supported by the Committee in order to support actions being put in place to address ULTH being an outlier nationally. In order to gain assurance that the actions were addressing the areas of concern the Committee would receive an update in 6-months.

Assurance in respect of other areas

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

- Draft Quality Accounts, LCHS and ULTH
- Group Board Assurance Framework 2025/26
- Risk Report
- Policy Position Update
- Committee Performance Dashboard
- LCHG Q4 QIA Assurance Report and LCHS Impact Assessment, Policy and QIA Template
- Terms of Reference and Work Programme

The Committee received and noted the development of the draft Quality Accounts for both LCHS and ULTH which had been aligned to the Group Strategic Objectives with the Committee offering comment on the draft documents prior to the final documents being offered for approval at the June Committee.

The Committee noted the continued development of the 2025/26 Board Assurance Framework with the revised format and alignment to the Group strategic aims and objectives. Following the concerns about the ability to rate the single objective the Committee noted that this had now been split into the 3 areas allowing great oversight of assurance.

The Committee received and noted the risk register noting the work recognising the ongoing work that was being undertaken to review and refocus risks appropriately to each of the Board Committees.

The QIA assurance reports were noted with the Committee acknowledging that assurance processes were in place and functioning. The Group QIA policy and template was approved by the Committee.

The policy position update highlighted the need for full population of the RAG ratings against the overdue policy documents presented to the Committee which was expected to be received by the Committee in June.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

The Committee referred to the People Committee the volunteer workforce to ensure that the Group was sighted on this area of the workforce and the contribution being made.

Attendance Summary for rolling 12-month period

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

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	*1 July 2025*
Item Number	*8.1*

Quality Committee Upward Report of the meeting held on 17 June 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 2025/26 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 – Improve patient safety, patient experience and deliver clinically effective care

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
- Clinical Effectiveness Upward Report
- Patient Safety Group (PSG) Upward Report
- High Profile Cases Report
- Maternity and Neonatal Oversight Group Upward Report
- Children and Young People Oversight Group Upward Report

The Committee noted the approach taken to the Patient Experience and Involvement Group, which had seen a governance light approach due to the meeting running a

communications workshop, with the outcome due to be presented to the Committee in July and informing the communications plan which was the largest factor of patient feedback.

The establishment of the patient panel in LCHS would result in the working across the Group and would support improvement in patient experience.

Moderate assurance was offered for the clinical audits received by the Clinical Effectiveness Group with relevant actions being monitored through the group. The Trust was identified as an outlier in the Laparoscopic audit with the Committee reassure that case note review will take place. Once completed, further information, if required would be offered to the Committee.

Completion of the mortuary refurbishment was noted with ongoing work to finalise the recommendations in the Fuller report.

Both Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) remained within expected levels for ULTH.

The Patient Safety Group report was received for assurance with recognition of clinical delays resulting in harm and the ongoing actions being taken in respect the MRSA cases within maternity services and improvement in the use of vascular device management.

The Committee received and noted the report offered in respect of visits across the Group to wards, departments and teams to support staff and patient engagement. The visits would be triangulated with other data sources and support for these visits would include Non-Executive Directors. The proposed approach was endorsed by the Committee.

The terms of reference for the Patient Safety Group were received and approved by the Committee.

The Committee received the Maternity and Neonatal Oversight Group Upward Report and associated appendices required in respect of the Clinical Negligence Scheme for Trusts (CNST) Maternity. The full suite of reports have been made available to the Board via the iBabs reading room.

The Board is asked to note the following CNST updates offered from the group and the associated appendices provided:

- CNST Standard 1- PMRT: Note receipt of Q4 PMRT report which includes details of the deaths reviewed **from 1 December 2024**, any themes identified and the consequent action plans, available in **Appendix 1.5**. This demonstrates that the PMRT has been used to review eligible perinatal deaths and that the required standards have been met. Group Board are required to receive this quarterly report outlining the above details.

- CNST Standard 3- ATAIN: Note update relating to continuation of the Quality Improvement Project 'Midwives as second checkers for neonatal IV antibiotics.'

- CNST Standard 4- Clinical Workforce:

    - For upward reporting and formal recording in Group Board minutes, please note the Neonatal medical workforce is staffed to BAPM recommendations.

    - For upward reporting and formal recording in Group Board minutes, please note that the neonatal unit does not meet the BAPM national standards of nursing staffing. The Group Board have received and approved previously an action plan for improvement. This relates specifically to the number of Qualified in Speciality (QIS) staff. Full detail is available within **Appendix 1.13**. Progress for upward reporting and formal recording in Group Board minutes is as follows:

        - QIS training opportunities have been maximised resulting in progress being made towards the 70% target.
        - Boston are now reporting 73.2% compliance, with Lincoln reporting 59.2% compliance with QIS.
        - The trajectory to achieve 70% target at both sites is set at January 2027

- CNST Standard 5- Midwifery Workforce:

    - For upward reporting and formal recording in Group Board minutes, please note the receipt of the midwifery staffing oversight report, available in **Appendix 1.11**.

    - This report, produced every 6 months, for upward reporting and for recording in Group Board minutes demonstrates:

        - Funded establishment is not compliant with outcomes of BirthRate+ or equivalent calculations. There is currently a deficit of 12.10wte staff. This shortfall is primarily due to the need for a 24/7 triage service which is not fully implemented.
        - The plan in response to this has been to uplift the workforce by 5.25wte midwives and 5.25 B3 support workers, thus mitigating the shortfall. This is above the current funded establishment.
        - The business case to close the deficit of 12.10wte staff is under review of substantive establishment processes. Any delays in progressing this plan for substantive staffing puts at risk the Trust's compliance with CNST year 7.
          (For more detail, please refer to the report in **Appendix 1.11**).

- CNST Standard 6- Saving Babies Lives Care Bundle: Note progress to achieve compliance with all six elements of SBLCB v3.1 as outlined in **Appendix 1**.

- CNST Standard 7- MNVP: Note the potential risk relating to the MNVP infrastructure. Owing to increased ask of MNVP lead attending ULTH meetings as a quorate member, review of MNVP infrastructure/funding required to identify if it still aligns with the national MNVP guidance. For formal escalation if required via PQSM to MNOG and LMNS Board. **Appendix 1.3**.

- CNST Standard 8- Training: Note receipt of the NLS Instructor mitigation paper and progress made from Year 6 CNST MIS in **Appendix 1.3** and the TDA mandatory training mitigation paper also available in **Appendix 1.3**.

- CNST Standard 9- Floor to Board:
    - Note, as evidenced via the PQSM document and through close working as part of the Maternity and Neonatal Oversight Group, that a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC).
    - For upward reporting and formal recording in the Group Board minutes, as evidenced via the PQSM document, that Board Safety Champion(s) are meeting with the perinatal leadership team bi-monthly during the Maternity and Neonatal Oversight Group (MNOG). This is evidenced also through this meeting's MNOG meeting minutes.
    - Note the receipt and review of the Trust claims scorecard, available at **Appendix 1.9** alongside a review of incident and complaint data with Maternity, Neonatal and Trust Board level Safety Champions at Trust level (Board Sub Committee Group level) meeting, as recorded in the Maternity and Neonatal Safety Assurance report.
    - Record in Group Board minutes progress with the Staff Experience Group (maternity and neonatal culture plan, available in **Appendix 1.17**).

- CNST Standard 10- MNSI:
    - For upward reporting and formal inclusion within Group Board Minutes:
        - Patient event numbers for CNST MIS Year 7 was provided: there have currently been 2 cases that qualify for MNSI and 0 that qualify for Early Notification.
        - There is currently 100% compliance with Duty of Candour in both verbal and written formats, including EN and MNSI information in accessible format in the patient's own language.

The paediatric epilepsy risk was noted as remaining very high with the service continuing to be fragile however the Committee was assured of the plans in place. Work was noted to remain ongoing in respect of paediatric cardiology with a recognition that some harm was being caused as a result of delays.

The progress for looked after children in respect of initial health assessments was noted with 85-87% being completed within 20 days which was a significant improvement from the end of the previous year. The Committee would continue to monitor the position.

Assurance in respect of other areas

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

- Group Board Assurance Framework 2025/26
- Risk Report
- Policy Position Update
- Committee Performance Dashboard
- Quality Account – LCHS/ULTH
- Terms of Reference and Work Programme

The 2025/26 Board Assurance Framework was received with the Committee noting the embedding of the update process and recognition of the assurance ratings which were confirmed to remain amber.

The Committee received and noted the risk register and noted the whole risk register deep dive that had been undertaken across both the LCHS and ULTH registers to consider the realignment of risk based on the new strategic objectives. Recommendations were being made regarding the alignment of risk which would be offered to each Committee prior to the process being concluded.

The policy position was noted with the Committee pleased to receive RAG ratings and position updates for all overdue policy and guideline documents relevant to the Committee. Ongoing work was recognised in respect of these being addressed.

The Committee received and recommended to the Board for approval the Quality Accounts for both LCHS and ULTH.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

No referrals required.

Attendance Summary for rolling 12-month period

Voting Members	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**
Jim Connolly Non-Executive Director (Chair)	X	A	X	X	X	X	X	X	X	X	X	X
Chris Gibson Non-Executive Director	A											
Karen Dunderdale Executive Director of Nursing, ULHT/LCHS												
Colin Farquharson Medical Director, ULHT	X	X	X	X	D	A	A	X	D	D	X	X
Rebecca Brown, Non-Executive Director (Maternity Safety Champion), ULHT/LCHS	X	X	X	X	A	X	X	X	X	X	X	A

Gail Shadlock, Non-Executive Director, LCHS	X	X	X	X								
Julie Frake-Harris, Chief Operating Officer, ULHT/LCHS	D											
Anne-Louise Schokker, Medical Director, LCHS	X											
Nerea Odongo, Group Chief Nurse	X	X	X	D	X	X	A	D	X	X	X	X
Caroline Landon, Group Chief Operating Officer		X	X	X	X	A	X	X	X	X	A	D
Daren Fradgley, Group Chief Integration Officer		X	X	X	D	A	X	X	D	X	A	X

X in attendance
A apologies given
D deputy attended

NHS
United Lincolnshire Teaching Hospitals
NHS Trust

Perinatal Assurance Report

Emma Upjohn
Director of Midwifery

V1.0
May 2025

CQC rating: Good

Caring and building a healthier future for all

Contents

Executive summary

In line with the Lincolnshire Community and Hospitals NHS Group (LCHG) values of Collaboration, Compassion and Innovation, and, as part of our commitment to provide safer and more personalised maternal and neonatal care supporting the national maternity ambition, this report demonstrates progress on maternity and neonatal transformation work, regulatory and professional requirements and national agendas.

This includes, but is not limited to the Perinatal Quality Surveillance Model (PQSM), Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), Saving Babies Lives care Bundle (SBLCB), the Three Year Delivery Plan and the Regional Maternity Heat Map.

ULTH progress is reported through the bi-monthly Maternity and Neonatal Oversight Group (MNOG) meeting. Output following review and discussion at MNOG is reported directly into Quality Committee (QC), a sub-board committee with delegated authority for maternity and neonatal oversight, ensuring that in-depth examination of data, reports, and practices provide the Board with a clear understanding of the performance on quality and safety, including any immediate priorities or exceptions. MNOG is chaired by the Director of Nursing, who, is also the Executive sponsor and Trust Board Maternity Safety Champion. The Non-Executive Director (NED) Maternity Safety Champion also attends this meeting.

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

2: National drivers

2.2 Perinatal Quality Surveillance Model (PQSM)

Appendix 1.1

The PQSM supports Trusts and ICB's to discharge their duties, while providing a safety net for any emerging concerns, trends or issues that are not quickly identified and addressed. ULTH perinatal services, in collaboration with the ICB, have adapted the PQSM into a local document to demonstrate:

- implementation of, and progress with, the model since release of the NHSE paper in 2020
- the process for Trust-level oversight within ULTH, including compliance with CNST MIS Safety Action 9
- the roles and responsibilities of the board level safety champions and maternity safety champions
- the integration of perinatal clinical quality into existing LMNS/ICS structures, including compliance with CNST MIS

Minimum data measure for Trust Board overview	Location of information within Perinatal Assurance Report	Additional papers within agenda	Links to National/Local drivers
Findings of review of all perinatal deaths using the real time data monitoring tool	• Maternity and Neonatal Dashboards • Learning lessons • CNST MIS Year 7 update	• Quarterly PMRT report *appendices 2.0-2.5* (March, May, September, November)	CNST MIS SA:1 CNST MIS SA:10
Findings of review of all cases eligible for MNSI	• Learning lessons • Maternity and Neonatal Dashboards • CNST MIS Year 7 update		CNST MIS SA:1 CNST MIS SA:10
Number of incidents graded as moderate or above and what action is being taken	• Learning lessons • Maternity and Neonatal Dashboards		
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	• Maternity and Neonatal Dashboards • CNST MIS Year 7 update		CNST MIS SA:8
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and	• Maternity and Neonatal Dashboards	• Bi-annual midwifery staffing report *appendix 6.0* (May & November)	CNST MIS SA:4 CNST MIS SA:5

midwife minimum safe staffing planned cover vs actual prospectively	• Maternity in-month update • Neonatal in- month update • CNST MIS Year 7 update		
Service User Voice feedback	• Listening to our families • CNST MIS Year 7 update		CNST MIS SA:7
Staff feedback from frontline champions and walk-abouts	• Listening to our staff • CNST MIS Year 7 update	• NED report *appendix 8.0*	CNST MIS SA:9
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	• Learning lessons • Maternity and Neonatal Dashboards • CQC update		
Coroner Reg 28 made directly to the Trust	• Learning lessons • Maternity and Neonatal Dashboards		
Progress in achievement of CNST 10	• CNST MIS Year 7 update		

Theme/trend/escalation	Additional actions being taken
MNVP commissioning and funding: Owing to increased ask (CNST MIS Year 7) of MNVP lead attending ULTH meetings as a quorate member, review of MNVP infrastructure/funding required to identify if it still aligns with the national MNVP guidance.	Meeting with CB (LMNS), SLT and Corporate Compliance Team 19/05/2025 to discuss- for formal escalation if required via PQSM to MNOG and LMNS Board

2.2 Clinical Negligence Scheme for Trusts (CNST), Maternity Incentive Scheme (MIS): Year 7

Appendix 1.2 and 1.3

Safety Action	Anticipated compliance	Comments	Upward reporting
SA1 PMRT	On track to achieve	On track • Q4 report: Agenda item	• Note receipt of Q4 PMRT report including details of the deaths reviewed **from 1 December 2024**, any themes identified and the consequent action plans.

SA2 MSDS	On track to achieve	On track	NA
3SA TC/ATAIN	On track to achieve	On track • Q4 ATAIN report including QI audit update: Agenda item	• Note update relating to QIP progress within Q4 upward report.
SA4 Clinical workforce	On track to achieve	On track • Obstetric workforce: Audits underway • Neonatal workforce update available within report and Neonatal Dashboards • Progress against agreed actions for QIS deficiency monitored through Risk Register and NeoSIP	• Record in Trust Board minutes that the Neonatal medical workforce is staffed to BAPM recommendations. • Record in Trust Board minutes progress against the previously agreed QIS action plan and trajectories. Update that this is also on the Risk Register.
SA5 Midwifery workforce	On track to achieve	On track • Bi-annual Midwifery report and action plan to address shortfalls: Agenda item	• Upward report to Board the staffing report in its entirety. • Record in Trust Board minutes receipt of the midwifery staffing oversight report covering staffing/safety issues in line with NICE midwifery staffing guidance and the agreed plan, including timescale for achieved the appropriate uplift in funded establishment including mitigations to cover shortfalls. • Reference update on BSOTs to Board and links to MNSI letter of concern.
SA6 SBLv3.1	On track to achieve	On track • Version 3.2 released in April • Quarterly meetings with LMNS continue: Update within report	• Note progress to achieve compliance with all six elements of SBLCB v3.1.
SA7 MNVP	At risk	Meeting with CB (LMNS), SLT and Corporate Compliance Team 19/05/2025 to discuss MNVP infrastructure/evidence that MNVP is commissioned and functioning as per national guidance alongside additional ask of MNVP as quorate member of maternity and neonatal meetings - for formal escalation if required via PQSM to MNOG and LMNS Board	• Escalation reporting if required following meeting on the 19th May to LMNS Board, Quality Committee and Trust Board.

SA8 Training	On track to achieve	On track
		• Compliance currently 90%
		• NLS RC Instructor update:
		  ○ Increase in number of GIC NLS instructors since CNST MIS Year 6, however capacity/resource for those trainers to complete all NLS updates remains challenging
		  ○ To further increase number of GIC NLS instructors requires invitation from the RC and can take up to 12 months to complete
			• Note receipt of the NLS Instructor mitigation paper (appendix 1.4) and progress made from Year 6 CNST MIS.
			• Note receipt of the TDA mandatory training mitigation paper (appendix 1.5)

		○ Ongoing plan for GIC NLS instructors to directly supervise/support trainers with NLS certificates ○ See appendix 1.4 for further detail • Tabaco Dependency Advisor (TDA) attendance a PROMPT update: ○ Capacity of TDA's to attend PROMPT is challenging with impact on ability to deliver Smoking Cessation service ○ TDA role in maternity up-banded to Band 4 to align with the wider trust TDAs with separate mandatory training requirement ○ NHSR confirmation: 'they should be encouraged to attend, but will not be required to attend to meet the MIS compliance assessment (therefore not included in the 90%)' ○ ULTH decision: TDAs no longer required to attend PROMPT ○ See appendix 1.5 or further detail	
SA9 Floor to Board	On track to achieve	On track • Claims Scorecard: Agenda item • Staff Experience Group update within report • NED report: Agenda item	• Note, as evidenced via the PQSM document, that a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC.) • Note receipt of the quarterly Claims Scorecard. • Record in Trust Board minutes progress with the Staff Experience Group (maternity and neonatal culture plan).
SA10 MNSI	On track to achieve	On track • Learning Lessons update within report	• Note receipt of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. • Note receipt of evidence that families have received information on the role of MNSI and NHS Resolution's EN scheme. • Note receipt must have sight of evidence of compliance with the statutory duty of candour.

2.3 Saving Babies Lives Care Bundle V3.2

Touchpoint	E:1	E:2	E:3	E:4	E:5	E:6	Total	Comments/actions
1: Q2 July-Sept 2023 02/10/2023	50%	90%	100%	20%	74%	33%	69%	Compliance remains the same as the previous 2 months. Two areas of non-compliance:

2: Q3 Oct-Dec 2023 29/12/2023	70%	90%	100%	100%	74%	83%	81%	• Documentation of evidence of discussion with neonatal team with a preterm birth, but a checklist is with CRG at the moment to help address this and perhaps Badgernet will help. • Next day scanning for RFM improved for February and was compliant, however we are waiting for 3 consecutive months of compliance before we can say we are fully compliant. SBLV3.2 has been benchmarked and will be implemented over the next few months, we don't anticipate a fall in compliance from this, however there are concerns that the introduction of Badgernet and reliance on documentation for SBL data that compliance will fall as a result. • Mitigations are being put into place with crib sheets for mandatory data requirements for SBL provided for all areas and regular report runs to monitor compliance weekly.
3: Q4 Jan-Mar 2024 18/03/2024	90%	95%	100%	100%	81%	100%	90%	
4: Q1 Apr-Jun 2024 24/07/2024	90%	100%	100%	60%	93%	100%	93%	
5: Q2 Jul-Sep 2024 1/10/2024	90%	100%	100%	80%	96%	100%	96%	
6: Q3 Oct-Dec 2024 30/12/2024	100%	100%	50%	80%	93%	100%	94%	
7: Dec-Jan 2025 21/02/25	100%	100%	50%	100%	96%	100%	97%	
8: Feb- March 2025 25/04/2025	100%	100%	50%	100%	96%	100%	97%	
9: April-Jun 2025 31/07/2025								
The above data demonstrates the percentage of interventions fully implemented following LMNS validation and have been taken from the SBLCB implementation tool. SBLCB v3.2 released May 2024								

2.4 Three Year Delivery Plan (3YD)

Theme	**Position** **Comments/actions**
Listening to women and families with compassion	Action now monitored through Maternity and Neonatal Safety improvement plan. Ockenden actions are also now monitored through the MatNeoSip. Please refer to MatNeoSIP headline report.
Supporting our workforce	
Developing and sustaining a culture of safety	
Meeting and improving standards and structures	

2.5 Regional Maternity Heat Map

Regional Maternity Heatmap

Data refreshed: 25/04/2025 08:56:20

Heatmap

Version: 2
Deployed Oct 2023

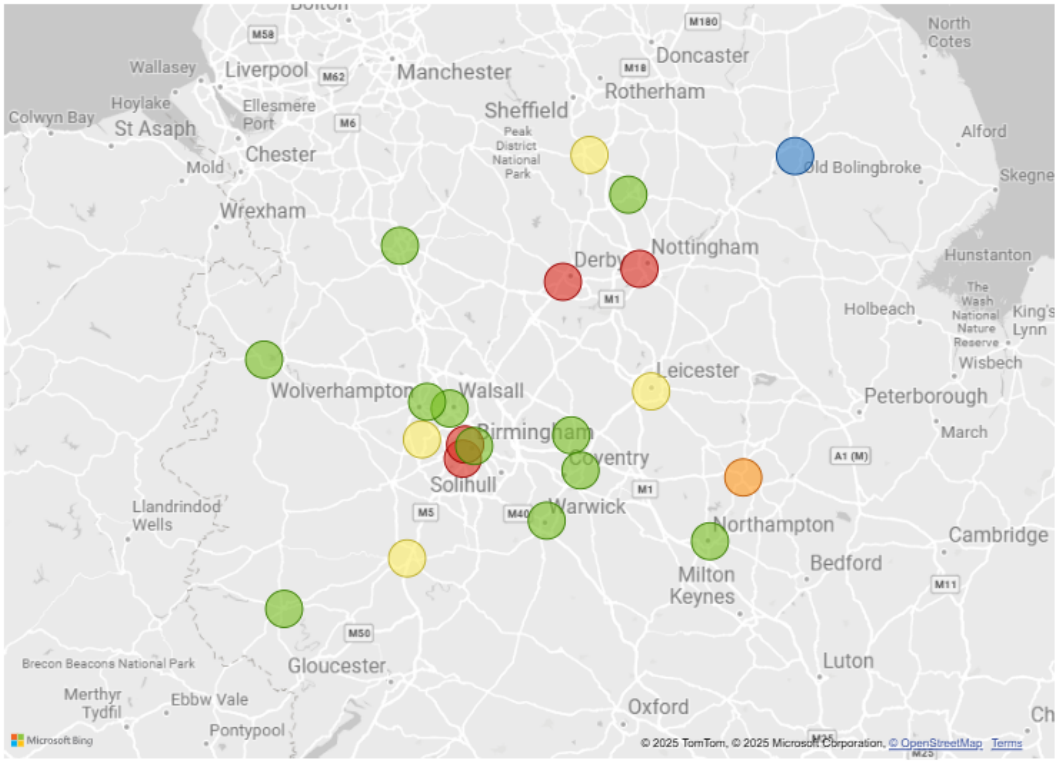
Region: Midlands

NHS England

Overall heatmap scoring key:

Region average score: **31.9**

Heatmap month: April 2025



Provider	Overall score
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	69.0
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	49.0
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	45.0
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	41.0
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	40.0
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	35.0
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	33.3
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	32.0
THE DUDLEY GROUP NHS FOUNDATION TRUST	32.0
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	29.0
GEORGE ELIOT HOSPITAL NHS TRUST	28.0
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	28.0
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	27.0
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	26.0
WYE VALLEY NHS TRUST	26.0
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	25.0
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	24.0
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	23.0
THE ROYAL WOLVERHAMPTON NHS TRUST	21.0
WALSALL HEALTHCARE NHS TRUST	21.0
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	15.0

2.6 Care Quality Commission (CQC)

CQC readiness pathway
Our service, supported by the corporate compliance team, is currently creating a comprehensive CQC readiness pathway to ensure continuous compliance with regulatory standards and to embed a culture of safety, quality and learning. This proactive approach will be aligned to the five domains (Safe, Effective, Caring, Responsive and Well-led), positions us to deliver consistent, high-quality care to women and their families. The pathway includes, but is not limited to: • Bi-monthly multi-disciplinary CQC readiness meetings • Continuation of benchmarking against the Single Assessment Framework and CQC reports for maternity services • Actions to be monitored through the MatNeoSIP • Staff support and engagement • Evidence management through the Maternity Evidence Library

NUH Benchmarking- appendix 1.6

3: Local drivers

3.1 Maternity and Neonatal Safety Improvement Plan (MatNeoSIP)

The Maternity Safety Improvement Plan (MatSIP) is a dynamic live document for the collation and monitoring of improvement actions arising from national maternity reports and assurance requirements as well as internally identified improvement actions e.g. actions identified through Serious Incidents. Due to significant changes in leadership, and challenges with acuity, minimal changes have been made to the MatSIP for this time period. Some actions have been identified for archiving, and will be discussed at the next appropriate MNSC meeting. CNST MIS Year 7 and Saving Babies Lives were published in April, and mapping is under way to understand the actions. The MatSIP will be updated in due course to reflect these changes.

Section	Total Actions	**Red** Not yet completed / significantly behind agreed timescales or non-compliance expected	**Amber** In progress / on track / completion expected	**Green** Completed & ongoing and / or not yet fully embedded (awaiting evidence of embedding)	**Blue** Completed & embedded with evidence, to be signed off at MNSC prior to closure
Optimise Experience	**15** (=)	**0** (=)	**14** (=)	**1** (=)	**0** (=)
Optimise Safety	**36** (=)	**0** (=)	**25** (=)	**8** (-1)	**3** (+1)
Improve Leadership	**4** (=)	**0** (=)	**4** (=)	**0** (=)	**0** (=)
Choice & Personalised Care	**3** (-2)	**1** (=)	**2** (=)	**0** (=)	**0** (-2)
Provide Assurance	**2** (=)	**0** (=)	**0** (=)	**2** (=)	**0** (=)
CNST	**10** (=)	**0** (-1)	**0** (=)	**-7** (=)	**+8** (=)
SBL	**6** (=)	**0** (=)	**3** (=)	**0** (-3)	**3** (+3)
3YDP – ULTH	**47** (=)	**0** (-1)	**10** (-6)	**25** (+4)	**12** (+3)
3YDP – ICB	**29** (=)	**0** (=)	**11** (=)	**18** (=)	**0** (=)
TOTAL	**152** (-2)	**1** (-2)	**69** (-6)	**54** (-7)	**28** (+13)
Archived Actions	**306** (+2)	Completed, embedded and signed off by MNSC for closure			

	Action No	**Action Milestone**	**Responsible Lead**	**Due Date**	**Comments**
1	CPC19	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Bereavement Midwife	30/09/2024	04/12/24 Training compliance as below. 100% not yet achieved for all staff groups. Individuals have been contacted directly. 12/03/25 Have seen some improvements with compliance. Drop in doctor compliance is due to some new doctors joining the Trust. Consultant Obstetrician is going to chase doctors. Individual emails are being sent by the education team. **Bereavement** LCH Consultants – April 82%, May 82%, June 91%, Sept 100%, Oct 100%, 08/Nov 100%, 26/11 100%, 06/01 92%, 12/03 100%, 03/04 100% LCH Registrars – April 27%, May 27%, June 27%, Sept 31%, Oct 50%, 08/Nov 71%, 26/11 86%, 06/01 86%, 12/03 93%, 03/04 93% (Garima Singh) LCH Junior Doctors – April 0%, May 0%, Sept 17%, Oct 33%, 08/Nov 33%, 26/11 33%, 16/01 17%, 12/03 83%, 03/04 83% (Nishikanta Verma and Eman Al-Hasan) LCH Midwives – April 40%, May 41% , Sept 62%, Oct 61%, 08/Nov 59%, 06/01 57%, 28/01 56%, 12/03 65%, 03/04 67% PHB Consultant – April 56%, May 56%, June 56%, Sept 60%, Oct 70%, 08/Nov 80%, 26/11 90%, 06/01 100%, 12/03 100%. 03/04 100% PHB Registrars – April 58%, May 67%, June 75%, Sept 69%, Oct 69%, 08/Nov 69%, 26/11 69%, 06/01 85%, 12/03 85%, 03/04 85% (Safia Mahmoud and Katherine Phipps) PHB Junior Doctors – April 0%, May 0%, Sept 75%, Oct 75%, 08/Nov 75%, 26/11 75%, 06/01 13%, 12/03 44%. 12/03 44% (Akwasi Bamfo-Quaicoe, Samuel Olaniyan, Jarred Barnabas, Xavier Cunago, Celia Torres-Pradillo)

					PHB Midwives – April 38%, May 38%, Sept 48%, Oct 49%, 08/Nov 52%, 06/01 49%, 12/03 60%, 03/04 57% Community Midwives – April 60%, May 60%, Sept 74%, Oct 70%, 08/Nov 69%, 06/01 71%, 28/01 72%, 12/03 73%, 03/04 70% **Post Mortem Consent** LCH Consultants – April 73%, May 82%, June 91%, Sept 92%, Oct 92%, 08/Nov 100%, 26/11 100%, 06/01 100%, 12/03 100%, 03/04 100% LCH Registrars – April 20%, May 20%, June 20%, Sept 19%, Oct 31%, 08/Nov 86%, 26/11 93%, 06/01 100%, 12/03 93%, 03/04 93% (Vedha Suhakar) PHB Consultant – April 78%, May 78%, June 78%, Sept 100%, Oct 100%, 08/Nov 100%, 26/11 100%, 06/01 100%, 12/03 100%, 03/04 100% PHB Registrars – April 42%, May 58%, June 67%, Sept 62%, Oct 69%, 08/Nov 77%, 26/11 77%, 06/01 85%, 12/03 92%, 03/04 (Katherine Phipps)

3.2 Maternity Dashboard updates

Dashboard item	SPC trigger	Current position	Comments/actions
Rate of stillbirth per 1000 births	3.8	2.97	We are currently at 2.97 against a threshold of 3.8. We are consistently below the target and investigate all stillbirths that occur. The stillbirth rate is consistently monitored and reviewed, displayed on the maternity dashboards and outcomes of reviews are actioned. The rate of stillbirth for the Trust is in line with the national picture however our local data is causing concern due to the SPC charts flagging
Number of births	≥385	349	Due to the geographical location of Lincolnshire women can choose to birth at out of area hospitals but this figure has not increased. The number of births are in line with the bookings carried out. We actively promote ULTH maternity service. With the expansion of the COCO teams this will hopefully encourage women to birth within ULHT. ULTH are monitoring the number of women who choose to birth elsewhere and a piece of work will be carried out to understand why this is their choice. The birth rate has decreased over the last decade and 2023 had the lowest number of births since 1977 (ONS, 2023)
Smoking at the time of booking/delivery	≤13%/≤6%	10.15%/6.90%	We are currently at 10.15% against a threshold of 13% for smoking at the time of booking. Historically Lincolnshire has had one of the worst SATOD rates both regionally and nationally and for 2023/24 Lincolnshire had the 6th worst SATOD rate in England. The SATOD rate for ULHT has fallen from 17.1% in 2020/21 to 11.9% in 2023/24; a decrease of 5.2%. The last 12 months have also seen a decrease. Postal NRT has recently started for women

			in remote areas and the issuing of vapes is in the final stages. Since Jan 23 NRT has been prescribed in house. Incentives started in Dec 24 in line with the national program. All women are offered smoking cessation referral which is opt out. Additional funding was secured for TDA advisors and therefore all women are now covered by the STAAR team. Funding was also secured from Lincolnshire County Council Tobacco Support Team to install window coverings in ANC windows at LCH and PHB sites to promote smoking cessation. There is a continued trend in monitoring CO testing compliance. The overall trend since Apr 21 has seen a decrease.
Breastfeeding initiation rates	≥72.9%	65.87%	The threshold has increased to 72.9%. Significant investment into infant feeding teams and support is needed to enable improvement- ULHT infant feeding team is significantly smaller than 1) teams in comparable Trusts and 2) other specialist teams at ULH relevant to workload. A County Wide Infant feeding strategy has been agreed by the LMNS, which recommends an uplift in ULTH infant feeding team, no increase in funding has yet been agreed/received. The Antenatal toolkit is well used by CMWs. Audit results show mothers have improved knowledge of benefits & how to BF. Parents version of antenatal toolkit in English and translated versions are available on Better Births Website. ANC/AAU areas have laminated parents versions of antenatal toolkit available while parents are waiting. Mothers guide leaflet universal provision. *Universal offer of Antenatal hand expression kits (including translations of leaflet)
Postpartum haemorrhage ≥2000mls/ ≥1500mls	≤1.3%/ ≤3.3%	0.86%/ 2.0%	All PPHs are reported and monitored through Datix, MDT reviews and quarterly reporting. Themes identified around rate of PPH at LSCS at LCH being addressed by Safety lead Midwife and Lead Obstetrician for Risk. PPH figures correlate with IOL and LSCS rates, ongoing monthly MDT reviews of all PPH over 1.5L. Now using thematic analysis involving human factors, themes and trends rather than looking at individual cases. Safety lead Midwife and Risk Obstetrician working together to develop actions around LSCS PPHs at LCH.

3.3 Neonatal Dashboard updates

Neonatal dashboard
• No babies born <30 weeks at either site • Deferred cord clamping compliance showing improvement at PHB • Temperature on admission compliance showing improvement at PHB • Antenatal steroids compliance showing improvements at PHB • No avoidable admissions at either site in March

3.4 Maternity and Neonatal Dashboards

Appendix 1.7

4: In-month updates

4.1 Maternity updates

Escalations:

Celebrations:

- Maternity remain blue with 15 points on the Regional Heatmap
- Secured funding to offer long term contraception to women whose unborn babies are subject to child protection plans, pre-proceedings or women who give birth under the age of 20
- The 2024/25 NHSE Smoking at Time of Delivery (SATOD) data shows that Lincolnshire ICB is ranked 1st for year on year change in SATOD rates with a reduction of 3.4% since 2023/24

Quality improvement/deep-dives/benchmarking/audit:

- Collaborative working between surgery and FH to commence 4 Elective LSCS lists on Lincoln Site. Commence in May/June 25
- Discussions ongoing about potential to use floor 1 for Elective LSCS on the LCH site
- Launch of the Branch Boxes for families whose babies are removed from their care on discharge from the hospital
- ULTH Maternity participated in the new ICON video

Training and education:

- Majority of staff now completed Badgernet training – launch date 7th May 2025

Workforce:

- **Midwifery** (see bi-annual staffing report)

- Inpatient matron recruited for PHB Maternity – Kate Hodkinson. Begins May 25
- Successful recruitment of HOM on Boston site

Additional updates:

- Maternity Triage
  - Launched on 28th April in Lincoln as an initial step to bringing the service in line with the national Birmingham Symptom Specific Tool with launch due in Boston on 2nd June.
  - The previously agreed uplift has been fully recruited to at PHB. The Lincoln uplift is proving more challenging with delays ongoing.
  - Improvements to safety due to introduction of a standardised initial assessment- during the first week of implementation, with 3 RMS working in triage, 86% of women were reviewed in 15 minutes, however this decreased during the second week, with 2 RMS, to 64%.
  - Lack of a staffed dedicated central telephone call system as recommended in both CQC reviews of maternity care and the maternity triage pathway. Until fully implemented maternity triage continues to provide day-assessment work, potentially impacting compliance with triage standards
  - Until the next phase Badgernet implementation, staff are duplicating documentation on Medway and on paper.
  - Progress on maternity triage has also been included within the bi-annual midwifery staffing report and the risk register update. A full report summarising work-to-date will be shared at MNOG in July.

4.2 Neonatal updates

Celebrations:

- The new Neonatal Safety Improvement Plan (NeoSIP) has been developed as a dynamic live document for the collation and monitoring of improvement actions arising from national neonatal reports and assurance requirements, as well as internally identified improvement actions e.g. actions identified through case reviews.
- Lincolnshire ICB level SATOD rate for the first 3 quarters of 2024/25 = 8.7%, a decrease of 3.4% versus the 2023/24 full year rate of 12.1%

Clinical pathways:

- Clinical pathways to be amended to 2 ITU cots at LCH, following peer review recommendations in respect of cot capacity figures over the last 12 months. This would mean a reduction in special care cots with opportunity to increase activity at PHB. To be discussed at next Cabinet meeting.

Quality improvement:

- Video laryngoscopes now in place and being used. The use of video laryngoscopes will improve patient outcomes in respect of those babies requiring intensive respiratory result.
- Active cooling equipment now in use and all training completed. This will provide optimisation of care due to the need to commence this treatment immediately and prior to transfer to a tertiary centre.
- New resuscitation documentation in process– to be reviewed by end of May 2025. Currently being piloted during SIM sessions across both sites. Once evaluated will be presented to APPG.
- Resuscitaire in LCH ED – There is no resuscitaire in ED at Lincoln which has identified a risk to babies brought into the department. There have been recent incidents escalated through governance processes. Awaiting outcome of funding requirements within ED and how this can be progressed asap.
- EMAS = Stakeholder meeting held in May to discuss direct admission to ED. This was not felt to be safe in all units and therefore no outcome was agreed. A further stakeholder meeting to be held.
- Ventilators – new ventilators ordered and awaiting purchase and training.
- Neonatal Reflections Service – In pilot phase. Awaiting evaluation.
- Volunteers – in place on both sites.
- Home Phototherapy –project now in progress and to be rolled out by July 25
- Ward Accreditation – Both sites have submitted silver documentation and acting on feedback prior to resubmission.
- Bliss Accreditation – Both units in process of updating action plan to resubmit for silver accreditation.
- BFI Lead – JD awaiting job matching this month

Training and education:

- Staff undertaking future QIS courses will be required to undertake 150 hours of practice in a regional centre. This will impact on rotas and the ability to send staff on QIS training. This may impact of staff willing to undertake the course as travel may impact on work/life balance. Full training trajectory to be completed to identify percentage of training required per month in relation to roster compliance. Honorary contracts to be written for staff needing to undertake practice within a Local Neonatal Unit.
- NLS: Lincoln 93%, Boston 97%. All staff booked on courses 19th and 20th May 2025 to ensure 100% compliance. Continue to work towards CNST requirements in relation to NLS yearly updates.

Workforce:

- *Medical*
    - Consultant posts fully recruited to.
    - Tier one rota fully established with ANNP workforce. Clinic cover using the ANNP workforce planned to release consultant time. Prolonged jaundice clinic at PHB in progress utilising APNP – this will improve capacity and flow within acute paediatrics.
- *Nursing*
    - Registered nurse vacancy at band 5 fully recruited to, however not all staff in post yet. A small amount of vacancy equating to 1.8wte band 6 exists and whilst not impacting daily, high levels of recent sickness have resorted in increased bank expenditure to ensure delivery of a safe service and support network capacity.
    - Unregistered workforce consultation underway, with 2nd planned meeting to take place mid-May, again this is impacting on service delivery and increased levels of bank expenditure. Cost of bank staff offset by the vacancy underspend. Whilst not compliant with the staffing template there have been no identified patient safety incidents.
    - Q4 workforce summary was completed and submitted to the Neonatal Network, identifying gaps within the AHP workforce. A business case has been written and currently sits with the ICB for consideration. (see appendix 1.8 and 1.9)
- *Qualified in Speciality (QIS) see appendix 1.10 for further detail:*
    - LCH - QIS trajectories in June should see a total of 64.4% with month-on-month improvement due to planned training at both Nottingham and Leicester Universities during 2025 and full compliance by January 2026. The figures include a forecast natural wastage of 2wte.
    - PHB – currently compliant – 71% QIS with a forecast to continue on an upward trend.

QIS Trajectories

Lincoln				
Month Ending	Total WTE qualified staff (incl. Ward Manager and Educator)	QIS (WTE) (incl. Ward Manager and Educator)	% QIS	QIS in training (WTE)
May2025	25.68	15.53	60.5%	1.44
June 2025	25.68	16.53	64.4%	1.44
October 2025	25.68	16.53	64.4%	4.24
December 2025	25.68	16.53	64.4%	4.24
January 2026	25.68	17.97	70.0%	2.8

Boston				
Month Ending	Total WTE qualified staff (incl. Ward Manager and Educator)	QIS (WTE) (incl. Ward Manager and Educator)	% QIS	QIS in training (WTE)
May2025	15.28	10.88	71.2%	2
June 2025	15.28	10.88	71.2%	2
October 2025	15.28	10.88	71.2%	2
December 2025	15.28	10.88	71.2%	2
January 2026	15.28	12.88	84.3%	

NNAP:

- Quarterly 1 report of NNAP data to be presented at CEG – June 25. Network compassions for NNAP data and NNAP report for 2024 can be found in appendix 1.11, 1.12 and 1.13.

5: Learning Lessons

5.1 Learning Lessons report

5.2 Incidents overview

Incidents *As of 30th April 2025*	**Obstetrics and community midwifery**	**Neonates**	**Actions being taken**
Patient safety incidents reported March - April '25 by severity	No Harm: 171 Low Harm: 39 Moderate Harm: 0 Fatal: 0	No Harm: 18 Low Harm: 5 Moderate Harm: 0 Fatal: 0	
Open incidents on Datix by month	**March:** Closed on time: 45 Not closed on time: 27 Still open: 45	**March:** Closed on time: 14 Not closed on time: 3 Still open: 5	Datix's monitored by the risk team to try and improve the compliance with timeframes. 7/5/25 – Obstetrics – all staff with open datix's have been messaged for prompt review and closure if able. Matron's to be messaged monthly with the number of datix's open for each member of staff to allow support to be offered to those who need it.
	April: Closed on time: 67 Not closed on time: 6 Still open: 48	**April:** Closed on time: 7 Not closed on time: 0 Still open: 2	
Open MNSI	6		2 cases published and currently within division to update action plans 1 case at draft phase and with trust for factual accuracy 3 cases still in process with MNSI
PSII	6 (All MNSI investigations)	0	All PSII are MNSI cases, therefore external investigations
AAR	2	0	Both ongoing AAR's, no new cases declared March - April '25.

Outstanding/Completed Duty of Candour	1	0	1 duty of candours have been completed within the timeframes.
PMRT (March – April 2025)	Stillbirths: 2 Late fetal losses: 0 Neonatal deaths: 0 ULHT published: 4 External reviews: 0		For individual actions from published reports, please see quarterly report.
Outstanding actions	31 outstanding actions 24 overdue	0 outstanding actions	Re-viewed monthly at the action review meeting with divisional and corporate governance teams. All 2023 actions now closed.
Accumulative Patient Event Numbers 8th Dec '23 – 30th Nov '24 (CNST MIS Year 6)			
MNSI - 6	Qualifies for Early Notification - 4	DOC verbal and written (including EN and MNSI information in accessible format in the patient's own language) – 6 (100%)	
Accumulative Patient Event Numbers 1st Dec '24 – 30th of Nov '25 (CNST MIS year 7)			
MNSI - 2	Qualifies for Early Notification - 0	DOC verbal and written (including EN and MNSI information in accessible format in the patient's own language) – 2 (100%)	

5.3 Details of incidents graded moderate or above

CNST Year 6 cases (8th Dec '23 – 30th Nov '24)				
MNSI number	Qualify for EN? If Yes, include reference	Have the family received notification of role of MNSI/EN?	Compliant with Duty of candour?	Details/update
MI – 036719	Yes	Notification of both	Yes, written and verbal	Report published, 3 safety recommendations: 1) The trust to ensure there is a robust system that supports IOL to be booked for the gestation that has been agreed and staff are supported to use this. 2) The Trust to ensure that Mothers are provided with information and discussion about the risks, benefits and options once a pregnancy reaches 41+0 weeks to support their involvement in the decision for and the timing of IOL. 3) The Trust to update the intrapartum fetal monitoring guideline and Cardiotocograph (CTG) assessment tool in line with national guidance, to support robust interpretation of fetal heart rate tracings.

				Closed and actions published.
MI – 037281	No	MNSI (don't qualify for EN)	Yes, written and verbal	Report published, 1 safety recommendation: 1) It is recommended the acute NHS trust and the NHS ambulance Trust work together to develop a process to communicate and record relevant clinical information so the decisions for care are made based on the whole clinical picture. Heard at Executive Oversight Group 15/1/25. Closed and actions published.
MI - 037631	Yes	Notification of both	Yes, written and verbal	Referred on the 8/7/24. MNSI met with family, TOR with the trust and staff interviews have been undertaken. AAR undertaken 2/8/24 Draft report received for factual accuracy and returned 4th March '25 Report Published, no safety recommendations, MDT held and updated action plan circulated for comments by 15/5/25
MI - 038500	Yes Declined	Notification to both	Yes, written and verbal	Referred on the 17/9/24. Timeline circulated AAR undertaken 28/01/25 Draft report received for factual accuracy to be returned 21st March Report Published, 1 safety recommendation: 1) The Trust to ensure that all mothers who report reduced fetal movements have a full risk assessment completed, including a computerised cardiotocograph, to assess fetal wellbeing in line with national guidance. (NHS England, 2023). MDT arranged for 13/05/25
MI - 038706	No	MNSI (don't qualify for EN)	Yes, written and verbal	Referred on the 21/10/24, Timeline circulated TOR received from MNSI HTA report submitted 17/12/24 and closed by the trust, action plan added. PMRT review 3/2/25 MNSI escalation of concern received and response sent 10/3/25
MI - 039079	Yes	Notification to both	Yes, written and verbal	Referred on 21/11/24, timeline circulated. TOR received from MNSI, staff meetings have been undertaken AAR undertaken 5/2/25 Draft report received for factual accuracy to be returned 12th May

Datix number and detail	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
Datix – 32576: IUD 39 weeks, attended for planned USS, no performed as ?SROM, no FH confirmed in AAC. Classified as intrapartum stillbirth as term ?SROM admission.	Obstetrics	Grade - Moderate Harm Declared as PSII to then be referred to MNSI	Case referred to MNSI AAR planned for 8/5/25
Datix – 30792: 18+4 late miscarriage, delivered on Gynae ward, retained placenta – delay in going to theatre, MROP, PPH (3.1l) and then transferred to ICU.	Obstetrics / Gynaecology	Grade – Low Harm Declared as MDT with case 32540, Gynae case also MROP, PPH and ICU admission.	Awaiting date for MDT (Clinical Governance to lead)
Datix – 34283: Stillborn baby transferred to QMC for post-mortem, parents wished hospital cremation but delay in arrangements. Day 56 baby found to be in fridge in extremely poor condition, no consideration or discussion about moving to freezer storage as per the HTA guidance at 30 days (now 56 days in mortuary)	Mortuary PHB	Grade – Moderate Harm Declared as PSII and reported to HTA as classified as a reportable incident.	PSII currently being undertaken

5.4 CNST MIS Safety Action Ten eligible cases

CNST Year 7 cases (1st Dec '24 – 30th Nov '25)				
MNSI number	Qualify for EN? If Yes, include reference	Have the family received notification of role of MNSI/EN?	Compliant with Duty of candour?	Details/update
MI – 039183	No	MNSI (doesn't qualify for EN)	Yes, written and verbal	Referred on 30/12/24, timeline circulated. AAR undertaken 25/2/25 TOR received and accepted.
MI – 039234	No	MNSI (doesn't qualify for EN)	Yes, written and verbal	Referred on 10/01/25, timeline circulated AAR undertaken 20/2/25 Case declined by MNSI 17/2/25 as unable to get patient engagement.

				Case Rejected by MNSI.
MI - 040715	No	MNSI (doesn't qualify for EN)	Yes, written and verbal	Referred on 18/03/25, timeline circulated AAR planned 8/5/25 Awaiting TOR from MNSI

5.5 Maternity risk register

Risk Description	Risk Score	Updates
As a result of insufficiencies within the current maternity services triage system, there is a risk that not all pregnant individuals will be able to access safe and timely care, which could lead to harm to the mother and baby.	16	Added following the MNSI escalation of concern following discussion at Risk confirm and challenge meeting 30/4/25.
Lack of adequate provision for appropriate clinical care of bereaved families within Obstetrics at Lincoln County Hospital.	16	Charitable funds are working with team at Lincoln to redesign room 4, although complete sound proofing is unlikely to be possible.
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.	16	To commence dedicated theatre lists at Lincoln for every day but a Monday starting June. Capacity remains an issue on Boston site but conversations are ongoing with surgery.
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.	16	This issue is ongoing and will remain the same until the refurbishment programme has been completed. Continue to receive poor patient feedback about being moved through corridors.

New risks March/April	Score
Insufficiencies within the current maternity triage service	16
Removal of the 1st class mail increases the risk of missed AN appointments	6

5.6 Neonatal risk register

Risk description	Risk Score	Updates
As a result of Neonatology patient information not being available in languages other than English, there is a quality risk due to inequity of access to information leading to poor patient experience.	15	Awaiting update from network about progress with this as some trusts have previously raised concerns about IG issues with CardMedic.
As a result of an inability to provide neonates with access to a full range of Allied Health Professionals, there is a safety and quality risk of poor long term outcomes if babies do not receive timely access to appropriate therapies.	12	LCHS have submitted a business case for funding for the 25/26 financial year. CSS division also have an active risk relating to this issue.
As a result of insufficient Qualified in Specialty (QiS) neonatal nurses, there is quality and safety risk if staff do not have the specialist knowledge and skills to support babies requiring neonatal care.	9	Trajectory continues to indicate that 70% of all registered staff will hold QIS status by 2026. It is not necessary to reduce this timeframe as it would necessitate committing more staff to the training programme which would adversely impact staffing levels.

New risks March/April	Score
No changes made to the neonatal risk register	

5.7 Key themes, trends and escalations

Theme/trend	Additional actions being taken
Trust Triage process are not in compliance with BSOTS and concerns have been raised by MNSI	Action plan has been developed and sent to MNSI in response to their Escalation of Concerns letter. Antenatal Triage Midwife is now in post and working towards the implementation of BSOTS with in the trust and over both sites. Up-lift of staff to make 24 hours triage cover from immediate effect. Added to the risk register – Risk grading 16
BBA's rates are high for the trust in relation to the national rates	BBA deep dive was undertaken for 2023 and this is being repeated for 2024 by the patient safety team.

Stillbirth rate highlighted as a regional outlier from the MBRRACE 2023 perinatal mortality report.	United Lincolnshire Hospitals NHS Trust (ULHT). The Trust's data for 2023 shows it is within expected limits, with perinatal mortality not flagged as significantly higher than peers: • Stillbirth: 3.06 per 1,000 (within 5%) NHS Lincolnshire ICB In contrast, Lincolnshire ICB is flagged as having above average stillbirth rates for 2023: • Stillbirth: 3.42 per 1,000 (over 5% higher than comparator group) The divergence arises from how perinatal data is attributed: • Trust-level data (e.g., ULHT) reflects outcomes only from births that occur within the Trust's facilities. • ICB-level data (e.g., Lincolnshire ICB) encompasses all births by Lincolnshire residents, regardless of where they occur. This issue has been escalated to the Local Maternity and Neonatal System (LMNS) for a deeper investigation and recommendations discussed within the Briefing paper attached (Appendix 1.15) The PMRT quarterly reports highlight themes and trends within the learning from the published reports. (Quarter 3 – Appendix- 1.16, Quarter 4 see agenda item)
We are highlighted by MNSI as an outlier within the region for not having reported any term Neonatal Deaths for investigation.	It was brought to our attention during the recent quarterly meeting with MNSI that we are showing as an outlier within the region due to not having reported any term Neonatal Deaths for investigation. MNSI investigate any term Neonatal deaths when within the first week of life (0-6 days) of any cause. We have crossed checked births from January 2022 – April 2025 using both the maternity and neonatal IT systems and there have been no term neonatal deaths which fall within the MNSI reporting criteria. There have been 3 neonatal deaths during this time and they were all below 37 weeks.

6: Listening to our families

6.1 Maternity Patient Experience report

Appendix 1.17

6.2 Feedback overview

Feedback type	Obstetrics and community midwifery	Neonates	Comments/actions
Open complaints	12	2	
Overdue complaints	0	0	
Open PALS contact	9	1	
Overdue PALS contact	0	0	
Compliments (SUPERB)			
Social media interactions	**March 2025:** Direct Messages: 1 Post comments: 110 Likes/Shares: 1124 **April 2025:** Direct Messages: 1		
MNVP Co-produced patient experience improvement plan	13 ongoing actions 10 Archived actions Top 3 themes: communication with women and their families, experience of AN appointments and postnatal information and discharge processes		No change since previous Quarterly Report – no concerns or escalations received however, meetings have been poorly attended and limited feedback received upon position of outstanding actions. New Terms of Reference has been devised for circulation, with a new Agenda. Meetings will be moved to a more suitable time and date to allow for maximum attendance for re-engagement.
Family and Friends Test	Qualitative March 2025: • *Antenatal:* Unavailable • *Birth:* 98%		

	• *Postnatal ward:* 100% • *Postnatal community:* Unavailable
Family Health Patient Experience Meeting escalation	Overarching National Survey action plan/key findings: • Red- D6: *provision of partner staying as much as the patient wanted*: Insufficient estates and facilities to be able to accommodate all birth partners on the AN/PN wards overnight. Is often supported on a case by case basis if assessment of woman's needs indicated a carer or significant person was beneficial to mental health. • Amber-C11: *women and partners being left alone at a time when it worried them*: not currently a recognised themes of concern within the service. ULTH ranks high in both patient feedback and on the regional heat map. Communication is primary topic of education throughout mandatory training and will continue through 2025/26. • Amber-D4: *were women given the information and explanations needed after they had their baby*: UTH Maternity PEG action plan includes an action to improve postnatal information including a QIP to improve obstetric debrief, patient information leaflets and the opportunity to ask questions and individualise information relevant to the woman's experience.

7: Listening to our staff

7.1 Maternity Staff Experience report

See update below

7.2 Feedback overview

Feedback type/source	Number/detail	Comments/actions
Staff experience group	Presentation shared at the Perinatal Culture and Leadership Programme on-going support Regional meeting Soft launch 12th May with two overarching projects and a plan to work with staff to create a 'maternity and neonatal vision' Staff story agreed as standing agenda item at Obs & Gynae Governance MOMENTS training 2nd July for 23 members of staff	
Greatix	November and December: 35 Since launch (Nov 22) >470	• 'For always greeting patients and staff with a smile and happy to help anyone with anything.' • 'For stepping up and coordinating a busy night shift on Nettleham ward even though she felt nervous doing it, she did an incredible job, thank you!' • 'For utterly fantastic support, with no task being beneath her, whilst providing great grounding during a very difficult shift.'

Staff surveys	NHS Staff Survey	Benchmarking results to feed into staff experience improvement plan
	NETS survey	Negative outlier on 3YDP NHSE oversight tool dashboard related to results of the NETS survey completed by our O&G trainees. Summary of proposed actions to improve these results next year and ensure our trainees are feeling valued and safe to speak up about any of their concerns: • Consultant midwife/FTSU/PMA to attend inductions to discuss wellbeing offer and pathways for speaking up, signposting to Trust policies for discrimination and sexual safety charter • Induction pack and intranet to be updated to include the above
	Postgraduate Doctors in Training survey	See appendix 1.18 for briefing paper on escalation of concerns
Freedom to Speak Up	Three trained FTSU champions from MDT, one consultant awaiting full training. Positive meeting with FTSU Guardian and NED to share plans for staff experience group and improvement plan FTSU feedback to form part of triangulation for SEG	

Source	Statement	2018	2020	2021	2022	2023	2024
NHS Staff survey	Proportion of midwives responding with 'agree or strongly agree' on whether they would recommend their trust as a place to work or receive treatment	34.6% 42.3%	59.8% 61.7%	55.1% 54.2%	57.7% 61%	57.52% 57.52%	Review underway
GMC National Training Survey	Proportion of speciality trainees in Obstetrics and Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours	87.5% (2019)	No data	78.79%	86.88%	88.89%	82.94%

Appendices:

(Please do not embed documents- send as appropriately titled separate documents with the report)

Appendix number	Title
Appendix 1.1	PQSM: V4.2
Appendix 1.2	CNST MIS Launch Paper
Appendix 1.3	CNST MIS May update
Appendix 1.4	CNST MIS SA8: NLS Update
Appendix 1.5	CNST MIS SA8: TDA PROMPT update
Appendix 1.6	CQC: NUH Benchmarking overview
Appendix 1.6.1	CQC: NUH Benchmarking report
Appendix 1.6.2	CQC: NUH Benchmarking process
Appendix 1.7	Local Maternity and Neonatal dashboards
Appendix 1.8	ULHT Lincoln Neonatal Workforce Tool: Q4
Appendix 1.9	ULHT Boston Neonatal Workforce Tool: Q4
Appendix 1.10	Qualified in Specialty: Q4 report
Appendix 1.11	NNAP: Q1 report
Appendix 1.12	NNAP: Data
Appendix 1.13	NNAP: 2024 report
Appendix 1.14	Learning Lessons: report
Appendix 1.15	Briefing paper: MBRACE 2023 report
Appendix 1.16	ULTH Q3 report (including identifiable details)
Appendix 1.17	Maternity Patient Experience report: Q4
Appendix 1.18	Briefing Paper: O&G escalations

Clinical Negligence Scheme for Trusts (CNST)
Maternity Incentive Scheme (MIS) Update report- May 2025

Amy Garratt
Maternity Safety Lead Midwife
Version 1.0
9th May 2025

Introduction

Following receipt of confirmation of full compliance with Year 6 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), United Lincolnshire Teaching Hospitals (ULTH) Maternity and Neonatal services have commenced work on Year 7 of the scheme. NHS Resolution (NHSR) launched Year 7 MIS on April 2nd 2025 (Appendix one), following release of a 'What to expect- an overview of changes' document in February 2025. The details and significant changes were benchmarked and actions progressed. The completed Board Declaration forms must be submitted by **12 noon** on **3rd March 2026** with the reporting period ending on **30th November 2025.**

Background

Now in its seventh year of operation, NHSR MIS continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST maternity incentive fund and they will also

receive a share of any unallocated funds. Further detail relating to reporting processes, submission conditions, external verification and Trust Board and LMNS sign-off requirements can be found in the launch report (Appendix two).

Purpose

This monthly update report provides an overview of progress towards achieving the ten safety actions including any immediate priorities, exceptions and escalations. The key meetings and dates in which this report will be shared with the wider maternity and neonatal service and system can be found at the end of this report.

Key dates and actions:

Date	Update	Action/progress
February 2025	NHSR released 'What to expect- an overview of changes' document	Benchmarked and actions ongoing
2nd April 2025	NHSR published Year 7 CNST MIS	
28th April 2025	CNST MIS Year 7 Online launch webinar	Attended by relevant safety action leads, LMNS Lead Midwife and Corporate Compliance Team. No additional/further information gained.
30th November 2025	End of compliance period	
3rd March 2026	Submission deadline	

Immediate priorities

Safety action	Priority	Lead	Update
SA3.2 TC/ATAIN	Milestones and progress on ATAIN QIP: 'Midwives as second checkers for IVABX'	Rachel Wright Sam Tinkler	• Progress paused during Badgernet launch- plan to recommence June 2025 with update to be provided at July MNOG and August QSM
SA5	Action plan	Emma Upjohn	
SA7 MNVP	Review MNVP infrastructure/evidence that MNVP is commissioned and functioning as per national guidance alongside additional ask of MNVP as quorate member of maternity and neonatal meetings- see appendix three for further detail.	Amy Garratt Clare Brumby (LMNS)	• Meeting with CB (LMNS), SLT and Corporate Compliance Team 19/05/2025 to discuss- for formal escalation if required via PQSM to MNOG and LMNS Board
SA8 Training	Resuscitation Council (RC) General Instructor Course (GIC) NLS instructors progress	Whitney Fountain David Speck	• Increase in number of GIC NLS instructors since CNST MIS Year 6, however capacity/resource for those trainers to complete all NLS updates remains challenging • To further increase number of GIC NLS instructors requires invitation from the RC and can take up to 12 months to complete • Ongoing plan for GIC NLS instructors to directly supervise/support trainers with NLS certificates • See appendix four for further detail
	Review Tabaco Dependency Advisor (TDA) attendance at PROMPT	Karen Ludkins Katy Carr	• Capacity of TDA's to attend PROMPT is challenging with impact on ability to deliver Smoking Cessation service • TDA role in maternity up-banded to Band 4 to align with the wider trust TDAs with separate mandatory training requirement • NHSR confirmation: 'they should be encouraged to attend, but will not be required to attend to meet the MIS compliance assessment (therefore not included in the 90%)' • Decision to be reached regarding attendance at PROMPT • See appendix five for further detail

Key escalations

Safety action	Escalation	Route	Narrative
• No escalations at point of report writing			

Progress

Safety Action	Anticipated compliance	Comments
SA1: PMRT	On track to achieve	• Q4 report to May MNOG • Midlands shared database now in use to ensure mutual aid to achieve external reviewer compliance
SA2: MSDS	On track to achieve	
SA3: TC/ATAIN	On track to achieve	• Q4 ATAIN report including QIP audit update to May MNOG • Delay to QIP: *see immediate priorities*
SA4: Clinical workforce	On track to achieve	• Obstetric workforce: Audits underway • Progress against agreed actions for QIS deficiency monitored through Risk Register
SA5: Midwifery workforce	On track to achieve	• Bi-annual Midwifery Staffing report to May MNOG
SA6: SBLv3.1	On track to achieve	• Version 3.2 released in April • Quarterly meetings with LMNS continue
SA7: MNVP	At risk	• *See immediate priorities*
SA8: Training	On track to achieve	• Compliance currently on track for all staff groups • NLS RC GIC Instructor update: *see immediate priorities* • TDA attendance at PROMPT: *see immediate priorities*
SA9: Floor to Board	On track to achieve	• Claims Scorecard to May MNOG • Staff Experience Group launch 12th May 2025 • PQSM under review
SA10:MNSI	On track to achieve	• Learning Lessons report to May MNOG • Resources now available in multiple languages

Report to be shared at:

- HoM Meeting: 06/05/2025 (included within Safety Lead report)
- Obstetrics and Gynaecology Governance: 09/05/2025 (included within Safety Lead report)
- Maternity and Neonatal Safety Collaborative: 14/05/2025 (included within Safety Lead report)
- Maternity and Neonatal Oversight Group: 27/05/2025 (included within Maternity and Neonatal Assurance report)
- LMNS Quality and Safety Meeting: 17/06/2025 (included within Maternity update report, following review at MNOG)

Appendix

Appendix one: CNST MIS Year 7- V1.0 Guidance
Appendix two: CNST MIS Year 7- Launch report V1.0 09052025
Appendix three: CNST MIS Year 7- SA7- MNVP escalation V1.0 FINAL 16/05/2025
Appendix four: CNST MIS Year 7- SA8- NLS Update V1.0 09052025
Appendix five: CNST MIS Year 7- SA8- TDA attendance V1.0 09052025

PERINATAL MORTALITY REVIEW TOOL (PMRT) QUARTERLY REPORT (QUARTER 4 – January - March '25)

1. INTRODUCTION

The aim of this quarterly report is to provide assurance to the Maternity and Neonatal Oversight Group and Board level Safety Champions (MatNeo Group) that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 DEFINITIONS

The following definitions from MMBRACE-UK are used to identify reportable losses:

- **Late fetal losses** – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- **Stillbirths** – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.
- **Terminations of pregnancy:** terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only

MIS Year 7 requirements to notify:

The following deaths should be reviewed to meet safety action one standards:

- **Late fetal losses** – the baby is born at 22 or 23 completed weeks' gestation showing no signs of life, irrespective of when the death occurred.
- **Stillbirths** – the baby is born from 24 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.

- **Neonatal deaths** – the death of a live born baby born from 20 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) occurring before 28 completed days after birth.

2. STANDARDS

A report has been received by the Trust Executive Board each quarter and evidenced that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. To maintain confidentiality, the quarterly reports, including the details of the deaths reviewed, any themes identified and the consequent action plans, were received by the Trust Executive Board via the reading room prior to the Public Board meeting. Subsequently, the quarterly report was shared at the Public Board meeting.

The MIS Year 7 scheme was released in April 2025 and will apply to babies who die between 1st December '2024 until 30th November '2025.

Standard	MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Compliance
Standard A	Notification of all perinatal deaths eligible to notified to MBRRACE-UK to take place within 7 working days	**100%**
Standard B	All parents will have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**
Standard C	A PMRT review must be commenced within two months following the death of a baby	**95%**
	A PMRT must be completed within six months of the death of a baby's death	**75%**
	An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	**50%**
Standard D	Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024.	**100%**

External member presence

Following the publication of CNST year 7 released April ’25 there is a further requirement for 50% attendance by an external panel member. External panel member(s) should be relevant senior clinicians who are currently practicing clinically and work in a hospital external to the trust undertaking the review and external to any trust involved in the care at any stage. Their role is to be present at the review panel and actively participate in the review to provide a ‘fresh pair of eyes’, independent and robust view of the care provided. With the 4 reviews that have been undertaken for the year 7 reporting period we are currently at 0%.

Currently working with other trusts in the region to create an ‘external contact pool’ with the aim of being able to reach 50% compliance by the end of the reporting period.

Year 7 CNST MIS reporting

In-line with Year 6, all quarterly reports will be made available to the Trust Executive Board each quarter evidencing that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. To maintain confidentiality, the quarterly reports, including the details of the deaths reviewed, any themes identified and the consequent action plans, will be made available to the Trust Executive Board via the reading room prior to the Public Board meeting. Subsequently, the quarterly report will be shared at the Public Board meeting.

3. RECOMMENDATIONS

3.1 Eligible Incidents in 2024-2025

There have been a total of 7 incidents (7 internal cases and 0 external cases) reported to MBRRACE-UK via the PMRT in Quarter 4.

Of these cases 3 have met the threshold for referral to the Maternity Neonatal Safety Investigation (MNSI) but 1 has been rejected due to not being able to get consent from the parents.

No concerns have been raised with the notification and surveillance submission and the current reporting process is to continue.

3.2 Summary of all incidents closed in Quarter 4

There have been 4 incidents closed in Q4 (all cases from the CNST year 6 reporting period). This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby.

Grading of care provided to the mother before the death of the baby

- 1 case had no issues identified that would have had an impact on the outcome.
- 2 cases had issues identified that would have had no impact on the outcome
- 1 case had issues that may have had a difference to the outcome.

Grading of care provided to the mother after the death of the baby

- 1 case had no issues identified that would have had an impact on the outcome
- 2 cases had issues that may have had a difference to the outcome.
- 1 case had issues were likely to have made a difference to the outcome.

Where actions have been identified, appropriate deadlines have been put in place.

3.3 CNST Compliance as per MIS Year 6 Standards

For CNST Year 6 we have achieved compliance within all eligible standards.

3.4 Learning and Action Logs for Outstanding Cases

The actions for all published PMRT cases are added to Datix IQ Mortality Module and a live register is produced for this report of all remaining open actions. Any actions closed within the reported quarter will therefore be deleted from the previous quarter's action log.

3.5 Summary of CNST Compliance as per MIS Year 7 Standards (across reporting period 1st December 2024 – 30th November 2025)

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Q4	Q1	Q2	Q3	Total
Notification of all perinatal deaths eligible to be notified to MBRRACE-UK to take place within 7 working days (Standard A)	100	7				7
		100%				100%
A PMRT review must be commenced within two months following the death of a baby. (Standard C)	95	5				5
		80%				80%
A PMRT must be completed within six months of the death of a baby's death. (Standard C)	75	Date not yet reached				
All parents will have been told that a review of their baby's death is taking place*/ and asked for their contribution of questions and/or concerns**. (Standard B)	95	7/4				
		100%/57%				
An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	50	4				
		0%				
Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions (Standard D)	100	100%				100%

*All parents routinely notified of PMRT process by Bereavement team at initial contact

**Parents questions and concerns are sought prior to the MDT review by the Bereavement Team. Timing of this action is dependent on the family's wishes.

4.0 Escalation

Current areas for concern with CNST year 7 compliance are in meeting the 50% of reviews with external representation and we are currently sitting below the 95% standard for reviews being commenced in 2 months. We are looking to improve compliance with the regional 'external contact pool' and by having band 6 support with the inputting of the data for PMRT reviews.

Author – Gemma Rayner, Risk and Clinical Governance Midwife

Date – 3rd April 2025

Maternity Incentive Scheme - SA9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

United Lincolnshire Hospitals NHS Trust

Claims Scorecard - April '14 – March '24

Top injuries by volume:	Top injuries by value:
• Unnecessary pain (14) • Psychiatric/psychological damage (12) • Stillborn (11) • Fatality (6) • Adtnl/unnecessary operations (4)	• Brain damage (2) • Hypoxia (2) • Stroke (1) • Psychiatric/psychological damage (12) • Stillborn (11)
Top causes by volume:	**Top causes by value:**
• Fail/delay in treatment (25) • Intra-op Problems (6) • Failure/delay in diagnosis (5) • Fail to warn – informed consent (5) • Fail to respond to abnormal FHR (4)	• Fail to respond to abnormal FHR (4) • Inadequate nursing care (4) • Inappropriate Discharge (1) • Fail/Delay Treatment (25) • Medication Errors (2)

Complaints Q4 24-25

There have been 12 complaints received.

The top themes are clinical treatment and communication.

Incidents Q4 24-25

1. Term Baby admitted to neonatal unit – 44
2. PPH >1500mls – 27
3. Delayed transfer / ARM >24hrs – 27
4. Delayed treatment or procedure – 25
5. Readmission of mother – 26

The top 5 haven't changed from Q3 but there has been a rise in ATAIN cases.
Number of datix's submitted for Obstetrics and Community Midwifery: 327

Themes Q4 24-25

- The trust has one of the highest's cases of BBA's per deliveries therefore there is a current deep dive being performed, with a spotlight on the impact potentially caused by the triage system.
- Concerns with the translations services have been highlighted in several reviews including PMRT impacting on the assurance that patients fully understand the information they are being given. Datix's are submitted and being reviewed by the communications team.

Learning Q4 24-25

MNSI Recommendation - The Trust to ensure that all mothers who report reduced fetal movements have a full risk assessment completed, including a computerised Cardiotocograph, to assess fetal wellbeing in line with national guidance. (NHS England, 2023)
MNSI Escalation of Concern – Insufficient triage processes in place to support safe care for mothers and evidence of the trust gate keeping access to acute care.

Action Plan Q4 24-25

Not started	In progress	Completed

Reviewing Datix and claims, Benchmarking Ferrinjet and Monofer, Patient information leaflet on staining and fishbane reactions.	01/06/25	
Thematic review for PPH at planned LSCS in twin deliveries.	01/04/25	
BSOTS implementation to improve the triage process to be implemented on both sites.	01/09/25	

Bi-annual Midwifery Staffing Oversight Report

October 2024- March 2025

Emma Upjohn
Director of Midwifery
ULTH
May 25 – Version 1.1.

Contents

Midwifery Staffing Oversight Report

October 2024- March 2025

Introduction

Birthrate Plus is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the Birthrate Plus® methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the Royal College of Midwives (RCM).

The RCM recommends using Birthrate Plus to undertake a systematic assessment of workforce requirements, since it is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3). Both the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) (NHSR 2023) and the Three-year delivery plan for maternity and neonatal services (NHSE 2023) include reference to using Birthrate Plus as a midwifery staffing tool.

This report provides an overview of the recently received Birthrate Plus (BR+) assessment, offers an update on safe midwifery staffing, and outlines key staffing metrics in line with CNST Standard 5. It also proposes actions for further discussion.

The maternity service follows a traditional model, with intrapartum care provided at both Pilgrim and Lincoln County sites. Despite a national and local decline in birth rates, the complexity of pregnancies has increased, with higher instances of safeguarding cases, high BMI, diabetes, and smoking during pregnancy. These challenges have persisted since the last staffing report.

United Lincolnshire Teaching Hospitals NHS Trust (ULTH) staffing is aligned with the 2021 BR+ recommendations, as well as the local staffing reviews conducted in October 2023. A more recent BR+ review was completed in March 2024, and this report includes a summary of its findings.

ULTH has achieved full compliance with Year 6 of the CNST, despite challenges in delivering the training requirements. Efforts are ongoing to meet Year 7 compliance. Regular staffing reviews are held every six months as part of the Trust's establishment assessments, with further monitoring occurring through twice-daily huddles and weekly operational meetings across all sites. Escalation processes, supported by local guidelines, are in place to manage staffing during periods of high demand or unexpected absences.

Background

Recruitment and retention of midwives remain challenging across the UK. ULTH has been fortunate in maintaining minimal vacancies, though the retirement of senior midwives has impacted on the skill mix. A

comprehensive preceptorship program has been developed to support newly qualified midwives (NQMs), and retention midwives are in place to provide additional support.

Recruitment efforts have been bolstered by the introduction of a midwifery program at Lincoln University, which helps attract local talent. However, there remains a significant risk due to the number of midwives approaching retirement within the next five to ten years.

Birthrate Plus (BR+) Findings

The 2021 BR+ assessment had recommended specific staffing levels for ULTH, but since then, patient acuity has increased. A recent case mix analysis (August to October 2023) showed a rise in the number of high-risk pregnancies (Categories 4 and 5), particularly at Lincoln County Hospital. Contributing factors include higher rates of gestational diabetes and comorbidities, as well as increased labour inductions. Table 1. Below.

Hospital	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	Combined cat 1-3	Combined cat 4 & 5	Combined cat 1-3 as % of all births	Combined cat 4 & 5 as % of all births
LCH	2.6%	8.2%	12.7%	29.0%	47.5%	23.5%	76.5%	40.7%	59.2%
PHB	2.4%	12.9%	19.3%	25.3%	40.1%	34.6%	65.4%	42.4%	57.5%

Comparison of non-clinical (management and specialist) midwifery roles

Current Funded Establishment	Birthrate Plus® recommended	Variance
28.96	27.76	+1.20

Comparison of clinical roles

Current funded establishment skill mix (recommended BR+ skill mix %: 95%/5%)	RMs	MSWs	Variance
	219.42	11.95	-13.30
	-12.61	-0.69	

Summary of results (planned vs actual midwifery staffing)

Current Funded Clinical, Specialist and Management wte	Birthrate Plus® Total recommended wte	Variance wte
247.03	259.13	-12.10

The Trust is currently operating with a deficit of 12.10 whole-time equivalent (WTE) staff, according to the latest BR+ assessment. This shortfall is primarily due to the need for a 24/7 triage service, which is not yet fully implemented. Some staffing adjustments are needed to meet these recommendations, and work is underway to evaluate the staffing requirements for a new triage model (BSOTS).

The trust has temporarily uplifted its whole time equivalent workforce by 5.25 wte midwives and 5.25 wte B3 support workers. These vacancies are currently going through the recruitment process. The business case for the 12.1wte is under review for substantive establishment and recruitment.

One-to-One Care and Supernumerary Labour Ward Coordinator

Providing one-to-one care during labour is a key safety metric, and the Trust consistently achieves a 99-100% compliance rate in this area, as monitored through the Local Maternity Dashboard which are shared bi-monthly via the Maternity and Neonatal Oversight Group. All episodes non-compliance are reviewed at local level. Cases where one-to-one care was not provided typically involved rapid deliveries, where such care was not feasible.

The supernumerary status of labour ward coordinators is another critical metric. ULTH has achieved near-total compliance, with occasional deviations due to workload demands. Any instances where supernumerary status was lost are investigated to ensure that labour ward coordinators were not providing 1:1 care to a women in labour. This provides assurance patient care was not compromised.

The following table depicts this performance:

Workforce Indicators ULHT																					
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
1-1 in labour	<100%		100%	CM/CNST	1-1Labour	100.00%	99.42%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		99.95%		
Co-ordinator Supernumerary	<100%		100%	Inpatient Matron/CNST	Co-ordinator	99.00%	99.30%	97.40%	98.70%	99.00%	99.70%	99.70%	99.00%	98.75%	99.50%	98.50%	98.50%		98.92%		

When there is no labour ward coordinator available to coordinate, the service implement a series of measures to ensure safe and effective service continuity. This includes but is not limited to:

- reallocation of staff across areas based on clinical need
- requesting additional cover through the site team or bank where necessary
- prompt and continuous involvement of matrons to deputise for oversight and decision-making.
- in certain situations, the service may facilitate cross-site staff transfers to address critical gaps.
- core Band 6 Labour Ward midwives may be asked to step into a coordinating role temporarily, with appropriate support, to maintain oversight of activity and safety on the ward.

Midwife to birth ratio

Midwife-to-birth ratio is a critical indicator of safe staffing levels in maternity services. The BR+ target is 1:27 (one midwife to every 27 births). Performance against this standard is monitored through the Local Maternity Dashboard which are shared bi-monthly via the Maternity and Neonatal Oversight Group which. Variation in month above the threshold highlight the identified shortfall. The maternity escalation plan and ongoing action plan within this report outline the services mitigations and escalations for managing the shortfall.

Workforce Indicators ULHT																					
Metric	Threshold			Data Source/ Standard		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Average Percentage	SPC Special Cause identified	Comments
	R	A	G																		
Midwife to Birth Ratio	01:27		01:26			01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26	01:26				
Midwife to Birth Ratio (Actual)	01:27		01:26			01:25	01:26	01:26	01:25	01:25	01:25	01:27	01:24	01:24	01:23	01:23	01:25				

Maternity escalation plan: mitigations and escalations for managing shortfalls

As part of the maternity escalation plan during times of high acuity, we activate a range of supportive measures to maintain safe and effective care. This includes but is not limited to:

- office-based specialist midwives are asked to provide frontline support where needed
- matrons and senior managers step in to assist with clinical coordination and staffing
- out of hours, community midwives and continuity teams may be contacted to provide additional support on the unit.
- maternity manager is available on call 24/7 to help coordinate escalation, provide guidance, and make decisions to ensure the safe running of the service.

Family Health Matrons play a key role in reporting daily maternity SitRep and OPEL status updates, ensuring accurate and timely communication to the region and Integrated Care Board (ICB). This includes maintaining oversight of operational pressures, capacity and staffing levels across maternity services. To ensure continuity and robust reporting structures, weekend cover is also provided by the matrons. In addition to their reporting responsibilities, they offer vital support to clinical teams, helping to manage escalation, address emerging concerns, and upholding safety across the service.

Conclusion and Proposed Actions

The current midwifery staffing establishment does not fully meet the latest BR+ recommendations, largely due to the need for a 24/7 triage service. However, specialist roles have been expanded to align with national standards.

The following actions will be added/updated to the action plan addressing shortfall *(appendix one):*

- Continue successful recruitment and retention efforts into the agreed temporary uplift of 10.25 wte B6's & B3's (new action: 1.5).
- Business case under review for agreement of 12.1 wte Band 6 in line with BR+ review (new action: 1.6)
- Risk Assessment has been completed and added to the risk register regarding the current staffing deficit (new action: 1.7)
- BSOTS model go live date 30/4/25 on both sites (updated action: 1.1).

Escalations for upward reporting

- Upward report to Board the staffing report in its entirety.
- Record in Trust Board minutes receipt of the midwifery staffing oversight report covering staffing/safety issues in line with NICE midwifery staffing guidance and the agreed plan, including timescale for achieved the appropriate uplift in funded establishment including mitigations to cover shortfalls.
- Reference update on BSOTs to Board and links to MNSI letter of concern.

Maternity and acuity red flag report
October 24 – March 25

Acuity data is recorded using the Birth-Rate Plus tool. Workload and staffing information is input by the Labour Ward Coordinator every four hours (+/- 30 minutes) as a standard requirement. Ad-hoc entries can be submitted out with the set times and allow the Labour Ward Coordinator to input information if they have missed the mandated time frame, or to provide additional information between these times if activity/acuity is high. In practice, we find that data is less likely to be provided at the set times when the ward is busy, as the coordinators are busy managing the workload. These factors contribute to the limitations of this tool, but we recognise that this does still give us a broad oversight of activity over a given period.

Another limitation to Birth-Rate Plus tool is that it allows for subjective data input/bias. The analysis should be interpreted with caution and considered alongside other sources of information.

The following data shows acuity information for the period October 2024 – March 2025 and includes all data entries.

Summary

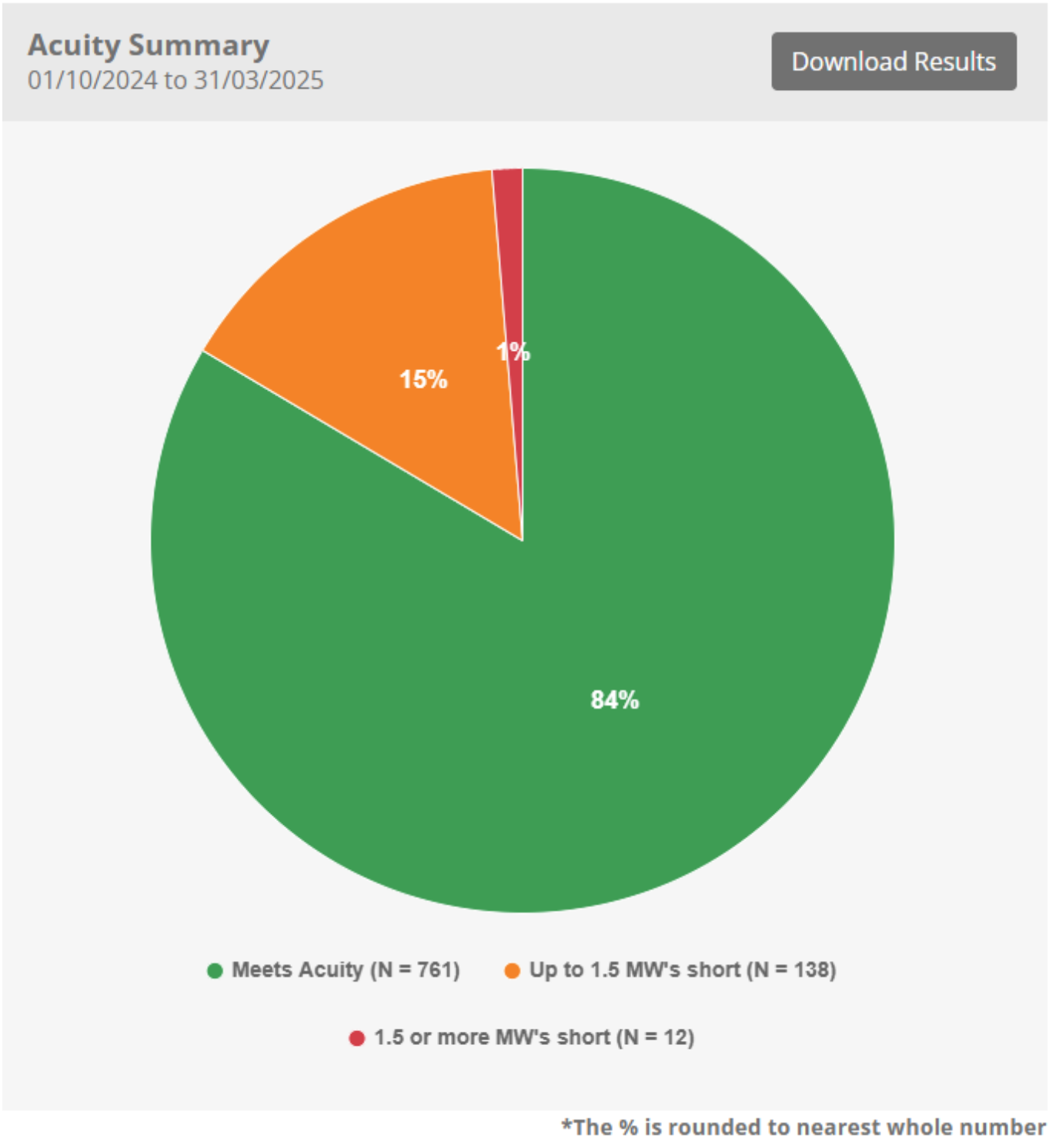
The birth-rate plus acuity tool displays a RAG dashboard and displays green when no staffing vs acuity issues, amber when an entry shows that a unit is up to 1.5 midwives short for the documented activity, then red when there is a calculated shortage of 1.5 or more registered staff at any data entry point.

Pilgrim hospital's results for the period October 24 to March 25 showed that they were green, on average, 84% of the time, amber 15% and red 1% of the time. This is a very similar picture to previous reports.

Lincoln hospitals results for the same period showed that they were green 67% of the time (a slight increase from 64% during the last reporting period), amber 30% and red 3% of the time.

Pilgrim Hospital Boston

There was 911 data entries out of a possible 1092. Compliance for data entry at pre-set timed at 83.42%, which is in line with previous compliance.
Acuity met on average, on 84% of data entries:



Staffing factors recorded included unexpected staff absence, unfilled rosters and no HCSW on shift. The most frequently recorded factor was unable to fill vacant shifts which occurred on 128 occasions. There

were vacant posts in this reporting period, but these vacancies have been filled so we would expect to see that reduce in the next report.

Number of Staffing Factors

01/10/2024 to 31/03/2025

Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected staff absence	120	26%
SF2	Unable to fill vacant shifts	128	27%
SF3	Staff on transfer	3	1%
SF4	Staff redeployed to another area	62	13%
SF5	No ward clerk	17	4%
SF6	No HCSW on duty	42	9%
SF7	Continuity of Carer Midwife present	62	13%
SF8	Continuity of Carer Midwife not available	33	7%
TOTAL		467	

*The % is rounded to nearest whole number

Number of Clinical Actions

01/10/2024 to 31/03/2025

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay in commencing IOL more than 2 hrs	39	30%
CA2	Delay in ARM of more than 4 hours	67	52%
CA3	Delay in scheduled LSCS of more than 4 hours	3	2%
CA4	Refusal of in-utero transfers due to acuity	0	0%
CA5	IOL-Delay in transferring to delivery suite following SROM for more than 4 hours	0	0%
CA6	Shift leader non supernumerary	21	16%
TOTAL		130	

*The % is rounded to nearest whole number

There remains a high level of delay in ARM, which can be attributed to the general rise in induction of labour, meaning an increase in the women who are eligible for this procedure. This is being monitored and to date there has been no impact on outcome for women.

It has been recorded that the shift leader was not supernumerary on 21 occasions (although not providing 1:1 care). This is a similar picture to the last reporting period. This is reflected in the shifts were escalation was required to ensure complete supernumerary status was returned. As detailed earlier in the report any instances where supernumerary status was lost are investigated to ensure that labour ward coordinators were not providing 1:1 care to a women in labour. This provides assurance patient care was not compromised.

When there is no labour ward coordinator available to coordinate, the service implement a series of measures to ensure safe and effective service continuity. This includes but is not limited to:

- reallocation of staff across areas based on clinical need
- requesting additional cover through the site team or bank where necessary
- prompt and continuous involvement of matrons to deputise for oversight and decision-making.
- in certain situations, the service may facilitate cross-site staff transfers to address critical gaps.

- core Band 6 Labour Ward midwives may be asked to step into a coordinating role temporarily, with appropriate support, to maintain oversight of activity and safety on the ward.

Number of Management Actions
01/10/2024 to 31/03/2025

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Escalation to community midwives	34	26%
MA2	Redeploy staff internally	24	18%
MA3	Staff unable to take allocated breaks	34	26%
MA4	Redeploy staff from non-clinical duties	3	2%
MA5	Staff stayed beyond rostered hours	11	8%
MA6	Management team/specialist midwives supporting clinically	10	8%
MA7	Patients transferred within the trust	12	9%
MA8	Full service closure	3	2%
TOTAL		131	

*The % is rounded to nearest whole number

The unavailability of breaks decreased to 26% which is reduction from 35% of the reported actions in the previous report.

Number of Red Flags recorded

01/10/2024 to 31/03/2025

Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	3	20%
RF2	Missed or delayed care (Delay in suturing more than 1 hour post birth except for water-births)	2	13%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	1	7%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	9	60%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) - more than 1 hr	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
TOTAL		15	

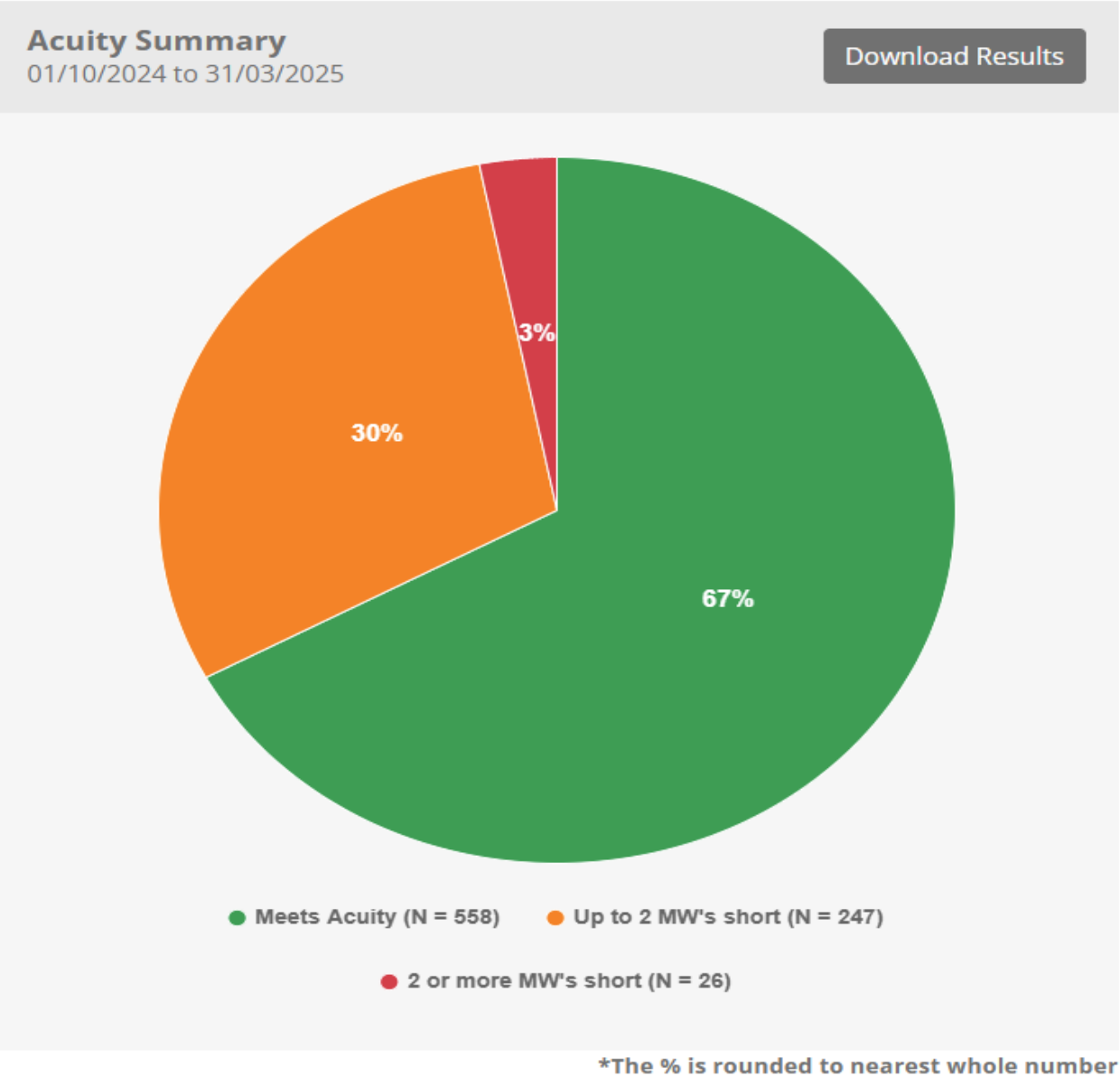
*The % is rounded to nearest whole number

Red flags were recorded on less than 1% of all data entries for the period – 15 occasions in total.

Lincoln Hospital

There were 831 data entries during the period, out of a possible 1092, with compliance for data entry at pre-set timed at 76.1%, which is similar to last reporting period. Compliance with data entry is higher when all entries are reviewed and not just those at pre-set times. When reviewing the data it would be expected that late entries would be red, hence the reason for the late data entry. However, for this reporting period the majority were green.

Acuity met on average, on 67% of data entries. This is an increase from the last reporting period which was 64%. Lincoln had some vacancies during this period which have since been recruited to. Therefore the expectation would be to continue to see this rise still further in the next report.



Number of Staffing Factors

01/10/2024 to 31/03/2025

Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected staff absence	75	14%
SF2	Unable to fill vacant shifts	113	21%
SF3	Staff on transfer	3	1%
SF4	Staff redeployed to another area	27	5%
SF5	No ward clerk on duty	139	26%
SF6	No HCSW on duty	22	4%
SF7	Staff absence due to illness/shielding/symptoms Covid-19	0	0%
SF8	Continuity of Carer Midwife present	76	14%
SF9	Continuity of Carer Midwife not available	82	15%
TOTAL		537	

*The % is rounded to nearest whole number

Staffing factors included were unexpected staff absence and unfilled rosters. This is an increase from the last report and largely attributed to the vacancy. Continuity of Care midwife was available more in this reporting period.

Number of Clinical Actions

01/10/2024 to 31/03/2025

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay in commencing IOL of more than 2 hours	27	7%
CA2	Delay in ARM of more than 4 hours	347	87%
CA3	Delay in scheduled LSCS of more than 4 hours	2	1%
CA4	Refusal of in-utero transfers due to acuity	2	1%
CA5	IOL-Delay in transferring to delivery suite following SROM for more than 4 hours	8	2%
CA6	Delay in transfer to delivery suite following prostin for PSROM for more than 2 hours	8	2%
CA7	Shift leader non supernumerary	3	1%
TOTAL		397	

*The % is rounded to nearest whole number

Clinical actions recorded in this report are similar to the last. Almost solely down to delay in ARM which accounted for 87% of the clinical actions recorded. This is being monitored and to date there has been no impact on outcomes for women. Delays are discussed on the safety huddle and plans made to transfer to Pilgrim if possible. The delays are reported to the region in the daily sit rep and external support sought if there is no plan feasible to resolve within the Trust.

It has been recorded that the shift leader was not supernumerary on 3 occasions. This was reviewed and was rectified with escalation. As detailed earlier in the report any instances where supernumerary status was lost are investigated to ensure that labour ward coordinators were not providing 1:1 care to a women in labour. This provides assurance patient care was not compromised.

When there is no labour ward coordinator available to coordinate, the service implement a series of measures to ensure safe and effective service continuity. This includes but is not limited to:

- reallocation of staff across areas based on clinical need
- requesting additional cover through the site team or bank where necessary

- prompt and continuous involvement of matrons to deputise for oversight and decision-making.
- in certain situations, the service may facilitate cross-site staff transfers to address critical gaps.
- core Band 6 Labour Ward midwives may be asked to step into a coordinating role temporarily, with appropriate support, to maintain oversight of activity and safety on the ward.

Number of Management Actions

01/10/2024 to 31/03/2025

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Escalation to community midwives	21	12%
MA2	Redeploy staff internally	89	49%
MA3	Staff unable to take allocated breaks	39	22%
MA4	Redeploy staff from non-clinical duties	4	2%
MA5	Patients transferred within the trust	5	3%
MA6	Staff stayed beyond rostered hours	11	6%
MA7	Management team/specialist midwives supporting clinically	6	3%
MA8	Full service closure	5	3%
TOTAL		180	

*The % is rounded to nearest whole number

Management actions recorded are a similar picture to the last reporting period. The unavailability of breaks decreased within this reporting period to 23% which is positive for the staff. Redeployment of staff to support and escalation of care needs decreased from 60% to 49%. This will have impacted those staff needing to be redeployed. Full service closure remained low and was only recorded on 5 data entries. This is reflected in the increase of patients being transferred within the Trust, and that is monitored on an ongoing monthly basis.

Number of Red Flags recorded

01/10/2024 to 31/03/2025

Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	2	33%
RF2	Missed or delayed care - Delay in suturing more than 1 hour post birth except for water-births	2	33%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	1	17%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	1	17%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) of more than 1 hr	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
TOTAL		6	

*The % is rounded to nearest whole number

Red flags were recorded on <1% of all data entries for the period – 6 occasions in total

Appendix one: Action plan addressing shortfalls

Action number	Objective	Action	Lead	Timescale	Progress	Evidence	RAG rating
1.0	Review triage and antenatal assessment services across ULTH in line with BSOTTs	Appoint B7 to lead on Triage and AAC	Karen Ludkins (Matron)	Aug 2024	**11/07/2024:** B7 appointed and due to commence post in August **01/11/2024:** Commenced in post 16th September	Job description	
1.1	Review triage and antenatal assessment services across ULTH in line with BSOTTs Maintain safe staffing in the period before uplift agrees and staff recruited	Review service in line with BSOTTs standards	Fran Stephens (B7 Triage lead)	Dec 2024	**11/07/2024:** Await B7 start **01/11/2024:** Benchmarking completed against RCOG Good Practice paper and CQC National Review. Triage action plan underway based on benchmarking activities. Red/amber actions to be added and monitored through MatSIP and all other actions to be monitored through Triage action plan by B& lead and ANC matron. Action plan to be reviewed at November MNSC and will subsequently follow usual reporting route through MNOG/QC and LMNS **01/11/2024:** Case in need submitted 31/10/2024 and plan for review at CRIG **30/04/2025:** BSOTs model introduced into practice following education and training lead **15/05/2025:** Business case written suggests 25 WTE required to fully implement BSOTs including one single point of contact, triage of labourers, PN care. Refer to action1.6 for new business case progress -BSOTs implementation monitored through risk register -in: Number 854, risk register rating 16- severe (including MNSI letter of concern)	Benchmarking Action plan	
1.2		Recommendations/report around provision of service to be written	Fran Stephens (B7 Triage lead) B7 lead and matron	Dec 2024 Jan 2025		Report	
1.3		Report to be presented to MNOG/LMNS to gain approval				Minutes Report	
1.4		Business case process to be followed to gain agreement to proceed to fully implement BSOTs		Feb 2025			
1.5		Continue successful recruitment and retention efforts into the agreed temporary uplift of 10.25 wte B6's & B3's	Matrons	September 2025	Out to advert		
1.6		Business case under review for agreement of 12.1 wte in line with BR+ review.	EU	September 2025	15/05/2025: Discussion with finance re source of funding		
1.7		Add to the risk register regarding the current staffing deficit	EU	Complete	Risk register number: 734, risk register rating 16- 12 (moderate)		

2.0	Maintain safe staffing in the period before uplift agrees and staff recruited	Daily safety huddle to review staffing across all sites and areas	Matrons	Ongoing until uplift agreed Ongoing until uplift agreed	11/07/2024: All actions in place and ongoing	Daily huddle reports, escalation policy, incident reports, bi-annual staffing report	
2.1		Twice weekly forward staffing review to ensure all services appropriately covered				Daily huddle reports, escalation policy, incident reports, bi-annual staffing report	
2.2		Robust escalation policy in place					
2.3		Monitoring of incident reporting related to staffing					

Date of Report	*09/01/ 2025*
Item Number	
Position Report Qualified in Speciality (QIS)	
Presented by	*Rachel Wright*
Author(s)	*Cathy Franklin Lead Nurse CYP*
	Rachel Wright Neonatal Matron

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

Risk Assessment	*N/A*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	

Executive Summary

Neonatal Services are delivered and aligned to national standards as identified within the Neonatal Toolkit. Neonatal nursing workforce standards are clearly defined within the Toolkit, with 70% of the registered workforce requiring to be Qualified in Speciality (QIS).

The current position of staff Qualified in Specialty (QIS) is currently:

- 59.2% Lincoln County Hospital
- 73.2% Pilgrim Hospital Boston

This report identifies one primary risk that there is a lack of QIS trained staff in the service preventing compliance with BAPM standards. Due to current staffing constraints the service is unable to release more candidates to training at LCH. Courses are available with 3 providers. As from November 2024 NHS England stipulate that all QIS candidates must complete 150 hours of placement in a Tertiary centre. Tertiary level staff are also expected to have placements in level 1 and level 2 Units.

The service is mitigating these risks as evidenced by a lack of incident or safety concerns relating to staffing being identified.

The service has taken action to improve the QIS compliance, with demonstrable evidence of improvement from early reported data from the beginning of 2024. However, more action is needed, and is being taken as summarised within this report. Based on the action taken and that planned, the service has set out a trajectory of achieving 70% compliance by January 2027. This trajectory considers projected turnover rates of 2.0WTE loss every April.

National Nursing Workforce Standards: British Associate of Perinatal Medicine (BAPM)

The British Association of Perinatal Medicine (BAPM) developed a Neonatal Toolkit in 2009, defining standards for the nursing workforce determined by the severity of illness and care required, to establish nursing/patient ratios.

In addition to ratios of care, the toolkit clearly defines a standard for the proportion of the nursing establishment whom are Qualified in Speciality (QIS). QIS nurses are those who have undertaken a university accredited post-graduate Neonatal Critical Care course.

In all neonatal units, at least 70% of Registered Nurses/Midwifery staff should hold a post registration qualification in neonatal care i.e. QIS, not including nurses in training. There is robust evidence of improved outcomes for those babies who are cared for by appropriately trained staff.

Context: Set-up of the local service

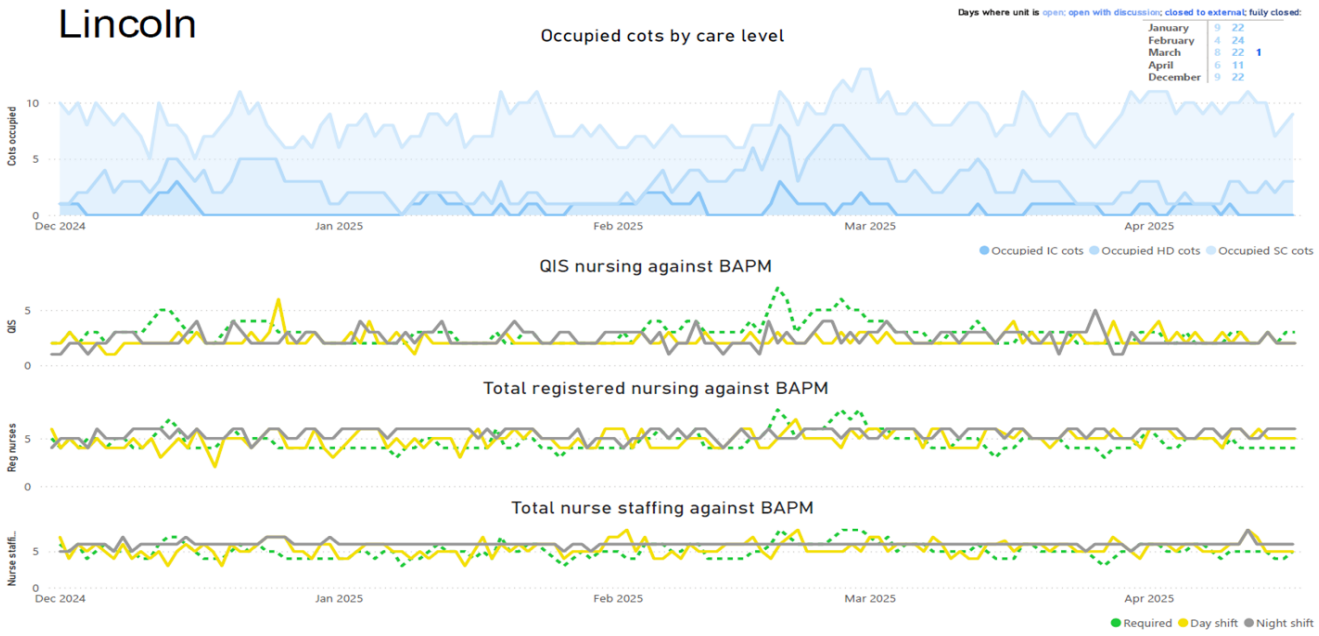
Lincoln County has a Local Neonatal Unit (LNU) providing short term Intensive, High Dependency and Special care to babies from Lincolnshire and the surrounding counties.

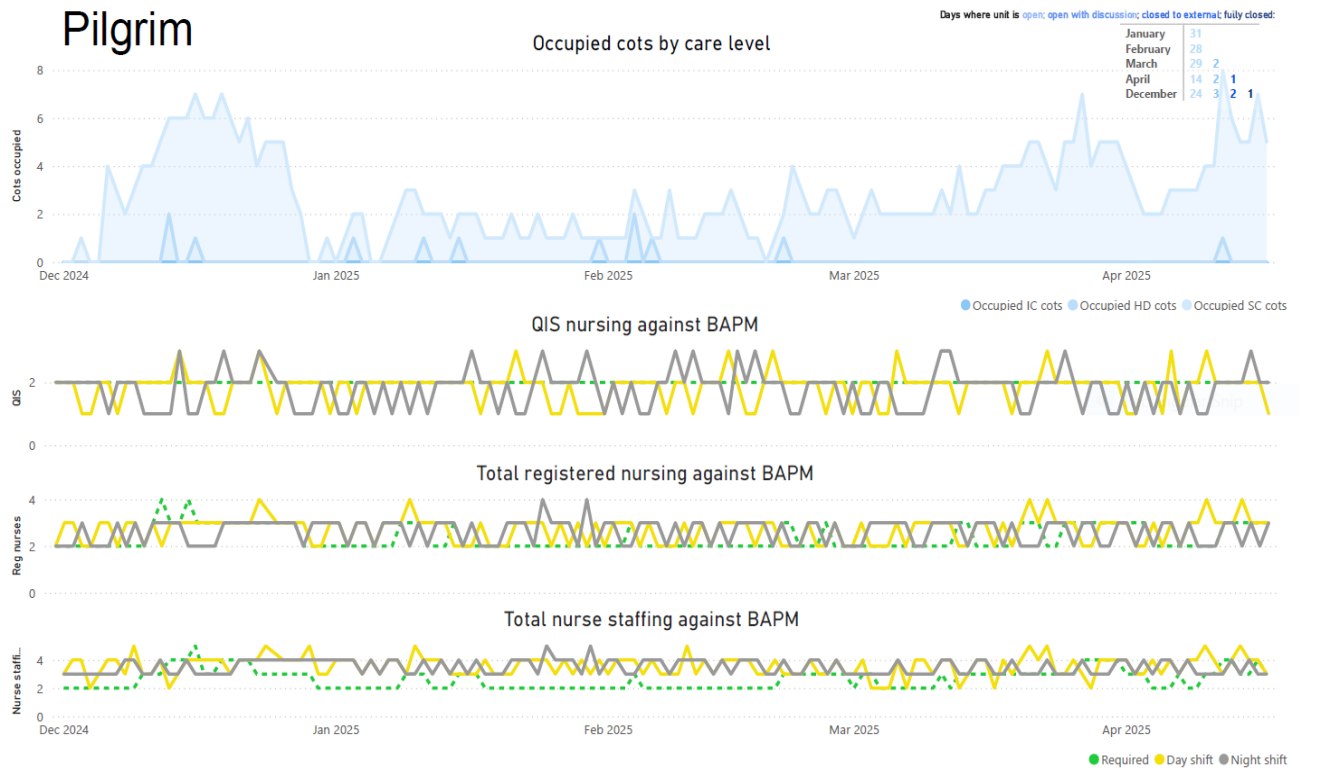
Pilgrim Hospital Boston has a Special Care Baby Unit (SCBU) providing care to term and pre-term babies. Babies who do not meet the admission criteria are stabilised prior to transfer.

Current Workforce Position

The following summaries of the workforce position have been provided by the East Midland Neonatal Operational Delivery Network (EMNODN) using data from Badgernet. These charts demonstrate:

- Position of both units within ULHT against national staffing standards.
- The service is not always able to meet national standards in relation to QIS.
- To understand the risk on an ongoing basis and for assurance purposes, patient outcomes are measured through the National Neonatal Audit Programme (NNAP) with quarterly reporting through Neonatal Governance.





Challenges and Risks Identified

Recruitment to vacant posts of staff with QIS:
This is a national challenge across the UK to achieve the 70% QIS target. This means that there are limited prospective staff who already hold QIS, when new staff recruitment is needed to fill vacancies. This often means that newly recruited staff require QIS training.

The local workforce is challenged due to retention of existing QIS nurses due to a high natural turnover rate linked to retirement, relocation, parenting leave and staff advancement and career progression.

The risk is that there are insufficient QIS nurses within the service.

To mitigate these challenges, the service are proactive in recruitment of staff to vacant posts as soon as notice of resignation is received. The service at Lincoln County is currently slightly over budget due to the over recruitment of registered nursing staff. In order to maintain patient and staff safety, the service are proactive in providing training and education to ensure staff are appropriately trained.

Availability of Post-Graduate Accredited QIS courses:

The challenge is further exacerbated by university provision of accredited QIS courses, with both local universities within Nottingham and Sheffield holding the course on the same day which impacts on the service ability to safely cover rosters.

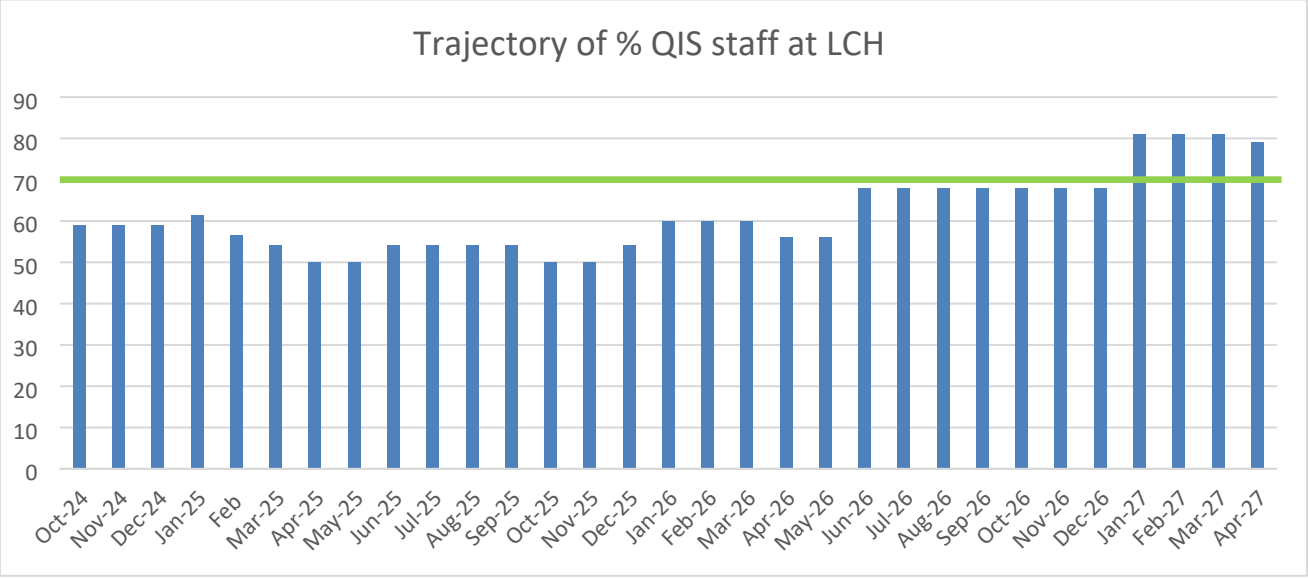
The risk is that there are insufficient courses to meet the QIS need/demand from the service.

To mitigate this challenge, access to accredited courses further afield are being explored, however it is noted that this may prove challenging due to the need for staff to travel out of the region. In addition, new and junior members of staff need to feel confident and competent to undertake post graduate training, and therefore need to be supported for a number of months prior to commencement of suitably accredited courses.

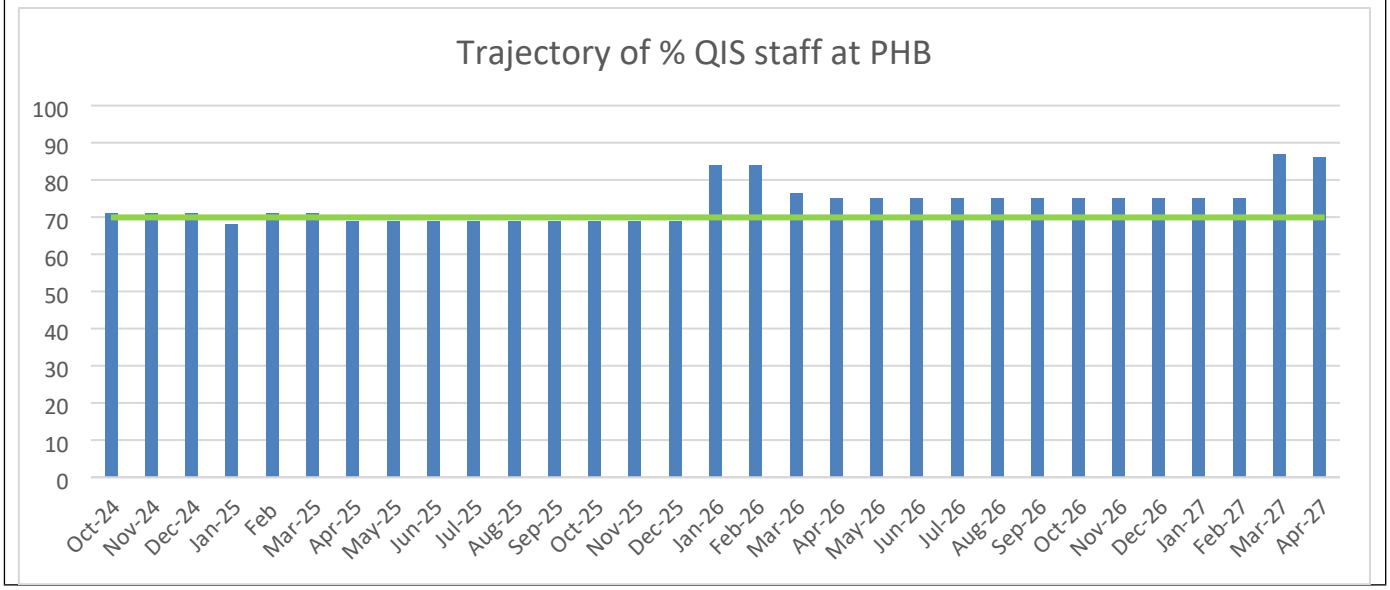
- **Trajectory to attain 70% target:**

Recognising the above risks and mitigations, the service has set out a realistic trajectory, to achieve the 70% QIS target, taking into account projected turnover rates[1]. This is demonstrated in the following charts for Lincoln and Boston.

These outline that 70% QIS trajectory should be attained by March 2026.
(see also **Appendix 1**).



[1] Projected turnover rate is based on 2 full time QIS trained staff at Lincoln, and 1 full time QIS trained nurse at Pilgrim Hospital, Boston



Summary of ACTION PLAN: To meet QIS target of 70%

Actions already taken:

- Completed training needs analysis for identification of funding
- Availability of QIS training sourced through various providers for staff to undertake. Currently accessing QIS training from Nottingham, Nottingham Trent and De Montfort University. Funding received through LBR.
- Utilise specialist nurses and Ward Manager during periods of high acuity to mitigate risks around insufficient staff with QIS
- Lack of QIS on Neonatal Risk Register
- QIS metric included in Neonatal monthly dashboard
- Staff access the network foundation course

The actions already taken (summarised above) has supported the service improve its QIS position. Further actions, as summarised below, are now underway to support achievement of the 70% QIS target.

Actions being taken now:

- Meeting with Finance monthly to monitor vacancy – pipeline for recruitment
- Track via incident reporting any quality and safety risks relating to staffing concerns
- Regular reviews of eligibility of staff to undertake QIS
- Ongoing assurance reporting via Family Health Cabinet and the Maternity, Neonatal Oversight Group (MNOG).

Mitigation of identified risks

To mitigate against non-compliance with BAPM QIS standards, the following is in place:

- Work closely with the EMNODN education team who provide a foundation programme for all new nurses working in neonates. At ULHT we are proactive in ensuring nurses where possible are able to complete this course with excellent feedback received.
- An increase in the Clinical Education budget to 1wte at Lincoln County to reflect the support required following the recruitment of junior staff. Pilgrim Hospital Boston equates to 0.6wte.
- Provision of an in house development programme available to all staff offered monthly
- Competency packs for all levels of staff
- Foundation programme run by the EMNODN for all new starters to the Neonatal Service
- A robust mentorship pathway is in place.

- A clearly structured approach through the appraisal process is embedded to enable career progression for all neonatal nurses. The Royal College of Nursing (RCN) novice to expert pathway is referred to, thus allowing progression from QIS to Advanced Neonatal Nurse Practitioner (ANNP), bridging the gap between nursing and medical roles.
- Proactive steps to gain Bliss and Baby Friendly Initiative (BFI) accreditation are underway, with the achievement of these evidencing the delivery of exceptional family centred care and improving patient outcomes. Through these initiatives, enhanced organisational reputation, retention and recruitment is achieved.
- National funding received for the implementation of Allied Health Professionals (AHP) at ULHT and have successfully recruited to the roles of Dietitian, Physiotherapist and Clinical Psychologist working Trust Wide.
- National funding received for the roles of Neonatal Risk Lead and a Practice Development Nurse (PDN), again supporting service provision
- Ward Manager, Matron, Clinical Education and Outreach team support the rota where required.
- Now offering 12 hours paid study time for QIS days.

The Trust shared its QIS position and articulated its plans to the East Midlands Operational Delivery Network (EMODN) during the network Peer Review in June 2024. The final report following the visit has just been received by the Trust (December 2024) and this will be used to identify and scope additional actions necessary to further support the Trust's QIS improvement action plan.

Conclusion

The neonatal service continues to closely monitor the QIS compliance of its workforce and this is reflected in monthly dashboard figures that are reported on.

The service will continue to access development programmes provided both internally and externally ensuring access for all appropriate staff. As a service, roster management is closely audited and scrutinised by the Executive team on a monthly basis, offering opportunity to monitor QIS provision with specialist nurses working in a clinical capacity when required.

Completion of staff competencies continue to be closely monitored through the education team and will be supported to undertake QIS training when in a position to feel confident to do so. Patient outcomes through NNAP data will also be monitored on a monthly basis and again scrutinised through governance processes.

References

Toolkit for High-Quality Neonatal Services. NHS & Department for Health (2009)

LCHS & ULTH Quality Accounts 2024-2025

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*1 July 2025*
Item Number	*8.2*

LCHS & ULTH Quality Accounts

Accountable Director	*Kathryn Helley, Group Chief Clinical Governance Officer*
Presented by	*Kathryn Helley, Group Chief Clinical Governance Officer*
Author(s)	*Bernadine Gallen Head Of Clinical Effectiveness & Complaints*
Recommendations/ Decision Required	*The Board are asked to* • *Note the Quality Accounts*

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

4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	*X*
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 Quality Account is a report about the quality of services offered by ULHT and LCHS.

The Trust has received confirmation the Quality Account has to be published by the 30 June 2025.

Since the COVID-19 pandemic, NHS providers are no longer expected to obtain assurance from their external auditor on their Quality Account so there will be no review of any quality indicators or the content within the Quality Account. There will be no limited assurance report.

The Quality Account has utilised the content requirements for Non-Foundation Trusts.

The Quality Account has been presented at Quality Committee in May and June to ensure the Quality Account is fully ratified prior to publishing on the 30 June 2025.

The three quality priorities for 2025-26 have been aligned to the LCHG 2025-2030 Strategy.

Healthwatch, ICB and Health Scrutiny Committee for Lincolnshire have provided their statements.

NHS
Lincolnshire Community Health Services
NHS Trust

Lincolnshire Community Health Services NHS Trust Quality Account 2024-25

Caring and building a healthier future for all

Glossary of Abbreviations

A&E	Accident & Emergency
AAC	Augmentative and Alternative Communication
BASHH	British Association for Sexual Health and HIV
BHF	British Heart Foundation
COVID-19	Coronavirus disease caused by the SARS-CoV-2virus
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DATIX	Internal Reporting System for Risk, Incidents, Complaints/PALS and Mortality
DKA	Diabetic Ketoacidosis
DQMI	Data Quality Maturity Index
DSPT	Data Security and Protection Toolkit
EATS	Electronic Assistive Technology Service
ECDS	Emergency Care Dataset
ED	Emergency Department
EDI	Equality Diversity and Inclusion
EPR	Electronic Patient Record
ERS	Employer Recognition Scheme
FPSG	Falls Prevention Steering Group
FFT	Friends and Family Test
FTSUG	Freedom to Speak Up Guardian
GLiSH	Greater Lincolnshire Integrated Sexual Health
HSJ	Health Service Journal
ICB	Integrated Care Board
ICNARC	Intensive Care National Audit and Research Centre

IG	Information Governance
JBDS	Joint British Diabetes Societies
KPI	Key Performance Indicator
LCHG	Lincolnshire Community & Hospitals NHS Group
LfD	Learning from Deaths
LiSH	Lincolnshire Integrated Sexual Health
MAPLE	Mental and Physical Lived Experience
ME	Medical Examiner
MINAP	Myocardial Infarction National Audit Programme
MMR	Measles, Mumps & Rubella
MorALS	Mortality Assurance & Learning Group
MRSA	Methicillin-Resistant Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
N/A	Not Applicable
NACEL	National Audit of Care at the End of Life
NACR	National Audit for Cardiac Rehabilitation
NAIF	National Audit of Inpatient Falls
NCEPOD	National Confidential Enquiry into Patient Outcomes and Death
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NWCSP	National Wound Care Strategy Programme
OSCE	Objective Structured Clinical Examination
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System

PbR	Payment by Results
PEIG	Patient Experience & Involvement Group
PEOL	Palliative End of Life
PHSO	Parliamentary and Health Service Ombudsman
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Investigation Response Framework
PURPOSE-T	Pressure Ulcer Risk Primary or Secondary Evaluation Tool
QC	Quality Committee
REACH	Race, Ethnicity and Cultural Heritage
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RSV	Respiratory Syncytial Virus
SAIS	School Age Immunisation Service
SEND	Special Educational Needs & Disabilities
SUS	Secondary Uses Service
SIG	Skin Integrity Group
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
TARN	Trauma Audit Research Network
TCS	Terms and Conditions of Service
TOMs	Therapy Outcome Measures
UTC	Urgent Treatment Centre
ULTH	United Lincolnshire Teaching Hospitals
VRRT	Vaccination and Rapid Response Team

Contents

Part 1: Chief Executive Statement

Welcome to the Quality Account for Lincolnshire Community Health Services NHS Trust (LCHS) for 2024/25. This document provides an overview of all the activity that has taken place in our community services over the past year, with a focus on improving the quality of care that we provide to our patients.

This year has seen the organisation come together as a Group with United Lincolnshire Teaching Hospitals NHS Trust (ULTH), which has enabled us to focus more than ever before on improving our services together for the benefit of the residents of Lincolnshire.

We are already seeing benefits in terms of more streamlined, effective and efficient services that are easier for patients to understand and access. There are examples of fantastic Group working across our services, which have reduced bureaucracy and put the patient at the heart of the design of our services.

However, this past year has not been without its challenges. We have continued to experience staffing challenges in a number of our services, as well as the impact of a spike in respiratory viruses during the winter season, which affected both our staff and our services. We have also faced a number of estates issues across our sites, including flooding and required fire safety improvements.

Achievements over the past year have included:

- Transforming Scotter Ward at John Coupland Hospital in Gainsborough. The £4.5 million construction work on Morton Suite converted it into state-of-the-art ward, which will be opening in the coming months.
- Securing the contract to continue providing integrated sexual health services in Lincolnshire and expanding to cover North Lincolnshire and North East Lincolnshire. The new service is known as Greater Lincolnshire Integrated Sexual Health (GLiSH).
- Expanding access to sexual health clinics in North East Lincolnshire with new clinics in Grimsby and Immingham.
- Improving the patient environment at Gloucester Ward at Skegness Hospital with hand-painted wall art and a cosy snug room, which patients can use when their families visit them.
- Achieving the Defence Employer Recognition Scheme (ERS) Gold Award for the support the Trust offers to the Armed Forces community.
- Offering additional therapy capacity in community hospitals.
- Piloting a project where community nurses and community paramedics support staff in the East Midlands Ambulance NHS Trust emergency operations centre by

screening patients and offering support through urgent care services for those who do not need an ambulance response.

- Numerous national award shortlists and achievements for individuals and teams across the Trust:
    - The prestigious Gold Standard Framework Quality Hallmark Award for Scotter Ward in Gainsborough.
    - The Lincolnshire Health and Care Apprentice Centre Team were finalists in The Excellence in Education and Training award in the NHS Parliamentary Awards 2024.
    - Wound care project reached the final of Health Service Journal (HSJ) Patient Safety Awards in the Community Care Initiative of the Year category.
    - Two colleagues from the Macmillan Team received prestigious Cavell Star Awards.
- Continuing to support our colleagues to achieve Queen's Nurse titles.
- Rolling out the Diamond Award in Quality Accreditation programme across our clinical areas, assessing and recognising high quality care.
- Improving equipment available to patients on the Cardiac Rehabilitation Service exercise programme in Bourne.

We also continue to involve our patients in discussions and decision making in the Trust, with the development of a new LCHS Patient Panel, which is involved in regular discussions about the development and improvement of services, as well as the delivery of broader public engagement activities around the development and delivery of specific services and service specifications.

Over the next year we will continue our focus on prioritising our services which deliver care close to the people that need them, improving quality of care for our patients and making sure that people are seen and treated in the right place, at the right time, by the most appropriate healthcare professional as part of Lincolnshire Community and Hospitals NHS Group.

Professor Karen Dunderdale,

Chief Executive

Part 2: Deciding our Quality Priorities for 2025-2026

To determine our quality priorities, we have consulted with several stakeholders including our Quality Committee (QC). The QC on behalf of the Trust Board approve the priorities and there will be regular reports on progress to QC throughout the year.

We have ensured that our quality priorities are aligned to the Group strategy. We have considered our progress throughout the year against last year's priorities to help decide which priorities need an ongoing focus within this year's Quality Account.

The following priorities have been identified for particular focus for the Group in 2025-26 from the Group Strategy 2025-2030. These priorities are extended over the coming years to ensure they are fully embedded within our organisation.

Priority 1 – Maximise safety of patients in our care, through learning from incidents and reducing incidents causing harm.

Why have we selected this Priority?

Safe patient care is the foundation of high-quality healthcare. Our strategy aligns with requirements of the National Patient Safety Strategy and the National Patient Safety Incident Response Framework (PSIRF), promoting a culture of openness, learning, and continuous improvement. We have looked at trends in our incident reporting over time and are working collaboratively to identify solutions, while promoting a strong organisational safety culture. We are driven to deliver the best possible care and health outcomes. We want to ensure our services remain safe and embed strong processes to learn from practise.

Our Current Status:

The number of incidents causing moderate or severe harm in 2024-2025:
Moderate = 587

Death = 2

What will success look like?

Number of incidents causing harm will be reduced.

How will we monitor progress?

Quarterly reports will be presented at the Quality Committee which will focus on highlighting progress and key actions/mitigations for off track actions.

Priority 2 – Identify areas where services do not meet best practice requirements and deliver demonstratable improvement in those areas.

Why have we selected this Priority?

Good infection prevention and control (IPC), including cleanliness, is essential to ensure that people who use health and adult social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are developed and maintained.

We must adhere to the Health and Social Care 2008: code of practice on the prevention and control of infections and related guidance. This is otherwise known as the "Hygiene Code." These are the 10 criteria against which the CQC will judge a registered provider on how it complies with the IPC (including cleanliness) requirements, which are set out in the regulations.

Our Current Status:

The Trust will need to demonstrate adherence to the following 10 criteria, currently there are 3 partially compliant areas in criteria 2 and 1 non-compliant area within criteria 3.

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2. The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3. Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4. The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5. That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

7. The provision or ability to secure adequate isolation facilities.
8. The ability to secure adequate access to laboratory support as appropriate.
9. That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
10. That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

What will success look like?

Improvement of adherence to National Infection Prevention Control (IPC) standards.

How will we monitor progress?

Quarterly reports will be presented at the Quality Committee which will focus on highlighting progress and key actions/mitigations for off track actions.

Priority 3 - Focus on improving the top three patient feedback themes: Communication, Appointments and Clinical Practice.

Why have we selected this Priority?

Patient experience is at the heart of everything we do. We understand that care is more than just clinical outcomes, it's about meeting the physical, emotional, and personal needs

of our patients and their families. Every person who uses our services should feel valued, respected, and well cared for. We know that patient experience is critical to both individual patients and their families and goes well beyond the health outcomes of their care.

Our Current Status:

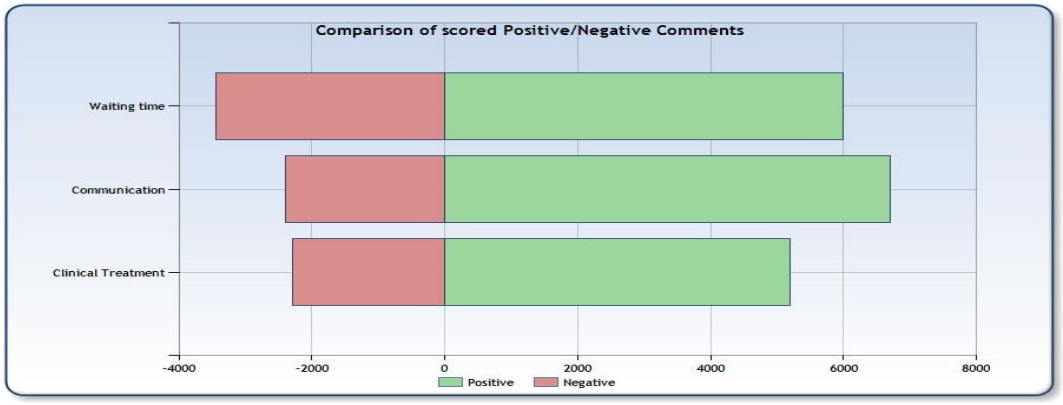
Top three themes of complaints during 2024-2025:

Complaint Categories	Number received	% of overall complaints
Access to treatment or drugs	98	48%
Patient Care including Nutrition/Hydration	34	17%
Communication	21	10%

The Trust received 88.27% Positive (66974 ‘Positive’ Responses / 75876 Total Responses) from the FFT.

Top three themes’ Friends & family Themes

- Waiting Times
- Communication
- Clinical treatment



What will success look like?

Reduction in the top three patient feedback themes, through complaints and Friends & Family Test.

How will we monitor progress?

Quarterly reports will be presented at the Quality Committee which will focus on highlighting progress and key actions/mitigations for off track actions.

Looking Back: Progress made since publication of 2023-24 Quality Account.

This section of the Quality Account presents in summary the Trust's progress since the publication of last year's account against the identified improvement priorities.

These were:

1. • **End of Life Care**
2. • **Presure area Care**
3. • **Diabetes Pathway**

Introduction

The Quality Account for 2023-24 outlined the Trust's proposed quality improvements for the year ahead (2024-25). These priorities were identified following engagement with patients, the public, staff and external stakeholders. During the year 2024-25 we have been monitoring our progress against these priority ambitions through our governance framework. The priorities that we have not carried forward will become 'business as usual' and we will have defined work streams to enable the Trust to deliver on the improvements not achieved in 2024-25.

Trust performance

This section provides detail on how the Trust has performed against the three priority ambitions. Results relate to the period 01 April 2024 - 31 March 2025 or the nearest period available. Mechanisms of measurement vary by priority and by the availability of national benchmark.

Priority 1: End of Life Care

We said we would:

Have a task and finish group who will review the standards and processes across the system to improve timely recognition and identification of people in their last year of life.

We have supported the review of the Lincolnshire strategy, which highlights the need for system wide approach to improving recognition and identification. Promotion of identification tools recommended by National Institute for Health and Care Excellence (NICE) have been achieved through education events and tools are available to each department. Work has commenced on exploring appropriate tools to support clinicians.

Have an education programme for End-of-life care rolled out across the Trust.

Fundamentals of Palliative & End of Life (PEOL) education delivered through PEOL Champions forum, Ward Ready programme and Dying Matters month. LCHS is a key partner in developing an Education Strategy for PEOL across Lincolnshire, which will support core education across the system. Staff have been involved in the development of ReSPECT podcasts. Once the education strategy is published (later this year) we will be able to roll out the updated education framework across the Group. Standard definitions for Palliative and End of Life Care have been developed and are awaiting final approval through organisations to improve understanding and reduce risk of patient harm due to lack of clarity across providers.

Review End-of-life documentation across the Lincolnshire system and standardised as appropriate.

The review of policy is completed and documentation for Five Priorities of Care being updated. Again, this is part of Lincolnshire system wide approach and covers partner organisations. Integrated care approach taken.

Capture End-of-life care within the Trust's Quality Accreditation programme.

Mapping of framework completed and recognition that the accreditation framework already supports majority of end of life care. Framework adapted to support elements of end of life care is being trialled; this includes personalised care approaches to nutrition and hydration and falls risk and appropriate monitoring of syringe drivers. This will inform review of the current accreditation tools going forward.

Increase the number of staff responding to the staff survey within the annual National Audit of Care at the End of Life (NACEL) survey to increase the staff voice in the care of end-of-life patients.

In 2021, a new element was introduced into the NACEL Audit which was the staff reported measure survey. This survey focused on themes of staff confidence, support and culture to staff working with end-of-life patients in inpatient settings. There were only 6 staff who participated in 2021 and 10 in 2022. The Audit was paused by NACEL in 2023. Through promotion of the staff reported measure survey at various meetings and communications staff participation increased to 38 in 2024.

Raise awareness of the shared end of life strategy across Lincolnshire and map progress through PEOL.

The strategy has been published. LCHS have collaborated with partner organisations as part of core palliative leadership system group to develop a socialisation plan. LCHS staff are also supporting socialisation of strategy in other organisations / areas as per plan.

Data Source: Palliative and End of Life Care Lead Nurse

What more do we need to do to achieve our success measures?

The initiatives initiated in 2024-25 are anticipated to deliver measurable benefits in 2025-26.

Priority 2: Pressure Area Care

We said we would:

There will be a standardised process for pressure ulcer risk assessment:
A Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE-T) is now utilised across all areas of the Trust, standardising how risk assessments are completed.

There will be a standardised template for recording pressure ulcer care and prevention:

The aSSKINg care bundle is a tool, which guides and documents pressure ulcer prevention and treatment, which is aimed at reducing the risk of patient harm. It is an evidence-based approach that can be adopted across a range of care settings. The aSSKINg care bundle is in place within the Electronic Patient Record (EPR) to support standardised and evidence-based care, which can be personalised to the needs of each patient.

A single policy for pressure ulcer care will be in place within LCHS and the wider system:

The development of a system-wide pressure ulcer policy proved challenging due to provider diversity across the system. Therefore, it has been agreed that the National Wound Care strategy will be used as a basis for all policies across system with providers being able to adapt this as required to meet the care needs of their populations.

Compliance with education objectives will improve:

Implementation of community nursing competencies and associated training packages to ensure all community staff have the relevant skills and training.

Progress of this priority and wider pressure ulcer care developments has been monitored through local governance meetings into the Skin Integrity Group and Patient Safety Group with upwards reporting to the Quality Committee.

Data Source: Tissue Viability Team

What we need to do to achieve our success measures?

The work undertaken throughout 2024-25 in pressure ulcers has laid a solid foundation for further improvement and impact in 2025-26.

Priority 3: Diabetes Pathway

We said we would:

Getting the Basics Right – Digital Transformation

Within the Trust's antenatal clinics, the diabetes specialist nurses are inputting into the maternity Medway system.

The Trust are using Advice & Guidance to its fullest potential in both Endocrinology and Lipidology, which uses an integrated care portal which is used system wide.

Defining Service Models

A business case has been developed to increase the number of Diabetic Specialist Nurses. The Team provides a community multi-disciplinary team to support the community Diabetic Specialist Nurses.

Improving Quality & Safety

Business cases have been submitted for an expansion of the Diabetic Specialist Nurses workforce to meet national benchmarking requirements, in addition to the business cases that have been submitted to initiate an endocrine specialist-nursing workforce and a secondary care lipid specialist nurse workforce.

The clinical governance leads receive monthly reports in diabetes/insulin related incidents within the hospital. We also have a Diabetic Ketoacidosis (DKA) task & finish group and have developed a new pathway for patients who develop DKA whilst in hospital.

Service Development for Lipid Specialist Nurse Service

A business case has been submitted to the Integrated Care Board (ICB) from the ICB Programme Manager for lipidology nurse specialists that sit within the community setting, with input to and from secondary care.

Sustainable and Multi-professional Workforce

A review of what is required to provide and develop the existing service we have, benchmarking against the Joint British Diabetes Societies (JBDS) workforce calculator (national), our current inpatient Diabetic Specialist Nurses workforce is only around 30% where it should be against nationally recommended guidance. For outpatient care we have predicted what proportion of current consultant delivered services could be switched to nurse led services.

Data Source: Endocrinology Department

What more do we need to do to achieve our success measures?

There are ongoing workstreams with our System Partners to improve the service we provide for our patients.

Statement of Assurance

Review of services

During 2024-25, the Lincolnshire Community Health Services NHS Trust (LCHS) provided and/or subcontracted 106 relevant health services.

The LCHS has reviewed all the data available to them on the quality of care in 106 of these relevant health services.

The income generated by the NHS services reviewed in 2024-25 represents 100% of the total income generated from the provision of NHS services by the LCHS for 2024-25.

Participation in Clinical Audits

During 2024-25, 7 national clinical audits and 1 national confidential enquiry covered relevant health services that LCHS provides.

During that period, LCHS participated in 100% of national clinical audits and 100% of national confidential enquiries, which it was eligible to participate in.

The national clinical audits and national confidential enquiries that LCHS participated in, and for which data collection was completed during 2024-25, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	LCHS Participation	Reporting Period	Number and % Required
British Association for Sexual Health and HIV (BASHH) Audit	Yes	2024	No case ascertainment
National Audit of Inpatient Falls (NAIF)	Yes	2024 - 2025	Data is submitted to ULTH and included within the trust data.
National Audit of Care at End of Life (NACEL)	Yes	2024 - 2025	No case ascertainment
UK Parkinson's Audit	Yes	2024 -2025.	No case ascertainment
SSNAP Stroke Audit	Yes	2024 - 2025 Report due April 2025.	No case ascertainment
Heart Failure Readmission Audit	Yes	April 2023 - 31 March 2024	36
British Heart Foundations (BHF) National Audit for Cardiac Rehabilitation (NACR)	Yes	2024-2025 Report due 2025.	No case ascertainment

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

During 2024-25, hospitals were eligible to enter data in up to 1 NCEPOD study. Below is a summary of the study in which LCHS participated. Studies for which LCHS were exempt

are not listed. Action plans are developed for any areas not achieving the recommended standards.

National Confidential Enquiries	LCHS Participation	Reporting Period	Number and % Required
ICU Rehabilitation – Community Care	Yes	Organisational questionnaire	100% completed/submitted

The reports of 1 national clinical audit was reviewed by the provider in 2024-25 and LCHS intends to take the following actions to improve the quality of healthcare provided (see tables below).

Descriptions of outcomes and improvements from a sample of the national audits:

National Audit	Headline Results and Actions Taken
Heart Failure Re-admission Audit	Total number of readmissions from 1 April - 31 March 2024 was 36. This was an increase from 26 during the previous year. This increase was due to treating a higher number of patients across the county. 25 patients were re-admitted where their admission was potentially avoidable with 11 patient readmissions being unavoidable. Actions identified: Case notes to be examined to establish whether referrals were made to the heart failure ACPs, and if so, were the patients discharged prior to being seen. Service delivery model for cardiology virtual ward due to change. Service delivery model for heart failure to change. Deliver a bespoke titration arm to the service for patients on the current caseload to prevent contact being deferred. Reduction of wait times for initial contacts/reviews. Virtual Ward audit planned.

Local Clinical Audit

The reports of 62 local clinical audits were reviewed by the provider in 2024-25 and LCHS intends to take the following actions to improve the quality of healthcare provided: (see tables below):

The local audit plan is linked to NICE, CQC, Best practice and key priorities for the Trust.

Examples of actions taken locally:

Local Audit	Actions - Improvements

Children in Care Record Keeping Audit	The transition to the SystmOne unit for children in care has greatly facilitated the completion of health assessments. This system has streamlined the process for the team, leading to a more efficient and accurate completion of assessments. Areas of improvement included ensuring equality and diversity template is completed at every contact, ensuring caseload holder details are always included within groups and relationships and Doctors.
Bladder and Bowel Team Records Audit	The implementation of the new specialist continence assessment template has significantly improved the standard of recording patient information and assessments. It allows for streamlined data entry, making the process more time-efficient and accurate.
North Lincolnshire Integrated Sexual Health (NLiSH) Clinical System Task Audit	A patient required a follow up appointment; however no follow-up task had been set on the clinical system (Inform) for a patient recall. Areas of improvement included delivering a training session on the clinical system, completion of sharing the results data with the LiSH Team, recall tasks to be set up correctly within the Inform clinical a system permitting a consistent approach to results management across LiSH and a weekly task audit to be completed.
Heart Failure Record Keeping Audit	Areas of improvement included arrange bespoke training around completion of the holistic template, ensuring all staff have training in the Rockwood Frailty Scale and ensuring all staff have completed appropriate ESR training.

Participation in Clinical Research

Clinical research is critical to delivering new treatments and care to our patients. Embedding research in everything we do ensures we do our best and enables better outcomes for our patients and staff. Through collaboration with our other Lincolnshire NHS partners, we are able to offer research along the patients care journey from pre-hospital to end of life care.

The trust relies on the approval process of clinical research studies through the Health Research Authority (HRA) and the local governance process for LCHS and the Lincolnshire GP practices gives capability and capacity approval/assurance.

In 2024-25, the trust approved 8 NIHR portfolio studies for LCHS and 46 for the GP practices. These were a mixture of recruiting sites and patient identification centre (PIC studies. LCHS recruited 235 participants, and the Lincolnshire GP practices 4,116.

The studies were in these research specialties: renal, primary care, children, musculo-skeletal, hepatology, health services research, public health, dermatology, respiratory, cancer and ageing.

LCHS ran its first commercial study in collaboration with Essity, which was looking at a new ecologically friendly incontinence product. This study recruited participants from 5 care homes in Lincolnshire. The product will be on the market later this year.

Use of the Commissioning for Quality and Innovation (CQUIN) Framework

The 2025-26 CQUIN scheme has been paused nationally while a wider review of incentives for quality is undertaken.

Care Quality Commission (CQC) Statements

The Care Quality Commission (CQC) are the regulators of quality standards within all NHS Trusts. They monitor our standard of care through assessments, patient feedback, and other external sources of information.

The Trust is required to register with the CQC, and its current registration status is registered. The Trust has no conditions on its registration. LCHS has not participated in

any special reviews or investigations by the CQC during the reporting period. The CQC has not taken enforcement action against LCHS during 2024-25.

The current CQC rating for LCHS is outstanding.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↑ Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018
Community health services for children and young people	Good ↑ Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018
Community health inpatient services	Good ↑ Sept 2018	Good →← Sept 2018	Outstanding ↑ Sept 2018	Outstanding ↑ Sept 2018	Outstanding ↑ Sept 2018	Outstanding ↑ Sept 2018
Community end of life care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Urgent care	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Outstanding ↑ Sept 2018	Good →← Sept 2018	Good →← Sept 2018
GP out of hours services	Good ↑ Sept 2018	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Overall*	Good ↑ Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Outstanding ↑ Sept 2018	Outstanding ↑ Sept 2018	Outstanding ↑ Sept 2018

Data Quality

NHS Number and General Medical Practice Code Validity

Lincolnshire Community Health Services NHS Trust submitted records during the year to the Secondary Uses Service for inclusion in Hospital Episode Statistics (HES) for Admitted activity (for the period April 2024 to January 2025 at the Month 10 inclusion date) and Accident & Emergency Care (for the period April 2024 to mid-March 2025).

The percentage of records in the published data:

- Which included the patient's valid NHS number was:
  - 100% for admitted patient care (National performance 99.7%)
  - 99.42% for accident and emergency care (National 97.2%)

- Which included the patient's valid General Medical Practice Code was:
  - 100% for admitted patient care (National performance 99.4%)
  - 99.99% for accident and emergency care (National 98.5%)

Data Security and Protection Toolkit (DSPT)

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security, and that personal information is handled correctly.

The 2023/24 evidence was assessed by the trust auditors and achieved 'Significant Assurance' for the fifth consecutive year.

Clinical Coding

Lincolnshire Community Health Services NHS Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2024/25 by NHS Improvement as no services are commissioned on a PbR basis. Any activity that is subject to Clinical Coding is provided by ULTH.

Data Quality

Data Quality is an important element of safe, quality care at acute sites and is a continuing focus for improvement at Lincolnshire Community Health Services NHS Trust. The following initiatives have been implemented during 2024-25 to improve the quality of our data:

- The Data Quality Maturity Index (DQMI) is used to provide data submitters within the NHS with timely and transparent information about data quality. The LCHS score has risen from 90.4% in November 2023 to 92.1% in November 2024, with the aim of reaching 95% by November 2025.
- The Big Surge Project is used to ensure accurate costing and external and internal reporting. This is an ongoing project which is expected to be completed during 2025/26.
- The Emergency Care Dataset (ECDS) and Admitted Patient Care Commissioning Dataset (APC CDS) now use the same data source as internal reporting and have been updated to allow more detailed coding.
- The RINSE Data Quality System is used to store, monitor, and manage data quality issues across all data domains. This has helped analysts work with services to

improve the capture of ethnicity data in Urgent Treatment Centres from 85% to over 90%.

- Implementation of the RACH Indicator System allows improved management of Key Performance Indicators (KPIs), allowing for interactive reporting at any level of the organisational hierarchy, ensuring consistent data is used for different reports.
- A central list of all Business Information, including Data Quality Kite Marks for reports, is being developed to enable users to be signposted to reports and help to create an interactive user experience on the reports themselves.
- Improved automation has enabled the Trust's Business Support Technicians to take on more data quality tasks and improve issues like uncashed contacts (where the contact status has not been updated after the activity) and inactive referrals (where the referral is open, but no activity has been recorded for a specified time-period).

Learning from Deaths

The Trust has an embedded process to screen, review and investigate inpatient deaths. The purpose of the Learning from Deaths Group is to provide assurance that the Trust has a robust internal quality assurance process that ensures patient safety, clinical effectiveness and user experience by monitoring and reviewing mortality related issues. The group undertakes reviews of all deaths within inpatient areas and the Butterfly Hospice and reports findings and recommendations through the relevant governance matrix.

The LCHS Learning from Deaths Group reports to the Clinical Effectiveness Group via a monthly update and quarterly Learning from Deaths report with upward reporting via the Mortality Assurance & Learning Group (MorALS) to the Trust Board, via a Quarterly Learning from Deaths report.

Measure	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments
Number of patients that have died within LCHS	50	63	81	54	During 2024-25, 248 of LCHS patients died. This line indicates the number of deaths which occurred in each quarter of that reporting period
Number of deaths that have had a	17	58	61	71	By March 2025, 207 case record reviews and

case record review/investigation					investigations have been carried out in relation to 248 of deaths included above. In 0 of cases a death was subjected to both a case record review and an investigation. This measure illustrates the number of deaths in each quarter for which a case record review or an investigation was carried out. In addition, 0 cases were also discussed within the Governance Meetings.
Number/percentage of deaths that escalated with problems in care	0	0	0	0	0 deaths representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been used for all cases that have been graded a 3.

Summary of what LCHS has learnt from case record reviews and investigations conducted in relation to deaths:

ReSPECT:

There has been improvement on completion and revision of ReSPECT forms, however there is still language being used such as “ward based care” which does not provide a clear plan for emergency / community services

There is commonality in wording / phases found in the patient preferences listed in the values and fears section, suggesting this may not be the patient’s own words.

The values and fears section continues to be the most commonly missed area.

Forms continue to be completed mainly towards end of life. Used as an end of life plan / resuscitation form.

There has been a sustained improvement in both capacity and best interest templates being initiated with many discussions held documented in relation to this. The safeguarding team have provided training sessions and improvement has been noted and monitoring continues through the monthly Learning from Deaths (LfD) meetings.

There continues to be cases where patients could be transferred into LCHS services earlier in their end of life phase and discussions continue cross the group to identify /address the barriers preventing this.

Pressure Area Care:

There have been cases where it has been highlighted that patients have developed pressure damage whilst in LCHS care. Action has been taken to address this through the Tissue Viability steering group.

Transfer of Patients:

The importance of the correct information being shared between the discharging hospital and the receiving hospital has been highlighted. Lessons learned was to specifically ask and record questions in regards to diet and fluids, sharing of that information throughout the team and professional curiosity in regards to thickener. Paperwork was also missed from transferring hospital with measures now in place to ensure all information is received.

Description of actions that LCHS have taken in 2024-25, and proposes to take forward in consequence of what the LCHS has learnt:

- Education relating to ReSPECT has continued throughout 2024-25 with the introduction of new training packages to support instigating conversations with patients and completing / revising ReSPECT forms. ReSPECT education will remain high on the agenda for the forthcoming year with a monthly audit taking place and findings shared in the monthly Learning from Deaths meeting.
- The Medical Examiner process continues to provide a platform to ensure that any concerns raised are fully investigated.
- Coronial enquiries continue to be discussed and any learning shared widely through Learning from Deaths and the quality governance structure.
- Closer working continues with the Patient Safety Team to triangulate the Medical Examiner and Coronial processes to ensure that relevant investigations take place in

line with the PSIRF framework ensuring that information and learning is aligned and shared.

- The Safeguarding Team continue to monitor cases discussed at the LfD meetings and provide feedback on aspects of positive practice and where improvements can be made.

Assessment of the impact of actions taken by LCHS during 2024-25:

- The Medical Examiner highlights any concerns raised during their screening process, which initiates further investigation and more in-depth learning.
- There has been improvement on completion and revision of the ReSPECT forms with further work required to ensure all areas of the form are completed.
- Staff participation within the Patient Safety Investigation Response Framework (PSIRF) investigation processes allows for in depth discussion and recognition of areas to improve outcomes with engagement by staff and identifying action of improvements required. LCHS utilise a grading of avoidability. The review grading is outlined below:

Grade 0 - Unavoidable Death, No Suboptimal Care

Grade 1 - Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome

Grade 2 - Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)

Grade 3 - Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)

Measure	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments
Number of reviews/ investigations completed which took place before the start of the reporting period	0	0	0	6	6 case record reviews and investigations completed after 31 March 2024 which related to deaths which took place before the start of the reporting period.

Number/Percentage of deaths that are judged likely not to be problems in care	0	0	0	0	0 representing 0% of the patient deaths during [the previous reporting period] are judged to be more likely than not to have been due to problems in the care provided to the patient.

Reporting Against Core Indicators

The tables below show the Trust's latest performance for 2024-25 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience. The following data relating to national reporting requirements in the Quality Account are provided by NHS Digital. NHS Digital provide data for 15 mandatory indicators, based upon the recommendations by the National Quality Board. The last two previous reporting periods available on NHS Digital for LCHS are to be reported within the Quality Account.

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

The data made available to the Trust by NHS Digital with regard to:

- The percentage of patients aged (ii) 16 or over readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (emergency readmissions)

Description	2021-2022	2022-2023	2023-2024
LCHS readmitted within 30 days: 16+	8.1	11	12
National Average: 16+	12	11.7	12.1
Best(B) / Worse(W) National Performance: 16+	2.1 (B) 110.2 (W)	2.5 (B) 46.8 (W)	1.7 (B) 26.8 (W)

LCHS considers that this data is as described for the following reasons:

The data is taken from the national mandatory Commissioning Data Set submitted by the Trust.

LCHS intends to take the following actions to improve this indicator and so the quality of its services by:

Working to ensure we treat and discharge patients appropriately so that they do not require unplanned readmission, working closely with system partners to ensure safe discharge practice.

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

The data made available to the Trust by NHS Digital with regard to:

- The number and, where available, rate of Patient Safety Incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death

Description	2022-23	2023-24	2024-25
LCHS %	(T) 27.9% (SD) 0.8%	(T) 28.3% (SD) 0.11%	(T) 27.5% (SD) 0.8%
National Avg %	(T) 47.0% (SD) 0.15%	(T) 51.3% (SD) 0.15%	(T) 51.5% (SD) 0.15%
LCHS Total No of Incidents (T) / Severe or Death (SD)	(T) 6,291 / (SD) 47	(T) 6,413 / (SD) 25	(T) 7,803 / (SD) 60

*Latest data available

LCHS considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to internal data.

LCHS intends to take the following actions to improve this indicator and so the quality of its services by:

Providing staff training in incident reporting and risk management.

Undertaking comprehensive investigations of and utilising varying forums for learning such as huddles and Trust Communications and Safety Bulletins.

Patient Safety Incident Response (PSIRF)

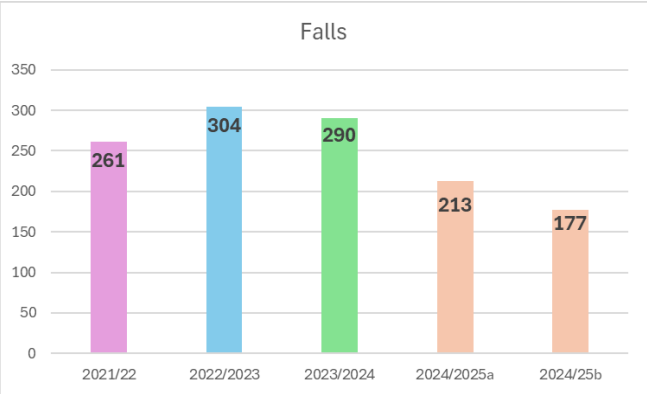
Last year we reported how we had launched the NHSE PSIRF, which replaced the national serious incident framework. This year we have completed our transition and collaborated with our ICB to develop a PSIRF plan and policy to underpin the change.

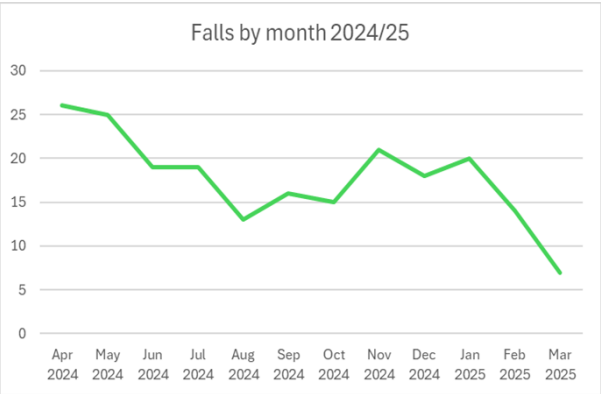
PSIRF set out a new direction for how the NHS responds to patient safety incidents, focusing on effective learning and improvement, compassionate engagement and embedding a patient safety culture.

Completing our transition has meant there is now greater focus on understanding the impact of systems and human factors in our patient safety incidents and we have greater understanding in the “what” not the “who” in investigations to support a just and learning culture. Not all serious events will lead to a Patient Safety Incident Investigation (PSII) – other tools will be available such as after action reviews, clinical audit or Mortality & Morbidity (M&M) meetings and greater support and involvement is being provided for those involved in patient safety incidents.

Patient Falls

Reducing falls within the Community Hospitals ward remains a priority for the Trust.





Previous years reported the total number of falls recorded by LCHS. From May 2024, reporting changed to only those relating to LCHS care. Column 2024/25a refers to all falls recorded and 2024/25b those occurring in LCHS care. Regardless of the change in reporting, there remains a significant decrease in falls in 2024/25.

Key achievements 2024/25

The governance structure in Collaborative Community Care was amended so that the three pillars of quality (clinical effectiveness, patient experience and patient safety) are discussed separately, with reference to a quality dashboard, rather than as more disparate items in a larger meeting. This has created a more joined up way of looking at the quality of our care in this area. The new governance structure has also enhanced the sharing of good practice. For example, the Falls Steering Group found that ‘people’ were a main theme in falls in Community Hospitals. Sharing this within the new governance meetings led to a number of initiatives to reduce falls:

Baywatch is a process where there is confirmed ‘eyes on’ bays where patients requiring enhanced care are looked after. Additionally, patients nursed in side rooms are now checked hourly, rather than 2-4 hourly.

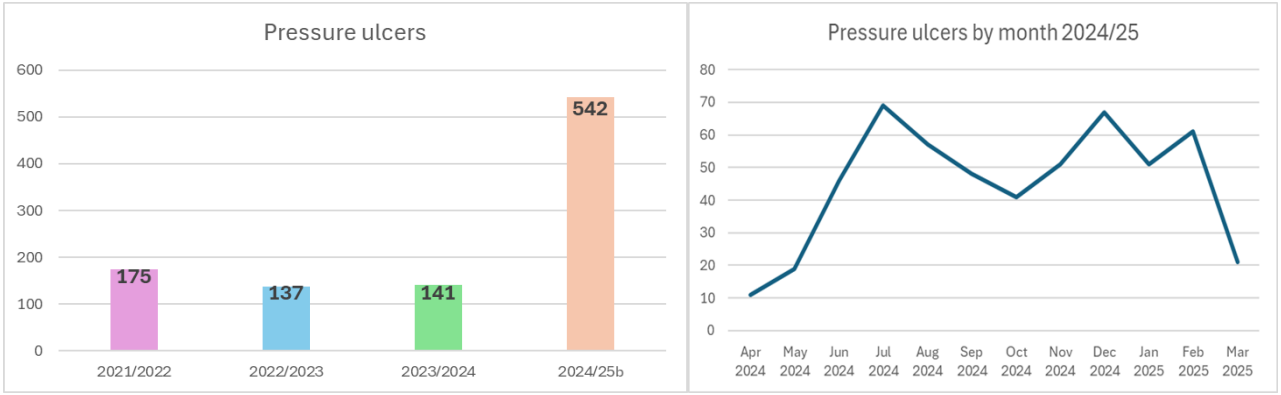
The Falls Standard Operating Procedure has been completed and is in use and a comprehensive Falls screening programme has been rolled out across Adult Therapy.

Next steps for 2025/26

- Following on from the Falls screening, we will identify and map the falls support offered by external services. This will enable patients to be signposted to appropriate services.
- The templates on the Electronic Patient Record (EPR) will be amended to better support personalised care and communication between professionals.

Pressure Ulcers

A pressure ulcer is damage to the skin and the deeper layer of tissue under the skin. This happens when pressure is applied to the same area of skin for a period of time and cuts off its blood supply. Without care, pressure ulcers can become serious, causing pain and a longer stay in hospital.



During 2024-25, the National Wound Care Strategy Programme (NWCSP) recommended that unstageable pressure ulcers be re-categorised category 3 or 4. Pressure ulcers are classed as unstageable when the base of the ulcer is covered by a layer of dead tissue preventing identification of the extent of damage. Previously, unstageable pressure ulcers were not categorised until sufficient dead tissue was removed to visualise the wound bed and therefore, the inclusion of unstageable pressure ulcers as category 3 or 4 has had a significant impact on the numbers reported.

The majority of initial and deteriorating pressure ulcers within LCHS are within the community nursing teams who work predominantly with frail patients, often with multiple co-morbidities and usually in their own homes or care home settings. This may impact on

the level of pressure area care the patient receives, for example a patient at home with a four times a day care package will only have assistance to change position four times a day, with no assistance during the night, whereas a patient in a care home or in hospital should receive regular pressure area care over a 24 hour period.

The Trust introduced the Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK updated 2023 and associated checklists in June 2023, with the aim of assisting practitioners and managers to appropriately care for patients at risk of or suffering from pressure ulcers. The resulting increase in associated investigations has offered considerable and invaluable insight into our care, which informed development and refinement of the improvement plan.

The initial focus during 2024-25 has been on getting the basics right and work to date includes:

- Implementation of community nursing competencies and associated training packages to ensure all community staff have the relevant skills and training.
- Implementation of escalation of care pathways which align to the National Wound Strategy to ensure community staff are aware and able to escalate care as needed.
- Processes such as the safeguarding checklist have been made simpler and validation of the checklist is now in place to support accurate completion.
- Assessments such as the holistic assessment, which should be used on admission to the community nurse caseload and updated as required, has been amended to include frailty and end of life care assessments. Similarly, the majority of initial and deteriorating pressure ulcers within LCHS are within the community nursing teams who work predominantly with frail patients, often with multiple co-morbidities and usually in their own homes or care home settings. This may impact on the level of pressure area care the patient receives, for example a patient at home with a four times a day care package will only have assistant to change position four times a day, with no assistance during the night, whereas a patient in a care home should receive regular pressure area care over a 24 hour period.
- The Trust introduced the Safeguarding adult's protocol: pressure ulcers and raising a safeguarding concern - GOV.UK updated 2023 and associated checklists in June 2023, with the aim of assisting practitioners and managers to care for patients at risk of or suffering from pressure ulcers. The resulting increase in associated investigations has offered considerable insight into the gaps found in our care.

- At the same time as the above intervention, a pressure ulcer improvement plan was also implemented which is currently ongoing but which will be reviewed and evaluated in April 2025. The focus has been on getting the basics right and work to date includes:
    - Development of community nursing competencies and training packages is now completed.
    - Implementation of escalation of care pathways which align to the National Wound Strategy to ensure community staff are aware of and able to escalate care as needed.
    - Processes such as the safeguarding checklist have been made simpler and validation is now in place to support accurate completion.
    - Assessments such as the holistic assessment, which should be used on admission to the community nurse caseload and updated as required, has been amended to include frailty and end of life care assessments. Similarly the Malnutrition Universal Screening Tool (MUST) assessments have been made easier to complete within the Electronic Patient Record and new continence assessments and pathways are in development.
    - Monthly quality assurance audits and a weekly pressure ulcer audit are now in place, with meetings every 2 weeks to review and scrutinise results with the teams and enable support to improve.

Next steps from April 2025 include:

- Pause and sense check: evaluate the impact of the current action plan and understand what is or is not working well enough.
- Continue to use themes emerging from investigations and determine the effectiveness of planned actions to address these.
- Agree a trajectory for improvement in pressure ulcer incidence and how this will be achieved.
- Essential community nurse training will be added to Electronic Staff Records to enable easier and more accurate tracking of compliance.
- Consider how learning from this work can be transferred to other services for example, Discharge to Assess and Community Hospitals.

Vaccination and Rapid Response Team 1

The Vaccination and Rapid Response Team (VRRT) deliver a communicable disease prevention programme through vaccination in both planned vaccination campaigns such

as Covid-19 / Flu / Respiratory Syncytial Virus (RSV) predominately offering a service to our deprived populations, as well as in response to national incidents for example, the recent measles outbreak and the 16-18 year olds catch up campaign.

In January 2023, the UK Health Security Agency declared a national incident over a surge in measles cases across the country. In response to this outbreak the system worked together to mobilise the Vaccination and Rapid Response Team and offer catch-up Measles, Mumps & Rubella (MMR) vaccinations across Lincolnshire within the school setting.

Schools were prioritised as those having the highest rate of zero doses of the MMR vaccine and 15% or more of the total school cohort not being fully vaccinated. There were 22 of the 285 primary schools (the majority in areas of higher deprivation) identified, totalling 1655 eligible pupils.

The Vaccination Team contacted each of the families at least twice prior to the school clinic session date, engaging in meaningful conversations regarding vaccinations to understand the barriers to vaccination and help to inform future vaccination delivery models. Language line was utilised frequently and translated resources were available.

All 22 of the prioritised primary schools in Lincolnshire were attended during March and July 2024, with 268 children receiving their MMR vaccination.

Vaccine and Rapid Response 2

During the Autumn / Winter 2024-25 there was a three-fold increase in influenza admissions to acute hospitals nationally, with case numbers in the Lincolnshire region four times higher than the previous year. Between October 2024 and January 2025, the Rapid Response Team responded to 22 Care Home acute respiratory infection outbreaks to identify and treat to both residents and staff in those settings with confirmed Influenza outbreaks.

School Aged Immunisation Service

The School Age Immunisation Service (SAIS) covers 395 education settings across Lincolnshire. Between September and December 2024, the SAIS team visited all education settings including primary, secondary, Special Educational Needs & Disabilities (SEND) and alternative provisions to administer Flu vaccinations to all year groups (reception to Year 11).

Over 800 immunisation visits were undertaken with each setting visited at least twice. To ensure that those absent from school or electively home educated had the opportunity to receive vaccines, 30 community clinics were held during school half term and after school. There were 56,702 immunisations administered, making Lincolnshire the highest performing area in the East Midlands for Flu uptake 2024.

Complex Needs Rapid Response Respiratory Service

The Complex Needs Rapid Response Respiratory Service provides specialist assessment, treatment and management of complex physical disabilities with additional respiratory problems in the community. The service aims to:

- Reduce hospital admissions, length of stay, readmissions, and the number of A&E attendances.
- Improve children, adults, and their carers' experience of using services by building on the existing integrated model to join up care between community services, acute services, and palliative care services.
- Proactively target children and adults at risk of acute respiratory infections early to help keep them healthy and prevent acute infections in the first instance.

The service provides both preventative and rapid response services; providing specialist respiratory physiotherapy assessment, management plans and training to keep children and adults with complex needs well and a rapid response to assessment and treatment when they are acutely unwell with a chest infection with the aim of preventing hospital attendance. Where hospital attendance cannot be avoided, the service works with acute and community settings to offer support and/or training whilst in hospital and facilitate early supported discharge.

The service has expanded to become a 7-day service from November 2023 following feedback from parents/carers/patients and now aligns to the virtual ward, consistently utilising over 80% of virtual ward bed allocation.

One of the main goals of the service is to empower the parents or care team around these children/adults so they become expert in the day-to-day management of their respiratory problems. This means that training of parents and carers remains a major focus for the team. This aims to develop their knowledge and understanding of respiratory problems, signs of deterioration, as well as developing their practical skills around chest physiotherapy.

Therapy Outcome Measures (TOMs) is a simple, cross-disciplinary and cross-client group method to assess the effectiveness of interventions used by the Rapid Response service. Patients/carers and therapists, score at the beginning and end of the intervention. This consistently shows improvements, particularly around the parents/carers wellbeing and confidence to manage the patients' respiratory problems at home (increase by 61%) and the patient's emotional health and wellbeing (51%).

The service will continue to work with patients, carers and partners to further develop the service during 2025-26.

Complaints

Complaints and enquiries are a key source of feedback for the Trust and informs us about our patients' views regarding the quality of services and care provided which enables us to examine our services and make improvements. All formal complaints received are responded to appropriately on an individual basis and are fully investigated through the Trust's complaints procedure.

The Trust ensures that complainants have the option to have their concerns dealt with informally or formally, via the NHS Complaints Procedure. All complaints, whether formal or informal, are monitored to identify if there are any trends and to provide a consistent approach for patients, carers and the public.

Each complaint is treated individually. Although the issue raised may be similar to others, the circumstances are often different for the individual concerned. The Trust aims to respond to complaints within 35 or 50 working days, dependent on the complexity and nature of the complaint, and the number of issues raised. If the timescale cannot be achieved, the complainant is informed of when they may expect their response. A group quarterly report is produced and presented the Patient Experience and Involvement Group and Quality Committee.

As part of the Group Model the Complaints and Patient Advice and Liaison Service (PALS) Teams for LCHS and ULTH are aligning their processes to enable a standardised

approach to handling complaints. The teams are committed to working together to provide a more seamless and effective complaints and PALS for patients, families and staff. By aligning our processes and working as a single, integrated team, we aim to enhance the way we handle concerns, share learning and improve patient experience across our services.

Number of complaints received:

	2022-23	2023-24	2024-25
New complaint received	154	144	204

The themes identified related to the following:

- Access to treatment
- Patient Care
- Admission / Discharge processes

Learning:

- Prior to completing referrals to the reablement team, the therapy team must inform the nursing team of any specific instructions for transfer/mobility to ensure accurate information is relayed when liaising with the care company.
- New skin integrity process, where teams are requested to do an assessment of 5 patients a week.
- Lincoln Electronic Assistive Technology Service (EATS) has updated its current referral form with the following information: *"Have you met the patient in person and completed a face-to-face assessment with this patient? If not, please contact the service to discuss the case prior to submitting a referral form".*
- The Lincoln EATS website is currently undergoing a redesign and as part of this, will be creating a training video on how to complete a specialised Augmentative and Alternative Communication (AAC) referral form correctly, to further support local therapists to complete the referral form adequately.
- Discharge process for Child Therapy circulated to ensure parents are always notified of discharge from the service. Process also clarified to ensure care is not ended following a missed appointment with a member of educational staff.

Patient Advice and Liaison Service (PALS)

PALS is a core service that provides timely and appropriate access to help, advice and information to the users of the service. PALS also facilitate self-advocacy and will assist with discussions and negotiations between service users and representative of the Trust.

During 2024-25 PALS dealt with 496 contacts were from patients, families and carers where support and investigation has been provided by the PALS team to enable resolution of their concerns in a timely manner. The resolution of these concerns by the PALS team has enabled the patient, families and carers to obtain the answers they require, therefore, reducing the number being escalated to a formal complaint.

PALS collate all comments, concerns and suggestions made and share this feedback directly with services and departments or by the patient experience feedback mechanisms available throughout the hospital.

Equality Diversity and Inclusion

Lincolnshire Community Health Services NHS Trust, as part of Lincolnshire Community and Hospitals NHS Group (LCHG), fully embraces Equality, Diversity, and Inclusion (EDI) across all protected characteristics of the Equality Act 2010. The Trust has a range of policies and procedures to support this. The Equality Impact Assessment is the primary mechanism to demonstrate the meeting of the legislative requirements that underpin the Trust's practice, policy, and service developments. All EDI business is managed and monitored through the EDI Group, which is led by the Deputy Director of People and comprises key stakeholders from across LCHG. From a governance perspective, the EDI Group reports upwardly to the Trust Board through the People Committee.

During 2024-2025, the Trust met all its statutory and contractual Equality, Diversity and Inclusion duties, these include:

- Publication of the Equality, Diversity and Inclusion Annual Report
- Publication of Equality Objectives
- Publication of the Gender Pay Gap data, report and action plan
- Publication of the Workforce Race Equality Standard data, report and action plan
- Publication of the Workforce Disability Equality Standard data, report and action plan
- Completion and publication of the NHS Equality Delivery System

- Completion and publication of the NHS Equality Diversity and Inclusion Improvement Plan and the associated High Impact Actions

All these reports are published on the Trust website: Equality and Diversity :: Lincolnshire Community Health Services NHS Trust

The Trust has a range of Staff Networks to support staff from a diverse range of backgrounds and impact positively on the delivery of patient services. Each of the staff networks has designated leads and is supported by a sponsor from the executive team. The current staff networks are:

- Armed Forces Network
- Carers' Network
- MAPLE (Mental and Physical Lived Experience) Network
- Men's Network
- PRIDE+ Network
- REACH (Race, Ethnicity and Cultural Heritage) Network
- Women's Network

All the networks meet regularly and have annual plans to ensure meaningful and supportive events are scheduled throughout the year. These events take place using a range of delivery options from face-to-face events to utilising the virtual platform / webinars.

Highlights from each of the networks are contained in the Equality, Diversity and Inclusion Annual Report.

The Trust has strong links nationally and regionally, working closely with NHS Employers and NHS England. This has been supported by technology, accessing webinars, and being involved in discussions both regionally and nationally. The EDI Team continues to roll out the Cultural Intelligence programme within the Trust and now across LCHG. The Cultural Intelligence programme equips leaders to lead their teams and services inclusively.

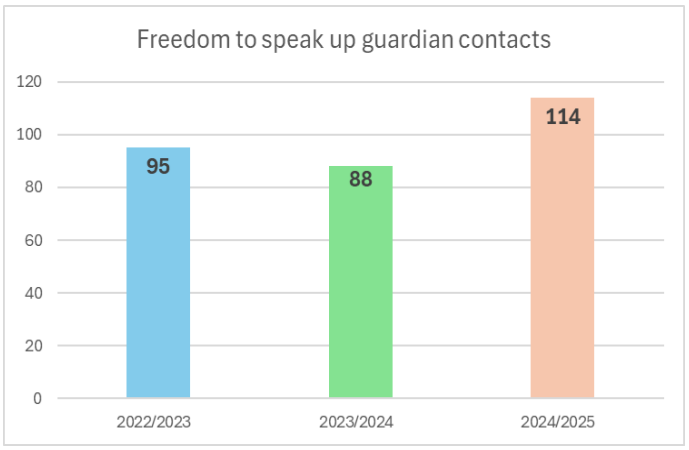
All EDI work in the Trust is currently being joined up across the Lincolnshire Hospitals and Community NHS Group and we are starting to work as a unified team across the Group.

Freedom to Speak Up

Since 2016, the Trust has complied with the NHS contract requirement to appoint a Freedom to Speak Up Guardian (FTSUG). The Trust Freedom to Speak Up Guardian is responsible for ensuring that concerns are handled appropriately and that the effectiveness of the local systems is considered by the Board.

Our Freedom to Speak Up Guardian works hard to ensure the National Guardians Office values and principles of speak up are embedded in their work, these being:

- Courage: speaking truthfully and challenging appropriately
- Impartiality: remaining objective and unbiased
- Empathy: listening well and acting with sensitivity
- Learning: seeking and providing feedback and looking for opportunities to improve



Contacts with the FTSUG increased in 2024-25 by 28%, with a noticeable rise in contacts around organisational change, processes, recruitment, and general working conditions (*n* = 50). Attitudes, behaviours, relationship issues and incivility also accounted for a significant number of contacts. The other major reasons for contact being attitudes and behaviours, relationship issues and incivility (*n* = 48).

The 2024-25 National Staff survey showed a small drop in the staff survey scores relating to FTSUG. In response to this, the FTSUG raised visibility, increasing visits to teams and sites as well as formalised activity in National Speak up Month in October. Further promotion took place in the form of a podcast/webinar in the style of “Conversations with a Speak Up Guardian”.

Annex 1: Stakeholder Comments

NHS Lincolnshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Lincolnshire Integrated Care Board (ICB) welcomes the opportunity to review and comment on Lincolnshire Community Healthcare Services (the Trust) Annual Quality Account 2024/25.

The Quality Account provides comprehensive information on the quality improvements that the Trust set as priorities in 2024/25. These were:

- End of life care
- Pressure area care
- Diabetes pathway

The ICB acknowledges the challenges faced with achieving all elements of the Diabetes Pathway and recognises the ongoing work in this area. The ICB commends the Trust on the work achieved relating to End-of-Life Care having successfully developed PEOL (Palliative and End of Life) Champions who have supported the roll out of an education programme for end-of-life care. The ICB thanks the Trust for supporting the review and development of the Lincolnshire PEOL Strategy which is in its final form and being socialised across the system.

The ICB recognises the scale of work undertaken in relation to pressure area care during 2024/25 with the implementation of a pressure ulcer improvement plan which included several initiatives, for example:

- Getting the basics right – introduction of community nursing competencies and training packages
- Standardisation of pressure ulcer risk assessments through the Pressure Ulcer Risk Primary and Secondary Evaluation Tool (PURPOSE-T)
- Standardised template for recording pressure ulcer care and prevention through the aSSKINg care bundle tool which is within the Electronic Patient Record
- Holistic assessments including frailty and end of life care assessments
- Weekly pressure ulcer audits and monthly quality assurance audits with fortnightly meetings to scrutinise the results

The ICB welcomes the continuation of this work to ensure high quality patient care and continuous learning across the Trust.

The Quality Account has several examples of the good work undertaken by the Trust during the past year including:

- The Trust moved into the Group model with United Lincolnshire Teaching Hospitals (ULTH) NHS Trust and the ICB welcomes the strengthening of ways of working which provides opportunity for collaborative approaches to patient care.

- A decrease in the number of patients falls with good practice being shared through the Falls Steering Group. A falls SOP has been developed and implemented along with a comprehensive falls screening programme being rolled out across Adult Therapy.

- Participation in a commercial research collaboration for the first time. This was trialling an ecologically friendly incontinence product with the product due to be on the market later this year.

- There is an embedded process for Learning from Deaths and learning is clearly linked with the End-of-Life care priority with ReSPECT being a continued area of focus into 2025/26.

The ICB notes the Trust has completed transition to the Patient Safety Incident Response Framework (PSIRF) resulting in greater focus on understanding the impact of system and human factors on patient safety incidents whilst supporting a just and learning culture.

The ICB acknowledges the last year has not been without its challenges with staffing being a challenge in some services and the spike in respiratory viruses during the winter season impacting staff and services.

The Trust's most recent overall CQC rating remains "outstanding" which was awarded in 2018.

Looking ahead into 2025/26 the ICB notes the Trust has aligned their priorities to those in the Group Strategy and are:

- Maximise safety of patients in our care, through learning from incidents and reducing incidents causing harm

- Identify areas where services do not meet best practice requirements and deliver demonstrable improvement in those areas
- Focus on improving the top three patient feedback themes: communication, appointments and clinical practice

The ICB welcomes these as priorities for the coming year noting the continued learning from incidents through the implementation of PSIRF; the Trust's current position in relation to infection prevention and control and the importance of getting this right for good patient experience; and the utilisation of themes from patient feedback as identified in 2024/25's Quality Account.

The ICB would like to thank Lincolnshire Community Health Services NHS Trust for their commitment and dedication working with Lincolnshire Health System and looks forward to continuing to work with the Trust and the Group in 2025/26.

Yours sincerely,

Vanessa Wort
Associate Chief Nurse
NHS Lincolnshire Integrated Care Board

Healthwatch Lincolnshire

Healthwatch Lincolnshire Quality Account Statement 2025

Lincolnshire Community Health Services NHS Trust (LCHS)

Healthwatch Lincolnshire welcomes the opportunity to comment on this year's Quality Account and acknowledges the Trust's ongoing dedication to service improvement and collaborative system-wide working. We recognise the considerable changes brought about by the formation of the Lincolnshire Community and Hospitals Group and hope this integrated approach continues to drive improvements in patient care and experience across the county.

Looking Back – Progress on 2023/24 Quality Priorities

We commend LCHS for the progress made against its 2023/24 priorities: End-of-Life Care, Pressure Area Care, and the Diabetes Pathway. We particularly note the Trust's openness in reporting both successes and ongoing challenges.

- The work on **End-of-Life Care**, including the education strategy, documentation review, and increased staff participation in the NACEL survey, reflects a joined-up, system-level approach. We welcome the focus on shared understanding and use of identification tools to reduce variation in care and promote person-centred support.
- The implementation of the **PURPOSE-T tool**, standardised care bundles like aSSKINg, and improved education reflect positive progress in **Pressure Area Care**. We appreciate the honest reporting around the difficulties of achieving a system-wide policy and the responsive use of national frameworks to drive consistency.
- Within the **Diabetes Pathway**, we note encouraging steps in digital transformation and advice and guidance use, while also recognising that several improvements are currently limited by the lack of approved business cases. Workforce shortfalls remain a concern, and we support the Trust's continued advocacy for investment in this area.

Quality Priorities for 2025/26

Healthwatch Lincolnshire supports the Trust's three overarching priorities, which reflect both national expectations and the key issues heard through patient feedback:

1. **Maximising patient safety** through improved learning from incidents and reductions in harm. The commitment to quarterly oversight, transparency, and embedding a culture of continuous improvement is essential.
2. **Improving compliance with best practice standards**, especially around Infection Prevention and Control (IPC). The Trust's attention to the CQC's "Hygiene Code" and identification of non-compliance in specific criteria demonstrates a realistic and proactive approach to addressing gaps.
3. **Focusing on communication, appointments, and clinical care**—themes consistently raised by patients in complaints and Friends and Family Test results. These areas are often linked and can have a cumulative impact on the overall patient experience, so we fully support the inclusion of this as a key strategic focus.

We are encouraged that these priorities are aligned across the Group and reflect feedback from patients and partners. We would welcome more public-facing updates on how progress is being tracked and communicated with those who use services.

Themes and Feedback from Local People

Healthwatch Lincolnshire's engagement over the past year highlights many of the same themes the Trust has identified:

- **Access and Appointments**: Delays in accessing services, including community nursing and therapy, continue to affect people across the county. While we understand the challenges around demand and workforce, communication around these delays is essential.
- **Communication**: Patients and carers regularly raise concerns about unclear or inconsistent communication between services, especially around referral pathways and discharge planning. Improvements in this area would support more joined-up care and reduce anxiety for patients.
- **Continuity of Care**: Several individuals have described fragmented experiences, particularly when receiving care from multiple teams. The expansion of services like the Complex Needs Respiratory Rapid Response Team is a positive step toward improving continuity and preventing avoidable admissions.

We welcome initiatives such as the Patient Panel, the Group-wide Complaints and PALS service alignment, and the roll-out of digital improvements—all of which should help address some of these concerns if effectively implemented and monitored.

Final Reflections

Healthwatch Lincolnshire values the transparent and comprehensive nature of this year's Quality Account. The Trust has shown both ambition and realism in its approach, recognising what has worked and where further effort is needed. We are particularly pleased to see how patient voice is influencing strategic priorities—from end-of-life care development to pathway improvements and communication standards.

We look forward to continued collaboration with LCHS welcome further opportunities to support with patient experience and insight improving patient outcomes and experiences in Lincolnshire.

Health Scrutiny Committee for Lincolnshire Statement on the *Quality Account* for 2024/25 of the Lincolnshire Community Health Services NHS Trust

The Committee is grateful to the Trust for sharing a copy of its draft quality account.

Presentation of the Document

The Committee recognises that there is a balance between making the document accessible to the public and meeting all the requirements of the regulations. In future, the Committee suggests an overview of the Trust's services be included, for example, providing information on headline activities and service volumes, such as attendances at urgent treatment centres. This would give the public a feel for the extent and locality of the services provided by the Trust.

Prescribed content does not assist the flow of the document. However, where information has to be included because it is a prescribed requirement, the Committee suggests there could be a brief explanation to assist the understanding of the lay reader. The Committee welcomes the inclusion of patient stories in the document.

Quality of Care – Trust's Priorities for Improvement

The Committee's View of Patient Priorities

The Committee would like to record its own views on what it sees as most important for patients and the public:

- improving access to all NHS services, by reducing waiting lists and waiting times, and providing equality of access to services
- providing seamless care between different NHS and other services, including from children's services to adult services
- providing high-quality safe services as locally as possible, to avoid unnecessary travel
- making sure patients are signposted to the appropriate service at the first point of contact, so as to avoid as much as possible onward transfer to other hospitals or services.

Many of these aspirations are reflected in national, local and the Trust's strategies.

Selecting the Trust's Priorities for Improvement for 2025/26

The Committee accepts that the Trust's priorities have been developed by reference to patient safety incidents and patient feedback, with three dominant themes in (communication, appointments, clinical practice). This demonstrates how patients and the public have been involved in the development of the document.

Specific Comments on the Trust's Priorities for Improvement for 2025/26

The Committee believes that *Priority One (Maximising Patient Safety)* should be intrinsic to the Trust's daily operations and would like to see how this priority will deliver shift changes in practice and benefits to patients, so that its adoption goes beyond what ought to be a 'business as usual' approach.

The Committee believes *that Priority Two (Improvement in Services not Meeting Best Practice)* is too broad and as a result risks lacking focus, with potential overlaps into *Priority One*. The Committee would like to see a list of measurable actions in support of the priority.

The Committee would like to see *Priority Three (Improvement of Patient Feedback Themes: Communication, Appointments and Clinical Practice)* broadened so that it is not solely focused on complaints, but could include other patient data on waiting times, re-admission rates, and ambulance handover times.

Progress on Priorities for Improvement for 2024/25

Although there has been progress with all three priorities for 2024/25, the Committee's preference is for a clear summary, with an indication, using red, amber or green, whether each action in support of a priority had been met. The Committee would not wish to see the progress made on these priorities lost, because they are not being carried forward into 2025/26.

Achievements During 2024/25

The Committee welcomes all the achievements, listed in the Chief Executive's statement, which include construction work at John Coupland Hospital Gainsborough; and improving the patient environment at one ward at Skegness Hospital. The Committee supports all developments improving the quality of care provided to patients, and recommends that the achievements fully outline all these benefits.

Engagement with the Health Scrutiny Committee for Lincolnshire

During 2024-25, engagement with the Health Scrutiny Committee for Lincolnshire has continued, with various representatives of the Trust attending four of the ten meetings of the Committee during the year. We look forward to continued engagement with the Trust's managers, and where appropriate clinicians, in the coming year. The Committee will be giving consideration to adding the following topics to its work programme in the coming year:

- Community Nursing Services
- Urgent Treatment Centres

Conclusion

The Committee is grateful for the opportunity to make a statement on the draft Quality Account. The Committee looks forward to the Trust's progress, not only with its three priorities, but also with national priorities in the coming year and will continue to engage the Trust at its meetings.

Trust Comments

Thank you for your comments. We recognise the importance of ensuring our Quality Account remains clear while also meeting public reporting requirements and regulatory standards. We also recognise the value of including key headline activities such as emergency attendances to give the public a clearer understanding of the locality and services provided by the Trust.

A brief explanation along prescribed content can support better understanding and improve accessibility to a wider audience. We will look to incorporate this where appropriate to enhance clarity going forward.

Thank you for highlighting the committee's view on patient priorities for 2025/2026 which we acknowledge and will ensure these will be reported through our established reporting processes.

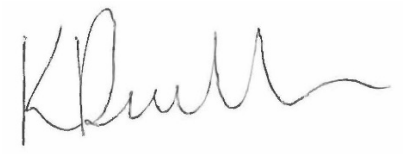
Regarding the 2024/2025 quality priorities, we can confirm that these will continue to be monitored through our governance processes to ensure effective oversight and progress.

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011, 2012 and 2017 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.



Professor Karen Dunderdale

Chief Executive Officer

Elaine Baylis

Chair, Trust Board

NHS

Lincolnshire Community and Hospitals NHS Group

United Lincolnshire Teaching Hospitals NHS Trust Quality Account 2024-25

Glossary of Abbreviations

AAA	Abdominal Aortic Aneurysm
BAU	Business As Usual
BAUS	The British Association of Urological Surgeons
BTS	British Thoracic Society
CBU	Clinical Business Unit
CDC	Community Diagnostic Centres
CDOP	Child Death Overview Panel
CMP	Case Mix Programme
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus disease caused by the SARS-CoV-2virus
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computerised Tomography
DCIQ	Internal Reporting System
DTA	Decision to Admit
DKA	Diabetic Ketoacidosis
DSPT	Data Security and Protection Toolkit
DTI	Deep Tissue Injury
ED	Emergency Department
EDI	Equality Diversity and Inclusion
EPR	Electronic Patient Record
ePMA	Electronic Prescribing and Medicines Administration
FaCTs	Falls Current Themes
FPSG	Falls Prevention Steering Group
FFT	Friends and Family Test

FTSUG	Freedom to Speak Up Guardian
GDH	Grantham and District Hospital
GSF	Gold Standards Framework
HES	Hospital Episode Statistics
HSMR	Hospital Standardised Mortality Ratio
IBD	Inflammatory Bowel Disease
ICB	Integrated Care Board
ICU	Intensive Care Unit
ICNARC	Intensive Care National Audit and Research Centre
JBDS	Joint British Diabetes Societies
KPI	Key Performance Indicator
LCH	Lincoln County Hospital
LCHG	Lincolnshire Community Hospital Group
LCHS	Lincolnshire Community Health Services NHS Trust
LEDs	Locally Employed Doctors
MASD	Moisture Related Skin Damage
MAP	Mean Arterial Pressure
ME	Medical Examiner
MINAP	Myocardial Infarction National Audit Programme
M&M	Mortality & Morbidity Meeting
MorALS	Mortality Assurance and Learning Strategy Group
MRI	Magnetic Resonance Imaging
NACEL	National Audit of Care at the End of Life
NAIF	National Audit of Inpatient Falls
NAoME	National Audit of Metastatic Breast Cancer
NAoPri	National Audit of Primary Breast Cancer
NBoCA	National Bowel Cancer Audit

NDFA	National Diabetic Foot Audit
NCEPOD	National Confidential Enquiry into Patient Outcomes and Death
NEIAA	National Early Inflammatory Arthritis Audit
NELA	National Emergency Laparotomy Audit
NHFD	National Hip Fracture Database
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NICOR	National Institute for Cardiovascular Outcomes Research
NIHR	National Institute for Health Research
NJR	National Joint Registry
NKCA	National Kidney Cancer Audit
NLCA	National Lung Cancer Audit
NMTR	National Major Trauma Registry
NNAP	National Neonatal Audit Programme
NNHLA	National Non-Hodgkin Lymphoma Audit
NOCA	National Ovarian Cancer Audit
NOD	National Ophthalmology Database
NOGCA	National Oesophago-Gastric Cancer Audit
NPaCA	National Prostate Cancer Audit
NRAP	National Respiratory Audit Programme
NVD	National Vascular Database
NVR	National Vascular Registry
OBD	Occupied Bed Days
O-G	Oesophago-Gastric
OSCE	Objective Structured Clinical Examination

PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PE	Pulmonary Embolism
PEOL	Palliative End of Life
PRM	Performance Review Meetings
PHB	Pilgrim Hospital Boston
PHSO	Parliamentary and Health Service Ombudsman
PMRT	Perinatal Mortality Reporting Tool
PROMs	Performance Reported Outcome Measures
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Investigation Response Framework
QC	Quality Committee
RCEM	Royal College of Emergency Medicine
RCPCH	Royal College of Paediatrics and Child Health
SJR	Structured Judgement Review
SUDIC	Sudden Unexpected Death in Childhood
SHMI	Standardised Hospital-Level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SIG	Skin Integrity Group
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
TCS	Terms and Conditions of Service
TVN	Tissue Viability Nurse
ULTH	United Lincolnshire Teaching Hospitals NHS Trust
UTC	Urgent Treatment Centre
VA	Visual Acuity

VAS	Visual Analog Scale
VBAC	Vaginal Birth after Caesarean
VTE	Venous Thromboembolism
YCWCC	You Care; We Care to Call
7DS	Seven Day Services

Contents

Part 1: Chief Executive's Statement

Welcome to the Quality Account for United Lincolnshire Teaching Hospitals NHS Trust (ULTH) for 2024/25. This document provides an overview of all the activity that has been taking place within our hospitals over the past year, with a focus on improving the quality of care that we provide to our patients.

This year has seen the organisation come together as a Group with Lincolnshire Community Health Services NHS Trust (LCHS), which has enabled us to focus more than ever before on improving our services together for the benefit of the residents of Lincolnshire.

We are already seeing benefits in terms of more streamlined, effective and efficient services that are easier for patients to understand and access. There are examples of fantastic Group working across our services, which have reduced bureaucracy and put the patient at the heart of the design of our services.

During the year, we also received the fantastic news that we were successful in our application for teaching hospital status. This is awarded by the Secretary of State for Health and Social Care, and will not only benefit our patients, but will further enhance our ability to attract top-tier talent to our hospitals, the Group, and the wider NHS in Lincolnshire.

However, this past year has not been without its challenges. We have continued to experience increased pressure on our Emergency Departments and continued challenges around cutting our waiting lists, as well as the impact of a spike in respiratory viruses and norovirus during the winter season, which affected both our staff and our services. We have also faced a number of estates issues such as water and power outages.

In spite of these, there is much to be proud of and celebrate when it comes to improvements in quality and delivering the best possible care to our patients.

This includes examples of improved performance in a number of national standards, notably including huge progress made in reducing ambulance handover times in our Emergency Departments, which has freed up ambulance service colleagues to serve our communities. We were also proud to have been moved out of the ‘tiering’ programme for elective and diagnostics by the NHS National Elective Recovery and Diagnostics Programme.

Other achievements over the past year have included:

- Construction of the first phase of the multi-million-pound Emergency Department at Pilgrim Hospital, Boston is almost complete.
- Opening of two new Community Diagnostic Centres in Skegness and Lincoln, at a cost of £38 million.
- Recruiting hundreds of patients to a wide range of clinical trials and studies.
- Starting work on the build of a £19 million new Endoscopy Unit at Lincoln County Hospital.
- Numerous national award wins for individuals and teams across the Trust.
- Continued to assess and recognise clinical areas as part of our ambitious Diamond Award in Quality Accreditation programme.
- Rollout of 'Martha's Rule' Call For Concern service at both Lincoln and Boston hospitals, offering patients, their families, and carers 24-hour access to a rapid review if they have concerns about a person's deteriorating condition.
- Opening of a new hub to support the wellbeing of care partners and provide practical advice and guidance at Pilgrim Hospital, Boston.
- Approval to procure an electronic patient record (EPR) which will transform how we manage patient records.
- Finished the implementation of a digital solution for Electronic Prescribing and Medicines Administration (ePMA).
- The expansion of the United Lincolnshire Hospitals Charity, which supports our staff and patients.

We also continue to involve our patients in discussions and decision making in the Trust, with our Patient Panel taking part in regular discussions about the development and improvement of services, as well as the delivery of broader public engagement activities around the development and delivery of specific services and service specifications.

Over the next year we will continue with our focus on moving more of our services closer to the people that need them, improving quality of care for our patients and making sure that people are seen and treated in the right place, at the right time, by the most appropriate healthcare professional as part of Lincolnshire Community and Hospitals NHS Group.

Professor Karen Dunderdale,

Chief Executive

Part 2: Deciding our Quality Priorities for 2025-26

To determine our quality priorities, we have consulted with several stakeholders including our Quality Committee (QC). The QC on behalf of the Trust Board approve the priorities and there will be regular reports on progress to QC throughout the year.

We have ensured that our quality priorities are aligned to the Group strategy. We have considered our progress throughout the year against last year's priorities to help decide which priorities need an ongoing focus within this year's Quality Account.

The following priorities have been identified for particular focus for the Group in 2025-26 from the Group Strategy 2025-2030. These priorities are extended over the coming years to ensure they are fully embedded within our organisation. Each of the priorities have been selected, as they are a key component of the patient experience.

Priority 1 – Maximise safety of patients in our care, through learning from incidents and reducing incidents causing harm.

Why have we selected this Priority?

Safe patient care is the foundation of high-quality healthcare. Our strategy aligns with requirements of the National Patient Safety Strategy and the National Patient Safety Incident Response Framework (PSIRF), promoting a culture of openness, learning, and continuous improvement. We have looked at trends in our incident reporting over time and are working collaboratively to identify solutions, while promoting a strong organisational safety culture. We are driven to deliver the best possible care and health outcomes. We want to ensure our services remain safe and embed strong processes to learn from practise.

Our Current Status:

The number of incidents causing moderate or severe harm in 2024-2025:
Moderate = 163
Severe = 49
Death = 21

What will success look like?

Percentage of incidents causing moderate or severe harm will be reduced.

How will we monitor progress?

Quarterly reports will be presented at the Quality Committee which will focus on highlighting progress and key actions/mitigations for off track actions.

Priority 2 – Identify areas where services do not meet best practice requirements and deliver demonstratable improvement in those areas.

Why have we selected this Priority?

Good infection prevention and control (IPC), including cleanliness, is essential to ensure that people who use health and adult social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are developed and maintained.

As an acute Trust we must adhere to the Health and Social Care 2008: code of practice on the prevention and control of infections and related guidance. This is otherwise known as the "Hygiene Code." These are the 10 criteria against which the CQC will judge a registered provider on how it complies with the IPC (including cleanliness) requirements, which are set out in the regulations.

Our Current Status:

The Trust will need to demonstrate adherence to the following 10 criteria, currently, we are compliant in all apart from 4 partially compliant areas within criteria 2.

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2. The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3. Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4. The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5. That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7. The provision or ability to secure adequate isolation facilities.
8. The ability to secure adequate access to laboratory support as appropriate.
9. That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
10. That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

What will success look like?

Improvement of adherence to National Infection Prevention Control (IPC) standards.

How will we monitor progress?

Quarterly reports will be presented at the Quality Committee which will focus on highlighting progress and key actions/mitigations for off track actions.

Priority 3 - Focus on improving the top three patient feedback themes; Communication, Appointments and Clinical Practice.

Why have we selected this Priority?

Patient experience is at the heart of everything we do. We understand that care is more than just clinical outcomes, it's about meeting the physical, emotional, and personal needs of our patients and their families. Every person who uses our services should feel valued, respected, and well cared for. We know that patient experience is critical to both individual patients and their families and goes well beyond the health outcomes of their care.

Our Current Status:

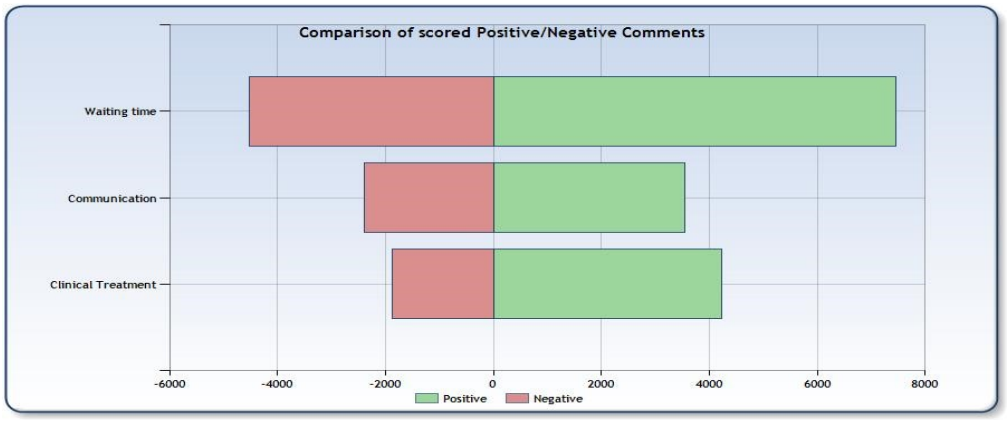
Top three themes of complaints during 2024-2025.

Complaint Categories	Number Received	% of overall complaints
Communication	408	32%
Clinical treatment	395	31%
Appointments	84	7%

The Trust received 89.84% Positive (54022 'Positive' Responses / 60134 Total Responses) from the FFT.

Top three themes' Friends & family Themes

- Waiting Times
- Communication
- Clinical treatment



What will success look like?

Reduction in the top three patient feedback themes, through complaints and Friends & Family Test.

How will we monitor progress?

Quarterly reports will be presented at the Quality Committee which will focus on highlighting progress and key actions/mitigations for off track actions.

Looking Back: Progress made since publication of 2023-24 Quality Account

This section of the Quality Account presents in summary the Trust's progress since the publication of last year's account against the identified improvement priorities.

These were:

1. • **End of Life Care**
2. • **Hear it Your Way**
3. • **Diabetes Pathway**

Introduction

The Quality Account for 2023-24 outlined the Trust's proposed quality improvements for the year ahead (2024-25). These priorities were identified following engagement with patients, the public, staff and external stakeholders. During the year 2024-25 we have been monitoring our progress against these priority ambitions through our governance framework. The priorities that we have not carried forward will become 'business as usual' and we will have defined work streams to enable the Trust to deliver on the improvements not achieved in 2024-25.

Trust performance

This section provides detail on how the Trust has performed against the three priority ambitions. Results relate to the period 01 April 2024 - 31 March 2025 or the nearest period available. Mechanisms of measurement vary by priority and by the availability of national benchmark.

Priority 1: End of Life Care

We said we would:

Have a task and finish group who will review the standards and processes across the system to improve timely recognition and identification of people in their last year of life.

ULTH have supported the review of the Lincolnshire strategy, which highlights the need for system wide approach to improving recognition and identification of patients in their last year of life. Promotion of identification tools recommended by NICE have been achieved through education events and tools are available to each department in their Palliative & End of Life (PEOL) Folders. Work has commenced on exploring appropriate tools to support clinicians, which links community to hospital. Exploration of Gold Standards Framework (GSF) implementation in ULTH commenced linking with the GSF team. Working with Stroke team to trial use of identification tool on admission.

Have an education programme for end-of-life care rolled out across the Trust.

Fundamentals of PEOL education delivered through PEOL Champions forum, Ward ready programme and Dying Matters month. ULTH is a key partner in developing an Education Strategy for PEOL across Lincolnshire, which will support core education across the system. Staff from the Trust have been involved in the development of ReSPECT podcasts. Once the education strategy is published (later this year), we will be able to roll out the updated education framework across the Group. Standard definitions for Palliative and End of Life Care have been developed and are awaiting final approval through organisations to improve understanding and reduce risk of patient harm due to lack of clarity across providers. One example is that as we start to work together as organisations, we are able to share more patient information to inform clinical decision making. There is a risk that different definitions may impact on clinical decision making. This has been noted when patients have been identified as end-of-life by GP and then attend ED. GP definition is that they are in the last year and still appropriate for escalation. ED definition is that the person was in the last days/weeks and that they person should not be for escalation therefore delaying appropriate treatment due to lack of clarity in clinical picture.

Review End-of-life documentation across the Lincolnshire system and standardised as appropriate.

The review of policy is completed and documentation for Five Priorities of Care was updated. This is part of Lincolnshire system wide approach and covers partner organisations. Integrated care approach taken and was completed in April.

Capture End-of-life care within the Trust's Quality Accreditation programme.

Mapping of framework completed and recognition that the accreditation framework already supports majority of end-of-life care. Framework adapted to support elements of end-of-life care and being trialled at hospice in the hospital; this includes personalised care approaches to nutrition and hydration and falls risk and appropriate monitoring of syringe drivers. This will inform review of the current accreditation tools going forward.

Increase the number of staff responding to the staff survey within the annual NACEL survey to increase the staff voice in the care of end-of-life patients.

In 2022, there were15 respondents therefore the Trust required 30 respondents to meet target. In 2024 (not run in 2023) there were over 100 respondents so target overachieved. This was through promotion by palliative champions and teams across ULTH at multiple events / forums / communications.

Raise awareness of the shared end of life strategy across Lincolnshire and map progress through PEOL.

The strategy has been published. ULTH have collaborated with partner organisations as part of core palliative leadership system group to develop a socialisation plan. This is commencing in ULTH and will be presented at Quality Committee in May 2025. ULTH staff are also supporting socialisation of strategy in other organisations / areas as per plan.

Data Source: Palliative and End of Life Care Lead Nurse

What more do we need to do to achieve our success measures?

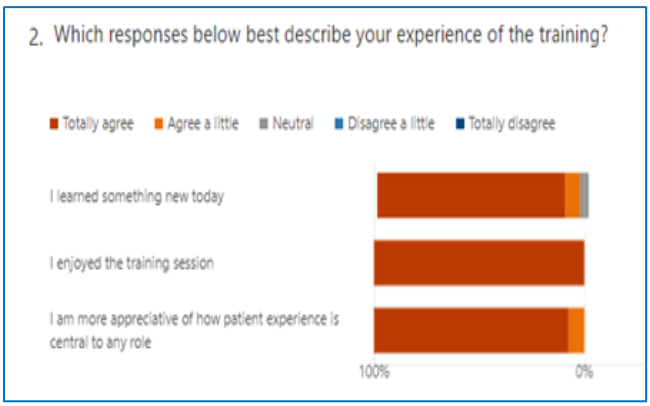
This work is ongoing and continuing into 2025-26.

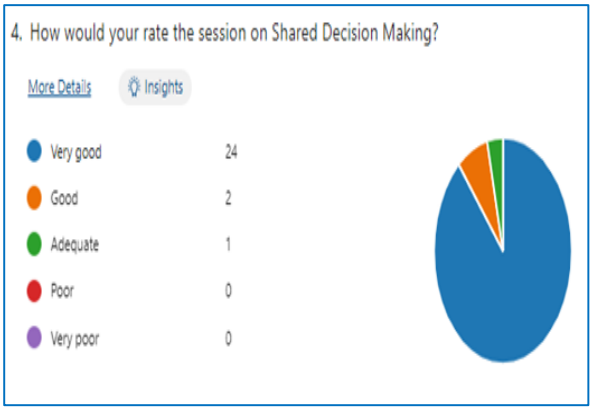
Priority 2: Hear It Your Way

We said we would:

Develop a Hear it Your Way Faculty within the Trust.

HIYW is an OSCE (Objective Structured Clinical Examination) type-training programme for staff that consists of a practical assessment designed to assess the skill, performance and competence of all staff in a range of communication skills. Scenarios from genuine complaints were designed that have patient actors in role and staff go to each 'station' and are observed with how they handle the situation. The observers are not 'scoring' staff rather they use a reflective approach, and ratings are designed from observations themes that are then used as general feedback. Three full day training sessions have been held during the year with 20 attendees at each and feedback has been excellent.





Data Source: Patient Experience Team

What we need to do to achieve our success measures?

There are mores sessions scheduled for 2025-2026 and discussions with LCHS colleagues who are keen to participate.

Priority 3: Diabetes Pathway

We said we would:

Getting the Basics Right – Digital Transformation

Within the Trusts antenatal clinics, the diabetes specialist nurses are inputting into the maternity medway system. The Trust are using Advice & Guidance to its fullest potential in both Endocrinology and Lipidology, which uses an integrated care portal which is used system wide.

Defining Service Models

A business case has been developed to increase the number of Diabetic Specialist Nurses. The Team provides a community multi-disciplinary team to support the community Diabetic Specialist Nurses.

Improving Quality & Safety

Business cases have been submitted for an expansion of the Diabetic Specialist Nurses workforce to meet national benchmarking requirements; plus new business cases have been submitted to initiate an endocrine specialist nursing workforce and a secondary care lipid specialist nurse workforce.

The clinical governance leads receive monthly reports in diabetes/insulin related incidents within the hospital. We also have a Diabetic Ketoacidosis (DKA) task & finish group and have a new pathway for patients who develop DKA whilst in hospital.

Service Development for Lipid Specialist Nurse Service

A business case has been submitted to the Integrated Care Board (ICB) from the ICB Programme Manager for lipidology nurse specialists that sit within the community setting, with input to and from secondary care.

Sustainable and Multi-professional Workforce

The Clinical Business Unit has undertaken a review of what is required to provide and develop the existing service we have, benchmarking against the Joint British Diabetes Societies workforce calculator (national), our current inpatient Diabetic Specialist Nurse workforce is only around 30% where it should be against nationally recommended guidance. For outpatient care we have predicted what proportion of current consultant delivered services could be changed to nurse led services.

Data Source: Endocrinology Department

What more do we need to do to achieve our success measures?

There are ongoing workstreams with our System Partners to improve the service we provide for our patients.

Statement of Assurance

Review of services

During 2024-25, the United Lincolnshire Teaching Hospitals NHS Trust (ULTH) provided and/or subcontracted 71 relevant health services.

The ULTH has reviewed all the data available to them on the quality of care in 71 of these relevant health services.

The income generated by the NHS services reviewed in 2024-25 represents 93% of the total income generated from the provision of NHS services by the ULTH for 2024-25.

Participation in Clinical Audits

During 2024-25, 58 national clinical audits and 8 national confidential enquiries covered relevant health services that ULTH provides.

During that period, ULTH participated in 100% of national clinical audits and 100% national confidential enquiries, which it was eligible to participate in.

The national clinical audits and National Confidential Enquiries that ULTH participated in, and for which data collection was completed during 2024-25, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	ULTH Participation	Reporting Period	Number and % Required
Peri and Neonatal			
State of Nation report UK Perinatal Deaths for babies born in 2022 (MBRRACE-UK)	Yes	January 2022 - December 2022 Published July 2024	No case ascertainment reported
Perinatal Confidential Enquiry (MBRRACE –UK) : The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death	Yes	Published December 2024	No case ascertainment reported
Saving Lives Improving Mothers Care	Yes	2020-2022 Report published October 2024	No case ascertainment reported
Neonatal Intensive and Special care (NNAP)	Yes	1st January – 31st December 2023 Report Published October 2024	LCH 64 PHB 28
Children			
National Children's & Young People Asthma Audit (NRAP)	Yes	2022- 2023 Breathing Well Report published August 2024	LCH 42 of 40 (105%), PHB 38 (63.3%)
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	1st April 2023- 31st March 2024 Published March 2025	LCH 164 PHB 122 GK 80

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Epilepsy 12 Audit	Yes	1 Dec 2021 - 30 November 2022 Round 4 Cohort 5 Report published October 2024	168/169 (99%)
Acute Care			
National Emergency Laparotomy Audit (NELA) – Laparotomy	Yes	1 April 2024 - 30 November 2024 Report published monthly	LCH 103 PHB 81
National Emergency Laparotomy Audit (NELA) – No Laparotomy	Yes	1 April 2024 - 30 November 2024 Report published monthly	LCH 9 PHB 8
Cardiac Arrest (National Cardiac Arrest Audit) ICNARC	Yes	Awaiting report	To be confirmed
Case Mix Programme (CMP) Intensive Care National Audit & Research Centre (ICNARC)	Yes	1 April 2024 - 31 December 2024 Report published quarterly	LCH 386 PHB 314 Case ascertainment is not reported
Royal College of Emergency Medicine (RCEM) QIPS c) Mental Health (Self Harm) (Year 2)	Yes	October 2022 - October 2023 Report published August 2024	LCH 276 (104%) PHB 308 (116%)
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Awaiting report	To be confirmed
National Audit of Care End at the End of Life (NACEL)	Yes	January – December 2024 Organisation audit, staff survey, bereaved relatives/carers survey. Real-time reporting available	PHB 120 LCH 135 GDH 45

National Audits	ULTH Participation	Reporting Period	Number and % Required
Royal College of Emergency Medicine (RCEM) QIPS b) Care of Older People (Year 2)	Yes	October 2022 - October 2023 Report published August 2024	LCH 304 (115%) PHB 313 (118%)
Royal College of Emergency Medicine (RCEM) QIPS d)Time Critical Medications (Year 1)	Yes	October 2022 - October 2023 Report published August 2024	LCH 322 (101%) PHB 377 (119%)
British Thoracic Society (BTS) Respiratory Support (RSU)	Yes	1 February 2021- 31 May 2023 Report published July 2023	Not applicable this is an organisation of service audit
Long Term Conditions			
Diabetes (National Adult Diabetes Audit)	Yes	1 January 2023 - 31 March 2024. Report published links to ICB data	Case ascertainment is not reported (data is linked to local CCG/ICB)
Diabetes (National Adult Diabetes Inpatient /Survey/ Audit HARMs)	Yes	Awaiting report	Case ascertainment is not recorded
National Gestational Diabetes Mellitus Audit	Yes	Awaiting report	Case ascertainment is not recorded. Data collected via the Maternity Services dataset (MDS)
National Diabetes in Pregnancy Audit	Yes	1t January 2024 - 31 December 2024. Awaiting report	LCH 31 PHB 26 Case ascertainment is not reported
National Diabetic Foot Audit (NDFA)	Yes	1 Jan 2024 – 31 March 2025. Awaiting report	LCH TBC PHB TBC Case ascertainment is not reported

National Audits	ULTH Participation	Reporting Period	Number and % Required
National IBD Registry Ulcerative Colitis & Crohn's Disease	Yes	2023 - 2024 Summary reports	Data submission quarterly
National Early Inflammatory Arthritis (NEIAA)	Yes	1 April 2023 - 31March 2024 Report published October 2024	44 Case ascertainment is not reported
National Adult Asthma Audit (NRAP)	Yes	2022 - 2023 Breathing Well Report published August 2024	LCH 74(59.2%) PHB 78 (57.8%) GDH 26 (57.8%)
Chronic Obstructive Pulmonary Disease (COPD) NRAP	Yes	2022 - 2023 Breathing Well Report published August 2024	LCH 412 (68.7%) PHB 513 (76%) GDH 83 (44.9%)
National Audit Dementia R6	Yes	August 2023 – January 2024.Report published December 2024	LCH 42 PBH 45
National Chronic Kidney Disease Renal Registry	Yes	Report awaited	To be confirmed
National Renal Registry Acute Kidney Injury	Yes	Data up to 31 December 2022 Report published December 2023	Case ascertainment is not reported
National Diabetes Audit Integrated Specialist Services and Structure Survey	Yes	Annual submission, November 2024 Report awaited	Not applicable refers to the organisation of service
Elective Procedures			
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Yes	1 April 2024 - 31 April 2024 Report published December 2024	LCH 10 Case ascertainment is not reported

National Audits	ULTH Participation	Reporting Period	Number and % Required
Cardiac Arrhythmia (NICOR)	Yes	April 2022 – 31 March 2023 2024 report published April 2024	Case ascertainment is not reported
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Yes	1 April 2022 - 31 March 2023 2024 report published April 2024	864 Case ascertainment is not reported
National Vascular Registry (NVR)	Yes	1 January 2023 - 31 December 2023 Report published November 2024	19 Elective infrarenal AAA repairs Case ascertainment >85% 46 Carotid endarterectomy Case ascertainment >85% 192 Lower limb angioplasty/stenting, Case ascertainment >85% 32 Lower limb surgical revascularisation, Case ascertainment 40-49% 28 Major lower limb amputation, Case ascertainment 50-59%
National Joint Registry (Hip, Knee, Ankle, Elbow and Shoulder Replacements)	Yes	1 January 2023 - 31 December 2023 Report published September 2024	GDH 801 LCH 227 PHB 93 Case ascertainment is not reported

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Ophthalmology Database (NOD): Age-related Macular Degeneration Audit	Yes	1 April 2023 - 31 March 2024 Report due to be published February/March 2026	Case ascertainment is not yet reported
National Ophthalmology Database (NOD): Cataract Audit	Yes	1 April 2022 - 31 March 2023 Report published May 2024	1512 (98.9%)
Cardiovascular Disease			
Stroke Care (National Sentinel Audit of Stroke) SSNAP	Yes	1 April 2023 – 31st March 2024 Report published November 2024.	Total = 908 (90%+)
Acute Myocardial Infarction & Other Acute Coronary Syndrome (MINAP)	Yes	1 April 2022 - 31 March 2023 2024 report published in April 2024	LCH 937 Case ascertainment Stringent (94.93%) Non-stringent (94.08%) PHB 178 Case ascertainment Stringent (291.8%) Non-stringent (237.33%)
Heart Failure	Yes	1 April 2022 - 31 March 2023 2024 report published in April 2024	LCH 438 PHB 412 GDH 93 Trust overall submitted cases is 943 No % is available
Cancer			
National Prostate Cancer Audit (NPCA)	Yes	1st January 2019 – 31st December 2023 Report published January 2025	455 (100%) Not available in data tables – NPCA emailed

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Audit of Primary Breast Cancer (NAoPri)	Yes	2019 - 2021 Report published October 2024	1254
National Audit of Metastatic Breast Cancer (NAoME)	Yes	2019 - 2021 Report published October 2024	161
National Lung Cancer Audit (NLCA)	Yes	1 January 2022 – 31 December 2022 Report published April 2023	408
National Bowel Cancer Audit (NBoCA)	Yes	1 April 2022 and 31March 2023 Report published January 2025	466
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	1 April 2021 and 31 March 2023 Report published January 2025	261
National Kidney Cancer Audit (NKCA)	Yes	1 January 2019 - 31 December 2021 Report published September 2024	282
National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	1 January 2020 - 31 December 2021 Report published September 2024	169
National Ovarian Cancer Audit (NOCA)	Yes	1 January 2021 - 31 December 2021 Report published September 2024	52

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Pancreatic Cancer Audit (NPaCA)	Yes	1 January 2020 - 31 December 2021 Report published September 2024	192
BAUS Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes	1 April 2024 - 31 May 2024 Report due to be published June 2025	GDH 1 LCH 3 PHB 1
Trauma			
National Hip Fracture Database (NHFD)	Yes	1 January 2023 – 31 December 2023 Report published September 2024	LCH 453 (101.1%) PHB 437 (99.8%)
National Audit Inpatient Falls (NAIF)	Yes	1 January 2024 - 31 December 2024. Report due to be published Oct 2025	LCH – to be confirmed PHB - to be confirmed
National Major Trauma Registry (NMTR)	Yes	1 January 2024 - 31 December 2024 Report expected to be published in 2026	LCH 98 PHB 336 Data submission commenced in April 2024
BAUS Penile Fracture Audit	Yes	1 April 2022 - 31 March 2024 Report due to be published June 2025	LCH 1
Blood Transfusion			
National Comparative Audit Blood Transfusion - 2024 Bedside Transfusion Audit	Yes	A sample of up to 40 patients being transfused in the months of March and April 2024	LCH 27 PHB 11

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Comparative Audit of Blood Transfusion (NICE Quality Standard QS138)	Yes	Data collection to completed December 2024	Results awaited
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	1 April 2024 – 31 March 2025	LCH 11 PHB 6 GDH 1

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

During 2024-25 hospitals were eligible to enter data in up to 8 NCEPOD studies. Below is a summary of those studies in which ULTH participated. Studies for which ULTH were exempt are not listed. Action plans are developed for any areas not achieving the recommended standards.

National	ULTH Participation	Reporting Period	Number and % Required
Confidential Enquiries			
End of Life	Yes	Organisational Questionnaire Clinical Questionnaire Report published November 2024	- 5/12 42%
Acute Limb Ischaemia	Yes	Organisational Questionnaire Clinical Questionnaire	Full study not yet closed
Emergency (non-elective) procedures in children and young people	Yes	Organisational Questionnaire Clinical Questionnaire	100% completed/submitted Full study not yet closed
Hypernatremia	Yes	Organisational Questionnaire	-

National	ULTH Participation	Reporting Period	Number and % Required
		Clinical Questionnaire	0/2 0%
Hyponatraemia	Yes	Organisational Questionnaire Clinical Questionnaire	- 3/7 43%
ICU Rehabilitation	Yes	Organisational Questionnaire Clinical Questionnaire	Grantham:16% completed/submitted Lincoln: 26% completed/submitted Pilgrim 20% completed/submitted 3/11 27%
Blood Sodium	Yes	Organisational Questionnaire Clinical Questionnaire	100% completed/submitted -
Juvenile Idiopathic Arthritis Study	Yes	Organisational Questionnaire Clinical Questionnaire Report published February 2025	100% completed/submitted -

The reports of 7 national clinical audits were reviewed by the provider in 2024-25 and ULTH intends to take the following actions to improve the quality of healthcare provided (see tables below).

Descriptions of outcomes and improvements from a sample of the national audits:

National Audit	Headline Results and Actions Taken
National Ophthalmology Database (NOD) Audit	• Cataract procedures performed during 2022-2023 • ULTH submitted 1512 eligible operations to the NOD Audit, which is an estimated 98.9% case ascertainment, an increase from 94.9% in the 2021 audit year. • The 1512 eligible operations were performed by 23 surgeons.

National Audit	Headline Results and Actions Taken
	• 89.2% of cases had recorded preoperative Visual Acuity (VA) data, which is an increase from 86.8% in 2021, and is above the national average of 86.5%. • 68.1% of cases had recorded postoperative VA data, which is an increase from 61.2% in 2021. This is below the national average of 69.0%. • The adjusted PCR rate for ULTH is 0.94%, above the overall for all centres of 0.61% but within the 95% confidence interval
National Neonatal Audit Programme (NNAP)	• July 2024: Provisional notification of positive outlier for National Neonatal Audit Programme (NNAP) 2022 measures • Pilgrim Hospital has been identified as Outstanding for the audit measure Retinopathy of prematurity screening • The result of interest for this measure is 100%. The national average result was 78.4%
MINAP (heart attack and Ischaemic heart disease)	• Door To Balloon - 85% compliant (above national 70%) with STEMI heart attacks undergoing primary PCI within 90 minutes. • Above national target for NSTEMI patients undergoing angiogram before discharge within 72hrs at 61% compliant. • NSTEMI Patients admitted to cardiology ward compliant and above national target at 85%
National Kidney Cancer Audit (NKCA)	• 282 patients diagnosed between 2019 and 2021 • 23% of people with a small renal mass (≤4cm) have a biopsy (national 20%) • 73% of people with a T3+ and/ or 10cm+ and/or N1 and M0 RC had a radical nephrectomy within 31 days of diagnosis (national 69%) • 0% of people with kidney cancer die within 30 days of SACT treatment (national 3%)
National Prostate Cancer Audit (NPCA)	• Review of outcome data continues with the Multidisciplinary Team (MDT) lead total number of cases submitted 346 • The National Cancer Audit Collaborating Centre (NATCAN) is in place to capture Trust data via the existing data sets collected nationally
National Oesophago-Gastric Cancer Audit (NOGCA)	• 261 patients diagnosed between 1st April 2021 and 31st March 2023 • 75% of patients diagnosed within 28 days of referral (national 73%) • 0% of people with stage 4 disease died within 30 days of starting SACT (national 5%)
National Non-Hodgkin Lymphoma Audit (NNHLA)	• 169 patients diagnosed in 2020 (86 high grade and 83 low grade) and 188 in 2021 (96 high grade and 91 low grade) • Overall one-year survival for both high and low grade lymphoma is better than the national average

Local Clinical Audit

The reports of 4 local clinical audits were reviewed by the provider in 2024-25 and ULTH intends to take the following actions to improve the quality of healthcare provided: (see tables below):

The local audit plan is linked to National Institute for Health and Clinical Excellence (NICE), CQC, Best practice and key priorities for the Trust.

Examples of actions taken locally:

Local Audit	Actions - Improvements
Managing AKI in Post-Operative Femur Fracture and other Orthopaedic Patients	**Orthopaedics** • Low compliance with local Guidelines for Management of Acute Kidney Injury (AKI) in first cycle of audit for femur fracture patients: 20% adherence to AKI bundle checklist. • Following first cycle interventions included education of junior doctors and nurses around the AKI bundle and management of post femur fractures, creation of a proforma and educational posters displayed in the resource room. • The re-audit highlighted significant improvement from 20% adherence in the AKI bundle to 100% adherence. There was 100% documentation of pre and post operative fluid status, 100% documentation of bloods on day 1 or day 2 and 100% of medications reviewed.
Subarachnoid haemorrhage caused by a ruptured aneurysm: diagnosis and management Re-audit	**Accident and Emergency** • The re-audit outcomes evidenced a considerable improvement compared to the outcomes within the 1st cycle. • Following the first audit, it was identified that it would be beneficial to deliver training in order to re-educate staff on the management plan of Subarachnoid Haemorrhages. • Red flags documentation improved from 45% in 1st cycle to 85% in 2nd cycle • Medical admission reduced by 20%, from 87% in 1st cycle to 67% in 2nd cycle • CT scan to be done with 6 hours of headache onset also improved from 4% to 50% in 2nd cycle
Facing the future – RCPCH Standard Re-audit	**Paediatrics** • At least two medical handovers every 24 hours are led by a consultant paediatrician. Morning (100%), evening (71.4%)

	• Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. • Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician. • The extension of consultant presence in the PAU to 21:00 during weekdays in Lincoln. (achieved in Pilgrim) • To make the clinical team including all doctors and nurses aware of this standard. This can be achieved by email and poster. Discussed in the consultants' meeting recommending the consultant to see the newly admitted patients after attending the evening handover.
Vaginal Birth after Caesarean (VBAC)	**Obstetric & Gynaecology** • PHB - Good compliance (100%) to 5 out of 6 standards. Rate of successful VBAC consistent with national standards. To improve on documentation of discussion and use of VBAC checklist. • Rate of successful VBAC consistent with national standard (61.5% in PHB vs 60.7% in NMPA) • Good compliance (100%) to 5/6 suggested auditable topics in GTG • 100% senior involvement in induction/augmentation of labour • New checklist being prepared/created. To inform and encourage incoming doctors the use of VBAC checklist

Participation in Clinical Research

ULTH remains committed to enhancing its capacity, capability and culture of clinical research development and delivery, as it prepares to transform into a University Teaching Hospital. Our Research and Innovation Department has a strong record of patient recruitment, as well as collaborative working. 2024-25 has seen a healthy growth in research delivery performance.

The number of patients receiving relevant health services provided or sub-contracted by ULTH in 2024-25, that were recruited to participate in research approved by a research ethics committee, and into National Institute for Health Research (NIHR) portfolio research, is 2946. These participants were recruited through 74 studies from 29 research specialties including: Ageing, Anaesthesia, Cancer, Cardiovascular Disease, Children, Critical Care, Dermatology, Diabetes, Gastroenterology, Genetics, Haematology, Musculoskeletal Disorders, Neurological Disorders, Renal Disorders, Reproductive Health & Childbirth, Stroke, Surgery, and Trauma & Emergency Care.

In 2024-25, the Trust has approved 51 new portfolio studies. (51 in 2023-24, 38 in 2022-23).

The two Research Departments across the Lincolnshire Community & Hospitals Group are developing a new Group strategy for Research to demonstrate its commitment to improving the quality of care and contributing to wider health improvement, through research. The Group is also linking in as an active partner of the Lincolnshire Integrated Care Board research leaders' group.

The Trust continues to play a significant role in improving patient care and in developing new and innovative drugs, treatment, and services. Research evidence shows that research active hospitals improve patient care and outcomes. Due to the increased number of commercial and non-commercial trials, Lincolnshire patients are benefitting by being given more opportunities to receive the latest medications and treatment options. The Trust has implemented the findings of trials, which has helped the Trust in improving patient care, as well as achieving cost savings. As the system continues to develop, it is hoped that even more benefits from research will be realised across the county.

Use of the Commissioning for Quality and Innovation (CQUIN) Framework

The 2025-26 CQUIN scheme has been paused nationally while a wider review of incentives for quality is undertaken.

Care Quality Commission (CQC) Statements

The Care Quality Commission (CQC) are the regulators of quality standards within all NHS Trusts. They monitor our standard of care through assessments, patient feedback, and other external sources of information.

The Trust is required to register with the CQC, and its current registration status is registered. The Trust has no conditions on its registration.

ULTH has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC has not taken enforcement action against ULTH during 2024-25.

CQC undertook unannounced visits to Emergency Departments in Lincoln and Boston in October 2024 and November 2024 respectively. The Trust is awaiting the final report but is acting on initial feedback from CQC.

The current CQC rating for ULTH is requires improvement.

	Safe	Effective	Caring	Responsive	Well-led	Overall
County Hospital Louth	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Lincoln County Hospital	Requires Improvement →← Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022
Pilgrim Hospital	Requires Improvement ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022
Grantham and District Hospital	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall trust	Requires Improvement →← Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Good ↑ Feb 2022	Requires Improvement →← Feb 2022

Data Quality

NHS Number and General Medical Practice Code Validity

United Lincolnshire Hospitals Trust submitted records during April 2024 to January 2025 at the Month 10 inclusion date to the Secondary Uses Service (SUS) for inclusion in Hospital Episode Statistics (HES), which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was:
  - 99.90% for admitted patient care (National performance 99.7%)
  - 99.97% for outpatient care (National 99.7%)
  - 99.67% for accident and emergency care (National 98.2%)

- Which included the patient's valid General Medical Practice Code was:
  - 99.97% for admitted patient care (National performance 99.4%)
  - 99.97% for outpatient care (National 99.3%)
  - 99.96% for accident and emergency care (National 99.2%)

Data Security and Protection Toolkit (DSPT)

The Data Security and Protection Toolkit (DSPT) is an annual online self-assessment tool via NHS England that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. As data security standards evolve, the requirements of the DSPT are reviewed and updated to ensure they are aligned with current best practice. Organisations with access to NHS patient data must therefore review and submit their annual assessment each year before the deadline.

All organisations that have access to NHS patient information must provide assurances that they have the proper measures in place to ensure that this information is kept safe and secure. Completion of the DSPT is therefore a contractual requirement specified in the NHS England Standard Conditions contract and it remains Department of Health and Social Care policy that all bodies that process NHS patient information for whatever purpose provide assurances via the DSPT.

Completion of the DSPT is also necessary for organisations, which use national systems such as NHSmail and the e-referral service.

ULTH's 2024-25 DSPT was submitted as 'approaching standards. An approaching Standards' assessment indicates that the Trust have demonstrated good progress but have not fully reached 'Standards Met'. The Trust develop and deliver to an improvement plan for those areas where work was identified as being needed and delivery of this is monitored through National Health Service England (NHSE).

Clinical Coding

ULTH commissioned an external provider to undertake a Clinical Coding audit in September 2024, as part of the Data Security & Protection Toolkit requirements, as well as ensuring internal processes are working as expected. Overall, the standard of Clinical Coding was rated as excellent, with Primary Diagnosis scoring a 94.5% accuracy rate, and Secondary Diagnosis scoring a 96.01% accuracy rate. Primary procedural coding scored 98.85% accuracy, with secondary procedure coding scoring 95.42%.

There were four key recommendations that came out of the audit, which the Head of Clinical Coding is leading on to ensure learnings and training are rolled out to the rest of the team.

Data Quality

Data Quality is an important element of safe, quality care at acute sites and is a continuing focus for improvement. United Lincolnshire Teaching Hospitals NHS Trust will be taking the following actions to improve data quality:

- An annual review of the main Key Performance Indicators (KPIs) that are reported to the Trust Board and Board Committees, including the addition of new metrics linked to a refresh of the Performance Review Meetings (PRM) that are undertaken for each Clinical Division. This will come into effect from January 2025. This involves understanding the metric itself, how it is calculated and assurance around underlying robustness of the metric, data source and collation/publishing.
- Work was paused on the application of the Data Quality Kite Mark. This will re-start in early 2025/26 and will alert end users to 4 indicators: Timeliness, Completeness, Validation and Process. Further work will ensure that all metrics are assigned a kite mark, and those assigned already are reviewed and updated as required.

- Work was completed to upgrade to the latest version of Careflow PAS (formerly known as Medway). We are also assessing the upgrades made available by the system supplier to enable our submissions to NHS England continue to be compliant to CDSv6.3 and ECDSv4
- The Clinical Coding department continues to work closely with the 4 Clinical Divisions and underlying Specialty Business Units; we are looking at what improvements can be made, including internal audit and training, and improved engagement with the Divisions.
- As part of the Group work bringing together United Lincolnshire Teaching Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust, the structure of the Information Services team is being reviewed to ensure we support the needs of the Group.
- We have adopted Microsoft PowerBI as the preferred visualisation tool for the Trust. Ongoing development of the data warehouse, coupled with PowerBI, will enable more timely reporting of information and assist with data quality reporting throughout the Divisions in the Trust.

Learning From Deaths

The Lincolnshire Medical Examiners review all deaths. The role includes reviewing medical records and liaising with bereaved relatives to assess whether the care provided was appropriate. Any death where a concern has been raised by the Medical Examiner is escalated for further review.

The Trust has an embedded process to screen, review and investigate inpatient deaths. Each Division has an embedded mortality review process to undertake reviews on any death to identify learning. The Mortality Meeting (MorALS) provides Executive-led scrutiny of mortality surveillance to ensure the Trust is driving quality improvement by using a systematic approach to mortality review and learning from death. The Group reports monthly to the Clinical Effectiveness Group.

Measure	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments
Number of patients that have died within ULTH	608	619	675	671	During 2024-25, 2573 of ULTH patients died. This line indicates the number of deaths which occurred in each quarter of that reporting period
Number of deaths that have had a case record review/investigation	608	619	675	631	By March 2024, 2533 case record reviews and investigations have been carried out in relation to 2494 of deaths included above. In 778 of cases a death was subjected to both a case record review and an investigation. This measure illustrates the number of deaths in each quarter for which a case record review or an investigation was carried out. In addition, 52 cases were also discussed within the Governance Meetings.
Number/percentage of deaths that	6	3	3	0	12 deaths representing 0.5% of the patient deaths during the reporting period are

escalated with problems in care					judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been used for all cases that have been graded a 3.

Summary of what ULTH has learnt from case record reviews and investigations conducted in relation to deaths

Circa 94% of the mortality reviews that were undertaken at the Trust identify that the death was unavoidable. The Trust objective is to learn from these cases of good care, as evidence suggests most care delivered in hospitals is of good or excellent quality, and as such, shared learning at M&M meetings from the review of high-quality care is key.

The Trust uses the Royal College of Physician's National Mortality Case Record Review Programme methodology known as the Structured Judgement Review (SJR). The Trust recognises that learning from the care given to patients in their final days of life enables us to understand where we have provided good care but also where there are opportunities for learning and improvement. It is vital to recognise that acknowledging the care given to patients at such a difficult time will improve the standard of care for all patients.

Other methodology and review tools are also used across the Trust regarding Learning from Deaths than may be more appropriate, such as:

Infant/child deaths may utilise alternative mortality reviews, such as:

- Sudden Unexpected Death in Childhood (SUDIC);
- Perinatal Mortality Reporting Tool (PMRT); or,
- Child Death Overview Panel (CDOP).

SACT 30-Day Mortality Reviews are completed for patient who die 30-days post-Systemic Anti-Cancer Therapy, even if an SJR has been completed previously.

Mortality and Morbidity meetings; where case reviews can be shared and learning from thematic analyses that related to concerns in care delivery.

Learning from Deaths allows for those identified concerns in care to be reviewed and discussed, and where possible, assist in opportunities to create service delivery improvements.

Learning identified from mortality reviews:

Documentation issues:

The Trust works with paper clinical records and there are concerns highlighted over loose notes and poor adherence to Trust policy when it comes to filing.

Several SJRs have highlighted poorly completed documentation in specific areas such as medications and fluid balance management.

End of Life:

The was a need for improvement in recognising the deteriorating patient and ensuring that End of Life discussion are held as soon as possible.

Delays within our Emergency Department (ED):

Patients were noted to have been within our ED for over 12-hours.

Issues with patients who have received a Decision to Admit (DTA) from ED, who were unable to be transferred to a ward within a timely manner due to bedspaces. This highlights the Trust discharge processes and how the flow within the Trust's Inpatients impacts the ED, increasing waiting times.

There was learning identified around transitional care patients from Children and Young Peoples services moving into adult care, whereby ownership could not be established due to the child's age.

Communication:

A highlighted issue at the Trust is our communications with families and carers in regard to issues access information about their loved ones on the wards, and the need to improve on difficult conversations and having these at the appropriate time; as well as ensuring these are accurately documented.

Fluid balance management:

This has been highlighted throughout our SJRs, whether this be poorly completed charts or where patients are not hydrated enough.

The review of 10 patients' death through an SJR process identified that these were more likely than not due to problems in care as such these cases were reviewed under our PSIRF criteria and approved as an individual PSII's.

ULTH reviews the Dr Foster system provided by Telstra Health UK, by completing monthly reviews on the Hospital Standardised Mortality Ratio (HSMR) data, which is reported to the Trust's Mortality Group (MorALS).

The Trust utilises this information to review the HSMR Diagnosis Group alerts and take a proactive response in providing thematic analyses and instigating in-depth case note reviews.

Description of actions that ULTH have taken in 2024-25 and proposes to take forward in consequence of what the ULTH has learnt.

Concerning the issues with documentation, audits have been included within the Quality Assurance Assessments completed by the Quality Matrons, which have a specific section that now reviews patient documentation; not only within the paper case notes but within some electronic records such as ePMA, which is used for prescribing medication.

Several specialties are completing audits around end-of-life care, to review the current practice and identify improvements. This is being completed alongside liaising with the Specialist Palliative Care Team to understand the wider impacts of end-of-life care.

We are working closer with our partner organisation LCHS and building relationships when it comes to end-of-life care delivery. With LCHS now attending many of our meetings to share insights and learning.

Delays in ED have been reviewed centrally by the Trust, with most of the cases highlighted by mortality review already being investigated by the department die to stringent national KPI's which they monitor.

Several projects have been completed across the reporting period to look to improve both discharge from hospital and improving patient flow from our ED departments in conjunction with the ICB and partner organisations.

New policies and pathways are being created with larger discussions between the Family Health and Medicine divisions around transitional care patients from Children and Young Peoples services moving into adult care.

New processes have been put in place to improve the communication with families and specifically when they try to call the wards via the telephone.

Discussions with the families are now documented more in the notes, as a result of discussions within Governance meetings. An understanding of documenting as much as possible will help when a case is reviewed by the Medical Examiner, or in the result of further investigations or complaints.

A 'Hear it Your Way' faculty has been launched with a number of sessions run; This looks to teach staff how to navigate challenging conversations with confidence and empathy and

master techniques for clear and concise communication, reducing the risk of errors and misunderstandings. Explore the importance of active listening and nonverbal cues in building strong patient clinician relationships.

Some of the wards are trialling new methods of providing hydration to patients with the jugs that have different coloured lids so it can be monitored more simplistically. The aims are to improve on patient hydration and reduce the need for IV fluids, which could come at a cost saving.

M&M meetings:

Newsletters and briefings are being issued that identify key learning issues and actions. This enables them to be sent to all staff within the relevant area and not only the people who can attend a meeting, ensure dissemination of shared learning.

The Learning from Deaths team has completed more thematic reviews on unavoidable deaths that had some element of suboptimal care that did not impact on the outcome. This enables the Trust to review themes and trends across department from cases where an individual review would not have identified a theme or improvements needed.

The Trust has moved all mortality information and not just SJRs into the DCIQ system making it a one stop for all mortality cases bring together SUDIC, PRMT, SACT, M&M and SJRs into one platform: with wider oversight of all learning from deaths in one system.

The Trust has continued to run the Mortality Masterclasses and opened these up to our partner organisation LCHS.

The Trust will be moving to Group working within 2025-26, and to be proactive the two Learning from Deaths teams have been working more collaboratively to review patients and share learning experiences.

Assessment of the impact of actions which were taken by ULTH during 2024 - 25.

Moving all the Learning from Death cases to DCIQ has enabled the Trust to support a larger number of timely reviews of patient deaths that meet the criteria defined within our Learning from Deaths Mortality Review policy.

The Trust reviewed the current Mortality and Morbidity (M&M) meetings. Positive engagement with the newer M&M processes, leading to the implementation of some CBU lead M&M's, taking wider discussion from multi-disciplinary specialists, highlighting concerns and sharing reviews and learning in a larger group rather than in silo by specialty.

Mortality Masterclasses that were run by the Learning from Deaths team in conjunction with the Medical Examiners service allowed for wider shared learning of process and procedures relating to patient deaths. It also allowed the Trust to explain some of the national metric such as HSMR and SHMI and how their work can impact these.

We are continuing to improve the clinical governance processes around Learning from Deaths and ensuring that we triangulate with other teams e.g. patient safety, complaints, and audit to optimise learning opportunities.

Due to shared working with our partner organisation LCHS, the Learning from Deaths teams are collaborating more frequently and looking to align processes. There is going to be new Mortality Oversight Group, with attendees from both organisations to look at Mortality, shared learning and insights, aligning these to Trust priorities alongside a new Group Learning from Deaths Mortality Review Policy.

United Lincolnshire Teaching Hospitals NHS Trust have been using a grading of avoidability since January 2016. The review grading is outlined below:

- Grade 0 - Unavoidable Death, No Suboptimal Care
- Grade 1 - Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome
- Grade 2 - Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
- Grade 3 - Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)

Measure	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments
Number of reviews/ investigations completed which took place before the start of the reporting period	82	16	2	1	101 case record reviews and investigations completed after 31 March 2024, which related to deaths, which took place before the start of the reporting period.
Number/Percentage of deaths that are judged likely not to be problems in care	1	0	0	0	1 representing 1% of the patient deaths during 1 April 2024 - 31 March 2025 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Reporting Against Core Indicators

The tables below show the Trust's latest performance for 2024/25 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience. The following data relating to national reporting requirements in the Quality Account are provided by NHS Digital. NHS Digital provide data for 15 mandatory indicators, based upon the recommendations by the National Quality Board. The last two previous reporting periods available on NHS Digital for ULTH are to be reported within the Quality Account.

Domain 1: Preventing people from dying prematurely.

The data made available to the Trust by NHS Digital with regard to:

- The value and banding of the Summary Hospital-level Mortality Indicator (SHMI) for the Trust for the reporting period

Description	Dec 2021 – Nov 2022	Dec 2022 – Nov 2023	Dec 2023 – Nov 2024
ULTH SHMI / Band	1.0267 / 2	1.0325	1.0999 / 2
National Average	0.9997	1.0033	1.0031
Best(B) / Worse(W) National Performance	0.7173 (B) / 1.2219 (W)	0.9578 (B) / 1.2564 (W)	0.7016 (B) / 1.2849 (W)

The data made available to the Trust by NHS Digital with regard to:

- The percentage of patient deaths with palliative care coded at either diagnoses or speciality level for the Trust for the reporting period

Description	Dec 2021 – Nov2022	Dec 2022 – Nov-2023	Dec 2023 – Nov 2024
ULTH%	33%	32%	32%
National Average %	40%	42%	44%
Best(B) / Worse(W) National Performance %	66% (B) / 13% (W)	66% (B) / 16% (W)	66% (B) / 17% (W)

ULTH considers that this data is as described for the following reasons:

Information relating to mortality is monitored monthly and used to drive improvements.

The mortality data is provided by an external source (Dr Foster).

The data is reviewed by the Learning from Deaths team, interrogated in line with the key lines of enquiry identified by the team and has reporting and governance arrangements in place.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Continually reviewing our mortality processes and reviewing our data.

Learning from deaths team continue to monitor palliative care coding against national best practice in order to ensure the number of expected deaths is accurately recorded.

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

The data made available by NHS Digital with regard to:

- The Trust's patient reported outcome measures scores for Total/Primary Hip replacement surgery & Knee replacement surgery-EQ:5D Index

Description	2020-2021	2021-2022	2023-2024
ULTH EQ:5D index Hip Replacement surgery (L) Low, (H) High	Pre Op (L) -0.484 (H) 0.796 Post Op (L) –0.264 (H) 1.0	Pre Op (L) -0.319 (H) 0.796 Post Op (L) 0.186 (H) 1.0	Pre Op (L) -0.248 (H) 0.814 Post Op (L) -0.239 (H) 1.0
National Avg EQ:5D index Hip Replacement surgery (L) Low, (H) High	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0
ULTH EQ:5D index Knee Replacement surgery (L) Low, (H) High	Pre Op (L) -0.074 (H) 0.796 Post Op (L) 0.516 (H) 1.0	Pre Op (L) -0.319 (H) 0.76 Post Op (L) -0.016 (H) 1.0	Pre Op (L) -0.239 (H) 0.796 Post Op (L) -0.239 (H) 1.0
National Avg EQ:5D index Knee Replacement surgery (L) Low, (H) High	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0

The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for:

- Total/Primary Hip replacement surgery & Knee replacement surgery-VAS Index

Description	2020-2021	2021-2022	2023-2024
ULTH VAS index Hip Replacement surgery - (L) Low, (H) High	Pre Op (L) 25 (H) 95 Post Op (L) 51 (H) 95	Pre Op (L) 0 (H) 90 Post Op (L) 45 (H) 100	Pre Op (L) 3 (H) 100 Post Op (L) 13 (H) 100
National Avg VAS index Hip Replacement surgery - (L) Low, (H) High	Pre Op (L) 0 (H) 100 Post Op (L) 0 (H) 100	Pre Op (L) 0 (H) 100 Post Op (L) 0 (H) 100	Pre Op (L) 0 (H) 100 Post Op (L) 0 (H) 100
ULTH VAS index Knee Replacement surgery - (L) Low, (H) High	Pre Op (L) 40 (H) 85 Post Op (L) 35 (H) 99	Pre Op (L) 29 (H) 95 Post Op (L) 35 (H) 93	Pre Op (L) 8 (H) 100 Post Op (L) 15 (H) 100
National Avg VAS index Knee Replacement surgery - (L) Low, (H) High	Pre Op (L) 0 (H) 100 Post Op (L 0 (H) 100	Pre Op (L) 0 (H) 100 Post Op (L 0 (H) 100	Pre Op (L) 0 (H) 100 Post Op (L 0 (H) 100

The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for:

- Total/Primary Hip replacement surgery and Knee Replacement Surgery-Oxford Score

Description	2020-2021	2021-2022	2023-2024
ULTH Oxford hip surgery score (L) Low, (H) High	L – 3 H - 48	L – 3 H - 48	L – 3 H - 48
National Avg Oxford Hip surgery score (L) Low, (H) High	L – 0 H - 48 (Actual High and low)	L – 0 H - 48 (Actual High and low)	L – 0 H – 48 (Actual High and low)
ULTH Oxford Knee surgery score (L) Low, (H) High	L – 5 H - 48	L – 4 H - 46	L – 5 H - 48

National Avg Oxford Knee surgery score (L) Low, (H) High	L – 0 H - 48	L – 0 H - 48	L – 0 H - 48

ULTH considers that this data is as described for the following reasons:

Patients undergoing elective inpatient surgery for a hip or knee replacement, funded by the English NHS are asked to complete a voluntary questionnaire before and after their operations to assess improvement in health as perceived by the patient themselves. The data is taken from NHS Digital PROMS data set.

ULTH intends to take the following actions to improve PROMS outcomes and so the quality of its services by:

We are continuing to focus on improving participation rates.

The Orthopaedic Team will review the data quarterly to ensure good participationn rates and any identify actions if any areas are below the required benchmark.

The data made available to the Trust by NHS Digital with regard to:

- The percentage of patients aged (i) 0 to 15 readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (emergency readmissions)

Description	2021-2022	2022-2023	2023-2024
ULTH readmitted within 30 days: 0-15	12.9%	12.4%	14.7%
*National Average: 0-15	12.5%	12.8%	12.4%
Best(B) / Worse(W) National Performance: 0-15	B - 3.3% W - 46.9%	B - 3.7% W - 302.9	B - 1.6% W - 69.1%

The data made available to the Trust by NHS Digital with regard to:

- The percentage of patients aged (ii) 16 or over readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (emergency readmissions)

Description	2021-2022	2022-2023	2023-2024
ULTH readmitted within 30 days: 16+	11.9	11.4	12.3
National Average: 16+	14.7	14.4	13.1
Best(B) / Worse(W) National Performance: 16+	B - 2.1 W -142.0	B - 2.5 W - 46.8	B - 1.7 W - 99.6

ULTH considers that this data is as described for the following reasons:

The data is taken from the Trust's Patient Administration System (Careflow).

The data is consistent with Dr Foster's standardised ratios for re-admissions.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Working to ensure we treat and discharge patients appropriately, so they do not require an unplanned readmission. Working with partners in the system to address long-standing pressures around demand, capacity and patient flow and working closely with system partners to ensure safe discharge practice.

Domain 4: Ensuring people have a positive experience of care.

The data made available by NHS Digital with regard to the:

- Trust's responsiveness to the personal needs of its patients during the reporting period

Description	2018-2019	2019-2020
ULTH	64.6	61.3
National Average	67.2	67.1
Best(B) / Worse(W) National Performance	B – 85.0 W – 58.9	B – 84.2 W – 59.5

*Latest data available

ULTH considers that this data is as described for the following reasons:

The data is provided by the national survey contractor.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Continuing to collect real-time feedback from patients as part of its inpatient survey, working to increase the FFT response rate this year and expanding the work of the Patient Experience Team.

The data made available by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period:

- Who would recommend the Trust as a provider of care to their family and friends

Description	2022	2023	2024
ULTH Strongly agree(SA) /Agreed (A)	42.7%	44.3%	48.96%
National Average Strongly agree(SA) /Agreed(A)	61.9%	63.3%	61.5%
Best(B) / Worse(W) National Performance	86.4% (B) 39.2% (W)	88.8% (B) 44.3% (W)	89.59% (B) 39.72% (W)

ULTH considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to published survey results.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Continuing to encourage participation in this survey and by developing local action plans and responses to the feedback received.

The data made available to the Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2):

- Patients who would recommend the Trust to family and friends: % recommended

Description	Nov 2024	Dec 2024	Jan 2025
ULTH ED / National Avg/ Best(B)-Worst(W)	ULHT – 73% National – 77% 100% (B) 36% (W)	ULHT – 70% National – 76% 95% (B) 13% (W)	ULHT – 73% National – 80% 97% (B) 56% (W)
ULTH Inpatients/National Avg/ Best(B)-Worst(W)	ULHT 90% National – 95% 100% (B) 75% (W)	ULHT – 89% National – 94% 100% (B) 72% (W)	ULHT – 90% National – 95% 100% (B) 72% (W)
ULTH Maternity /National Avg/ Best(B)-Worst(W)	No Responses recorded	No Responses recorded	No Responses recorded

ULTH considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to published survey results.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Improving our communication and keeping our patients informed and updated on their care and treatment.

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

The data made available to the Trust by NHS Digital with regard to the:

- Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Description	October 2024	November 2024	December 2024
ULTH %	97.85%	97.68%	97.36%
National Avg %	90.19%	90.34%	89.69%
Best(B) / Worst(W) National Performance %	(B) 100% / (W) 13.73%	(B) 99.96% / (W) 14.50%	(B) 100% / (W) 12.65%

ULTH considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to internal data.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Continuing with our VTE programme aims to reduce preventable harm to our patients by promoting timely and accurate VTE risk assessment and ensuring thromboprophylaxis is prescribed accurately and administered effectively when required.

Provide VTE risk assessment data to clinical areas.

A VTE Nurse Specialist has been appointed.

The data made available to the Trust by NHS Digital with regard to:

- The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reported period.
-

Description	2021-2022	2022-2023	2023-2024
ULTH	24.60	25.08	30.95
National Avg	43.73	43.58	46.67

Best(B)-Worst(W) National Performance	(B) 0 / (W) 138.38	(B) 0 / (W) 133.64	(B) 0 / (W) 131.2

ULTH considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to internal data.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Focusing on improving hand hygiene; adopting national and local campaigns including visual prompts.

Training staff on infection prevention and hand hygiene; focusing on high standards of cleanliness, screening of emergency and elective patients and focusing on effective antibiotic stewardship and ensuring that patients are effectively isolated and monitoring and feeding back on cases where inappropriate prescribing is a possible contributory factor.

The data made available to the Trust by NHS Digital with regard to:

- The number and, where available, rate of Patient Safety Incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death

Description	Oct 2018 - Mar 2019	Apr 2019 - Sep 2019	Oct 2019 - Mar 2020
ULTH %	(T) 27.9% (SD) 0.21%	(T) 28.3% (SD) 0.11%	(T) 27.5% (SD) 0.13%
National Avg %	(T) 47.0% (SD) 0.15%	(T) 51.3% (SD) 0.15%	(T) 51.5% (SD) 0.15%
ULTH Total No of Incidents (T) / Severe or Death (SD)	(T) 6,291 / (SD) 47	(T) 6,413 / (SD) 25	(T) 5,914 / (SD) 28

*Latest data available

ULTH considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to internal data.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Providing staff training in incident reporting and risk management.

Undertaking comprehensive investigations and utilising varying forums for learning such as huddles and Trust Communications and Safety Bulletins.

Part 3: Review Quality Performance

Patient Safety

The safety of our patients is central to everything we want to achieve as a provider of healthcare. We are committed to continuously improving the safety of our services and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by successfully implementing proactive patient safety improvement programmes and by working to better understand and improve our safety culture. We recognise the importance of a culture where staff are comfortable to report when things go wrong, and we work hard to ensure that the appropriate support for staff is available in an effective, efficient, and timely way.

We will also continue to conduct thorough investigations and analyse when things go wrong, identifying and sharing learning, and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident and will strive to eliminate avoidable harm as a consequence of care we have provided.

Patient Safety Incident Response Framework (PSIRF)

Last year we reported how we had launched the NHSE PSIRF which replaced the national serious incident framework. This year we have completed our transition and collaborated with our ICB to develop a PSIRF plan and policy to underpin the change.

PSIRF set out a new direction for how the NHS responds to patient safety incidents, focusing on effective learning and improvement, compassionate engagement and embedding a patient safety culture.

Completing our transition has meant there is now greater focus on understanding the impact of systems and human factors in our patient safety incidents and we have greater understanding in the “what” not the “who” in investigations to support a just and learning culture. Not all serious events will lead to a Patient Safety Incident Investigation (PSII) – other tools will be available such as After-Action Reviews, clinical audit or Mortality & Morbidity (M&M) meetings, and greater support and involvement is being provided for those involved in patient safety incidents.

Never Events

Never Events are serious, largely preventable, safety incidents that should not occur if the available preventative measures are implemented. The Trust is committed to identifying, reporting and investigating never events, and ensuring that learning is shared across the organisations, and actions are taken and embedded to reduce the risk of recurrence.

From April 2024 – March 2025 the Trust had three never events:

1. Wrong sided femoral nerve block
2. Retained swab
3. Wrong mole removal

Two of three Never Event investigations have been completed, and the following learning has been identified:

Femoral Nerve Block Incident:

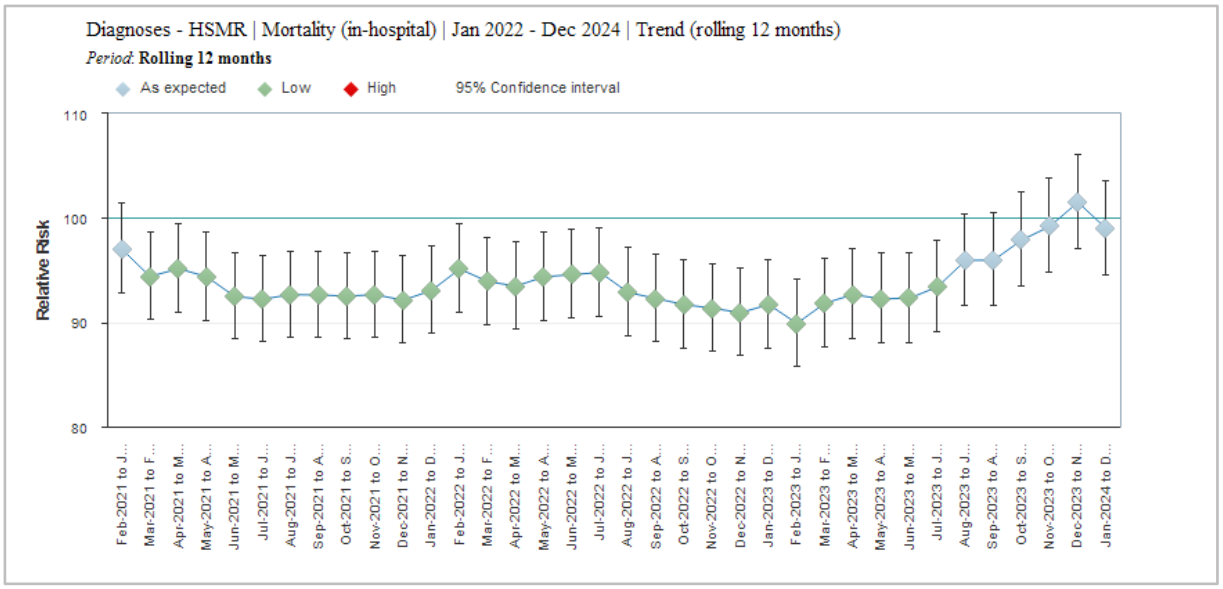
- Distractions within the anaesthetic room
- Workplace pressure and its impact on staff
- Stop Before You Block equipment availability
- Stop Before You Block staff training
- Human Factors Training

Retained Swab Incident

- Policy and Process related to item counting during surgery.
- Staff changeover due to an extended surgery and complications arising
- Consideration of theatre lists for complex gallbladder cases.
- Converting from laparoscopic to an open procedure during the operation.
- Protocol for a patient that has a significant bleed during the operation.
- Requirement for a debrief following surgery

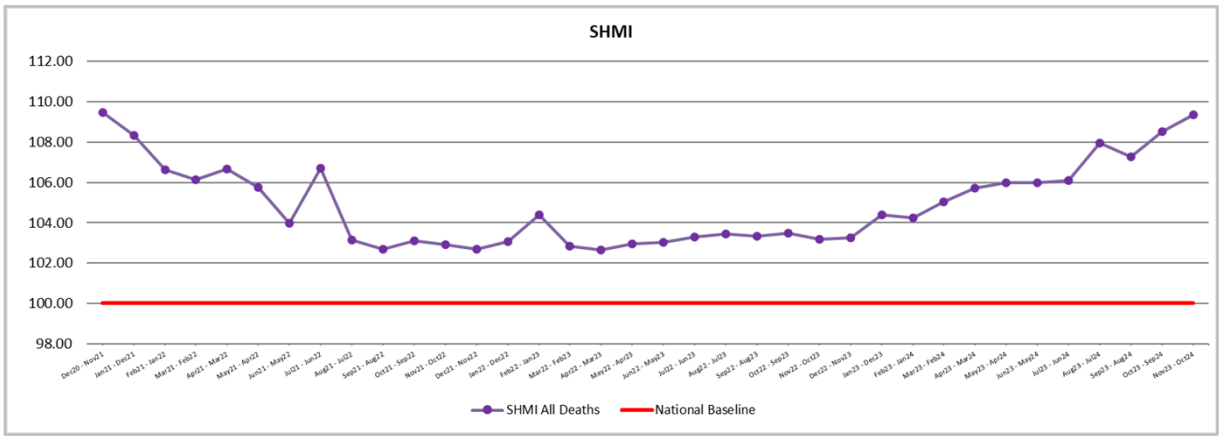
HSMR/SHMI

HSMR is an indicator of healthcare quality that measures the ratio of observed deaths to expected deaths, and whether the number of deaths in hospital is higher or lower than would be expected. At the time of writing the latest 12 month rolling HSMR for the Trust relates to the January 2024 – December 2024 Dr Foster report. HSMR for the rolling 12-months is 98.98, which places the Trust in the ‘As Expected’ banding.



SHMI

The Summary Hospital Level Mortality Indicator (SHMI) is a mortality measure that takes account of a number of factors, including a patient's condition. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the NHS average, which is 100, a score below 100 denotes a lower-than-average mortality rate. It is recognised that SHMI cannot be used to directly compare mortality outcomes between Trusts. The Trusts SHMI from November 2023 – October 2024 (there is a 6-month data lag) is 109.53 which is 'As expected'.



Mortality Assurance (MorALS) Group

The Mortality Assurance Learning Strategy (MorALS) Group meet every month and has oversight of the activities of all mortality review processes across the Trust, including the activities of Learning from Deaths and promoting the learning from mortality reviews. The meeting provides an opportunity to discuss any issues arising and to help support the development of learning culture in the organisation in line with our Learning from Deaths

policy. The monthly outputs from the Divisions are described in this meeting and the targeted areas for improvement reviewed. The development of this group into something that has greater oversight of the Trust-wide mortality review process has been the focus of our energies. It is also responsible for ensuring the Trust has oversight of the key mortality measures for the Trust and reporting on any concerns arising, which it does via a monthly report to the Clinical Effectiveness Group, which upwardly reports to Quality Committee and Trust Board.

Call for CONCERN

Call for Concern enables patients, families, and carers to call for urgent help and advice if they are concerned that a patient's deteriorating condition is not being adequately recognised by Ward teams. This initiative acknowledges that relatives/carers/friends often possess the ability to recognise 'soft signs' of patient deterioration before it becomes apparent to staff.

The service is coordinated by the Critical Care Outreach Team who support the Ward teams by assessing and reviewing patients as well as offering advice on how to manage the patient's condition. The team will ensure an appropriate care plan is in place for the patient.

The pilot was launched on the Lincoln County Hospital site in December 2024 and on the Pilgrim Hospital site in February 2025 and includes all adult

Care Partner Hub

The Care Partner Hub is a joint venture between the Trust and Carers First which aims to improve the quality of life of care partners, including young carers, those caring for someone at the end of their life or with dementia and those that have been bereaved.

Volunteers from ULTH and Carers First offer a wide range of services and comprehensive local resources, including carers assessment referrals and support, carers awareness training for professionals, and information, advice, and signposting, in addition to being a friendly space for a chat with people that understand.

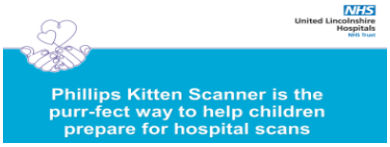
The Care Partner Hub is part of the Trusts commitment to recognising the invaluable role of carers as experts, and the hub will raise awareness of the Trust's Care Partner Badge Scheme, which helps recognise the role of care partners within hospitals to give them greater flexibility to stay outside of visiting hours and inclusion in care, admittance and discharge discussions if they choose to be.

Patient stories

Each month a digital patient story is presented to Trust Board, and these are all now available to all staff within our Patient Story Library on the intranet. Patient stories are also presented to Patient Experience Group as part of divisional assurance reports and clinical business units and governance groups have a story to start their meetings.

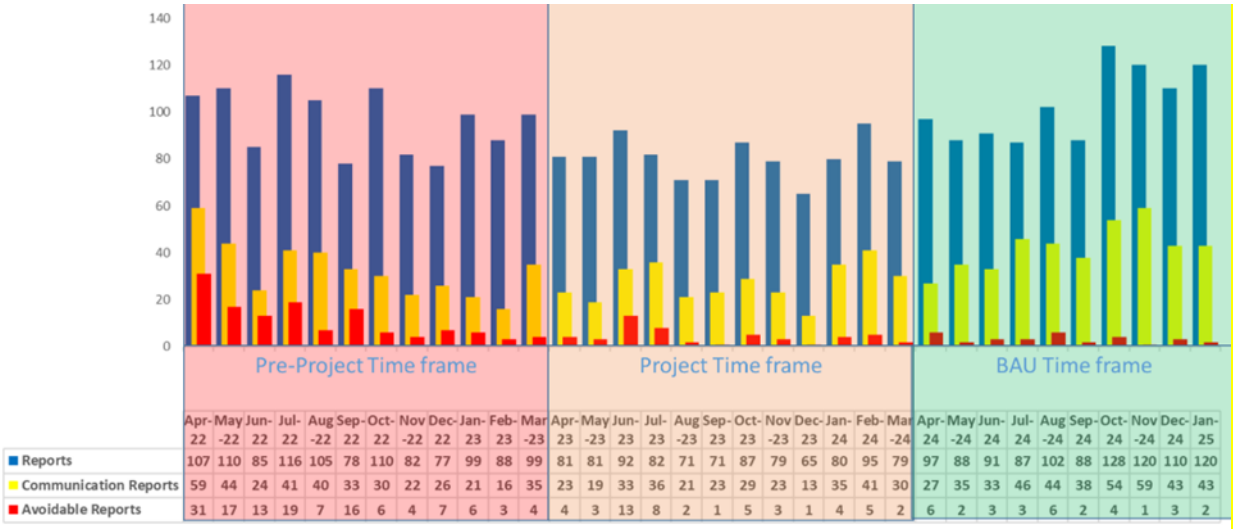
The following are example stories shared at Trust Board during 2024-2025

William's story William who is part of the Deaf community in Lincolnshire and tells of his poor experiences being Deaf when accessing hospital services.  https://youtu.be/WTjFnUNDqls	**Ethan's story** This story told by Ethan's mum Celia, who talks about the amazing work done by the Complex Needs Rapid Response Respiratory Service in Lincolnshire.  https://www.youtube.com/watch?v=7wp3NycE3Tk
Phillips Kitten Scanner is the purr-fect way to help children prepare for hospital scans	**Young Carers** This film featured three Lincolnshire Young Carers stories, and we hear how being a Young

The story follows the heart-warming experience of Phoebe, a young patient at our hospital who recently underwent an MRI after having a session using the new Kitten scanner.  https://youtu.be/fJQ5C2DsbVk	Carer affects their family life and describes some of the barriers and challenges they face when accessing our healthcare services.  https://youtu.be/0LEHw1LaNN8

You Care; We Care to Call (YCWCC)

In April 2023, the Trust launched the YCWCC project aimed to ensure we proactively keep relatives up to date with important information without them having challenges of getting through to the right person on the ward. We knew that staff were busy, and phone calls were being missed or not answered as our families were telling us this. Many patients were able to update families themselves or had family members coming in to visit but there were also a large number who were so unwell or vulnerable that families understandably would call to see how they were doing. The principle is to first confirm who needs an update phone call, when and how frequently, what information needs to be shared and to establish the best person to make that call. This not only reduced phone traffic but also, most importantly, communicated more effectively with families. The project was included in the 2023-2024 Integrated Improvement Plan with a target to roll out across 38 wards and reduce avoidable complaints by 50%. Both these targets were achieved and exceeded. An avoidable complaint is one that had a proactive YCWCC call been made then that complaint could have been avoided. The measure is determined by reviewing all complaints and PALS concerns against this criterion. YCWCC has continued to be monitored - the graph below shows the period prior to the initiative being launched, the project year itself and this last year under ‘business as usual’ (BAU). Communication complaints and PALS concerns overall are back to around the 2022-23 level (having dropped while the project was ongoing and being focussed on heavily in 2023-24) what we can see is that the numbers of avoidable complaints are still under control and haven't increased again following the move to BAU.



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Reports	107	110	85	116	105	78	110	82	77	99	88	99	81	81	92	82	71	71	87	79	65	80	95	79	97	88	91	87	102	88	128	120	110	120
Communication Reports	59	44	24	41	40	33	30	22	26	21	16	35	23	19	33	36	21	23	29	23	13	35	41	30	27	35	33	46	44	38	54	59	43	43
Avoidable Reports	31	17	13	19	7	16	6	4	7	6	3	4	4	3	13	8	2	1	5	3	1	4	5	2	6	2	3	3	6	2	4	1	3	2

Patient Information

Work to review all our existing patient information started in 2023, continued during 2024 and the backlog was finally completed in the summer enabling a move to ‘business as usual’. By December 2024 601 leaflets had been reviewed, 455 of these were approved and have been published with the remaining either being redirected to a Trusted Source provider or no longer being needed. The approval group meets virtually when new leaflets are submitted or existing ones due for review and can turn around approvals much quicker.

There are two repositories: the internal intranet and external website. Some information is published in both but there are some pieces that require being discussed with patients on receipt and some also have space for individual information to be written in – for this reason these are not placed on the external website. Over a recent 90-day period there were 4,869 visits to view or download information from the internal repository and the most traffic was via desktop computer at 98.7%.

The external website Patient Information Library allows patients to directly access and download information. These are grouped under 48 headings such as Audiology, Gastroenterology, Head and Neck and Physiotherapy. As the external website has the ‘ReciteMe’ functionality these can then be viewed in multiple languages and formats. Over the same recent 90-day period the public website library had 645 visits showing that our public are accessing it.

Sensory Aids

The sensory aids are being offered to help soothe dementia patients during their stay within the Trust. The Precious Petzzz, are life-like animals, the cats purr and they all simulate breathing as they sit on the beds and laps of patients. The designs include spaniel and border collie puppies, as well as a variety of cats. All come with their own bed. United Lincolnshire Hospitals Charity has funded these sensory dog and cat aids which will soon be available at Lincoln, Grantham and Pilgrim hospitals.

Access to Diagnostic Testing

Over the past few years, we have been working to make accessing these tests easier and more convenient through the development of Lincolnshire's Community Diagnostic Centre (CDC) programme. Each CDC has been designed to consider what the local community needs. CDCs are facilities in the community, away from busy hospitals, where you can access tests such as MRI, CT and non-obstetric ultrasound scans, X-rays or blood tests.

In March 2024, Grantham's CDC, underwent a £5million expansion to include state-of-the-art CT and MRI scanners. In November 2024, a new Skegness CDC opened, and a new Lincoln CDC opened in December 2024.

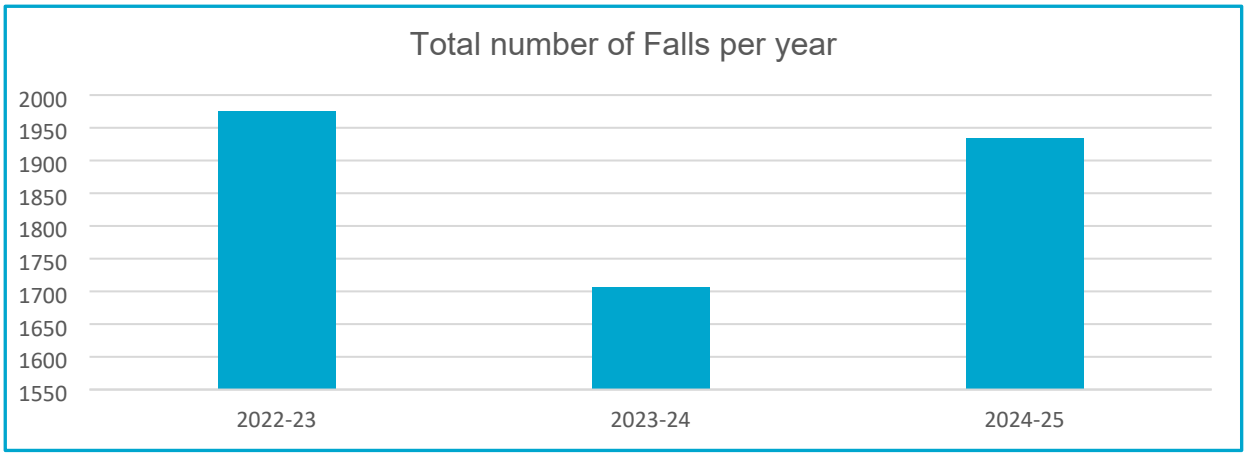
Patient Falls

Falls prevention continues to be a key patient safety focus for the organisation. The Trust aims to reduce our rate of avoidable falls and continue our quality improvement journey through collaborative working across the organisation and with our system partners.

Falls amongst inpatients has historically been the most frequently reported safety incident in NHS hospitals with 50% of patients over 80 estimated to fall at least once a year, and 30% of over 65's. Approximately 30-50% of falls result in some form of injury and fractures occur in 1 to 3% of incidents.

Our annual falls numbers have shown an increase during 2024 however, they remain below the levels seen in 2022-23 and we have not seen an associated increase in the level of harm. Taking into consideration a continued rise in admissions and increase in the number of patients admitted with complex care needs that increases their risk of falling; this still demonstrates an encouraging position. Reducing the number of patients who fall in our care and reducing the risk of harm associated with a fall are key quality and safety issues and a priority for improvement for the Trust.

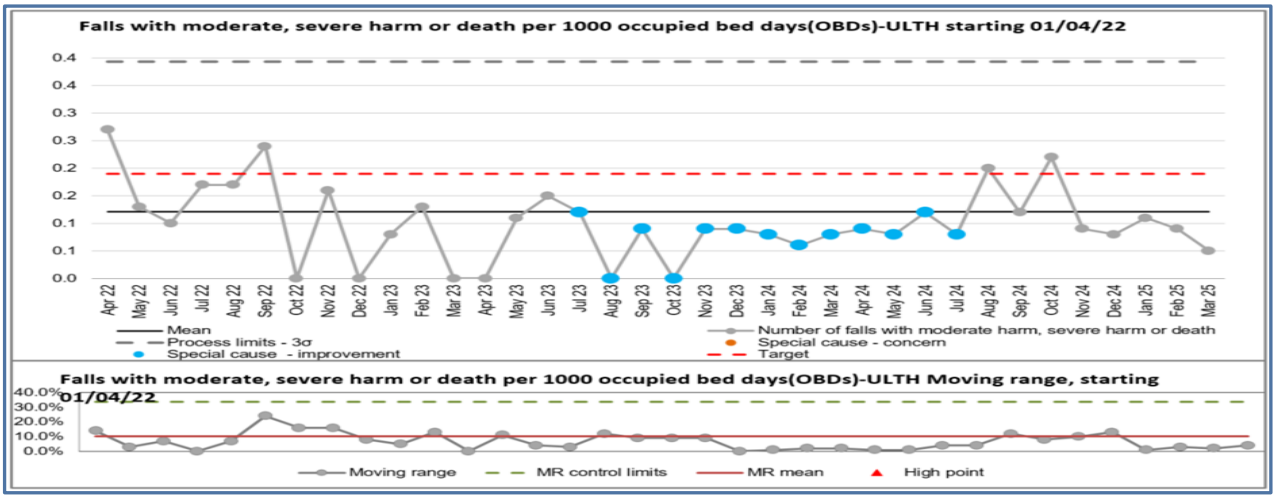
Annual falls performance 2022-2025



Reducing avoidable harm from patient falls

Falls incidents can result in psychological and physical harm, also having a substantial financial impact to the NHS. Falls resulting in harm are more likely to occur in acute Trusts like ours. These incidents may affect patient confidence, and the resulting injuries could mean a longer stay in hospital. In some cases, following a fall, a patient cannot be discharged to their usual place of residence, which is a significant life change. Moving to a Group model has seen acute and community care partners increasingly work together to share data, experiences and learning to support each other to reduce avoidable patient falls.

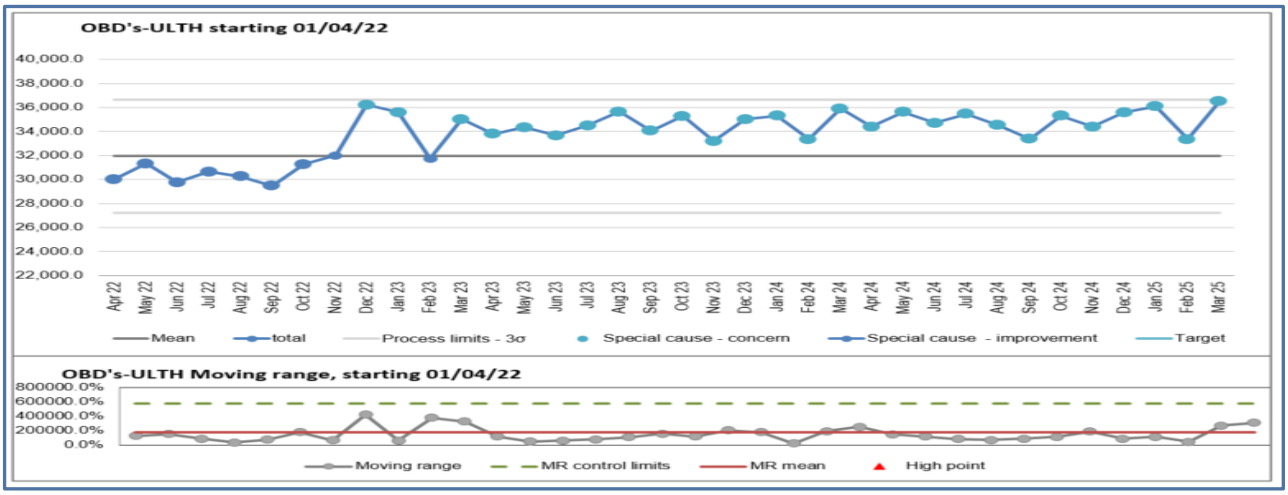
Falls resulting in moderate harm, severe harm or fatal per 1000 bed days April 2022 – March 2025



The Trust target for falls resulting in moderate, severe harm and death is 0.19. The Trust has been below this target for thirty-two of the thirty-six months shown in the above chart. The pattern for the data detailed above is different from the pattern in which our occupied bed days (OBD) rate has changed over the same time-period.

Falls data continues to show some variation over the previous 3 years, however the number of occasions where the Trust have failed to achieve the target has not increased. As demonstrated in the chart below, the number of occupied bed days have shown an upward trend although the months with the highest OBD's do not have correlating peaks of falls resulting in level 3 harm or above; demonstrating that the ongoing improvement actions in place across the organisation to mitigate and prevent falls, are continuing to limit the severity of harm and are positively impacting on the safety of our patients.

Occupied bed days April 2022-March 2025



Key Achievements

- The Falls Prevention Steering Group (FPSG) continues to meet monthly and has been developing into a Group meeting across LCHG. The group has a multidisciplinary membership and provides oversight, monitoring and accountability of the ongoing improvement work around falls prevention. Patient stories are regularly shared at FPSG to ensure wider learning and prompt person focused improvement ideas.
- Falls prevention documentation and care is reviewed in the weekly Ward/Department Leader's assurance and monthly Matrons audits as a component of the Quality Accreditation Programme. The monthly Quality Metrics review meeting chaired by the Deputy Director/Assistant Director of Nursing monitors ward and departments' performance relating to falls.
- Representatives from the clinical and quality teams continue to be actively involved in system wide and regional falls prevention meetings where local and national data and initiatives are shared and acted upon.

- Monthly lessons learned and educational Falls Prevention Bulletin's continue to be produced and shared with our clinical teams to improve staff knowledge regarding falls prevention.
- Falls ambassador huddles recommenced in 2024, giving a platform for staff to share and discuss new initiatives, share lessons learnt and provide peer support for any areas experiencing challenges in falls prevention.
- We continue to produce and share our quarterly newsletter to provide staff with an oversight of current national and local priority topics, share and celebrate team's improvement initiatives, and provide dates for up-and-coming Trust events relating to falls prevention.
- We held a successful falls prevention awareness study day during national Falls Awareness week in September 2024. Following positive feedback on the day a series of quarterly study days are being established. We also facilitated two falls prevention 'Focus on Fundamentals' months in August 2024 and February 2025. These included a range of activities and use of Trust social media sites and communications channels to maximise awareness for all staff, celebrate successes and share improvement ideas.
- The Quality Matron team have collaborated with the University of Lincoln and have started to deliver a falls prevention educational session to second year Student Nurses.
- We have introduced Falls FaCTs (Falls Current Themes) delivered as short drop-in sessions each month which are open to all staff.
- 'Baywatch' a method to ensure staff are consistently present and visible in ward bay areas has been reinvigorated, with particular focus in those areas experiencing a higher number of falls. Clinical areas have used this as an opportunity to introduce improvement initiatives; examples are the use of yellow lanyards to indicate the staff member with responsibility for Baywatch at a given time and the introduction of additional patient stations to support staff to stay in the area to undertake their work. This supports the increased the visibility of patients who are vulnerable to falling.
- Divisional falls focus groups are now established and support a multidisciplinary approach to reviewing falls incidents and sharing learning.
- The B.I.G Question was developed with the aim of encouraging all staff at the end of every patient contact to ask 'Before I Go' to check if there is anything else the patient needs. This was developed in response to an increase in patients falling following interventions such as clinical observations or medication rounds.

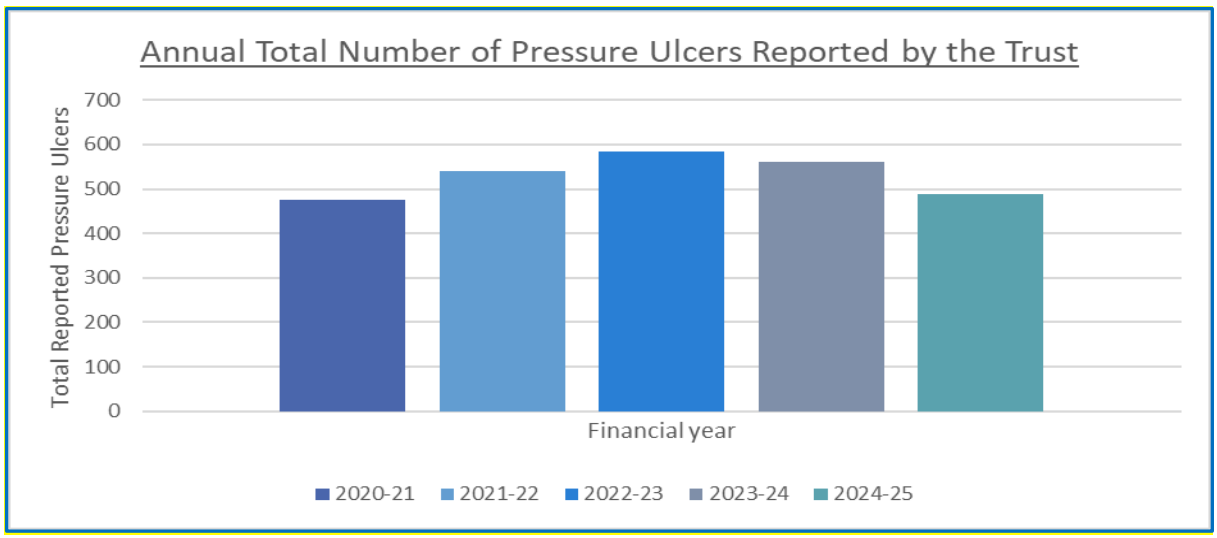
- As part of the Quality Accreditation programme Harm Free certificates continue to be awarded to those areas who have periods with no falls incidents. This year we have celebrated 30 areas achieving a year of providing falls harm free care.
- Representatives from our quality, patient safety and patient safety partner teams have been collaborating to develop several human factors based educational falls videos. These demonstrate a variety of scenarios that may result in a patient fall and discussion points to get staff thinking about how these could be approached differently.
- The falls improvement online teams channel has more than doubled its membership; providing a central point for staff to access and share educational resources, updates and improvement projects.

Aims for 2025/26

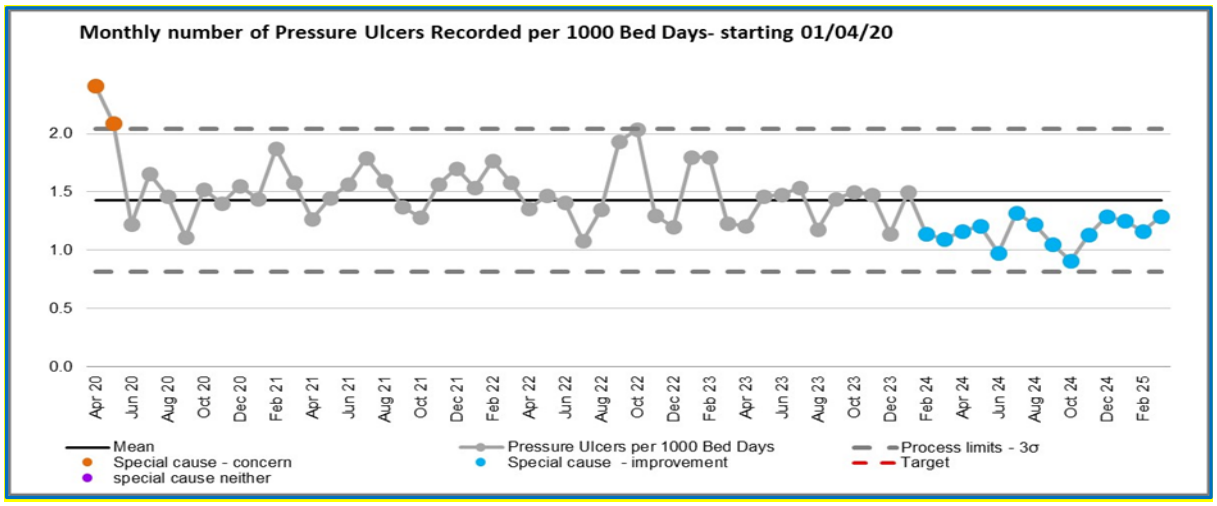
- Continue with our quality improvement work and focus on reducing avoidable falls across the organisation.
- Continue to develop the Falls Ambassador program to drive understanding and ownership of improvement activities at a local level.
- Review and build on existing falls prevention education and training offer.
- Develop the work focused on raising awareness of deconditioning and embed the culture of reducing deconditioning and promoting safer mobility in all clinical areas.
- Continue to explore opportunities for implementing digital and technological solutions to aid in the prevention of falls.
- Continue to create opportunities to integrate joint processes and improvement initiatives across the Group and System.

Pressure Ulcers

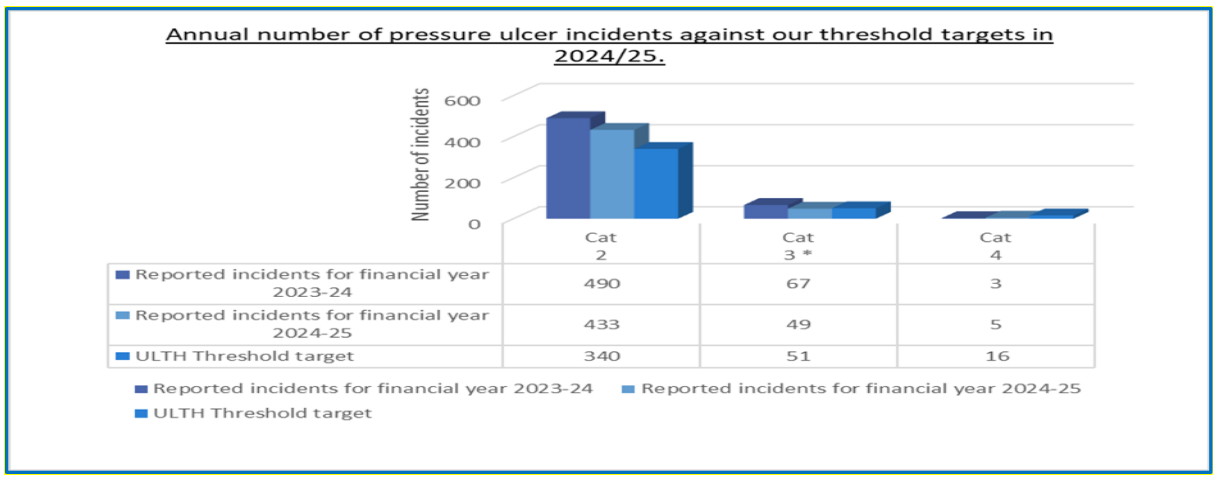
Pressure ulcer prevention remains a key priority for the organisation. The Trust aims to reduce our rates for hospital acquired pressure ulcers through quality improvement work and continues to focus on education, training, staff and patient awareness. Throughout 2024-25, the overall number of hospital acquired pressure ulcers has continued to decrease. This progress, especially in the context of a continued rise in admissions and increase in the number of patients admitted with complex care needs and additional vulnerabilities placing them at an increased risk of developing skin damage, is a positive position. Pressure ulcer prevention continues to be a patient safety priority and area of focus for the Trust.



Note: Total number of pressure ulcers recorded includes categories 2, 3, 4, and Unstageable combined.



This year the total number of category 3 and 4 pressure ulcer incidents that represent the most severe levels of harm achieved our ambition against the threshold targets the Trust had set. Whilst the threshold set for our category 2 pressure ulcers was exceeded, the total number reported this year has fallen by 11.6% compared to the previous year. This demonstrates that the preventative and supportive measures in place are having a positive effect on reducing the number and severity of patient harm from hospital acquired pressure ulcers.



*Since April 2024, Category 3 pressure ulcer numbers were reclassified to include those pressure ulcers previously known as unstageable. For ease of reporting the number of category 3 incidents from 2023-2024 include pressure ulcers that would have been previously classified as Category 3 or Unstageable.

The Trust continues to monitor Deep Tissue Injuries (DTI's) and Moisture Related Skin Damage (MASD) incidents and highlight those patients who are at an increased risk and vulnerable to further skin damage. Thematic reviews undertaken have enabled us to implement focused improvement actions in efforts to reduce the number of patients who experience this type of skin damage whilst in our care. Our annual number of hospital acquired Deep Tissue Injuries (DTI's) over the last three years has remained relatively consistent. Whilst the number of hospital acquired MASD incidents has seen an upward trend over the last year, this picture is reflective of a comparative increase in patients who are presenting with MASD when they arrive at our hospitals, demonstrating the increased vulnerability of patients within the communities we serve.

Key Achievements:

- Skin Integrity documentation and care is reviewed in the weekly Ward/department Leader's assurance and monthly Matrons audits as a component of the Quality Accreditation Programme. The monthly Quality Metrics review meeting chaired by the Deputy Director/Assistant Director of Nursing monitors ward and departments' performance relating to pressure ulcers.
- As part of the Quality Accreditation programme Harm Free certificates continue to be awarded to those areas who have periods with no pressure ulcer related incidents. This year we have celebrated 17 areas achieving a year of providing pressure ulcer harm free care, and an impressive 8 areas achieving 2 years harm free care.

- In line with the National Wound Care Strategy Programme recommendations for best practice, the Trust continues to review and adapt its guidance and practice relating to pressure ulcer prevention and management.
- The Skin Integrity Group (SIG) continues to meet monthly and has now developed into a Group meeting. The group has a multidisciplinary membership and provides oversight, monitoring and accountability of the ongoing improvement work around prevention of pressure ulcers. Patient stories are regularly shared at SIG to ensure wider learning and prompt improvement ideas.
- We had a successful 'Focus on Fundamentals' Tissue Viability month in November 2024. This included events to promote "International Stop the Pressure Day", use of social media and Trust communications to promote the activities, celebrating success and encouraging staff to have a conversation about skin integrity. This year the first Group Stop the Pressure Day Conference was facilitated for skin integrity ambassadors and clinical staff across both ULTH and LCHS joined by colleagues from across the Lincolnshire System. The day included interactive sessions and workshops on the key themes that have been identified from incidents and are focus areas to improve upon.
- Mandatory Tissue Viability E-learning training for all staff was implemented in 2021. This year we have consistently maintained a Trust compliance level of >90%.
- The Tissue Viability Ambassador programme, aimed to develop confidence, knowledge and skills in skin integrity care within our clinical teams, continues to be an effective resource in reducing our skin integrity incidents. We currently have 30 ambassadors trained with a number of other staff members booked in to complete their training. In those areas who have a Tissue Viability Ambassador there has been some reduction in pressure ulcer incidents observed.
- Monthly educational Pressure Ulcer Prevention Bulletin's continue to be produced and shared throughout the Trust to our clinical teams to improve staff knowledge regarding pressure ulcer prevention. The content of the bulletins are based upon the Trusts current risks and incident themes.
- Representatives from the Tissue Viability and Quality teams continue to participate in a system wide pressure ulcer improvement programme of work. Sharing learning from our patients and staff perspective.
- Our quarterly newsletter called "Tissue Viability Matters" continues to be produced and shared to provide staff with an oversight of current national and local priority

topics, share and celebrate team's improvement initiatives, and provide dates for up-and-coming Trust events relating to Tissue Viability.

- We upgraded our dynamic air mattress and cushion fleet supported by a programme of training and education. Feedback since the equipment has been updated has been very positive.
- The Tissue Viability team (TVN) and Quality Matron have created an annual programme of Tissue Viability Matters Improvement and Learning forums to deliver face to face training and educational updates to clinical staff. The forums are conducted bimonthly at each of the main hospital sites, with the content delivery based upon current national and local priorities.
- The Trust have implemented the use of nationally created pressure ulcer prevention leaflets designed to support both patients and relatives/care partners in understanding the risks of pressure ulcer development and what practical steps they could take to reduce their individual risks.
- Continue to support personal care packs for patients awaiting admission to ward areas, allowing them to independently manage their hygiene needs as required during this time to support the prevention of moisture associated skin damage.
- The TVN have streamlined and updated our MASD pathway making the process easier for staff to manage this type of skin damage.
- The TVN team have supported the review of different respiratory devices with the aim of reducing device related skin integrity incidents whilst maintaining the effectiveness of the device required.
- Face to face teaching sessions regarding medical devices have been delivered by the TVN team, the Quality Matron and external company representatives regarding best practice use to limit the risk of skin integrity harms.

Aims for 25/26

- Continue with our quality improvement work and focus on reducing pressure ulcers across the organisation.
- Continue working towards an ambition to eliminate all Category 4 pressure ulcers.
- Update the Trusts skin integrity documentation with the introduction of Purpose T Risk assessments.

- Continue to work collaboratively with the Digital Team on improving electronic resources relating to tissue viability and pressure ulcer prevention including clinical photography.
- Continue to create opportunities to integrate joint processes and improvement initiatives across the Group and System.

Complaints

Complaints and enquiries are a key source of feedback for the Trust and informs us about our patients' views regarding the quality of services and care provided which enables us to examine our services and make improvements. All formal complaints received are responded to appropriately on an individual basis and are fully investigated through the Trust's complaints procedure.

The Trust ensures that complainants have the option to have their concerns dealt with informally or formally, via the NHS Complaints Procedure. All complaints, whether formal or informal, are monitored to identify if there are any trends and to provide a consistent approach for patients, carers and the public.

Each complaint is treated individually. Although the issue raised may be similar to others, the circumstances are often different for the individual concerned. The Trust aims to respond to complaints within 25, 35 or 50 working days, dependent on the complexity and nature of the complaint, and the number of issues raised. If the timescale cannot be achieved, the complainant is informed of when they may expect their response. A quarterly report is produced and presented the Patient Experience and Involvement Group and Quality Committee.

Number of complaints received:

	2022-23	2023-24	2024-25
New complaints received	835	1044	1273

The Trust has seen an increase in the number of complaints year on year. Reviews have been completed to identify if any themes are increasing.

The following themes were identified from the complaints received:

- Clinical Treatment
- Communication
- Discharge
- Appointments

Examples of learning from complaints:

Complaint received regarding a patient where family members were not informed about their loved ones ward moves which caused distress to the family and hindered effective communication during their transition of care. As a result, a new section has been added to the handover sheet from January 2025, requiring documentation of family notification. The discharging ward must confirm that they have contacted the family, and the receiving ward must ensure that this information is updated and recorded.

The Trust received a complaint regarding a patient that was inappropriately discharged home via a taxi without adequate consideration of their mobility and care needs. This resulted in the patient being placed at risk during their journey and arrival at their home. A discharge risk assessment form has been devised. This will be completed for all patients awaiting transport home by taxi. This form will verify the patient's mobility and whether additional assistance or supervision is required during transport and once they return home. If a patient does require further assistance, then alternate arrangements would be made.

The Trust have received complaints regarding the completion of electronic Discharge Documents (eDD). The feedback is that there have been inaccuracies, and they are not being completed correctly. As a result, the Complaint Facilitator for the General Surgery division will be undertaking ward level training sessions to feedback and reinforce the importance of these documents being correctly completed in conjunction with junior doctor training sessions.

Patient Advice and Liaison Service (PALS)

PALS is a core service that provides timely and appropriate access to help, advice, and information to the users of the service. PALS also facilitate self-advocacy and will assist with discussions and negotiations between service users and representative of the Trust.

During 2024-25 PALS dealt with 7397 contacts were from patients, families, and carers where support and investigation has been provided by the PALS team to enable resolution of their concerns in a timely manner. The resolution of these concerns by the PALS team has enabled the patient, families, and carers to obtain the answers they require, therefore, reducing the number being escalated to a formal complaint.

PALS collate all comments, concerns and suggestions made and share this feedback directly with services and departments or by the patient experience feedback mechanisms available throughout the hospital.

Themes identified from PALS:

- Being unable to get hold of appointment services or department secretaries despite leaving messages patients are not being called back.
- Delay in letter being received.
- Delay in appointments.

Improvements:

- Lost property – The policy is now in place on wards, and they are following the correct process and investigation when a concern has been raised about a patient's private property going missing.
- Business Units are provided with a monthly report of PALS. We have seen improved ownership of the cases which has prompted quicker responses and support.
- Call for Concern – PALS have been able to provide the contact for this which had enabled families to speak with someone when they are unsure of the clinical information given to them.
- The Task and Improvement Group within ED Pilgrim continues to make positive improvements.

Seven-Day Services

The seven-day hospital services (7DS) programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

The Trust is committed to delivering high-quality services that ensure equity of access for all patients 24 hours a day, seven days a week. The Trust has been participating in the national audits for seven-day hospital services against the four clinical priority standards:

Priority Clinical Standards	• Standard 2: Time to Consultant Review • Standard 5: Diagnostics • Standard 6: Consultant Directed Interventions • Standard 8: On-going Daily Consultant Directed Review

Standard 2	Standard 5	Standard 6	Standard 8
All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital	Access to Consultant-directed Diagnostics within one hour if critical, 12 hours if urgent and 24 hours for non-urgent patients	Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols	Patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours

The Trust currently has multiple work-streams dedicated to the delivery of improved patient flow through the organisation. Whilst many services are delivered on a seven-day basis, in other services there remains a differential between weekdays and weekends. There is however clear clinical commitment to move towards seven-day services within our Divisions. The Trust has become a Group with LCHS which will also help improve patient pathways and seven day working.

Equality Diversity and Inclusion

United Lincolnshire Teaching Hospitals NHS Trust, as part of Lincolnshire Community and Hospitals NHS Group (LCHG), fully embraces Equality, Diversity, and Inclusion (EDI) across all protected characteristics of the Equality Act 2010. The Trust has a range of policies and procedures to support this. The Equality Impact Assessment is the primary mechanism to demonstrate the meeting of the legislative requirements that underpin the Trust's practice, policy, and service developments. All EDI business is managed and monitored through the EDI Group which is led by the Deputy Director of People and comprises key stakeholders from across LCHG. From a governance perspective the EDI Group reports upwardly to the Trust Board through the People Committee.

During 2024-2025, the Trust met all its statutory and contractual Equality, Diversity and Inclusion duties, these include:

- Publication of the Equality, Diversity and Inclusion Annual Report
- Publication of Equality Objectives
- Publication of the Gender Pay Gap data, report and action plan
- Publication of the Workforce Race Equality Standard data, report and action plan
- Publication of the Workforce Disability Equality Standard data, report and action plan
- Completion and publication of the NHS Equality Delivery System
- Completion and publication of the NHS Equality Diversity and Inclusion Improvement Plan and the associated High Impact Actions

All these reports are published on the Trust website: Equality, diversity and inclusion - United Lincolnshire Hospitals

The Trust has a range of Staff Networks to support staff from a diverse range of backgrounds and impact positively on the delivery of patient services. Each of the staff networks has designated leads and is supported by a sponsor from the executive team. The current staff networks are:

- Armed Forces Network
- Carers' Network
- MAPLE (Mental and Physical Lived Experience) Network
- Men's Network
- PRIDE+ Network
- REACH (Race, Ethnicity and Cultural Heritage) Network
- Women's Network

All the networks meet regularly and have annual plans to ensure meaningful and supportive events are scheduled throughout the year. These events take place using a range of delivery options from face-to-face events to utilising the virtual platform / webinars.

Highlights from each of the networks are contained in the Equality, Diversity and Inclusion Annual Report.

The Trust has strong links nationally and regionally, working closely with NHS Employers and NHS England. This has been supported by technology, accessing webinars, and being involved in discussions both regionally and nationally. The EDI Team continues to

roll out the Cultural Intelligence programme within the Trust and now across LCHG. The Cultural Intelligence programme equips leaders to lead their teams and services inclusively.

All EDI work in the Trust is currently being joined up across the Lincolnshire Hospitals and Community NHS Group and we are starting to work as a unified team across the Group.

Freedom to Speak Up

Since 2016, the Trust has complied with the NHS contract requirement to appoint a Freedom to Speak Up Guardian (FTSUG). In 2021, the Trust appointed a full time Freedom to Speak Up Guardian to demonstrate their commitment to supporting and listening to staff who speak up. The Trust Freedom to Speak Up Guardian has lead responsibility to ensure that the appropriate handling of concerns is in place and the effectiveness of the local systems is considered by the Board.

The Trust has incorporated the new national NHSE/I Freedom to Speak Up policy into it's local 'Voicing your concerns' policy, which describes the different ways to speak up and who to speak up to, the process and an appendix, which provides assurance to staff that anyone speaking up with genuine reason should not suffer detriment/disadvantageous behaviour and the process to follow. To complete the Speak Up process, feedback questions are asked to gain assurance that actions have been taken or questions answered and to highlight any potential service improvements/learning.

A database and dashboard have been produced for intelligence, to capture metrics, including number of cases, thematic information, who is speaking up and protected characteristics. The database will measure all open cases, feedback, and follow up from closure of a case over a twelve-month period to establish any detriment/disadvantageous behaviour.

Drop-in sessions, twilight and weekend shifts have been organised to capture staff across all sites, covering day and night staff and weekend workers. The FTSUG attends a virtual drop-in session with Rebecca Brown, Deputy Chair, Non-Executive Director, Maternity Safety Champion.

Speak Up training has been approved as core learning and is now included for all staff. Listen Up training is being sent to all managers to complete, by the FTSUG and will be reviewed for core learning. The Chair, Chief Executive, Directors, and Non-Executive Directors attended the FTSU board development session (Follow up module).

The Board self-assessment (reflection and planning tool) has been completed at a Board development session and any gaps will be actioned across the Group.

How does the Trust support staff to speak up:

- Voicing Your Concerns Policy
- Freedom to Speak Up Guardian
- Freedom to Speak Up Champions from across different staff groups and staff networks, who have been engaged to promote speaking up and signpost to the appropriate person or relevant policy
- The commitment of the Board to champion the importance of speaking up
- The Board receives a quarterly report on speaking up and has completed the speaking up self-assessment (Reflection and Planning Tool)
- The board have completed a board development session on FTSU follow up training
- The Non-Executive Champion for FTSU completed the National Guardians Office training development session
- The Freedom to Speak Up Guardian meets monthly with the Group Chief Executive, Group Trust Chair and Non-Executive Champion for Speaking Up, FTSUG also has direct access to the board, if needed.
- Mandatory Speak Up training is Core Learning for all staff and FTSU is discussed at all new starter's induction
- Virtual drop-in session held with the Deputy Chair/Non-Executive Director / FTSUG for neonates & maternity
- There are promotional materials which includes posters / pens and post it notes with FTSUG / Champions contact details
- FTSU intranet page
- Promotes through Chief Executive / Directors blogs
- Information is included within the Communications round up
- Information on contacting FTSUG on the Trust internal incident reporting tool (Datix)
- Promotional events across the wider organisation

What should staff do if they have a concern?

- Approach their line manager or senior divisional manager or any appropriate manager
- Contact anyone named in the 'Voicing Your Concerns Policy'
- Contact the Freedom to Speak Up Guardian through the dedicated confidential email address ulth.freedomtospeakguardian21@nhs.net telephone number 07471110490, via Teams or in writing
- Contact a Freedom to Speak Up Champion

- Contact the Non-Executive Director for Freedom to Speak Up
- Contact the National Guardians Office

Guardians of Safe Working

The Guardian of Safe Working will support safe care for patients through protection and prevention measures to stop doctors working excessive hours. The Guardian of Safe Working oversees the exception reporting process and has the power to levy financial penalties where safe working hours are breached. The role sits independently from the management structure, and the Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and / or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe. The Guardian has a permanent 0.6 WTE administrative post to support them in this role.

The Office of the Guardian continues to hold regular Resident Doctors Forum meetings on a two monthly basis and doctors have felt comfortable to raise issues at these meetings, which have been escalated further and addressed by senior management. The Guardian also continues to hold Educational / Clinical Supervisors' training / update sessions over Teams. These are well attended and have received excellent feedback. The training sessions are held twice a year (March / April and September / October). The purpose of these sessions is to increase awareness of exception reporting, support the Clinical / Educational Supervisors in the reporting mechanism and give supervisors opportunity to feedback on issues they may have.

The Guardian reports quarterly and annually to the People and Organisational Development Committee meeting. The reports contain the number of exception reports submitted per quarter, split by speciality, grades of doctors and the issue, such as working hours, work pattern, educational issues and immediate safety concerns. Common themes are documented, which can then be used to improve the experience of the Resident Doctors within the Trust. Resident Doctors are continually encouraged to submit exception reports, to help identify where rotas and working patterns differ from those described in the doctor's individual work schedule. The Trust is committed to supporting Resident Doctors who raise exception reports and ensuring that they are confident to raise issues where necessary.

The Guardian’s Office has continued its commitment to ensure that the Locally Employed Doctors (LEDs) working within the Trust are supported in the same way as the Resident Doctors. The Guardian’s Office is pleased to report that all the LEDs are now allocated a Clinical Supervisor to support them and be able to exception report through the Allocate system. The Trust is working towards streamlining their contracts of employment. The Guardian’s Office is aware that it is a nation-wide issue and hopes that an appropriate solution will be drawn soon.

Annex 1: Stakeholder Comments

NHS Lincolnshire Integrated Care Board (ICB) welcomes the opportunity to review and comment on the United Lincolnshire Teaching Hospitals NHS Trust (the Trust) Annual Quality Account 2024/25.

The Quality Account provides a comprehensive summary of the Trust's key quality improvement priorities which were:

- End of life care
- Hear It Your Way
- Diabetes pathway

The ICB acknowledges the challenges faced with achieving all elements of the Diabetes Pathway and recognises the ongoing work in this area, and they commend the Trust on the work achieved relating to End of life care and Hear It Your way.

The Trust have developed and successfully rolled out an education programme for end-of-life care with Palliative and End of Life (PEOL) Champions supporting this work. The ICB thank the Trust for supporting the review and development of the Lincolnshire PEOL Strategy which has been finalised and is being socialised across the system.

A Hear It Your Way faculty was achieved with successful roll out of training sessions which have received excellent feedback. The ICB notes the commitment into 2025/26 for more sessions to be scheduled and to be expanded to colleagues from Lincolnshire Community Health Services under The Group model.

The ICB recognises the scale of work that was required to apply for teaching hospital status and was delighted when this was awarded by the Secretary of State for Health and Social care during 2024/25. This will be of benefit to patients as well as enhancing the Trusts' ability to attract highly skilled professionals to the organisation and into Lincolnshire.

In addition, the Quality Account highlights numerous achievements in 2024/25 including:

- The Trust moved into the Group model with Lincolnshire Community Health Services and the ICB welcomes the strengthening of ways of working which provides opportunity for collaborative approaches to patient care.
- Roll out of Martha's rule across Lincoln County and Pilgrim Hospitals – the "Call for concern" initiative acknowledges that families and carers may identify changes or a deterioration in a patient's condition before they become apparent to staff
- Falls prevention continues to be a focus of patient safety and, whilst the number of falls has increased, there has not been an associated increase in the level of harm. The Trust is actively involved with system and regional falls prevention meetings ensuring learning is shared and acted upon
- The Trust has achieved a reduction in the overall number of hospital acquired pressure ulcers and pressure ulcer prevention continues to be an area of focus. The Skin Integrity Group provides an opportunity for a multi-disciplinary approach to learning and oversight of improvement activities. Wider education is provided in multiple formats ensuring staff across the Trust are aware of latest developments improving patient outcomes

The ICB recognises that this year has not been without its challenges with increased pressure continuing within the Emergency Departments (ED) and increasing demand on hospital services generally. The ICB acknowledges the Trust's commitment to improve patient experience and the work it has undertaken to reduce ambulance handover times in ED, supporting ambulance service colleagues to serve the communities.

The current CQC rating for ULTH is Requires Improvement which was awarded in February 2022 following an unannounced inspection in October 2021. The ICB note that the CQC conducted unannounced visits into Lincoln County and Pilgrim Emergency Departments, October and November 2024 respectively and that the Trust await the final report. The ICB welcomes the action being taken based on the initial feedback received while the Trust await the final report.

Looking ahead into 2025/26 the ICB notes the Trust has aligned their priorities to those in the Group Strategy and are:

- Maximise safety of patients in our care, through learning from incidents and reducing incidents causing harm
- Identify areas where services do not meet best practice requirements and deliver demonstrable improvement in those areas
- Focus on improving the top three patient feedback themes: communication, appointments and clinical practice

The ICB welcomes these as priorities for the coming year noting the continued learning from incidents through the implementation of PSIRF; the Trust's current position in relation to infection prevention and control and the importance of getting this right for good patient experience; and the utilisation of themes from patient feedback as identified in 2024/25's Quality Account.

The ICB would like to thank United Lincolnshire Teaching Hospitals NHS Trust for their commitment and dedication working with Lincolnshire Health System to ensure patient's needs are met.

Yours sincerely,

Vanessa Wort
Associate Chief Nurse
NHS Lincolnshire Integrated Care Board

Healthwatch Lincolnshire Quality Account Statement 2025

United Lincolnshire Teaching Hospitals NHS Trust (ULTH)

Healthwatch Lincolnshire welcomes the opportunity to respond to ULTH's Quality Account 2024/25 and values the Trust's continued commitment to transparency, service improvement, and meaningful engagement with patients and communities. We also note with interest ULTH's recent transition to Teaching Hospital status and its strengthened collaboration with Lincolnshire Community Health Services NHS Trust as part of the Lincolnshire Community and Hospitals Group. We hope this joint working leads to improved coordination and continuity for patients.

Looking Back – Progress on 2023/24 Priorities

We commend the Trust's efforts over the past year to address its three priority areas: end-of-life care, communication, and diabetes services.

- We particularly welcome the focus on **end-of-life care**, including the education and engagement of staff, system-wide strategy development, and improved documentation processes. Increasing NACEL survey responses and supporting alignment across settings demonstrates positive progress.
- The **Hear It Your Way** programme is an innovative training approach to improving communication, and we are encouraged to see good staff feedback and a commitment to continued roll-out.
- Despite ongoing challenges, progress has also been made in the **diabetes pathway**, including digital improvements, pathway reviews, and quality governance. However, we note that key developments remain contingent on business case approvals and funding.

These efforts reflect responsiveness to feedback and learning, but we note the need for consistency in embedding changes across the Trust.

Priorities and Challenges for 2025/26

Healthwatch Lincolnshire supports the Trust's three Quality Priorities for the coming year:

1. **Maximising patient safety** through learning from incidents, this is rightly identified as a foundational priority. Reducing the number of incidents causing moderate or severe harm, alongside alignment with the Patient Safety Incident Response Framework (PSIRF), is a positive and necessary focus.
2. **Improving compliance with best practice**, especially around infection prevention and control (IPC) and hygiene standards. This is essential given the clinical risks involved and public concern around cleanliness in hospitals. We support the Trust's commitment to meeting the CQC's "Hygiene Code" requirements and hope to see the Trust move from partial to full compliance.
3. **Addressing top themes from patient feedback**, including communication, appointments, and clinical care. Healthwatch Lincolnshire recognises these as consistent issues in public feedback we have received. Efforts to reduce complaints and improve Friends and Family Test (FFT) scores in these areas will be key indicators of success.

We appreciate that these priorities are clearly aligned to what matters to patients and hope the Trust ensures tangible impact and communication back to the public about changes made.

Themes from Public Feedback

Our insight over the past year continues to reflect recurring issues that patients and families face when accessing hospital services:

- **Communication**: As acknowledged by the Trust, patients often report unclear or delayed communication about appointments, treatment plans, and clinical updates. This contributes to anxiety and confusion. While initiatives such as 'Hear It Your Way' and Call for Concern show promise, these must translate into consistent frontline practice.
- **Waiting Times and Access to Services**: Feedback often highlights long waits for diagnostics, outpatient appointments, and procedures. The development of new diagnostic centres is welcome, and we would encourage further public updates on their impact.

- **Transfers of Care and Discharge**: Issues around delayed discharges and coordination between hospital and community services persist. We urge ULTH to work closely with LCHS and the ICB to ensure safe and timely transitions.

Final Comments

Healthwatch Lincolnshire appreciates ULTH's ongoing engagement with system partners and patient voice, including the Trust's use of a Patient Panel and broader engagement forums and welcome further opportunity to work with Healthwatch to provide patient experience insight.

Health Scrutiny Committee for Lincolnshire Statement on the *Quality Account* for 2024/25 of the United Lincolnshire Teaching Hospitals NHS Trust

The Committee is grateful to the Trust for sharing a copy of its draft quality account.

Presentation of the Document

The Committee recognises that there is a balance between making the document accessible to the public and meeting all the requirements of the regulations. In future, the Committee suggests an overview of the Trust's services be included, for example, providing information on headline activities and service volumes, such as accident and emergency attendances, at each hospital. This would give the public a feel for the extent and locality of the services provided by the Trust.

Prescribed content does not assist the flow of the document. However, where information has to be included because it is a prescribed requirement, the Committee suggests there could be a brief explanation to assist the understanding of the lay reader. The Committee welcomes the inclusion of patient stories in the document.

Quality of Care – Trust's Priorities for Improvement

The Committee's View of Patient Priorities

The Committee would like to record its own views on what it sees as most important for patients and the public:

- improving access to all NHS services, by reducing waiting lists and waiting times, and providing equality of access to services
- providing seamless care between different NHS and other services, including from children's services to adult services

- providing high-quality safe services as locally as possible, to avoid unnecessary travel
- making sure patients are signposted to the appropriate service at the first point of contact, so as to avoid as much as possible onward transfer to other hospitals or services.

Many of these aspirations are reflected in national, local and the Trust's strategies.

Selecting the Trust's Priorities for Improvement for 2025/26

The Committee accepts that the Trust's priorities have been developed by reference to patient safety incidents and patient feedback, with three dominant themes in (communication, appointments, clinical practice). This demonstrates how patients and the public have been involved in the development of the document.

Specific Comments on the Trust's Priorities for Improvement for 2025/26

The Committee believes that *Priority One (Maximising Patient Safety)* should be intrinsic to the Trust's daily operations and would like to see how this priority will deliver shift changes in practice and benefits to patients, so that its adoption goes beyond what ought to be a 'business as usual' approach.

The Committee believes *that Priority Two (Improvement in Services not Meeting Best Practice)* is too broad and as a result risks lacking focus, with potential overlaps into *Priority One*. The Committee would like to see a list of measurable actions in support of the priority.

The Committee would like to see *Priority Three (Improvement of Patient Feedback Themes: Communication, Appointments and Clinical Practice)* broadened so that it is not solely focused on complaints, but could include other patient data on waiting times, re-admission rates, and ambulance handover times.

Progress on Priorities for Improvement for 2024/25

Although there has been progress with all three priorities for 2024/25, the Committee's preference is for a clear summary, with an indication, using red, amber or green, whether

each action in support of a priority had been met. The Committee would not wish to see the progress made on these priorities lost, because they are not being carried forward into 2025/26.

Achievements During 2024/25

The Committee welcomes all the achievements, listed in the Chief Executive's statement, which include completion of the first phase of the new emergency department at Pilgrim Hospital, Boston; opening two Community Diagnostic Centres in Lincoln and Skegness; and starting construction of the new endoscopy unit at Lincoln County Hospital. Achievements also include procurement of an electronic patient record system, which will represent a significant improvement, when paper records are replaced. The Committee supports all developments improving the quality of care provided to patients and recommends that the achievements fully outline all these benefits.

Engagement with the Health Scrutiny Committee for Lincolnshire

During 2024-25, engagement with the Health Scrutiny Committee for Lincolnshire has continued, with various representatives of the Trust attending five of the ten meetings of the Committee during the year. We look forward to continued engagement with the Trust's managers, and where appropriate clinicians, in the coming year. The Committee will be giving consideration to adding the following topics to its work programme in the coming year:

- Stroke Services
- Maternity Services
- Patient Discharge Arrangements

Conclusion

The Committee is grateful for the opportunity to make a statement on the draft Quality Account. The Committee looks forward to the Trust's progress, not only with its three priorities, but also with national priorities in the coming year and will continue to engage the Trust at its meetings.

Trust Comments

Thank you for your comments. We recognise the importance of ensuring our Quality Account remains clear while also meeting public reporting requirements and regulatory standards. We also recognise the value of including key headline activities such as emergency attendances to give the public a clearer understanding of the locality and services provided by the Trust.

A brief explanation along prescribed content can support better understanding and improve accessibility to a wider audience. We will look to incorporate this where appropriate to enhance clarity going forward.

Thank you for highlighting the committee's view on patient priorities for 2025/2026 which we acknowledge and will ensure these will be reported through our established reporting processes.

Regarding the 2024/2025 quality priorities, we can confirm that these will continue to be monitored through our governance processes to ensure effective oversight and progress.

Annex 2: Statement of Directors' Responsibilities

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011, 2012 and 2017 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

Professor Karen Dunderdale

Chief Executive Officer

Elaine Baylis

Chair, Trust Board

NHS
Lincolnshire Community and Hospitals NHS Group

Delivery plan for recovering urgent and emergency care services

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

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Delivery plan for recovering urgent and emergency care services

Accountable Director	*Daren Fradgley, Deputy CEO/Group CIO*
Presented by	*Daren Fradgley, Deputy CEO/Group CIO*
Author(s)	*Sameedha Rich-Mahadkar Director of Improvement and Integration* *Nathan Steadman, Senior programme manager* *Rebecca Maxwell, Strategy manager*

Recommendations/ Decision Required

- *The Board is asked to:- the key points from the recently released UEC plan.*
  - *This plan prioritises cross-sector, system working to achieve improvements in UEC over winter. Local partners within every system will be responsible and accountable for effectively managing UEC demand, with an emphasis on multidisciplinary, neighbourhood working.*
  - *All winter plans must be developed and tested prior to implementation, and lead to an increase in urgent care services provided in the community. This includes improving uptake of the flu vaccination among NHS staff, and expanding virtual wards.*
  - *Capital funding injections and supportive national resources will be simplified, to ensure a bigger impact. Over £370m will be invested into supporting UEC, which could provide the equivalent of 40 new same day emergency care (SDEC) units and urgent treatment centres (UTCs). Detail on how this funding can be accessed is not yet clear.*

A summary of the key actions is outlined in Table 1. We will work with ICB UEC system colleagues to understand our gaps and where we are monitoring delivery against these.

How the report supports the delivery of the LCHG strategic aims & objectives	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*

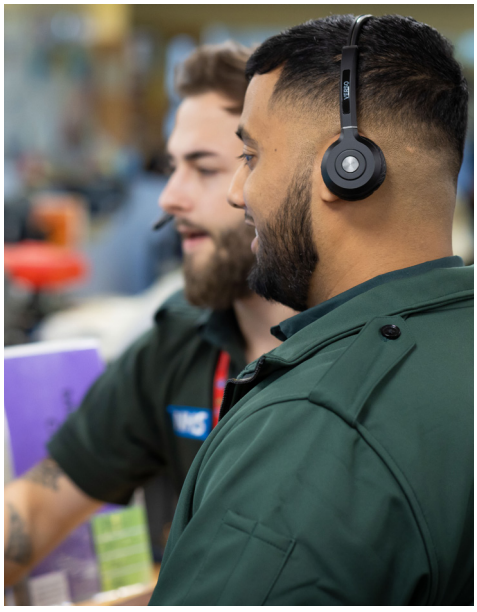
1d: Provide modern, clean and fit for purpose care settings	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	
2b: Empower our people to continuously improve and innovate	
2c: Nurture compassionate and diverse leadership	
2d: Recognising our people through thanks and celebration	
Population: Better Health – Improve population health:	
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	*X*
3c: Enhance our digital, research & innovation capability	
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	

Department of Health & Social Care

NHS England

Urgent and emergency care plan 2025/26

June 2025



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Summary of priority actions and their impact

Actions	**Impact for patients and carers**
Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter	By the year-end, with improvement over winter, we expect to: • reduce ambulance wait times for Category 2 patients – such as those with a stroke, heart attack, sepsis or major trauma – by over 14% (from 35 to 30 minutes) • eradicate last winter's lengthy ambulance handover delays by meeting the maximum 45-minute ambulance handover time standard, helping get 550,000 more ambulances back on the road for patients • ensure a minimum of 78% of patients who attend A&E (up from the current 75%) are admitted, transferred or discharged within 4 hours, meaning over 800,000 people a year will receive more timely care • reduce the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so this occurs less than 10% of the time. This will improve patient safety for the 1.7 million attendances a year that currently exceed this timeframe • reduce the number of patients who remain in an emergency department for over 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month • tackle the delays in patients waiting to be discharged – starting with the nearly 30,000 patients a year staying 21 days over their discharge-ready-date, saving up to half a million bed days annually • increase the number of children seen within 4 hours, resulting in thousands of children every month receiving more timely care than in 2024/25
Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter	• improve vaccination rates for frontline staff towards the pre-pandemic uptake level of 2018/19. This means that in 2025/26, we aim to improve uptake by at least 5 percentage points • increase the number of patients receiving urgent care in primary, community and mental health settings, including the number of people seen by Urgent Community Response teams and cared for in virtual wards

	• meet the maximum 45-minute ambulance handover time standard • improve flow through hospitals, with a particular focus on reducing patients waiting over 12 hours and making progress on eliminating corridor care • set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings • reduce length of stay for patients who need an overnight emergency admission. This is currently nearly a day longer than in 2019 (0.9 days) and needs to be reduced by at least 0.4 days
National improvement resource and additional capital investment is simplified and aligned to supporting systems where it can make the biggest difference	Allocating over £370 million of capital investment to support: • around 40 new same day emergency care centres and urgent treatment centres • mental health crisis assessment centres and additional mental health inpatient capacity to reduce the number of mental health patients having to seek treatment in emergency departments • expansion of the Connected Care Records for ambulance services, giving paramedics access to the patient summary (including recent treatment history) from different NHS services, enabling better patient care and avoiding unnecessary admissions

Introduction

1. This summer will mark a turning point for the NHS: the 10 Year Health Plan will set the most transformative agenda we have seen in over 2 generations.

2. But we cannot wait for the publication of the plan to fix those things we can change now.

3. Working across whole systems to improve urgent and emergency care (UEC) won't just deliver a better winter for our patients and staff, it will start to free up leadership headroom. Improving this important UEC pathway will help financially challenged systems become more productive and cost-effective.

4. But most of all, this plan is about being accountable to our communities. It's about committing to working around the clock this summer to prepare for winter 2025/26. Ultimately, this is about improving patient outcomes.

The imperative for change

5. The current performance of UEC services does not meet the standards our patients need or our frontline staff want to deliver.

6. It has been over 5 years since the 18-minute response to Category 2 ambulance calls standard was met, and over a decade since the service delivered the standard for 95% of patients waiting 4 hours or less in A&E.

7. The public continue to feel the impact of poor UEC delivery. The British Social Attitudes Survey into the NHS and social care, published in April this year, showed that satisfaction with the NHS and, in particular, A&E services – already at a record low last year – has deteriorated even further and is declining at a faster rate than before.

8. In short, we've normalised asking our staff to deliver sub-optimal care, and our patients have all but given up hope of expecting a reliable service in urgent care.

9. The burnout our frontline staff feel – particularly in the acute sector who feel the brunt of the consequence of poor system-wide urgent care delivery – has been clear in the conversations we've had with staff as part of the Change NHS process. The stories our patients have told us through the same process – sometimes heartbreaking descriptions of truly terrible experiences – underpin the urgency we now expect NHS leaders to have to meet essential constitutional standards.

10. We must do everything we can to significantly improve UEC services this winter compared to what our patients and staff have experienced in recent years, and this plan sets out clear expectations about what each part of the NHS needs to do – starting from today – to make this happen.

11. Every day, over 140,000 people access UEC services across the country, including more than 11,000 who are so unwell they need to be admitted to hospital for a day or more, and 20,700 people who are seen by the ambulance service. Since 2010/11, the number accessing UEC services has risen by 90%, and the number seen by the ambulance service has risen by 61%.

12. This huge increase in reliance on UEC services has only in part been fuelled by an ageing population and an increase in multiple long-term conditions and mental health needs. In truth, it is largely a consequence of services being organised in a confusing and

disparate way by multiple providers. We do not always work together to deliver services in a way our communities would expect and NHS staff would like.

13. Our inability – and, in some exceptional circumstances, unwillingness – to work more coherently across different service providers in the NHS and social care has led to a deterioration in performance that would have been unimaginable a decade ago.

14. When patients feel they have no choice but to go to emergency departments or call an ambulance just to access care, the system has failed them.

15. There are some exceptionally effective UEC services – however, this isn't consistently the case, with wide variation across the country. A significant and tangible step change is needed from all boards and chief executives to fully optimise all available services to improve UEC. Successful systems have reformed their approach to improving UEC; they have a shared focus on maximising the use of primary care and community diagnostics, as well as working closely with acute providers to improve internal flow.

16. While the 10 Year Health Plan will set a new course for how we deliver health and care services in the future, there are things we can and must do now to ensure our patients receive a better service this coming winter.

17. To make that commitment more than just a set of words in another publication, there are 3 things we need to change at different levels of the health and care system.

18. First, we all need to focus as a whole system on the 7 priorities that will have the biggest impact on UEC improvement this coming winter. As a minimum, these are:

- patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – receive an ambulance within 30 minutes
- eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes
- a minimum of 78% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours
- reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time
- reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month

- tackling the delays in patients waiting once they are ready to be discharged – starting with reducing the 30,000 patients staying 21 days over their discharge-ready-date
- seeing more children within 4 hours, resulting in thousands of children receiving more timely care than in 2024/25

19. Second, leaders will need to commit to developing and testing collective winter plans, which will be signed off by every board and chief executive within each system by summer 2025. Regions will work with systems and providers on an exercise to stress-test and refine their plans in September 2025 and will continue to oversee improvement support to the most challenged organisations in the run up to and throughout this winter. As a minimum, each plan should show how, by this winter, systems will:

- improve vaccination rates
- increase the number of patients receiving care in primary, community and mental health settings
- meet the maximum 45-minute ambulance handover time standard
- improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care
- set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings

20. Each part of the system has responsibility for improving UEC performance. However, blame shunting has become a feature in some poorly performing systems and can no longer be tolerated. Each part of the system has responsibility for improving UEC performance, so systems' winter plans should evidence how:

- **integrated care boards (ICBs) and primary care** are demonstrably improving access to primary and community care and driving stretching system-wide improvement to prevent avoidable admissions and discharge rates
- **community providers** are quantifying demonstrable improvement in admission avoidance, making more effective use of community beds and care home facilities, and using technology to support people to stay well at home
- **trusts** are using all available tools to improve patient flow, including: optimising triage and appointment systems to direct less urgent cases to same day emergency care (SDEC); optimising the use of urgent treatment centres (UTCs) and Hot Clinics; ensuring medical directors and chief nurses are applying clinical operational standards to ensure all specialties – not just UEC – lead UEC improvement; and training and empowering medical staff to use the clock to drive performance improvements

- **ambulance trusts** are rapidly adapting best practice to maximise improvement opportunities this winter and nominating an executive director to work with every ICB to develop the system winter plan

21. To support providers and systems to accelerate improvement, we will significantly increase the amount of data available to the NHS and the public. We will undertake an urgent review of UEC data by the end of June 2025 (Q1), with improvements rapidly implemented as part of the NHS Federated Data Platform Operational Dashboard work. We will also explore how to improve the transparency of individual site-level improvement plans, enabling patients to understand the actions being taken to improve services and address their concerns.

22. Finally, we will simplify and align the numerous national improvement resources and additional capital investment to support the systems where those resources can make the biggest difference. There are currently multiple resources, teams and funding sources aligned with various elements of UEC improvement, all of which add value but are confusing. We have started work to bring together these resources and deliver them through a one-team approach to support local leaders, trusts and systems in driving UEC improvement faster this year than ever before. This will be achieved through a redesigned improvement function to ensure we target resources to those systems that need them most.

23. Leadership is the single most crucial factor that will determine our success this winter**.** Every leader must ensure that both within their organisation and across their system everything possible is being done to improve care. Where this was most effective last winter, chief executives, chief nursing officers and medical directors regularly worked from the emergency department to support staff on the frontline. This now needs to be the norm.

Delivering the asks for 2025/26

From treatment to prevention: taking steps now to reduce demand for urgent care later this year

24. To protect the most vulnerable and keep vital health and care services running when respiratory viruses surge, there is more we can do to reduce the effects of the flu.

25. Last winter, we heard your feedback that the restrictions on the National Booking Service and the lack of information on clinic times were suboptimal. That is why, this year, we will commit to:

- expanding the use of the National Booking Service for flu vaccination to make more appointments available, including keeping it open until the end of the flu campaign in March
- developing the “flu walk-in finder” so that, from October 2025, patients can easily look up when they can walk into a community pharmacy to get a vaccination

26. Regions will work with ICBs to develop a plan by the end of Q1 on how they will strengthen the childhood vaccination offer. Increasing vaccine uptake among children is one of the most impactful interventions, with every thousand childhood vaccinations saving around 4 hospital admissions. As a minimum, these plans should set out how:

- GPs and school-aged immunisation providers will increase vaccination rates, working with local directors of public health
- local campaigns will target those in clinical risk groups

27. To support this, we will ask some systems to test the use of health visitors to administer childhood flu vaccinations and other routine immunisations for eligible children. These systems will test the feasibility and value for money of different approaches and provide evidence to inform national roll-out from 2026/27.

28. Plans should also set out the delivery approach to the year-round RSV vaccination programme for older adults and pregnant women (for infant protection), ensuring all those in the older adult catch-up cohort (aged 75 to 79) have been offered a vaccination by 31 August 2025. The aim is to achieve 70% for the catch-up cohorts and 60% in the routine cohort during 2025/26. RSV vaccination provides multi-year protection, so those vaccinated now will have protection this coming winter. The UK Health Security Agency continues to analyse and evaluate these new programmes, with early assessment of the RSV vaccination programme in older adults showing it led to a 30% reduction in the confirmed RSV hospital admission rate among eligible 75 to 79-year-olds.

29. While some trusts have a strong offer, we know that many staff still find it difficult to access a flu vaccination. We will therefore ask all trusts to have an accessible occupational health vaccination offer to staff throughout the entire flu campaign, including onsite bookable and walk-in appointments. All trusts will be asked to have a fully developed plan for improving flu vaccine uptake for NHS staff by the end of Q1, incorporating a stretching target percentage increase on last year’s uptake. This plan should include:

- improved communications and engagement with staff to increase their vaccination rates and to support the promotion of vaccination to eligible patients, better highlighting the link with winter pressures

- work with sector partners to proactively promote available vaccination offers to those who provide and draw on care
- a requirement for NHS hospitals to offer vaccination on discharge to any patients going into a care home

30. We will work with NHS communication teams to share details of the most effective staff vaccination programmes from 2024/25. We will support this with national materials where this is deemed effective. We will also work with professional bodies, patient representative groups and charities to support consistent clinical advice about the benefits of flu jabs for patients in clinically vulnerable groups.

31. In 2024/25, there were patients ready to be admitted but, in some cases, trusts did not have an actionable infection prevention and control (IPC) strategy. Therefore, all systems should test their winter virus resilience plans against the IPC mechanisms available both in and out of hospital. This includes making sure they have identified cohorting spaces ready to be actioned, explored the direct admission of flu patients into community bedded capacity and followed appropriate policies and procedures.

From hospital to community: increasing the number of patients receiving care in community settings

32. At least 1 in 5 people who attend the emergency department don't need urgent or emergency care. An even larger number of attendees could be more efficiently managed by growing community capacity.

33. The Neighbourhood health guidelines published in January 2025 set out the 6 core components of neighbourhood health that all local health and care systems will start to implement systematically this year. This will help people stay independent for as long as possible, reduce avoidable exacerbations of ill health and minimise the time people need to spend in hospital or in long-term residential or nursing home care. This includes neighbourhood multidisciplinary teams (MDTs) co-ordinating proactive care for population cohorts with complex health and social care needs, integrated intermediate care with a "Home First" approach, and scaled and standardised urgent neighbourhood services for people with an escalating or acute health need.

34. We can see the benefit of this approach in examples across the country. In Washwood Heath in Birmingham, social care, primary care, mental health, community nursing teams and secondary care respiratory services are all working together to improve discharge, reduce admissions and provide SDEC for respiratory and cardiovascular disease patients. Over the last year, they have seen A&E attendances fall by over 30% among targeted patients, length of stay in hospital fall by over 14% and Category 3 ambulances are now conveyancing patients to the health centre instead of the emergency department.

35. Similarly for patients living with frailty or complex needs, neighbourhood multidisciplinary teams have been shown to reduce demand on hospital-based unplanned care. In Northamptonshire, local integrated teams involving a range of health and care providers are delivering responsive interventions, such as extended GP reviews, peer support groups, clinical-supported decision-making and remote monitoring. In the 18 months to March 2023, this approach resulted in a 9% reduction in hospital attendances for over 65s and a 20% reduction in falls-related acute attendance due to improved rapid response.

36. Achieving this shift is everyone's responsibility and requires everyone's full participation. As part of their system winter plan submission, ICBs will need to evidence how NHS providers and local authorities (through health and wellbeing boards) will improve discharge and admissions avoidance. System winter plans should build on the Better Care Fund (BCF) plans agreed between ICBs and local authorities in March 2025, which include local goals for performance on emergency admissions for over 65s and timely discharge. Where ICBs and local authorities are facing challenges in achieving these goals, the newly formed Discharge and Admissions Group will agree improvement plans with them, as set out in paragraph 76 below.

37. System winter plans should clearly set out how local partners – NHS acute trusts and primary care – are working together to identify patients who are most vulnerable during the winter period and co-ordinate proactive care for them. They should also detail how they plan to expand access to SDEC and enable direct ambulance off-loading at specialty facilities, such as SDECs.

38. Plans should set out how systems intend to expand access to urgent care services at home and in the community, so patients don't need to attend hospitals unnecessarily. This includes understanding the actual volume and optimising the use of urgent community response and virtual ward capacity in each integrated care system (ICS) as well as planning with the ambulance service and 111 how to use this capacity most effectively.

39. This will mean more 999 callers receive timely, clinically appropriate care without requiring hospital conveyance. Currently, half of ambulance incidents convey patients to an emergency department – a reduction on previous years, but there is still significant regional variation (45 to 54%). This new approach will enable ambulance services to prioritise the most critical cases while providing alternative pathways for those with less urgent needs. To achieve this, we will:

    - undertake and implement the findings of an evidence-based clinical review of categorisation, increasing clinical triage of 999 calls to identify patients who can be safely assessed and managed remotely, directing them to appropriate urgent care pathways such as virtual wards or urgent community response teams

- enhance paramedic-led care in the community to ensure more patients receive effective treatment at the scene or in their own homes, reducing avoidable hospital conveyance. This will be delivered through ambulance crews operating a call before convey principle and enabling “see and treat”, supported by additional clinicians in emergency operating centres (EOCs) and single points of access (SPoAs)
- expand overnight support for 999 call handlers and clinicians to provide urgent in-home care for clinically assessed patients, with follow-up services available the next day
- reduce the variation in rates of hear and treat (currently 8.1% to 20.7%) and see and treat (currently 25.6% to 36.7%), building on the progress we have already made. Progress will be reviewed monthly and research undertaken to understand what types of community capacity are most effective in preventing an avoidable conveyance

40. This model is already demonstrating success. For example, Hampshire’s call before convey initiative reduced emergency department attendances or admissions for 32 to 38% of cases, with 24% avoiding hospital entirely. This saved up to 87 hours over 3 weeks. Similarly, urgent community response services in Dorset and Kirklees have successfully managed approximately 80% of eligible patients without hospital attendance.

41. To support these initiatives, we have published ambulance commissioning guidance for systems – including ambulance trusts, acute trusts, and community providers – to enhance capacity and capability across urgent and emergency care pathways. Priorities in the guidance include:

- increasing the number of multidisciplinary clinicians in EOCs and enhancing their skills to improve patient management
- building on the EOC capacity by developing SPoA that accept calls directly from care homes and GPs, avoiding the need for clinicians to ring 999
- expanding capacity in the community sector, broadening access criteria and extending service availability beyond core hours
- strengthening ambulance trust access to SDEC and UTCs, supported by trusted assessor principles

42. The guidance also reinforces the “call before convey” principle, ensuring paramedics can access senior multidisciplinary decision-making support at the scene. This will help identify safe and appropriate alternatives to emergency department conveyance when this is not the most suitable option. By prioritising the right care in the right setting, we can optimise emergency resources for those with the greatest need.

43. We will publish and implement the recommendations from the 111 review to make the service quicker and simpler to navigate. This includes using natural language processing technology to improve call streaming from October 2025. We will also work with GPs and other healthcare providers to improve the patient referral process to primary care. Additionally, we will work with stakeholders to develop new measures that reflect the quality of care provided by 111 (including disposition outcomes) not just how quickly calls are answered, with the aim of implementing these in April 2026.

High-quality emergency care: meeting the maximum 45-minute ambulance handover

44. Putting a greater leadership focus on increasing and improving UEC services outside hospital will help colleagues to be more ambitious about improving ambulance handovers. The only way we are going to consign 8 and 12-hour ambulance handover times to history is by ripping the plaster off and ambulance services and trusts collectively signing up to a stretching but deliverable standard.

45. Most trusts are already implementing the Release to Rescue standard, and it should now be delivered without exception, including in the winter months.

46. This will be triggered once a handover reaches 30 minutes, meaning that all ambulances will complete their handover and leave the hospital site at 45 minutes. This allows ambulances to be cleared and available for the next call. To achieve this, ambulance services will do everything they can to avoid conveyance, and no 111 dispositions should occur without going through validation, even if that means holding risk out-of-hours and overnight. All acute trusts will be required to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target. This will significantly reduce ambulance response times across the country, with evidence from 2024/25 demonstrating that Release to Rescue implementation across London reduced the average length of ambulance handovers by 11%. The benefits of this approach can be seen in increased capacity to respond to those in need within the community, improved 4-hour performance, and reduced congestion in emergency departments.

Improving flow through hospitals

47. We will provide clear pathways and the right waiting environment when people do need to come to a hospital site with an urgent need. We will take a significant step to separate urgent from emergency care, so that people are treated in the most appropriate setting.

48. The evidence shows that co-located UTCs reduce both the number of people who spend time in emergency departments and overcrowding. Without this separation, everyone can often wait much longer. In UTCs, over 95% of people are treated and discharged within 4 hours.

49. For people who require treatment that can be completed within a day, we are expanding SDEC services across the country. The evidence shows that patients treated in an SDEC wait less on average for a clinical review, spend less time in an emergency department and in hospital overall, and are more likely to go home to their usual place of residence.

50. We know co-located UTCs and SDECs improve the patient experience and hospital flow, which is why we want to accelerate their implementation across England. We are allocating £250 million of capital budget to continue this expansion, the equivalent of 40 new SDECs or UTCs. We will prioritise supporting those systems that can best evidence how early investment will impact service improvement this winter.

51. Every patient living with frailty should be identified early in their journey and a comprehensive geriatric assessment initiated or amended. This assessment and early involvement of a frailty team is proven to reduce admissions and length of stay and improve the patient's chance of maintaining independent living.

52. We should be seeing more children within 4 hours based on the occupancy levels of most of the country; Lord Darzi's independent investigation identified more than 10,000 infants, some of the most vulnerable members of our society, have been left waiting for over 6 hours in A&E departments. We need to use UTCs effectively, as well as children and young people's specific services, and standards need to be refined. ICBs should also consider commissioning means of local advice and guidance (such as Healthier Together) so parents can navigate their local systems and care provisions more effectively.

Ending 12-hour waits in corridors for a bed

53. Last year, we saw too many patients cared for in corridors, waiting over 12 hours for a bed. This should never happen. We're asking our patients to accept care that falls below the standards they deserve while also asking our staff to do things we've no right to ask them. This is why this spring we have committed to publish the collected data on the prevalence of corridor care for the first time. In 2025/26, we will seek to publish site-level performance data on total attendances, admitted attendances and long waits.

54. We also know that when some patients arrive at an emergency department they require immediate treatment to avoid unnecessary deterioration. In some cases this is obvious, while for others, this may be more subtle. According to the UK Sepsis Trust, 245,000 people are affected each year by sepsis, with 48,000 deaths every year determined as sepsis-related. We know that early identification and accurate diagnosis, allowing appropriate management, can save lives. Everyone should be using the National Early Warning Score (NEWS2) to help identify symptoms early, and we will continue to work

with the Royal Colleges and Societies on updating and sharing sepsis guidance and learning from best practice.

55. As soon as possible, and set out in the system winter plans, we need to ensure that people see the right clinician and don't stay longer in the emergency department than necessary.

56. System winter plans need to set out how their clinical model will be configured and adapted to make sure the most appropriate clinician is consistently available to provide continuity of care, proactively identify deteriorating conditions, support rapid assessments into the most appropriate pathways, and join up more effectively with primary and community teams. While safety is always the priority, we also need to work to time-bound standards. This will speed up the decision-making process, with rapid specialty opinions and diagnosis and with only the patients who genuinely meet the "criteria to admit" standards (as published on FutureNHS – password required) being admitted.

57. We will work with the Royal Colleges and Societies to consult, publish and audit trusts against new clinical operational standards for the first 72 hours of care. These will set the minimum expectations in areas such as time to review following referral, availability for advice, and what happens to patients when multiple specialist teams need to input into care. We will publish these standards by late summer 2025, allowing them to be implemented by winter.

Mental health teams leading from the front

58. Mental health provision is critical to improving UEC services, and mental health trust chief executives and boards need to play a full and active role in the development of their system winter plan.

59. An emergency department is seldom the most appropriate setting for people experiencing a mental health crisis, yet too often, service users find themselves with no local alternative. As a result, too many patients wait for 24 hours or more in emergency departments. This is not acceptable. Those systems that invested in crisis assessment centres or specialist alternatives to emergency departments are able to evidence both a positive impact for service users in crisis and a broader impact on improving UEC provision in their areas. Those systems that haven't yet been able to invest in crisis assessment centres have seen benefits from ensuring community assertive outreach and crisis intervention teams are working with acute providers to support patients who attend an emergency department with mental health-related issues.

60. We will provide an additional £26 million of capital to support those systems that can demonstrate they can invest in crisis assessment centres in-year, ahead of this winter. They should be able to demonstrate they can offer rapid assessment and short-term

support in a therapeutic environment to ensure people in mental health crisis have timely access to specialist support and are directed to the right care pathway. All areas will have an opportunity to apply for this funding.

61. Too many mental health patients are still admitted to mental health hospitals far away from their home and family. We know this risks higher rates of suicide, depression and anxiety for patients following discharge due to being far away from their normal support network. This is why we are providing £75 million to eliminate inappropriate out-of-area placements by delivering additional capacity to improve local mental health inpatient provision. The new capacity will be available by the end of this financial year. We expect this to lead to a reduction of around 150 to 160 patients in inappropriate out-of-area placements at any one time.

62. System winter plans will need to demonstrate how local mental health providers can evidence that mental health inpatient stays will be as short as possible. Plans should set out:

- how the number of patients in out-of-area placements (OAPs) will be reduced as part of a broader commitment to eliminate all ICB commissioned OAPs by March 2027
- how mental health providers will proactively identify and reduce the re-admissions of high intensity users of crisis pathways. They will also be required to produce their own percentage reduction target of re-admissions for their highest intensity users
- how they will ensure fewer patients who need a mental health admission wait over 24 hours. This will include the consistent and systematic use of the mental health UEC Action Cards in all relevant settings (acutes) and delivery of the 10 high-impact actions for mental health discharges to support flow through all mental health (including child and adolescent mental health) and learning disability and autism pathways

A whole-system approach to improving patient discharge

63. In some trusts, 1 in 4 bed days are lost due to delayed discharges. This is unacceptable.

64. Acute trusts need to set stretching local performance targets for daily pathway 0 discharges and profile them through the week to ensure they are met, so we don't create problems we can't solve at the weekend. Acute trusts and local authorities should set local performance targets for pathway 1, 2 and 3 patients, ensuring patients are discharged as soon as possible to appropriate rehabilitation, reablement or recovery support, based on the "Home First" principle. ICBs should work with local authorities to ensure that BCF capacity plans include appropriate capacity for surges over winter, both for step-up and step-down care, making effective use of the 3.9% increase in the NHS

minimum contribution to adult social care announced in the 2025/26 BCF policy framework. As part of local plans, acute trusts, local authorities and ICBs should progressively eliminate the longest and most unacceptable discharge delays, starting with the 0.7% of patients who wait more than 21 days beyond their discharge ready date. All settings should eliminate any internal delays to discharge of more than 48 hours. These actions must combine to ensure that ICBs and local authorities achieve their local goals for reducing discharge delays, 1 of the 3 goals in the new BCF policy framework.

65. System winter plans must demonstrate effective use of capacity across the full system. The discharge rates of people who are ready to leave community beds are markedly low, with 1 in 5 beds occupied by people with no criteria to reside in the service. Reviewing bed usage and returning people to home-based care where possible will reduce long stays and increase capacity for those who need it. As well as providing surge capacity, additional beds have the potential to support acute admissions avoidance for respiratory and flu cases, alongside IPC cohorting where it is effective and appropriate to do so.

66. Focusing community bedded capacity on higher levels of dependency can have a profound impact. In Leicester, Leicestershire and Rutland, a joint health and care initiative relocated 25 beds in over 3 locations to a single 15-bed high dependency unit. Patients who do not meet the criteria to reside within the high dependency unit are managed within home-based services. The service is provided in 3 wings of an independent care home, with an onsite therapy and nursing MDT and in-reach mental health and other more specialised services as required. Funding is provided via the BCF and is not significantly higher than previous costs. 6 months in, the system has already seen a reduction in acute delays from 12 days to 1.45 days, saving 777 bed days (equating to around £0.5 million within the system) and a 50% reduction in one-to-one care on discharge.

67. We are seeing the impact of where trusts, local authorities and ICBs are collaborating to drive down discharge delays through early discharge planning, efficient in-hospital processes, streamlining complex discharge processes and matching intermediate care capacity to people's needs. The key to improvement in these systems is actively using data about discharge-ready dates and proactively reviewing the reasons for delays to tackle variations in performance.

68. Systems that are struggling to improve discharge can use the additional guidance and best practice we have produced, including:

- care transfer hubs best practice, which sets out the 9 essential features of effective discharge arrangements for people with more complex needs
- Community rehabilitation and reablement model, which sets out best practice for commissioners and providers of intermediate care

- Neighbourhood health guidelines 2025/26, which support acute and community trusts, ICBs and local authorities to determine how neighbourhood MDTs will work with hospital wards and care transfer hubs, helping people with more complex needs return home with the right community support for their ongoing recovery

From analogue to digital: using data and digital investment to improve flow

69. 2025/26 is about getting the digital basics right for urgent and emergency care. We will use technology to speed up and improve patient care, allowing clinicians to view records and make referrals more efficiently – and to reduce the administrative burden on staff.

70. We have already seen the impact this can have, which is why we are providing an additional investment of £20 million in the Connected Care Records programme for all systems. This will establish the interoperability necessary for paramedics to see the patient summary from all different NHS services, including the patient's most recent treatment. All ambulance trusts will have sight of the summary by the end of 2025/26, up from 50% who currently have access. This in turn will enable them to provide better care to patients and avoid unnecessary admissions. For example, One London Shared Care Record provides a single, secure view of patient information, helping to speed up communication between care professionals across London.

71. We will continue to drive adoption of the NHS Federated Data Platform (FDP). The FDP will have been rolled out to 85% of acute trusts by the end of March 2026, with 77% of acute trusts having access by the end of Q2 this year, allowing for adoption ahead of winter. By expanding the use of the FDP, systems and trusts can consolidate multiple frontline operational systems into a single view, facilitating more effective and efficient clinical and operational decisions.

72. Rolling out the FDP is one thing: ensuring it is used effectively is another. System winter plans will need to evidence how teams will use FDP real-time data and forecasting tools to better manage demand, for example, by detailing how:

- the A&E Forecasting Tool is providing intelligence to support local operational decision-makers with resource and capacity management
- the Timely Care Hub is providing task tracking, monitoring and reporting of key metrics for quality
- the Optimised Patient Tracking and Intelligent Choices Application (OPTICA) system is providing clear visibility of all tasks required within the discharge process, supporting patients to return home or into step-down care

73. Finally, falls place a significant burden on UEC services, costing the NHS more than £2.3 billion a year. Falls in social care, home and community settings make up around 75% of this cost. Care technology in these settings can support people to live independently and avoid falling; for example, remote monitoring technology in care homes has been found to halve falls and prevent “long lies”, strongly associated with hospital admissions. To increase providers' confidence to adopt suitable, safe and future-proof technologies, we will set new national standards for initial priority care technologies by March 2026 and publish guidance to support providers to implement technology effectively.

Giving urgent care improvement the system-wide focus it deserves

74. None of the expectations set out in this plan will happen by accident: they require every leader in health and care to be purposeful and focused on getting the best out of their own teams and organisation and working across systems to create the most stretching ambitions for winter improvement we have seen in recent years. At its heart, this challenge is all about leadership.

75. We are combining the various elements of improvement support that have been developed – sometimes in silos – and using these resources to create a meaningful offer to systems to support them to realise their ambitions. We will also use the new NHS Performance Assessment Framework, which incorporates a range of metrics across all sectors, including primary care, hospitals, and ambulance, community and mental health trusts. This will drive the required focus and subsequent improvement that will support UEC recovery. We will also commit to publishing league tables on performance to drive improved transparency and public accountability and also to encourage less effective systems to work more closely with high performing systems to accelerate improvement.

76. Every system can access:

- **the model health system data** – available for all systems and providers to support UEC improvement. It includes a range of benchmarking data designed to help trusts review their practices and reduce unwarranted variation, which in turn delivers improvements, efficiencies and unlocks savings
- **UEC operational data dashboard** – this will be updated daily to provide a single version of the truth on key UEC performance metrics
- **improvement guides** – available to provide guidance on best practice in the areas that will drive maximum impact against the data points identified in their benchmarking data
- **learning and improvement networks** – led by a high-performing chief executive in each region with the responsibility to focus on reducing variation through the

application of best practice. The Learning and Improvement Networks will bring together clinical and operational leaders to identify opportunities for improvement and explore ways to deliver the improvement and share best practice. They will focus on the reduction of the percentage of patients in hospital over 7 days, supporting flow and reducing corridor care

- **training for on the ground clinical and operational leaders** – covering the fundamentals of operational management, leadership and improvement, including how to use improvement tools like LEAN. We have resourced this to ensure it can be accessed by 25,000 NHS staff this year and will be available from June 2025

77. **For those systems requiring additional support,** regional teams will provide this, including reviewing benchmarking data, improvement plans and associated resourcing, such as buddying teams, so that high-performing systems can support those who are struggling through peer-review.

78. **For those most challenged systems that demonstrate limited progress**, we will use a one-team approach to provide a joined-up intervention and support package. Where capacity allows, every site will have experienced clinical and operational improvers from the national teams assigned to them. These specialists will help identify the root cause of the issues, using the available data sources and implementing solutions, before winter, based on the improvement guides. This package will be for a 6-month period and will have personal oversight from the national director, national clinical director, chief nurse and NHS medical directors, delivering a plan that is owned at board and clinician level.

79. Finally, as set out in the Better Care Fund policy framework for 2025/26, the Department of Health and Social Care (DHSC), NHS England and the Ministry of Housing, Communities and Local Government (MHCLG) are adopting a more targeted approach to oversight and support for local authorities and ICBs in their development and implementation of BCF plans. The newly formed Discharge and Admissions Group will work with challenged systems to help drive improvements in discharge and foster effective collaboration between the NHS, local authorities and social care providers to help prevent avoidable admissions. Where there are significant performance challenges with the 3 BCF headline metrics (emergency admissions for over 65s, delayed discharges, care home admissions for over 65s), DHSC, NHS England and MHCLG will work with local areas to agree improvement plans or, where necessary, revised BCF plans.

Detailed actions: roles and responsibilities

NHS England and DHSC	• Undertake an urgent review of UEC data by the end of June 2025. • Simplify the national improvement and capital investment offers to align to the systems where those resources can make the biggest difference. • Expand the use of the National Booking Service for flu so more flu vaccination appointments are available. • Develop the "flu walk-in finder" so that, from October 2025, patients can look up when they can walk into a community pharmacy to get a vaccination. • Communications teams to share details of the most effective staff vaccination programmes from 2024/25. • Work with professional bodies, patient representative groups and charities to support consistent clinical advice about the benefits of flu jabs for patients in clinically vulnerable groups. • Undertake and implement the findings of an evidence-based clinical review of categorisation, with the aim of improving the clinical triage of 999 calls. • Publish and implement the key recommendations from the 111 review to make the 111 service quicker and simpler to navigate. • Allocate £250 million of capital budget to continue the expansion of co-located urgent treatment centres and same day emergency care. • Publish site-level performance data on total A&E attendances, admitted attendances, long waits and prevalence of corridor care. • Continue to work with the Royal Colleges and Societies on updating and sharing sepsis guidance and best practice. • Work with Royal Colleges and Societies to consult, publish and audit trusts against new internal clinical operational standards for the first 72 hours of care. • Allocate £26 million of capital budget to support systems to invest in crisis assessment centres. • Allocate £75 million of capital budget to eliminate out-of-area placements by delivering additional capacity to improve local mental health inpatient provision. • Invest an additional £20 million in the Connected Care Records programme for all systems. • Continue to drive adoption of the NHS Federated Data Platform (FDP).

	• Set national standards for initial priority care technologies and publish guidance to support providers in implementing technology effectively. • Use the new NHS Performance Assessment Framework to drive the required focus and improvement that will support UEC recovery. • Identify which systems require the most support and intervention.
System winter plans should include	• Delivery approach to strengthening the childhood vaccination offer. • Delivery approach to the year-round RSV vaccination programme for older adults and pregnant women, ensuring all those in the older adult catch up cohort (75 to 79) have been offered a vaccination by 31 August 2025. • Stretching plan for flu vaccine uptake by NHS staff with a target percentage increase on last year's uptake. • Winter virus resilience plans against the infection protection and control (IPC) mechanisms available both in and out of hospital, including appropriate policies and procedures, appropriate cohorting spaces and exploring the direct admission of flu patients into community bedded capacity. • How NHS providers and local authorities (through health and wellbeing boards) will improve discharge and admissions avoidance. • How local partners are working together to identify patients who are most vulnerable during the winter period and co-ordinate proactive care for these individuals. • How systems intend to expand access to urgent care services at home and in the community, so patients don't need to attend hospitals unnecessarily. • How their clinical model will be configured and adapted to make sure that the most appropriate clinician is consistently available to provide continuity of care, proactively identify deteriorating conditions, support rapid assessments and join up more effectively with primary and community teams. • How local mental health providers can evidence that, when mental health patients are admitted to an inpatient setting, their stay will be as short as possible. This should include producing their own % reduction target of re-admissions for their highest intensity users, how the number of patients in out-of-areas placements will be reduced, and how to reduce the number of patients who need a mental health admission waiting over 24 hours

	• Evidence how teams will use FDP real-time data and forecasting tools to better manage demand.
NHS trusts	• Demonstrate plans to improve vaccination rates in health and care workers. • Have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments. • Acute trusts to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target. • To achieve the target of more children being seen within 4 hours, deliver effective utilisation of UTCs, children and young people's specific services and standards. • Acute trusts to set stretching local performance targets for daily pathway 0 discharges and profile them through the week. • Acute trusts and local authorities to set local performance targets for pathway 1, 2 and 3 patients. • Demonstrate effective use of capacity across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside IPC cohorting where it is effective and appropriate to do so.
Systems	• Some systems to test the use of health visitors to administer childhood flu vaccinations and other routine immunisations for eligible children. • Implement the "Release to Rescue" standard without exception, including in the winter months.
Integrated care boards	• Consider commissioning means of local advice and guidance (such as Healthier Together) so parents can navigate local systems and care provisions effectively. • Work with local authorities to ensure that BCF capacity plans include appropriate capacity for surges over winter, both for step-up and step-down care.
Ambulance trusts	• Operate a call before convey principle and enable "see and treat", supported by additional clinicians in emergency operating centres and single point of access. • Expand overnight support for 999 call handlers and clinicians to provide urgent in-home care for clinically assessed patients, with follow-up services available the next day. • Reduce the variation in rates of "hear and treat" and "see and treat".

Delivery plan for recovering urgent and emergency care services

1. Introduction

In 2023, the government published a plan for recovering urgent and emergency care services, which built on two headline targets: reducing average category two ambulance response times to 30 minutes, and improving A&E waiting times.

On 6 June 2025, the Department of Health and Social Care published a new Urgent and Emergency Care Plan (UEC Plan). Building on its previous iteration, this plan emphasises a whole-system approach to tackling UEC pressures and includes examples of best practice from across the country. Detail plan can be found NHS England » Urgent and emergency care plan 2025/26

A summary of the key actions is outlined in Table 1. We will work with ICB UEC system colleagues to understand our gaps and where we are monitoring delivery against these. An update will come back to ELT in 2 weeks.

2. Key Points

- This plan prioritises cross-sector, system working to achieve improvements in UEC over winter. Local partners within every system will be responsible and accountable for effectively managing UEC demand, with an emphasis on multidisciplinary, neighbourhood working.

- All winter plans must be developed and tested prior to implementation, and lead to an increase in urgent care services provided in the community. This includes improving uptake of the flu vaccination among NHS staff, and expanding virtual wards.

- Capital funding injections and supportive national resources will be simplified, to ensure a bigger impact. Over £370m will be invested into supporting UEC, which could provide the equivalent of 40 new same day emergency care (SDEC) units and urgent treatment centres (UTCs). Detail on how this funding can be accessed is not yet clear.

The whole system must focus on seven key areas. These are:

1. Category 2 patients must receive an ambulance within 30 minutes.
2. Ambulance handovers must not exceed 45 minutes.
3. At least 78% A&E patients to be discharged, admitted or transferred within 4 hours.
4. Less than 10% patients to wait over 12 hours for admission or discharge from an ED.
5. Reduce the number of mental health patients waiting in EDs for over 24 hours.
6. Reduce the number of patients staying 21 days over their discharge-ready date.
7. See more children within 4 hours.

To ensure success of winter UEC plans, all plans must be signed off by all trust boards and CEOs in every system by Summer 2025. By September 2025, these plans should have been stress-tested by regional and system leaders. Each plan should outline how the system will:

- Improve rates of vaccination.
- Increase the level of care provided in primary, community and mental health settings.
- Meet the 45-minute ambulance handover time.
- Improve flow through hospitals.
- Eliminate discharge delays of over 48 hours and set local performance targets to improve discharge times more generally.

There will be a requirement for every plan to outline:

- How ICBs are improving access to primary and community care.
- How community providers are improving admission avoidance.
- How trusts are using tools to improve patient flow, including optimising triage processes.
- How ambulance trusts are maximising opportunities this winter. They are required to nominate an executive director to work with ICBs to support development of the system winter plan.

NHSE has committed to reviewing all available UEC data by the end of June 2025, and work to improve transparency of data at a local level. UEC performance will be published in league tables, to increase accountability.

3. Delivering the asks for 2025/26

a. From treatment to prevention: taking steps now to reduce demand for urgent care later this year

NHSE set out its plan to reduce the effects of flu over winter. Trusts will need to have a fully developed plan for improving flu vaccine **uptake for NHS staff by the end of quarter one (including details on how to improve communications and promote vaccinations offers**), while NHSE has committed to:

• expanding the use of the National Booking Service for flu vaccinations, and
• from October 2025, allowing patients to look up available walk-ins for flu vaccinations via a “flu walk-in finder”.

b. From hospital to community: increasing the number of patients receiving care in community settings

At least 20% of people who attend ED don’t need to be there: this new plan outlines a strategy by which to improve community care. The neighbourhood health guidelines (January 2020) outlined the core components for efficient neighbourhood working, including proactive care led by multidisciplinary teams and standardised urgent neighbourhood services. Using this, systems will need to outline in their winter plans:

- How local partners will work together to provide proactive, integrated care for vulnerable patients.

- The UEC Plan uses Washwood Health in Birmingham as a case-study to exemplify best-practice when it comes to delivering efficient, integrated SDEC. How urgent care will be expanded into the home and the community, for example through virtual wards.

- How local partners are working together to identify vulnerable patients who need proactive care

c. High-quality emergency care: meeting the maximum 45-minute ambulance handover

The Plan asks for delivery of the 'Release to Rescue' standard 'without exception'. Evidence from the standard's usage in London in 2024/25 show a reduction in ambulance handovers by 11%.

d. Improving flow through hospitals

This Plan commits to improving urgent and emergency care through separating the two, ensuring
patients are treated in the correct setting. This involves:

- Expanding SDEC and UTC services across the country, supported by £250 million in capital funding (equating to 40 new UTCs or SDECs).
- Co-locating UTCs and SDECs to reduce overcrowding and time spent in EDs.

Other initiatives that will be put in place to improve flow include:

- Frail patients will have proactive geriatric assessments initiated to reduce admissions.
- Ensure better utilisation of, and greater communications about, Children and Young People's (CYP) services, to avoid unnecessary admission.

e. Ending 12-hour waits in corridors

From 2025/26, NHSE will publish data on corridor care, long waits and admissions to drive accountability. It will also publish guidance and best practice relating to early sepsis detection and require all systems to outline in their winter plans how they will ensure that patients see the most appropriate clinician to their needs. By summer 2025, new standards for the first 27 hours of care will be published, with audits to ensure compliance.

f. Mental health

System winter plans must show how local mental health providers will ensure inpatient stays are as short as possible. Plans should include:

- Reducing out-of-area placements (OAPs) to eliminate all ICB commissioned OAPs by March 2027.
- Identifying and reducing re-admissions of high-intensity crisis pathway users, with specific reduction targets.
- Ensuring fewer patients wait over 24 hours for mental health admissions by using UEC Action Cards and implementing 10 high-impact actions for mental health discharges across all relevant pathways.

g. A whole-system approach to improving patient discharge

Acute trusts must set and meet ambitious daily discharge targets, including weekends, and eliminate delays over 48 hours. Local authorities and ICBs should ensure winter plans include surge capacity, using the 3.9% NHS funding increase for adult social care. The Plan emphasises reducing the longest delays, starting with patients waiting over 21 days.

Additional guidance and best practice have been produced for system struggling to improve discharge:

- Care transfer hubs best practice: 9 essential features for effective discharge arrangements for complex needs.
- Community Rehabilitation and Reablement Model: Best practices for intermediate care.
- 2025/26 neighbourhood health guidelines: Coordination of neighbourhood MDTs with hospital wards and care hubs for ongoing recovery support.

The Plan outlines requirements for system winter plans to:

- Strengthen vaccination offers.
- Deliver a year-round RSV programme for older adults and pregnant women, targeting the 75-79 age group by 31 August 2025.
- Increase NHS staff flu vaccination uptake, aiming for a higher percentage than last year.
- Enhance winter virus resilience with IPC mechanisms, policies, co-horting spaces, and direct admission of flu patients to community beds.
- Improve discharge processes and admissions avoidance through NHS and local authority collaboration.
- Coordinate proactive care for vulnerable patients during winter.
- Expand access to urgent care services at home and in the community to reduce unnecessary hospital visits.
- Adapt clinical models for clinician availability, continuity of care, rapid assessments, and better integration with primary and community teams.
- Minimise mental health inpatient stays by setting targets for reducing re-admissions, decreasing out-of-area placements, and ensuring no patient waits over 24 hours for admission.
- Use FDP real-time data and forecasting tools to manage demand effectively

Table 1: Summary of priority actions and their impact

Actions	Impact for patients and carers	Assurance RAG	Our current position *As of 01/06/25*	12-month average *01/06/24 – 01/06/25*
Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter	Reduce Ambulance Wait Times For Category 2 Patients – Such As Those With A Stroke, Heart Attack, Sepsis Or Major Trauma – By Over 14% (From 35 To 30 Minutes)		May 2025: 34.08 mins	38.69 mins
	Eradicate Last Winter's Lengthy Ambulance Handover Delays By Meeting The Maximum 45-Minute Ambulance Handover Time Standard, Helping Get 550,000 More Ambulances Back On The Road For Patients		92% < 60 minutes 69% < 30 minutes	88% < 60 minutes 71% < 30 minutes
	Ensure A Minimum Of 78% Of Patients Who Attend A&E (Up From The Current 75%) Are Admitted, Transferred Or Discharged Within 4 Hours, Meaning Over 800,000 People A Year Will Receive More Timely Care		76%	74%
	Reduce The Number Of Patients Waiting Over 12 Hours For Admission Or Discharge From An Emergency Department Compared To 2024/25, So This Occurs Less Than 10% Of The Time. This Will Improve Patient Safety For The 1.7 Million Attendances A Year That Currently Exceed This Timeframe		11.64%	16%
	Reduce The Number Of Patients Who Remain In An Emergency Department For Over 24 Hours While Awaiting A Mental Health Admission. This Will Provide Faster Care For Thousands Of People In Crisis Every Month		May 2025: 0	0.21 for year
	Tackle The Delays In Patients Waiting To Be Discharged – Starting With The Nearly 30,000 Patients A Year Staying 21 Days Over Their Discharge-Ready-Date, Saving Up To Half A Million Bed Days Annually	tbc	May 2025: 65	3 per day for year

	Increase The Number Of Children Seen Within 4 Hours, Resulting In Thousands Of Children Every Month Receiving More Timely Care Than In 2024/25	tbc	May 2025: 78.34%	77.64%
Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter	Improve Vaccination Rates For Frontline Staff Towards The Pre-Pandemic Uptake Level Of 2018/19. This Means That In 2025/26, We Aim To Improve Uptake By At Least 5 Percentage Points	tbc		
	Increase The Number Of Patients Receiving Urgent Care In Primary, Community And Mental Health Settings, Including The Number Of People Seen By Urgent Community Response Teams And Cared For In Virtual Wards	tbc		
	Meet The Maximum 45-Minute Ambulance Handover Time Standard		May 2025: n=23.3 per day %=85.37%	n=28 per day %=81.26%
	Improve Flow Through Hospitals, With A Particular Focus On Reducing Patients Waiting Over 12 Hours And Making Progress On Eliminating Corridor Care	tbc	May 2025: n=61.74 per day	n=64 per day
	Set Local Performance Targets By Pathway To Improve Patient Discharge Times, And Eliminate Internal Discharge Delays Of More Than 48 Hours In All Settings	tbc	May 2025: n=116.2 per day	n=177 per day
	Reduce Length Of Stay For Patients Who Need An Overnight Emergency Admission. This Is Currently Nearly A Day Longer Than In 2019 (0.9 Days) And Needs To Be Reduced By At Least 0.4 Days	tbc		

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	*1 July 2025*
Item Number	

Finance and Performance Committee Upward Report of the meeting held on 22 May 2025

Accountable Director	*Paul Antunes-Goncalves, Group Chief Finance Officer*
Presented by	*Dani Cecchini, Finance and Performance 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 and Performance 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 2025/26 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 1b Reduce waiting times for our patients

Operational Performance Report – ULTH/LCHS and Committee Performance Dashboard

The Committee received the reports noting from a LCHS perspective that a number of targets would be re-designed in order to ensure these were set appropriately.

Volumes had increased in respect of the Urgent Community Response service however a decrease in performance was noted as a result. Improved performance was noted in respect of Urgent Treatment Centres however

concern was noted in respect of some of the services being appropriately located within the estate which was being addressed.

Performance in respect of discharge to assess was noted with volumes increasing as planned and the intention to increase the capacity of the discharge to assess team which would support pathway one capacity.

Virtual ward improvements were being seen however this needed to be supported by the operations centre with a need to address vacancies to support this.

ULTH performance was noted with ongoing challenges experiences in Urgent and Emergency Care performance with a deterioration seen in performance against ambulance handover times, patient exceeding 12 hours in A&E and the overall 4 hour A&E wait. This was due to an increase seen during April of ambulance conveyances and the impact of increased patient acuity on the service. Performance of the 4hr target was noted as 77.32% compared to the target of 78% which had been achieved in March. An improvement in performance was expected in the May data.

DM01 performance continued to underperform at 67.47% compared to the target of 99%. Concern was noted specifically within audiology and associated wait times however this was recognised as a national issue with work underway to find alternative solutions.

Cancer performance was noted as remaining static however there was recognition of positive movement within the urology specialty.

The Committee noted the development of the new performance dashboard which would allow greater oversight of performance due to the ability to drill down into the data.

Assurance in respect of Objective 1c Improve productivity and deliver financial sustainability

Finance Report inc CIP and Capital

The Committee received the report noting the month 1 position of a £4.2m deficit, in line with plan with the intended move to a breakeven position by the end of the year.

Cost Improvement Programme delivery was noted as on plan with capital delivery slightly behind plan due to timing however this would correct in month 2. It was noted that Better Payment Practice Code (BPPC) data would be included within the report on a monthly basis.

The Committee noted the need for the corporate cost return to be submitted by the end of May with work taking place to ensure that this was considered across the Group.

Budget Setting Update
The update was received in respect of budget setting with positive progress noted in month 1.

The Committee noted that budget setting would conclude in month 2 with the Care Groups well engaged in the process.

Post Investment Evaluation
Post investment evaluations were noted as a key improvement and a best practice approach with the Committee noting the steps being taken to ensure focus on this. A plan was being developed to ensure evaluations were taken through the appropriate governance processes and offered to the relevant Committees.

Car Parking Charges
The Committee received the report for information noting the recommendation that had been made in respect of charges.

Assurance in respect of Objective 1d Provide modern, clean and fit for purpose care settings

Emergency Preparedness, Resilience and Response (EPRR) Annual Report – LCHS/ULTH

The Committee received the annual reports for LCHS and ULTH **(appended)** and recommended to the Board for approval. Significant improvements were noted in the core standard for LCHS.

The Committee received the EPRR policies for approval noting the requirement for each organisation to have a policy in place. The Committee approved the policies, as recommended by the Emergency Planning Gorup.

Estates and Facilities Assurance Report inc PLACE report
The Committee received the report noting the impact of current vacancies within the directorate however recognised that these were being addressed.

The Committee noted the carbon energy fund bid and the requirements for Board approval to secure funding in order to progress the net zero agenda of the Group.

It was noted that work was ongoing in relation to identifying appropriate space for services where estates concerns had been raised and the Committee was pleased to note that the safety groups were now supporting the Group with representation from NHS Property Services also in place where relevant to support discussions and actions.

The Committee noted the commissioning of an external Planned Preventative Maintenance Audit across the Group to support the provision of external assurance and review of risk.

The Patient-Led Assessment of the Care Environment (PLACE) report was received for both ULTH and LCHS with improvements noted across both organisations. Concerns were noted however in respect of food for patients in both reports with a request for a referral to the Quality Committee.

Action plans had been developed in all areas and would be monitored through the PLACE working groups and would be reported to the Committee via the estates report.

Assurance in respect of other areas

Board Assurance Framework 2025/26
The Committee noted the ongoing development of the Board Assurance Framework and recognised the change to the risk scores for objectives 1b and 1c as a result of the risk matrix being corrected within the document.

The Committee noted the need to ensure audit reports were included as sources of assurance and recognised that the BAF would continue to be embedded in the coming months.

Risk Report
The Committee received the risk register noting the need to review current risks captured to ensure these were accurately reflected both in narrative and level of risk.

Policy Position Update
The Committee received the report noting that the compliance position remained static and noted the ongoing engagement within the organisations to ensure RAG ratings and narrative updates were provided for the relevant overdue policy documents. The Committee noted the positive outcome from the internal audit in respect of the processes in place for managing policy documents.

Information Governance Group Upward Report
The Committee noted the progress in respect of the subject data request (SAR) backlog and noted the need for appropriate resource to support Freedom of Information requests.

A significant reduction in the number of open SARs was noted with the team anticipating the closure of the backlog by August 2025. An increase in concerns regarding missing personnel files was noted with consideration being given to the risk being captured on the risk register.

Cyber Assurance Update
The cyber assurance update offered the Committee a position in respect of patching and threat assessments with the recognition of the continuous work within digital services to ensure the security profile of the Group.

Internal Audit Recommendations
The Committee noted the internal audit recommendations noting the need to ensure timely updates to internal audit in respect of the closure of recommendations.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

The Committee referred to the Quality Committee the issue of patients being prepared to receive meals at the appropriate time.

Attendance Summary for rolling 12-month period

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

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	*1 July 2025*
Item Number	

Finance and Performance Committee Upward Report of the meeting held on 20 June 2025

Accountable Director	*Paul Antunes-Goncalves, Group Chief Finance Officer*
Presented by	*Dani Cecchini, Finance and Performance 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 and Performance 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 2025/26 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 1b Reduce waiting times for our patients

Operational Performance Report – ULTH/LCHS and Committee Performance Dashboard

The Committee received the reports noting that stability was being seen in respect of handover delays and compliance of the 45-minutes standard within Urgent and Emergency Care (UEC) however pressures were starting to be seen in Lincolnshire due to the time of year and impact of weather.

4-hour performance had further reduced to 75.86% however work was being undertaken on the flow programme to support this including the expansion of the Same Day Emergency Care (SDEC) capacity. Urgent Treatment Centres

(UTCs) were delivering the 98% target with the exception of Grantham and Skegness, with Skegness impacted due to the seasonal increase in residents visiting the coast.

Discharges continued to be an area of concern with a need to ensure that earlier discharges were achieved in the day to resolve the front door pressures with the Committee noting the go live of the Optica system due in July. The Committee commended the roll out of the system which had been achieved in 3.5 months, quicker than any other Trust.

Planned care was noted to be delivering as expected however concern was noted with delivery against the 52-week target where some fluctuation had been seen however was expected to improve in the coming months.

Improvements in cancer performance was noted at the end of the 2024/25 year however April was reported as a challenging month.

Diagnostics had seen a signification improvement in May however Dexa, ultrasound and audiology continued to be the main areas of pressure, despite the improvements seen.

Theatre Utilisation Update
The Committee received the report and sought to understand when the productivity would result in the reduction of cancelled operations and improvement in performance, supporting elective care and cancer care metrics.

There was recognition of improvements being achieved however this was not through additional activity, but activity delivered at a lower cost. Based on the current position the Committee recognised the need for further work in order to increase activity and productivity.

Assurance in respect of Objective 1c Improve productivity and deliver financial sustainability

Finance Report inc CIP, Capital and CRIG
The Committee received the report noting that the month 2 position was in line with plan. Whilst capital was noted as being behind plan recovery was anticipated in subsequent months. Cash was reported as a positive position with this being higher than expected at month 2.

The Cost Improvement Programme (CIP) was noted to be on plan. The committee noted the significant stepped increases due in months 4 and 7 in respect of delivery.

The Committee noted that the risk in respect of efficiency delivery with corrective actions being taken including the Vacancy Control Process (VCP) which would remain in place until assurance on delivery was achieved.

The regional position was noted by the Committee with a recognition of the challenge across the year and therefore the requirements on providers to deliver efficiencies.

The Committee noted the Elective Recovery Fund (ERF) activity which was slightly behind planned performance however corrective action was being taken with the largest area of opportunity noted as outpatient activity in respect of performance and recovery.

External support was noted by the Committee in a number of areas which would assist in the identification and delivery of further efficiencies.

Corporate Cost Reduction Report
The Committee received the report noting the compliant submission that had been made which included areas of exclusions for which NHSE feedback was awaited.

Procurement Quarterly Report
The Committee received the report noting the ongoing work to identify senior responsible officers aligned to contracts to support timely review and progress of these.

There was a recognition of further savings that could be achieved through partnership working with neighbouring Trusts and at system level in order to leverage price benefits.

Increased use of the Atamis system was acknowledged which would support forward planning and engagement with teams as well as continuing to deliver complaint processes.

Assurance in respect of Objective 1d Provide modern, clean and fit for purpose care settings

Estates and Facilities Assurance Report
The Committee received the report noting that there were no escalations made to the Committee.

The red assurance rating within the BAF was noted by the Committee with consideration given to the assurances that would be required to be received in order to achieve movement on this. This was anticipated to be reviewed as authorised engineer reports were received, particularly in respect of the LCHS estate, offering assurance on the position of the estate and statutory compliance.

Concern was noted in respect of the fire safety mandatory training compliance with the Committee making a referral to the People Committee to ensure oversight and progress of this.

Space utilisation was noted with recent recruitment having been undertaken to support this agenda and the delivery of CIP as a result. Space utilisation in

respect of transformation of the use of space was reported to the Integration Committee.

Assurance in respect of other areas

Board Assurance Framework 2025/26
The Committee received the Board Assurance Framework noting the ongoing work to embed this and recognising the updates offered to the Committee. There was recognition that further updates were required to ensure that the community elements were clearly narrated within the BAF.

The Committee confirmed that the assurance ratings would remain as reported with no changes made in month.

Risk Report
The Committee received the risk register noting the current risks presented which were currently being reviewed through the governance process, therefore the Committee expected to see movement in the risks in the coming months.

Policy Position Update
The Committee received the report noting the progress made in identifying risk ratings, with updates offered in respect of the majority of the overdue policy and guideline documents which would continue to be monitored.

Cyber Compliance Report
The Committee received the report noting the ongoing efforts of the teams to deliver the Windows 11 roll out across ULTH. The Committee noted that, where possible, benchmarking data would benefit the Committee in understanding the position of the digital and cyber services.

Internal Audit Recommendations
The Committee received and noted the internal audit recommendations as presented.

Productivity, Improvement and Transformation Oversight Forum Upward Report
The Committee received the report with **assurance** noting the need to ensure the balance of the reporting across the Committees however recognised the assurance this provided to the Committee.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

The Committee referred to the People Committee the issue of mandatory training compliance in respect of fire safety training.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Emergency Preparedness, Resilience and Response (EPRR) Annual Report LCHS: Finance and Performance Committee

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

Meeting	*Finance and Performance Committee (FPC)*
Date of Meeting	*Thursday 22nd May 2025* *EPRR Annual Report previously considered at EPG on 14 April 2025.*
Item Number	*9.1*

Emergency Preparedness, Resilience and Response (EPRR) Annual Report - LCHS

Accountable Director	*Mike Parkhill, Accountable Emergency Officer*
Presented by	*Mike Parkhill, Accountable Emergency Officer*
Author(s)	*Connor Smart, EPRR Lead (LCHS)*
Recommendations/ Decision Required	*The Board is asked to note the content of the report and identify if any further action is required to provide assurance that LCHS is suitably prepared to respond to incidents and emergencies under its legislative and guidance requirements.*

How the report supports the delivery of the LCHG strategic aims & objectives	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings	*X*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	*X*
2b: Empower our people to continuously improve and innovate	*X*
2c: Nurture compassionate and diverse leadership	*X*
2d: Recognising our people through thanks and celebration	*X*
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*X*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	*X*
3c: Enhance our digital, research & innovation capability	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	*X*

Executive Summary

Summary/Key Points:

- LCHS has been assessed by NHS England (NHSE) as fully compliant on 48 of the 58 Core Standards and partially compliant for 10.
- As presented at confirm & challenge, it is both our and the Lincolnshire Integrated Care Board's (LICB) belief that LCHS is fully compliant with Core Standard 2 (EPRR Policy statement) and this has been reflected within our final self-assessment submission (49 fully compliant standards out of 58).

The Action Plan at Annex 2 details the work required and timescales to address areas of partial compliance.

1. Purpose

The purpose of this report is to provide the Group Board (via FPC) with an overview of LCHS' current position in relation to compliance against the NHSE Core Standards for EPRR and an appraisal of key EPRR work for the previous year 2024 / 25.

2. Legislation and Guidance

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHSE and the NHS in England.

Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS-funded services to comply with the NHSE EPRR Framework and other NHSE guidance.

3. NHS Core Standard Purpose and Process

NHSE produce a set of EPRR Core Standards (CS) whose purpose is to:

- Enable health agencies across the country to share a common approach to EPRR.
- Allow co-ordination of EPRR activities according to the organisation's size and scope.
- Provide a consistent and cohesive framework for EPRR activities.
- Inform the organisation's annual EPRR work programme.

58 CS are applicable to Community Trusts like LCHS, and the Emergency Planning (EP) team self-assess compliance for each Core Standard as either Non, Partial or Fully compliant whilst providing evidence to support this. The LICB and NHSE (Midlands) then audit all evidence and determine if the self-assessment is correct.

For the period covering September 2023 – August 2024 (henceforth referred to as '2024') LCHS has been assessed by NHSE as fully compliant on 48 of the 58 Core Standards and partially compliant for 10.

As presented at confirm & challenge, it is both ours and the LICB belief that LCHS is fully compliant with Core Standard 2, and this has been reflected within our final self-

assessment submission (49 out of 58). This gives an overall compliance of around 84% which makes LCHS 'partially' compliant overall.
Details of each area of partial compliance, together with the actions and timeframes to achieve compliance are set out in Appendix 2. Oversight of the implementation of outstanding actions is undertaken by FPC through the Emergency Planning Group (EPG) on a quarterly basis.

4. Training and Exercising

For the year 2024-25 the following key EPRR roles were identified:

- An average of 10 Strategic Commanders were maintained / trained.
- An average of 20 Tactical Commanders were maintained / trained.
- An average of 25 Operational Commanders were maintained / trained.
- An average of 3 Communications Leads / Officers were maintained / trained.

Key figures for compliance / completed training include (as of 27/03/2025):

- **Principles of Health Command (every 3 years):**
  - Strategic: 70%
  - Tactical: 80%
- **EPRR Incident Commander Training / Basic EPRR Overview (annually):**
  - Strategic: 80%
  - Tactical: 100%
  - Operational: 96%
- **Defensible Decision Making (every 2 years)**
  - Strategic:10%
  - Tactical: 50%
  - Operational: 60%
- **Working with your Loggist (every 2 years)**
  - Strategic: 20%
  - Tactical: 55%
  - Operational: 60%

All training compliance statistics are reported via each quarterly EPG. LCHS did not have in place an all-staff EPRR training and awareness package for 24/25 which has been recognised as an action on the EPRR workplan.

The Trust took part in the following regional exercises:

- Ex Solana Fury (April 2024) – which explored the health response to heatwave pressures in England in conjunction with multiple operational pressures/scenarios and the interdependencies with Local Resilience Forum (LRF) partners in responding to these pressures.
- Ex IMP (May 2024) – a multi-agency CBRN exercise.
- Ex Winter Wren (September 2024) – ICB-organised winter preparedness exercise.
- Ex Blue Kite (October 2024) – a multi-agency 'EMERGO' training exercise that explored the response to a mass casualty event.

Internally, the Trust held the following exercises:

- Ex Pressure Gauge (July 2024) – Annual Tabletop
- Ex Ascending Ladder 2 (July 2024) – Communication Systems Exercise.
- Ex Hermes Down (November 2024) - Tabletop
- Ex Ascending Ladder 3 (December 2024) - Communication Systems Exercise.

All exercise reports were sighted at the next EPG following the exercise.

5. Additional Assurance Processes

1.1. The following actions were also undertaken to help maintain compliance to the core standards:

- The EPRR workplan and assurance documents were reviewed monthly by the EP Lead and presented quarterly to EPG.
- The EPRR risk register was reviewed monthly by the EP Lead via Datix and presented quarterly at the EPG.
- The EP Lead continued to work with UTC staff / leads to ensure that routine checks of CBRN / Initial Operational Response (IOR) equipment were being undertaken with results reported via the IUEC Quality Scrutiny Group (QSG).
- The designated Incident Coordination Centre (ICC) and its associated equipment at Beech House was inspected quarterly to ensure it remained fit for purpose.
- The following plans / policies were updated and approved at the EPG in 2024/25:

  - Infectious Disease and Emerging Pandemics Plan
  - Incident Response Plan
  - Incident Coordination Centre Plan
  - Incident Communications Plan
  - Treatment of a VIP Plan
  - Managing Strike Action Plan
  - BCMS
  - EPRR Policy
  - Mass Casualty Plan
  - Adverse Weather Plan
  - BC Policy
  - CBRN Plan
  - On Call Policy
  - Resilient Telecommunications Plan
  - Fuel Plan
  - Surge and Escalation Plan

- LCHS representatives routinely attended Health Emergency Planning Operations Group (HEPOG) meetings and applicable Lincolnshire

Resilience Forum (LRF) forums like the Resilient Telecommunications Group (TCG).
- All commanders were asked to populate a Personal Development Portfolio (PDP) to see how their skills and knowledge align to the NHSE EPRR Minimum Occupational Standards (MOS). Uptake and return of these PDPs was generally challenging with around 50-60% returned for Strategic, Tactical and Operational.

6. Major, Critical and Business Continuity Incidents

The following incidents (declared under the NHSE EPRR Framework) were experienced during 2024 - 25:

- A Business Continuity Incident (BCI) was declared on 19 July 2024 in response to the Cloudstrike / Microsoft software issue that caused widespread / global issues. The BCI was stood down the same day. From this incident there were lessons learned around health rostering and how comprehensive the relevant BCP was and the need for updating as well as data redundancy measures, ease of commander access to sitrep forms and an incident checklist for commanders to tick-off as they work through an incident alongside a reminder to keep internal staff updated on the situation.

All incident reports were sighted at the next EPG following the incident.

Lessons and Learning:

- A structured debrief for the incident was delivered.
- An incident report (with associated action logs) was produced and sent to all relevant members within the Group and to the ICB and NHS England for wider learning.
- All actions within the report was added to an EPRR lessons learned database that is scrutinised monthly by the EP Team and quarterly at EPG meetings.
- As of 27/03/2025 the lessons learned figures for LCHS stood at the following:

- Organisation Lessons: 162 total, 140 completed (86%).
- Regional Lessons: 704 total, 409 completed (58%)

7. Business Continuity

Audit
In early 2024 (Jan – March) Tiaa undertook an external audit of the LCHS EPRR and business continuity program. The final findings of the audit found that the EPRR and BCP program for LCHS was providing '**Reasonable Assurance'** for processes and controls in place to respond to an emergency situation and business continuity. This result was reported / presented at the April 2024 EPG.

LCHS also undertook a routine internal audit in July 2024 which highlighted that the Trust had some actions required in which to improve its Business Continuity Management System (BCMS) overall. All audit findings (both internal and external) are reported through the EPG with updates provided regarding actions closed and actions open. The internal audit overview alongside the BCMS Key Performance Indicator (KPI) summary can be found in Appendix 3.

BIAs and BCPs

The Trust continues to maintain team/service level BIAs and BCPs with compliance tracked against the following metrics:

- BIA / BCP reviewed within last 12 months (and 1st sign-off approved)
- BIA / BCP reviewed within last 12 months (and 2nd sign-off approved)
- BCP exercised within last 12 months.

As of the end of December 2024 the BC compliance figures stood at the following:

Service Area	BIAs Reviewed within last 12 months (and 1st stage signed off)	BCPs Reviewed within last 12 months (and 2nd stage signed off)	Second-stage approval achieved	Exercised within last 12 months (Service/Team Exercising)
Corporate	92% 13 out of 14	100% 14 out of 14	64% 9 out of 14	1 out of 14 7%
IUEC	100% 14 out of 14	100% 15 out of 15	100% 15 out of 15	0%
CoHo	75% 3 out of 4	75% 3 out of 4	0% 0 out of 6	0%
Community Nursing	66.6% 4 out of 6	66.6% 4 out of 6	66.6% 4 out of 6	0%
CYP/SS	100% 18 out of 18	100% 18 out of 18	100% 18 out of 18	0%
CPP	100% 3 out of 3	100% 3 out of 3	100% 3 out of 3	0%

The board should note that services have until end of June 2025 in which to complete their BC exercising as this was a new ask which went out to services in November 2024. All BCMS compliance figures are routinely reported into EPG on a quarterly basis.

8. Conclusion / Recommendations

That the committee notes the content of the report and identifies if any further action is required to provide assurance that LCHS is suitably prepared.

Appendices

Appendix 1: EPRR Core Standards – LCHS Compliance Overview
Appendix 2: EPRR Core Standards LCHS Action Plan
Appendix 3: LCHS BCMS Internal Audit Findings and Action Plan

Appendix 1: EPRR Core Standards – LCHS Compliance Overview

No.	Core Standard Domains	No of Standards	Compliance
1	Governance	6	**5 Fully Compliant** **1 Partially Compliant**
2	Duty to Risk assess	2	**2 Fully Compliant**
3	Duty to maintain plans	11	**9 Fully Compliant** **2 Partially Compliant**
4	Command & Control (C2)	2	**2 Fully Compliant**
5	Training and Exercising	4	**3 Fully Compliant** **1 Partially Compliant**
6	Response	5	**5 Fully Compliant**
7	Warning and Informing	4	**3 Fully Compliant** **1 Partially Compliant**
8	Cooperation	4	**4 Fully Compliant**
9	Business Continuity	10	**7 Fully Compliant** **3 Partially Compliant**
10	CBRN	10	**9 Fully Compliant** **1 Partially Compliant**

Appendix 2: EPRR Core Standards LCHS Action Plan

No.	Core Standard	LCHS Self-Assessment Deficiency / NHSE Feedback	Action Required	Accountable Team/Person	Timescale
3	**EPRR Board Reports**	Exercising was listed well in the Board Report that was provided as evidence but the training overview needed more detail. Learning was very briefly touched on, suggest including more detail including figures of staff trained against Key Performance Indicators as a percentage.	Cover off in more detail those sections required when writing the EPRR Annual Report in November/December 2024 like lessons learned etc (NHSE.ICB Feedback).	AEO / EP Team	April 25
14	**Countermeasures**	Self-assessed as partial – no challenge from NHSE.	To work with ICB to understand what more Community Trust needs to input into this plan / process and what will get us fully compliant.	EP Team	May 25
17	**Lockdown**	Self-assessed as partial – no challenge from NHSE.	Support wards and departments in the creation of Lockdown plans appropriate to their size and scope. Ensure a training, exercising and audit program is in place.	Fire and Security Team and EP Team	Sep 25

25	**Staff Awareness & Training**	LCHS did not have an all-staff training package in place.	Incorporate ULHT all staff EPRR awareness training into LCHS and ensure compliance rates are recorded/able to be pulled.	EP Team	June 2025
35	**Communication with Partners & Stakeholders**	LCHS EPRR statement was not published online in the organisational statement of accounts. Self-assessed as partial. No challenges.	Only outstanding action for this should be publication of org annual report which didn't occur before 30 August 2024 deadline. This was raised to Director of Corporate Governance and AEO and will ensure this is captured next year in 2025.	EP Team / Comms Team	June 2025
51	**BC Audit**	Self-assessed as partial. No challenges.	Ensure a full BC internal report is written with remedial actions and presented to EPG before evidence deadline next year. What have currently might suffice for fully compliant for this 'LCHS BCMS Internal Audit & KPIs - 22 July 2024' but NHSE / ICB might be able to advise if this meets compliance standard or not. If not, to take feedback and rope into internal audit process next year.	EP Team	June 2025

52	**BCMS Continuous Improvement Process**	As was first time implementing a new BCMS system this year 2024 we didn't have enough accrued evidence to submit to be FC. Self-assessed as partial. No challenges.	As was first time implementing a new BCMS system this year 2024 we didn't have enough accrued evidence to submit to be FC. But by summer 2025 we should have enough evidence from the current BCMS process accrued to move to fully compliant including: - EPG mins / agendas - upward reporting (quarterly and annual report) - Lessons learned database - After Action Reviews / debriefs - Exercise reports. - internal audit report."	EP Team	June 2025
53	**Assurance of Commissioned Providers / Supplier BCPs**	Process not fully established or sufficient evidence to show this was being undertaken within LCHS. Self-assessed as partial. No challenges.	To link in with procurement team / ULTH EPRR team and see how can address this more fully / systematically under the new Group Model and update BCMS accordingly.	EP Team / Procurement Team	June 2025
56	**Hazmat / CBRN Risk Assessments**	No site risks assessments in place. Just a generic CBRN risk on Datix / EPRR risk register. Self-assessed as partial. No challenges.	Undertake CBRN site risk assessments and approve at EPG.	EP Team	January 2025

Appendix 3: LCHS BCMS Internal Audit Findings and Action Plan

LCHS BCMS Internal Audit Outline & KPIs– 22 July 2024

Audit Undertakers:

Lorna Adlington – Head of Quality, Safety and Risk Patient Safety
Tanya Marten – Operational Response Manager

The below sets out the broad parameters for the LCHS internal audit which should take place annually as a minimum. The checklist on the following page can be amended / tailored with the below in mind to create an audit checklist.

Audit Scope:

- All BC/BCMS matters pertaining to Lincolnshire Community Health Services (LCHS).

Audit Objectives:

- To ensure LCHS has a robust and thorough BCMS and is adhering to the requirements as set out in the Trust BC and BCMS policies.

Areas of organisation to be audited:

- LCHS BC & BCMS Policy.
- BCMS Governance Structures (EPG/QCC/EPRR Reports & Papers)
- All Clinical Service Areas (BIAs and BCPs).
- All Corporate Service Areas (BIAs and BCPs).

Compliance Elements to be Audited:

- Number of BIAs/BCPs in place.
- Percentage of BIAs/BC Plans in place successfully reviewed within 12 months.
- Are plan details coherent and correct?
- BC testing / exercising results & compliance – Has every BC plan been tested/exercised at least once annually with lessons recorded?
- Staff BC Training Compliance.
- Have BC documents gone through the correct governance pathways (QSG, corporate committees, EPG etc)

Audit Methods (as appropriate / required):

- Document reviews.
- Questionnaires
- Survey
- Face to face interviews.
- Sampling / Sample dip.

Governance / Outcomes of Audit:

- Audit results should be produced in a separate report and discussed with the EPRR Lead before results are then taken to the next EPG.

No.	Audit Particulars	RAG Status	Notes/Comments	LCHS EPRR Action Plan to Address:
A. Policy & Programme Management				
1	Is a Business Continuity / Management System Policy available documenting the purpose, context, scope and governance of the Trust pertaining to BC/BCMS?		Noted that this is available and has the appropriate content. Learning – how to raise visibility across the organisation. Noted on intranet.	
2	Is the policy supported, approved, and owned by top management with effective governance & leadership?		Yes	
3	Is the scope of Business Continuity Management defined?		Scope defined in policy	
4	Is Business Continuity regularly featured as an agenda item at the Emergency Planning Group?		No visible evidence of agenda or standing agenda item	Agenda does include Business Continuity on recent agendas and will continue to do so moving forward.
5	Confirm knowledge and awareness of all BIAs and BCPs being in place across the organisation that are required.		Page 17 of policy defines who requires BCP / BIA and spreadsheet of those required and held shared.	
B. Analysis, Design & Implementation of BC Documents				

(Dip Sample of Clinical and Corporate Documents: Minimum 2x BIA and BCP from each separate service area)				
1	Is there a consistent approach to performing the BIA throughout the organisation?		Standard template, training and format. Standardised support and workshops offered.	
2	Is there a consistent approach to performing the BCP throughout the organisation?		Standard template, training and format. Standardised support and workshops offered.	
3	Does the BCP accord closely (not necessarily completely due to flexibility permission) to the NHSE BCP Checklist?		Yes	
4	Determine whether an adequate and accurate Business Impact Analysis (BIA) has been completed for the service.		IUEC – Boston and Lincoln UTC Assume accuracy as signed off by HO Urgent Care. Document thoroughly completed. High priority and high impact completed. All mitigations clearly outlined. Community Hospitals – Not accurately completed, no date, no sign off, not evidence that this is accurate. Cardiac Rehab – signed off, in date, mitigations in place and all accurately completed.	All BIAs moving forward will be quality checked briefly by EPRR Lead to ensure uniformity in completing by services.
5	Determine if the scope and objectives are documented in the BC Plan.		IUEC - Yes Cardiac Rehab – yes Community Hospitals – yes – however BCP is not signed off.	

			Learning – versions required sign off and authorisation to demonstrate accuracy and time stamp.	
6	Determine whether the Maximum Tolerable Period of Disruption (MTPD) and Recovery Time Objectives (RTO) are documented for the service.		All three BIAs have these MTPD an RTOs detailed.	
7	Determine whether the Business Continuity Plan (BCP) identifies appropriate backup and/or alternative contingencies for recovery.	Due to action cards not being fully populated.	IUEC – action cards not visible. Not all action cards thoroughly completed. On page 19 of BCP internal and external dependences are listed which provide alternative contingencies. Community hospitals – butterfly hospice – one action card. Displays contingencies and back up. Cardiac Rehab – detailed contingencies and back up. Action cards completed.	New BCP template for 2024-25 contains detailed action cards and are mandated by services to complete unless not applicable in certain action areas. New template also contains section asking services to identify backup premises for services.
8	Determine whether the BIA & BCP identifies critical functions, services or systems relevant to the service in question.		IUEC – all detailed within BCP. Action cards to be fully completed. Cardiac Rehab – all detailed within BCP. Butterfly – all completed.	
9	Determine whether the BIA & BCP identifies critical outsourced or stakeholder activities.		Detailed in all three services, however not all documented in the same section of the template. Not standardised.	

10	Determine whether the Recovery Point Objective (RPO) is documented		Not clear within documentation if covered.	RPO is slightly unclear as a whole and its inclusion but EPRR Lead aware and considering this element.
11	Determine if document / version controls are appropriate and compliant for BIAs and BCPs.		Current documents are not all signed off and authorised. In year reviews are underway. No current in date BCPs / BIAs	Version control in place for new BIA and BCP templates.
12	Determine if appropriate action cards are in place within the BCPs.		Not all currently up to date in UEC. Audit showed updated cards in place in CH and CYPSS.	All BCPs moving forward will be quality checked briefly by EPRR Lead to ensure uniformity in completing by services.
13	Take into consideration Equality and Health Inequalities factoring in the Public Sector Equality Duty (PSED) when developing Business Continuity Plans.		This is not visible within the plans	Unsure what this requires but to look into for next year review period.
14	Determine if supplier dependencies and contingencies are mapped.		Butterfly – yes IUEC – information is missing Adult Therapy – information is missing. Some information is available.	New BCP templates has specific sections for identifying supplier dependencies and contingencies both internal within LCHS and externally.
C. Validation ***(Dip Sample of Clinical and Corporate Documents: Minimum 2x BIA and BCP from each separate service area)***				
1	Determine whether the BCP has been appropriately tested/exercised within the last 12 months.		Training and exercise log exists on the template but are not completed within those reviewed as part of dip sample	Putting in exercise regime for services for year coming 2024-25 and tracking completion via central spreadsheet.
	Has the Business Continuity Plan, Business Impact Analysis & associated documents undergone a review in line with		Services are currently undertaking annual review of documentation in	

2	the organisation's procedures and timescales as defined within the Business Continuity Policy to ensure relevance and accuracy?		line with local policy and as part of review across the 'group'	
3	Evidence that the Business Continuity lifecycle (BIAs, BCPs & exercising) have been reviewed through internal audit.		No evidence available.	Audit folders for BC tidied up so easier to find evidence as one was done last year.
4	Determine whether corrective and preventative findings have been documented and communicated.		No evidence available	Moving forward, BC audit findings/action plan will be standing agenda item on EPG as for previous year it wasn't.
5	Has the BIA/BCP been validated via the stated governance processes (QSG for clinical BC and committees governing corporate side or EPG)		No evidence within the sign off process / front page to demonstrate this sign off process has been completed.	New central spreadsheet tracks governance sign-off and new templates have better sign-off / front pages.
6	Determine if the providers of contracted services/suppliers are being assured in accordance with the process established within the BCMS.		No evidence	This one is tricky generally but EPRR Lead looking into / addressing for year coming.
7	Determine whether appropriate business continuity risks are documented in Divisional / Departmental risk registers and/or the Trusts risk register.		Good visibility of risk	
8	Evidence of BC Training / training records and if these are accurate, clear and sufficient.		Training resources are available but there is no evidence of training records and training undertaken.	EPRR Lead unclear on BC training requirements / it is something being investigated for year coming.
9	Evidence of EPG oversight of key BC KPIs.		TOR and standard agenda in place. No clear review specifically for KPIs.	KPIs shall be reported to August 2024 EPG and are evaluated/ added in by the EPRR Lead to this audit below.

10.	Liaise with Digital Health/Arden & GEM and attain copy of relevant cyber/IT services BIA & BCP and: • Ensure BIA and BCP have been reviewed within previous 12 months. • Contains details of LCHS core systems, critical services and functions and their prioritisation for recovery. Contact details for key personnel.		No evidence of this.	EPRR Lead to accrue Arden & GEM BC plans or at least make sure Digital Health have most up to date copy.
D. Embedding				
1	Evidence of staff knowledge around BC within the organisation. This could take place as a short questionnaire / survey with a sample of staff from each service area. Questions should include as a minimum: • Are you aware of the Trust BC and BCMS Policies? • Do you understand what is meant by business Continuity? • Do you know what your role would be in a business continuity incident? (relevant to your service area) • Do you know how to access / find your service area BIA and BCP? • Are you aware of your BCP Action cards? • To the best of your knowledge/awareness, has your		Local staff knowledge within UTCs and Community hospital wards has been tested through local survey / questionnaire. CBRN testing at UTCs (un-announced visits) on workplan and signed as completed. Evacuation and shelter review in community hospitals. Establishing roles and process. There is some evidence of this.	EPRR Lead to look into a staff survey for BC to garner more detailed responses and metrics. To do this in 2024 and report findings to EPG.

	service area undertaken a BC exercise within the last 12 months? • Have you had any role or input into your service BIA/BCP? • Have you had any communication from your service area leads regarding Business Continuity?			
2	Determine whether the Business Continuity / BCMS Policies identify appropriate training requirements.		Training support is visible within the policy but training requirements need to be strengthened. More detailed information is available within the BC procedure. It would be useful of training needs were specified.	BC training still being worked out for year coming and this will be updated in policies once clarified.

Business Continuity Key Performance Indicators (KPIs) for September 2023 – Augst 2024

(Information as of 06 August 2024)

KPI	Has the KPI Been Met / Result?	Action to Address if Required
Number of BIAs/BCPs in place per Division/Department area.	Every service/team area has an old template (v1) BIA/BCP in place. New templates for August 2024: IUEC: 0 CYP/SS: 1 CPP: 1 CoHo: 0 CN: 0 Corporate: 4	New templates to be issued to all services and for service leads to review how many BIAs / BCPs they need and confirm these numbers.
Number of BIAs/BCPs reviewed at least annually (must be 90% minimum of total)	Number of plans moved onto new templates / reviewed for August 2024: IUEC: 0 CYP/SS: 1 CPP: 1 CoHo: 0 CN: 0 Corporate: 4	Regular reminders to services to review their BIAs and BCPs before the end date of the next review period which will be 15 April – 30 June 2025.
Number of staff trained in BC	Zero at current.	BC training to be included as part of all-staff EPRR training via ESR.

Number of plans exercised/tested within an annual period (must be 90% minimum)	CoHo, CN, CYP/SS, IUEC and Ops Centre BC Plans tested in annual tabletop exercise (Ex Pressure Gauge – 04 July 2024). No other specific or team level exercises carried out.	Roll out team/service area exercise templates and reports. Regular reminders for services to complete exercising by 30 June 2025.
BC Lessons learned for Sep 2023 – August 2024 (total lessons, lessons completed and lessons outstanding).	BC Lessons Learned: 6 BC Lessons Completed: 0 BC Lessons Outstanding: 6	Complete those 6 BC lessons from 2023-24. Ensure BC learning is captured and actioned from incidents and exercises throughout 2024-25.

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NHS
Lincolnshire Community and Hospitals NHS Group

Emergency Preparedness, Resilience and Response (EPRR) Annual Report ULTH: Finance and Performance Committee

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

Meeting	Finance and Performance Committee
Date of Meeting	*Thursday 22nd May 2025*
Item Number	*9.1*

Report Title

Accountable Director	Mike Parkhill, Accountable Emergency Officer
Presented by	Mike Parkhill, Accountable Emergency Officer
Author(s)	Nick Leeming, Head of Emergency Planning (EP)
Recommendations/ Decision Required	*The Board is asked to note the content of the report and identify if any further action is required to provide assurance that ULTH is suitably prepared*

How the report supports the delivery of the LCHG strategic aims & objectives	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings	*X*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	*X*
2b: Empower our people to continuously improve and innovate	*X*
2c: Nurture compassionate and diverse leadership	*X*
2d: Recognising our people through thanks and celebration	*X*
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*X*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	*X*
3c: Enhance our digital, research & innovation capability	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	*X*

Executive Summary

Summary/Key Points:

- ULTH has been assessed by NHS England as fully compliant on 57 of the 62 Core Standards and partially compliant for 5.

- As presented at confirm & challenge, it is both our and the ICB belief ULTH is fully compliant with Core Standard 2 and this has been reflected within our final self-assessment submission (58 out of 62).

The Action Plan at Appendix 2 details the work required and timescales to address areas of non-compliance.

1. PURPOSE

1.1. The purpose of this report is to provide the Trust Board with an overview of the ULTH's current position in relation to compliance against the NHS Core Standards for EPRR.

2. LEGISLATION AND GUIDANCE

2.1. The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England.

2.2. Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.

3. NHS CORE STANDARDS PURPOSE AND PROCESS

3.1. NHS England produce a set of EPRR Core Standards (CS) whose purpose is to:

- Enable health agencies across the country to share a common approach to EPRR
- Allow co-ordination of EPRR activities according to the organisation's size and scope
- Provide a consistent and cohesive framework for EPRR activities
- Inform the organisation's annual EPRR work programme.

3.2. 62 CS are applicable to Acute Trusts and the EP team self assess compliance for each CS as either Non, Partial or Fully compliant whilst providing evidence to support this. The Lincolnshire Integrated Care Board (ICB) and NHS England then audit all evidence and determine if the self assessment is correct.

3.3. For 2024 ULTH has been assessed by NHS England as fully compliant on 57 of the 62 Core Standards and partially compliant for 5.

3.4. NHS England challenged our compliance against Core Standard 2 as the EPRR Policy and Annual Report had been presented to the FPEC and not to the board directly. This contradicts all previous assessments where FPEC has been deemed a direct representative of the Board. As presented at confirm & challenge, it both ourselves and the ICB believe that ULTH is fully compliant with Core Standard 2 for this year and this has been reflected within our final self-assessment submission (58 out of 62). This gives an overall compliance of 94% which makes ULTH substantially compliant overall.

3.5. The ICB have recommended that we submit this Annual report and the EPPR Policy directly to the Board in order to maintain full compliance with Corse Standard 2 for the 2025 review.

3.6. Details of each area of non-compliance, together with the actions and timeframes to achieve compliance are set out in Appendix 2. Oversight of the implementation of outstanding actions is undertaken by FPEC through the Emergency Planning Group on a quarterly basis.

4. Training and Exercising:

4.1. Since the previous annual report in January 2024 the following has been achieved:

- 6 Strategic Commanders were trained.
- 5 Tactical Commanders were trained.
- The Trust Mandatory Major Incident training (ESR) averaged 92% this compared favourably to the 88% average in 2023.
- The Trust took part in the following regional exercises:
    - Ex Solana Fury – which explored the health response to heatwave pressures in England in conjunction with multiple operational pressures/scenarios and the interdependencies with Local Resilience Forum (LRF) partners in responding to these pressures.
    - Ex IMP – a multi agency CBRN event.
    - Ex Winter Wren - LRF winter preparedness exercise.
    - Ex Blue Kite – a multi agency ‘EMERGO’ training exercise that explored the response to a mass casualty event.
    - Ex Blue Snapper – a SitRep Exercise
- The EP and Digital Services team delivered the following internal tabletop exercise:
    - Ex Penfold - exercise to test the denial of the blood tracking service due to software attack.
- The EP team delivered a live CBRN decontamination exercise at Grantham District Hospital.

5. Additional Assurance Processes:

5.1. The following actions were undertaken to help maintain compliance:

- The EPRR workplan and assurance documents were reviewed on a monthly basis.
- The risk register was reviewed via Datix for EPRR risks on a monthly basis.
- The A&E staff at Lincoln and Pilgrim and Grantham were randomly selected each quarter and given a verbal test of their knowledge for the following:

    - How to respond to a Major Incident
    - How to treat a self-presenting casualty that is contaminated
    - How to register an unknown patient in accordance with national guidelines

- The CBRN maintenance, storage and servicing of the CBRN equipment at the Lincoln, Pilgrim and Grantham sites were checked by the EP team - The CBRN leads are maintaining excellent standards in this regard. EMAS also undertook an independent audit of the Lincoln and Pilgrim sites (with extremely positive feedback).
- Communication cascade tests were successfully undertaken quarterly at the Lincoln, Pilgrim and Grantham sites.
- The designated Incident Control Centre areas for Lincoln, Pilgrim and Grantham hospitals were inspected quarterly to ensure that they remain fit for purpose.
- The following plans and policies were updated and approved at the EPG:

    - Pandemic Infection Plan
    - Incident Response Plan
    - Incident Response Communications Plan
    - VIP Policy
    - Industrial Relations Action Plan
    - BCMS
    - EPRR Policy
    - Mass Casualty Plan
    - Adverse Weather Plan
    - Lockdown Policy
    - BC Policy
    - CBRN Decontainer Plan
    - Lincoln Evac Plan
    - Pilgrim Evac Plan
    - Grantham Evac Plan
    - Incident Response Communications Plan
    - EPG TORs

- ULTH representatives attended the Local Resilience Forum and Health Emergency Planning Operations Group meetings.
- National Occupational Standards self assessment returns were sent to all Strategic and Tactical commanders. Commanders used these questionnaires to self-assess their knowledge and understanding of how to respond to emergencies identify any areas in which they feel that they require additional training. The returns allowed the EP team to identify any trends in areas that require improved training and also to provide bespoke training where required.
- Staff tests of knowledge with respect to Major Incident response were undertaken at all three hospitals.
- Communications cascade tests were undertaken at all three hospitals.

6. Major, Critical and Business Continuity Incidents

6.1. The following Critical Incidents were experienced since the previous annual report in January 2024:

- A Critical Incident (CI) was declared on 30th January when a fractured water pipe was found in the underground network by the estates team. This pipe was identified as the main feed to the Lincoln Site. The damage was too severe to repair so a large section was replaced and the CI was stood down the same day when this had been done.
- A CI was declared on 4th December due to a loss of critical IT systems, telephone lines and continued pressure on ULTH urgent and emergency care pathways. Although all systems were recovered in the morning, the resulting extra pressure on pathways meant that the CI was not stood down until the early evening of that day.

6.2. The following Business Continuity Incidents (BCI) were declared since the previous annual report in January 2024:

- A BCI was declared on the 19th July 2024 for IT issues affecting the PACS systems, Health Roster and Radiology reporting.
- A BCI was declared on 16th December 2024 due to a failure of an Air Handling Unit in the Catheter Lab.
- A BCI was declared on the 4th and 5th March 2025 when Pilgrim Hospital's high voltage system tripped out during a planned electrical test. This resulted in many areas remaining on emergency power supplies or in some areas (including some diagnostics) losing all power.
- A BCI was declared on the 24th March 2025 when Lincoln County Hospital experienced a loss of water supply feed to the main site.

6.3. Lessons and Learning:

- Structured debriefs for both CIs were delivered.
- Debriefs were undertaken for each BCI. Lessons identified were used to update Business Continuity Plans appropriately.

- Full reports for each Incident (with associated action logs) were produced and sent to all relevant members within the Group and to the ICB and NHS England for wider learning.
- All actions within the reports were added to a Lessons Identified Log that is scrutinised monthly by the EP Team and quarterly at EPG meetings.

7. Business Continuity

7.1. Divisional Directors for Surgery, Medicine, Clinical Support Service and Family Health are challenged to provide comprehensive answers to the questions below at every EPG:

- How many plans their Division require
- How many of those plans have had BC Lead allocated to them
- How many of the required Business Impact Analysis (BIA) have been written
- How many of the required Business Continuity Plans (BCP) have been written
- How many of the BIAs and BCPs have been tested in the last 12 months

7.2. Progress against these metrics is tracked and reported to the board via the Finance Performance and Estates Committee via formal report post each EPG.

7.3. The Corporate and Estates & Facilities divisions are currently identifying the plans that they require and will be required to provide the information listed above at future EPG meetings in 2025.

7.4. Since the previous annual report in January in 2024 the EP Team delivered 30 tabletop exercises for Business Continuity Plans to provide an independent testing regime.

8. Independent Assurance Review of Business Continuity and Emergency Planning

8.1. During 2024 TIAA (a Business Assurance Services Auditor) undertook an external audit of the ULTH Business Continuity and Emergency Planning. The audit was completed in October and final report declared that the EPRR and BC program for ULTH is providing '**Reasonable Assurance'** for processes and controls in place to respond to an emergency situation and business continuity.

8.2. The report highlighted 6 action points; none were urgent, 1 was important, 2 were routine and 3 were operational. All action points have either been addressed or an action plan is in place to achieve compliance.

9. RECOMMENDATIONS

That the committee notes the content of the report and identifies if any further action is required to provide assurance that ULTH is suitably prepared.

Appendix 1: EPRR Core Standards ULTH Compliance Overview:

No.	Core Standard Domains	No of Standards	Compliance
1	Governance	6	**Fully Compliant**
2	Duty to Risk assess	2	**Fully Compliant**
3	Duty to maintain plans	11	**9 Fully Compliant** **2 Partially Compliant**
4	Command & Control (C2)	2	**Fully Compliant**
5	Training and Exercising	4	**Fully Compliant**
6	Response	7	**6 Fully Compliant** **1 Partially Compliant**
7	Warning and Informing	4	**Fully Compliant**
8	Cooperation	4	**Fully Compliant**
9	Business Continuity	10	**9 Fully Compliant** **1 Partially Compliant**
10	CBRN	12	**Fully Compliant**

Appendix 2:
EPRR Core Standards ULTH Action Plan

No.	Core Standard	ULTH Self-Assessment Deficiency / NHSE Feedback	Action Required	Accountable Team/Person	Timescale
Duty to Maintain Plans					
14	**Countermeasures:** In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment.	Lincolnshire LRF executives had previously agreed that a hub and spoke model was the best solution for Lincolnshire. ULTH had a local plan to receive the bulk medication then breakdown and distribute mass prophylaxis to remote distribution centres. In July 24, the LRF requested that ULTH re-write the plan to distribute the mass prophylaxis at the Lincoln and Pilgrim sites. Work has now begun to create a plan to achieve the new directive.	A new plan is currently being written which will draw out the 'asks' from system partners (security, rotoring and communication of arrival times to patients etc). This may require a separate system plan.	EP Team	May 25
17	**Lockdown:** In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Due to structural obstacles, locking down corridors or large rooms rather than wards will be considered in order to provide 'Safe Havens'. In office spaces where this is also not feasible the national 'Run-Hide-Tell' protocol will be advised. Each level of response will be implemented based on Security Risk Assessments, CTR levels, and historic incidents captured on Datix. These various lockdown options will be able to be implemented using the progressive, incremental and full lockdowns, however, as they are scaled to an appropriate level for the area or ward, it is anticipated that the process will be far more efficient. The use of Snap Comms, Ambulance Safe Routes, Who can activate a lockdown, and Lockdown Card Templates are also being reviewed.	Support wards and departments in the creation of Lockdown plans. EP Team to conduct exercise of perimeter lockdown at GDH, with subsequent exercises conducted at PHB and LCH after a thorough Post-exercise review identifying lessons learnt has been completed.	Fire and Security Team and EP Team	Sep 25

Response					
29	**Decision Logging:** To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Although the Trust does not have the funding for 24 hour loggists, we do hold a list of trained loggists within the trust that may be called upon. These staff have often worked outside their core hours to fulfil loggist duties.	Now we have a Group model, the possibility of forming an on call rota, utilising loggists from both Trusts is being explored.	AEO and EP Team	May 25
Business Continuity					
49	**Data Protection and Security Toolkit:** Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Information Governance identified 3 areas of non-compliance this year.	An action plan has been put in place **DSPT_Improvement_plan_RWD_V1.03** and approved by NHS England	Information Governance	As per Improvement Plan

NHS
Lincolnshire Community and Hospitals NHS Group

Finance Briefing

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*1 July 2025*
Item Number	*8.5*

Finance Report

Accountable Director	*Paul Antunes Goncalves, Group Chief Finance Officer*
Presented by	*Paul Antunes Goncalves, Group Chief Finance Officer*
Author(s)	*Finance Team*
Recommendations/ Decision Required	*The Board is asked to:-* • Note the contents of the Finance report in respect of Revenue, Capital, Cash and CIP positions. • Note the three key areas of focus – delivery of our variable income, delivery of our efficiency target and workforce controls (bank and agency). • Note the additional capital allocation into the system of £6m relating urgent and emergency care performance.

How the report supports the delivery of the LCHG strategic aims & objectives	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
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	*X*
1d: Provide modern, clean and fit for purpose care settings	
People: Better Opportunities – Develop, empower and retain great people:	
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	
Population: Better Health – Improve population health:	
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, research & innovation capability	
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	

Executive Summary

The Board is asked to note the following:

- **2025/26 Revenue position M2 YTD (Year to date)**
  The Group delivered a £8.1m deficit (£0.1m better than planned).

- **2025/25 Capital position M2 YTD**
  The Group delivered capital expenditure of £3.3m (£1.7m lower than planned).

- **2024/25 CIP position M2 YTD**
  The Group delivered savings of £5.9m (£0.2m better than planned).

- **M2 Cash position**
  The Group ended the month with a cash balance of £39.1m (£2.3m **higher** than planned).

Main Body
which should not exceed 5 sides of A4

Lincolnshire Community and Hospitals NHS Group
Trust Board – 1 July 2025
Finance Briefing

Executive Summary

The Group have started the year in line with plan, which has been supported by a small over delivery on our efficiency programme of £0.2m. The Group is required to increase our savings as we progress through the year which will return the Group to financial balance by 31 March 2026.

The Group have three key areas of focus to support the revenue position: variable income delivery, efficiency delivery and workforce controls (bank and agency). These are at the centre of our discussions with our care groups to ensure delivery of our financial plan.

Our capital spend is behind our planned level, mainly driven by delays in approval, it is anticipated that this will be recovered by the end of the financial year. Since our plan submission, ULTH has been advised of a further £1m award in recognition of being amongst the top 10 most improved Trusts against the 4-hour performance target in 2024/25. In addition, the Lincolnshire System is also to receive £5m extra, as a reward for being the 2nd most improved System in 2024/25 against the Cat 2 response time target. This will allow for additional capital spend to be made to our front-line services.

The cash position is £2.3m ahead of plan, with a cash balance at the end of month 2 of £39.1m. The Group will need to ensure we are monitoring our cash position linked to the revenue profile during the financial year.

Summary Position

Month 2 Position	Group performance			LCHS performance			ULTH performance		
	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)	(8.2)	(8.1)	0.1	(1.1)	(1.0)	0.1	(7.1)	(7.1)	0.0
CIP Delivery	5.7	5.9	0.2	0.5	0.7	0.2	5.2	5.3	0.0
Capital Spend	5.0	3.3	(1.7)	1.5	1.2	(0.3)	3.5	2.1	(1.4)
Agency Spend	(2.7)	(3.4)	(0.8)	(0.1)	(0.3)	(0.2)	(2.6)	(3.2)	(0.6)
Cash Balance	36.8	39.1	2.3	25.7	25.1	(0.6)	11.1	14.0	2.9

Revenue Position

The Group's financial position is an £8.1m deficit after two months, this position is £0.1m better than our planned position. Although we are better than plan the monthly position must improve significantly to ensure delivery of our breakeven position at the end of the year. A key driver of the improved performance is the phasing of our efficiency plans that step up at month 4 and month 7.

There are three key areas of focus to ensure delivery of our financial position:

1. **Delivery of our variable income** – The Group is required to delivery on our planned care activity, which is subject to variable payment e.g. we will only be paid for the work we undertake. At month 2, ULTH is behind our planned level and required improvement. This is being driven through our planned care board with a key focus on our outpatient activity.

2. **Delivery of our efficiency target -** Although efficiency delivery is slightly ahead at the end of month 2, some schemes have not delivered as intended. Additional assurance meetings have taken place with our care groups to understand risk and develop mitigations. This position is a key area of focus and is reported weekly to executive colleagues.

3. **Workforce controls (Bank and Agency)** – Although our whole-time equivalent position is reducing month on month, the level of reduction is behind our workforce plan. A key driver of this is our temporary workforce, workforce colleagues are working with our nursing and medical teams on addressing this position at pace.

The Group continues to have in place enhanced vacancy controls through our executive led vacancy control process, this is informed by our Quality Impact Assessment. We are also targeting our non-pay discretionary spend with enhanced approvals also required for spend on specific categories.

Capital Position

The Group has the largest ever capital programme of £119.9m with key schemes including Community Diagnostic Centre at Boston, first year of our ePR, new ED department at Pilgrim Hospital and Endoscopy improvements.

At month 2 the Group were £1.7m behind our capital plan, this was driven by delays on approvals for our ePR and Community Diagnostic Centre. These have now been received, and progress is underway.

The capital resource limit award of £1.0m direct to ULTH and £5.0m to the Lincolnshire system in recognition of the improvement in performance demonstrated in 2024/25 against urgent and emergency care targets.

Since our plan submission, ULTH has been advised of a further £1m award in recognition of being amongst the top 10 most improved Trusts against the 4-hour performance target in 2024/25. In addition, the Lincolnshire System is also to receive £5m extra, as a reward for being the 2nd most improved System in 2024/25 against the Cat 2 response time target. This will allow for additional spend to be made to our front-line services. This allocation of £6m is not cash backed.

2024/25 Annual Accounts

In line with the national timetable, the Group have completed the annual accounts for both organisations. I would like to thank the team for all the hard work that has gone into the process.

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	*1 July 2025*
Item Number	*9.1*

People Committee Upward Report of the meeting held on 21 May 2025

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Vicki Wells, Non-Executive Director*
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 2025/26 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 – Enable our people to fulfil their potential through training, development and education

Education Oversight Group Upward Report
The Committee received the report with **assurance** noting that statutory and mandatory training compliance was about the 90% KPI. Continuing Professional Development (CPD) spend was also noted as fully allocated and reconciled for the 2024/25 year.

The Committee recognised the 129% achievement of the apprenticeship levy and was pleased to note that the group had implemented the KPI dashboard.

The national programme, which would support staff transferring to a new place of work, had now been signed up to by all NHS organisations. This meant that training records, for statutory and mandatory training, would transfer with staff, resulting in hours being saved.

Safer Staffing Nursing and AHP
The Committee received the joint report with **assurance** noting that safe care compliance had improved to 90% and a reduction in harms from falls had been seen in the community.

The benchmarking in community nursing demonstrated higher contact rates but shorter interactions, indicating a need to shift further from task-based activities to caseload-based care.

A review of job profiles was now underway following the release of the national agenda for change job profiles to ensure these were aligned.

Ward Establishment Review update
The Committee received the update noting that the submission had not been made due to the data quality issues that had been identified. The assurance report identified that there had been no impact on patient harm and positive increases were noted within the staff survey.

A well-being programme was in place to support staff due to sickness rates.

Safer Staffing Medical
The Committee received the report with **assurance** noting the ongoing development of the report. A significant improvement in the vacancy rate for medical staff was noted with the rate reported at 6.4% with sickness rates remaining low across the staff group.

Bank and agency spend remained high in urgent care, in line with national trends and the Committee requested further detail in respect of recruitment challenges in future reports.

Urgent Care Update – outline of work undertaken to support staff
The Committee received the report with **assurance** noting the ongoing work to support staff within urgent care following historical issues that had been raised.

There had been ongoing support from the organisational development team to ensure that the ED leaders could provide support despite operational pressures.

The Committee requested a further update be provided in 6-months to demonstrate the benefits of the support as well as to identify lessons learned that could be applied in other areas.

Assurance in respect of Objective 2b – Empower our people to continuously improve and innovate

Workforce Strategy Group Upward Report and Committee Performance Dashboard
The Committee received the upward report and performance dashboards noting that sickness within ULTH had stabilised however an increase was noted within LCHS, primarily due to anxiety and depression.

Job planning compliance had achieved 88.5% for the 24/25 year and the 25/26 year to date had a compliance rate of 49.15%.

The Committee noted the importance of return to work interviews being completed to support staff who had had a period of sickness and recognised the development of the Managing Attendance Policy across the Group.

Band 2 and Band 3 Financial Output/Analysis and final outcomes of consultation – LCHS/ULTH
The Committee received the report with **assurance** noting that 223 ULTH staff and 17 LCHS staff had opted to remain at band 2.

1700 staff would need to complete the care certificate training in order to achieve the uplift and dedicated Talent Academy resource had been allocated to accelerate the training programme. It was anticipated that, due to the volume of staff requiring training, this would be completed by March 2026.

Guardian of Safe Working Quarterly Report
The Committee received the report with **assurance** noting the position presented and would receive the annual report to the June meeting.

Assurance in respect of Objective 2c – Nurture compassionate and diverse leadership

Culture and Leadership Group Upward Report
The Committee received the report noting that the launch of the new Group values and Better Together event had taken place with the development of a leadership framework underway.

The group had reviewed the health and well-being action plan with the Committee noting that all 32 actions were on track for delivery. Progress was noted on the Just Culture programme with a new e-learning package in place.

There was a recognition of the need to align the cultural work across all professional groups with support offered from the Group Chief Nurse to bring the various groups together.

Development of AAC Recruitment
The Committee received the report with **assurance** noting the ongoing development of the recruitment process. There had been a number of issues noted by the Committee which were anticipated to be resolved through the intended improvements.

Staff Survey Feedback and Plan
The Committee received the report for information noting that due to the timing of data availability this had been received by the Board in May. Action plans were currently being developed at a local level and would be reviewed through the Group Leadership Team.

Assurance in respect of Objective 2d – Recognising our people through thanks and celebration

Assurance report discussion
The Committee noted the need to consider the reports required that would provide assurance in respect of objective 2d, noting that this would include staff stories, as a way to celebrate staff.

Assurance in respect of other areas

Group Board Assurance Framework 2025/26
The Committee received the Board Assurance Framework noting the progress to populate the template effectively.

The assurance and risk ratings were noted with the Committee requesting that this also be shared with the Committee reporting groups to support the update process and proposal of assurance levels.

Risk Report
The Committee received the joint report with **assurance** noting that the risks remained static with a deep dive session due to take place to confirm that the appropriate risks were being reviewed by the Committee.

Policy Position Update
The Committee received the report noting the position presented and recognised the progress in respect of the development of Group policies with a prioritised approach taking place to address contractual policies in the first instance.

Internal Audit Recommendations
The Committee received the report noting the open recommendations.

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	J	J	A	S	O	N	D	J	F	M	A	M
Phil Baker, Non-Executive Director, ULTH (Chair)					X	X	X	X	X	X		
Vicki Wells, Non-Executive Director (Chair – from March 25)					X	X	X	X	X	X	X	X
Gail Shadlock, Non-Executive Director, LCHS					X	A	X	X	A	A	X	X
Claire Low, Group Chief People Officer					X	D	X	X	X	X	D	X
Colin Farquharson Group Chief Medical Officer					D	X	X	A	D	X	X	X
Nerea Odongo, Group Chief Nurse					X	X	X	X	D	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	*1 July 2025*
Item Number	*Item*

People Committee Upward Report of the meeting held on 24 June 2025

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Vicki Wells, Non-Executive Director*
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 2025/26 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 – Enable our people to fulfil their potential through training, development and education

Education Oversight Group Upward Report
The Committee received the report noting the continued positive performance in relation to statutory and mandatory training, above the national average.

The Committee was pleased to note the ongoing use of apprenticeships across the Group in all staff areas and noted the discussions in respect of Advanced Clinical Practitioner development and the use of the Continuing Professional Development (CPD) funding.

Changes to the apprenticeship levy were noted in respect of this now not being available for level 7 apprenticeships however discussions were taking place with a local university to understand how these could continue to be supported.

Safer Staffing Nursing and AHP
The Committee received the joint report with **assurance** noting that there had been an increase in nursing vacancies within ULTH which aligned to the Cost Improvement Programme (CIP) plans to return to establishment levels.

Recruitment drives had been undertaken in respect of Health Care Support Workers to drive the vacancy position down and SafeCare had been embedded in Community Hospital Wards.

The Committee noted the work being undertaken in respect of professional judgement and skill mix review due to an increase in falls and pressure ulcers, not related to staffing levels.

A number of areas of concern were noted however actions were being taken to address these, including supporting international nurses to gain driving licences.

Safer Staffing Medical
The Committee received the report with **assurance** noting that additional information had been provided within the report to focus on areas of concerns in respect of vacancies.

A low vacancy rate was noted for ULTH at 6.7% which was noted as positive with a sickness rate of 2.22%. Whilst the LCHS vacancy rate was noted as 26% (there was a recognition that the WTE was low due to the workforce within the Trust).

The Committee noted the Extra Contractual Rate (ECR) recognising that local negotiations with the British Medical Association had been ceased at national level. This would result in increased control processes, due to the cost implications, and would likely drive-up bank and agency use as a result.

Medical Education Update
The Committee received the report noting the recent positive feedback from NHS England, following a number of trainees participating in engagement sessions.

Education space was noted as a concern by the Committee and noted that, whilst education could at times be delivered virtually, the volume of equipment required for face-to-face training limited the spaces that could be utilised.

The Committee noted the recent release of the General Medical Council (GMC) survey with results expected to be received in August.

Challenges were noted in undergraduate training where vacancies existed in difficult to recruit to posts. This results in additional costs due to the need to fund training where agency and locum doctors are unable to teach.

Volunteer Workforce
Following the referral from the Quality Committee in respect of the volunteer workforce the Committee received the report noting the number of volunteers across the Group with a drive in recruitment being undertaken.

The Committee noted the significant number of hours offered by volunteers and considered the benefit of receiving a staff story from a volunteer perspective.

A further update would be offered to the Committee in 6-months so that the Committee could continue to have oversight of this element of the workforce.

The Committee noted the recent celebration events for volunteer's week where the Group had held events across the county in order to recognise the significant contribution made by volunteers.

Assurance in respect of Objective 2b – Empower our people to continuously improve and innovate

Workforce Strategy Group Upward Report and Committee Performance Dashboard – LCHS and ULTH
The Committee received the upward report and performance dashboards noting that vacancy rates remained above expected levels which would likely continue for the remainder of the year due to the vacancy control processes in place.

Despite the vacancy position improvements were noted in respect of AHP and HCSW vacancies with a significant pipeline due to come through in August which would support a reduction in the use of temporary staffing.

The Committee was pleased to note the reduction in sickness rates across the Group, demonstrating positive progress. The appraisal season was noted, which had been aligned across the Group, utilising the approach of LCHS as best practice. This meant that appraisals were due to be completed by the end of quarter 1 for all staff with positive progress noted to date.

Workforce Hub Upward Report
The Committee received the report with **assurance** noting the creation of the hub to support the number of change programmes being undertaken and to ensure a centralised and coordinated approach to these.

It was noted that this included Organisational Development and Health and Wellbeing support so that staff would have the right level of support where required.

Mutually Agreed Resignation Scheme Update
The Committee received the report noting the progress of the scheme to date and the assumptions made in respect of potential financial savings as a result of the scheme being undertaken. Staff will be contacted by 30th June to understand the outcome of the expression of interest in MARS applications. All applications are being assessed closely monitoring the risk associated with supporting applications.

Response to agency letter from Department of Health
The Committee received the report noting the requirements to respond to and take action in respect of agency usage. The Committee noted that the actions required were already being undertaken across the Group and had been considered through other agenda items during meeting.

Guardian of Safe Working Annual Report and quarterly report
The Committee received the annual report and also considered the quarterly report in detail noting that 178 exception reports had been made in the 24/25 year.

Whilst this was noted as a slight reduction from the previous year, there was recognition of the improved access to the reporting system for Locally Employed Doctors.

Ongoing concerns were noted by the Committee including the delay in the closure of exception reports and the lack of rest spaces for resident doctors.

The Committee noted that rest spaces were inconsistent across the estate and therefore agreed to make a referral to the Integration Committee to explore this.

Assurance in respect of Objective 2c – Nurture compassionate and diverse leadership

Equality, Diversity and Inclusion (EDI) Group Upward Report
The Committee received the report and noted the need for work to be undertaken in respect of the recent reduction in EDI related scores. A deep dive would be commenced by the group to explore this is more detail and identify actions to be taken.

There was also recognition of the need to strengthen the group to ensure that quoracy was met.

Culture and Leadership Group Upward Report
The Committee received the report noting that the final contractual policy was being completed prior to publication as a Group policy with the recognition of the significant work undertaken to develop and approve these across the Group.

The volume of changes programmes across the Group were noted with the group maintaining focus on this and supporting the recent roadshows to

support staff in understanding national messages and to present the Group values.

Employee Exclusions
The Committee received the report noting that there were a total 5 exclusions across the Group, 3 for ULTH and 2 for LCHS.

Assurance in respect of Objective 2d – Recognising our people through thanks and celebration

No reports due

Assurance in respect of other areas

Group Board Assurance Framework 2025/26
The Committee received the Board Assurance Framework noting the progress in respect of the actions to address gaps in controls and assurance and noted that the assurance ratings would remain as presented.

Risk Report
The Committee received the joint report that the risks remained static however recognised the need to undertake a review to ensure these were appropriately scored and articulated.

Policy Position Update
The Committee received the report noting the position presented and the ongoing progress to develop across the Group.

Internal Audit Recommendations
The Committee received the report noting the open recommendations with an anticipation of the closure of a number of these following the submission of evidence of completion.

Issues where assurance remains outstanding for escalation to the Board

None

Items referred to other Committees for Assurance

The Committee determined a referral to the Integration Committee regarding the availability of space for doctors rest spaces would be made, following escalation by the Guardian of Safe Working

Attendance Summary for rolling 12-month period

Voting Members	J	A	S	O	N	D	J	F	M	A	M	J
Phil Baker, Non-Executive Director, ULTH (Chair)				X	X	X	X	X	X			
Vicki Wells, Non-Executive Director (Chair – from March 25)				X	X	X	X	X	X	X	X	X
Gail Shadlock, Non-Executive Director, LCHS				X	A	X	X	A	A	X	X	
Claire Low, Group Chief People Officer				X	D	X	X	X	X	D	X	X
Colin Farquharson Group Chief Medical Officer				D	X	X	A	D	X	X	X	X
Nerea Odongo, Group Chief Nurse				X	X	X	X	D	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	*1 July 2025*
Item Number	*10.1*

Integration Committee Upward Report of the meeting held on 27 May 2025

Accountable Director	*Daren Fradgley, Group Chief Integration Officer/Deputy CEO*
Presented by	*Jim Connolly, Integration Committee Deputy Chair*
Author(s)	*Jayne Warner, Director of Corp Affairs*
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 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 2025/26 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 – Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services / Objective 3b – Move from prescription to prevention, through a population health management & health inequalities approach

Estates and Facilities Update

The Committee received the report with **assurance** noting the first reporting from the Space Group. This indicated only a 50-60% utilisation rate of available space and this information would now be shared through PRMs. The Committee noted that a CIP was in place for under utilisation in order to target savings and enable monitoring.

Alliance Steering Group Upward Report
The Committee received the report noting the progress in respect of the Alliance Care Group and the planned first meeting of the Alliance Steering Group later in the month.

The Committee noted the four workstreams of the Alliance Steering Group, these being the LCHG Planned and Unplanned Care Group, left-shift redesign, Integrated Neighbourhood Teams and Health Inequalities.

Planned and Unplanned Care – The Committee noted that Care Groups were working on the lead KPIs to structure and enable the workstream. The Executive leads were able to assure the Committee that the workstream had already started to create positive impacts for patients.

Integrated Neighbourhood Teams – Relationship development continued with the PCN Alliance. A number of PCN Clinical Directors had now approached the Group to further look at ways of working more closely together.

The Committee debated the level of assurance being offered and agreed that the focus for the Committee was the assurance around the stage that the programme was at, not assurance around delivery of the full programme and asked for this clarity to be given in the upward report to Board.

The Committee considered what an Integrated Community Team would look like and agreed that this would be explored further at a future meeting. The Committee considered the potential impact of any future national industrial action against the Group's ability to deliver transformation. This was being tracked through the risk register.

ICB Target Operating Model Developments

The Committee received the report for noting that the due diligence in this area continued. The complexity of movement in some of these areas from a financial and legal perspective was noted.

Assurance in respect of Objective 3c – Enhance our digital, research and innovation capability

Electronic Document Management System (EDMS) Deep Dive

The Committee received the report with **assurance** recognising the project would be a vital part of the electronic patient record allowing information to be more readily available and on hand alongside a reduction in paper notes came savings in respect of storage, transportation and cancelled appointments. The Committee were advised that the programme was delivered over 8 years, but the Group continued to consider ways that this project could be delivered sooner.

The Committee noted that the procurement process had closed. Scanning would be able to commence by January 2026.

The Committee recognised the risk associated with staffing in this area and that timing as key in managing the workforce element as well as supporting teams impacted. The Committee would receive a further report in support of this risk.

Research and Innovation Report
The Committee received the report noting the risk to research delivery associated with the changes within the Pharmacy team. This had impacted on plans to expand capacity. Recruitment remained a focus to meet the needs of the commercial studies.

The Committee heard about an innovative potential collaboration with a university in Dubai specialising in engineering AI and cyber security.

The Committee heard the importance of the Group supporting the work to further identify areas of grants and funding and the team needed to develop in this area

Assurance in respect of Objective 3d – Drive forward our improvement and efficiency agenda including sustainability and Green Plan

Productivity, Improvement and Transformation Oversight Forum (PITOF) Upward Report
The Committee received the reports from PITOF which had been it's first meeting. The Committee were advised that the remit of the Forum was to provide assurance around transformation schemes, CIP and productivity programmes.

The Committee noted that the meeting had focussed on some of the larger cross cutting CIP schemes and had discussed how the meetings would operate and the terms of reference.

The Committee noted that completion of QIA's was a risk in terms of the volume needing to be completed and reviewed but were reassured that the approach was being phased and the Executive leads were confident of delivery.

Focussed Discussion Discharge Improvement Plan

The Committee received a report detailing the challenges within discharge and flow and offering details of the framework for operational transformation across all pathways to improve experience within hospital and community settings.

The Committee recognised that going forward performance in this area would continue to be reviewed through the Finance and Performance Committee whilst transformation remained at Integration Committee.

Quality Improvement Plan

The Committee received and noted the development of the plan which would provide a set of standards, alongside monitoring and sharing best practice and learning. The Committee noted that strong improvement methodology would be key to transformation.

Assurance in respect of other areas

Risk Report
The Committee received the report noting that there had been no changes from the previous report. A review of risks with the Quality Committee had highlighted a need to move some risks to the Integration Committee.

Board Assurance Framework 2025/26
The Committee received the 2025/26 Board Assurance Framework (BAF).

The Committee noted that the development of the content of the BAF in respect of the relevant controls, assurances and associated gaps and mitigations which were due to be completed ahead of the Board meeting.

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	M	J	J	A	S	O	N	D	J	F	M	A	M
Rebecca Brown, Non-Executive Director (Chair)							X	X	X	X	X	X	X
Gail Shadlock, Non-Executive Director, LCHS							X	X	A	A	X	X	A
Sarah Buik, Associate Non-Executive Director							X	X	X	X	X	X	X
Daren Fradgley, Group Chief Integration Officer							X	X	X	X	X	X	X
Mike Parkhill, Group Chief Estates and Facilities Officer							X	X	X	X	X	D	X

Caroline Landon, Group Chief Operating Officer							A	X	D	D	D	X	X
Claire Low, Group Chief People Officer							A						X
Colin Farquharson, Group Chief Medical Officer							A	A	X	X	X	X	D
Nerea Odongo, Group Chief Nurse							A	D	A	D	X	D	X
Kathryn Helley, Group Chief Clinical Governance Officer							A	X	X	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*
Date of Meeting	*1 July 2025*
Item Number	*10.1*

Integration Committee Upward Report of the meeting held on 19 June 2025

Accountable Director	*Daren Fradgley, Group Chief Integration Officer/Deputy CEO*
Presented by	*Jim Connolly, Deputy 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 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 2025/26 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 – Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services

Estates and Facilities Update

The Committee received the report with **assurance** noting the ongoing large-scale projects including the Pilgrim ED, maternity scheme, stroke and endoscopy project, alongside the ongoing space utilisation and other capital investments.

The ED phase 1b and 2 had commenced with the Committee noting that this remained on track for phase 1b to complete in August 2025. The maternity

scheme was in the scoping phase with the intention to develop to a stage 2 design for both Pilgrim and Lincoln Hospitals.

The Committee was pleased to note the progress of the endoscopy project which was now out of the ground and progressing well with significant improvements in service delivery excepted as a result of the investment.

Space was noted as being underutilised by 54% with actions being taken to improve space management across the Group with a specific area of work being the Urgent Treatment Centres at Skegness, Louth and Gainsborough to ensure environmental and patient flow improvements.

Objective 3b – Move from prescription to prevention, through a population health management & health inequalities approach

Alliance Steering Group Upward Report
The Committee received the report noting the establishment of an Alliance Senior Leadership Team to bring together the operational and strategic developments which would also support collaboration across the alliance.

The four workstreams of community planned and unplanned care transformation, left shift and Integrated Neighbourhood Teams (INTs) and health inequalities were noted with these providing specific areas of improvement and transformation across the Group.

Focussed discussion – Role of Integrated Neighbourhood Teams to inc regional slides
The focused discussion held by the Committee provided **assurance** on the development of the role of the INTs with the positive feedback from the regional event commended by the Committee.

There was recognition of the need to utilise health inequality and population heath data in order to appropriately develop INTs across the county, in response to population needs.

The Committee considered the need to further develop and support the education of the population in health behaviours and whilst the Group could influence this, there was a reliance on system partners delivering and supporting this.

The workstream would be monitored and upwardly reported to the Committee through the Alliance Steering Group.

TOM Group Upward Report - Verbal
The Committee received a verbal update in respect of the Target Operating Model (TOM) and noted the further developments that were taking place.

Update on AGEM digital Move
The Committee noted the ongoing work to bring the digital services to the Group from Arden and Greater East Midlands (AGEM) as part of the TOM recognising that this was due to be in place from 1 October 2025.

The services would include the Integrated Care Board (ICB) corporate digital services and GP IT which would achieve an efficiency saving of circa £710k for the ICB.

Assurance in respect of Objective 3c – Enhance our digital, research and innovation capability

Digital Delivery Plan Update
The Committee received the report with **assurance** noting the significant programmes of work being undertaken by the team and recognising the work being undertaken to prioritise the work being undertaken to ensure successful delivery.

Constraints on resource were noted, some as a result of funding availability, however actions would be progressed in areas where funding was readily available to support.

Digital Oversight Group Upward Report
The Committee received the upward report focusing on the development of the One Digital Strategy that had been finalised through the group. The Committee recommended the strategy to the Board for approval **(appended)**.

There was a recognition of the volume of programmes of work being delivered by digital services with successful delivery of the Maternity Badger Net and NHS Net in recent months. Work continued in respect of the Electronic Patient Record (EPR) with Cabinet approval received and the contract now progressing with the supplier.

Assurance in respect of Objective 3d – Drive forward our improvement and efficiency agenda including sustainability and Green Plan

Sustainability and Green Strategic Plan
The Committee received the draft Green Plans for both LCHS and ULTH noting the requirement for separate plans of the statutory organisations.

The ongoing development was recognised with a need to further define the deliverables and timelines included within the plans which would be presented back to the Committee in July.

Productivity, Improvement and Transformation Oversight Forum (PITOF) Upward Report
The Committee received the reports noting that the second PITOF meeting has been held where there was oversight of the productivity and transformation work being undertaken.

There was recognition of the continuing development of the group to ensure the right oversight and assurance was offered to the relevant Committees with focus being given in the first and second meetings to CIP and transformation projects respectively.

Assurance in respect of other areas

Board Assurance Framework 2025/26
The Committee received the Board Assurance Framework noting the ongoing work to provide updated narrative with a recognition of the significant updates provided in respect of objective 3c.

The Committee noted the assurance ratings presented and confirmed there were no changes to be proposed in month.

Committee Performance Dashboard
The Committee received the report with **assurance** noting the significant progress in the development of the performance dashboard and SPC charts in order to monitor performance.

The dashboard would include top-level views as well as the ability to drill down I to the data through interactive buttons in order to provide a comprehensive view of the performance metrics across the pathways.

Work remained ongoing to develop dashboards for each of the Committees, in conjunction with the Executive leads and Committee Chairs. The use of the dashboards through Committees and Performance Review Meetings (PRMs) would ensure consistency of information as well as accountability.

Proposal for Discharge Dashboard
The Committee received the dashboard noting that the focus was on reducing the average length of stay (LOS) in each pathway due to the quality impact being seen such as the functional decline in patients, driving up long-term health issues. Improvements achieved in LOS would also support achievement of efficiencies and financial improvements for the Group.

The proposed dashboard would enable quick identification of problem areas, allowing action to be taken to address and resolve issues. The Committee approved the use of the length of stay as a key metric and supported the direction of travel for the discharge dashboard.

Risk Report
The Committee received the report noting the position presented and recognising that, whilst there had been no changes to the risks in month, the ongoing review of the risk register would result in changes. Recommendations of the proposed risks, to be re-aligned to the Committee, would be presented in July for approval of the realignment.

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

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Caring and building a healthier future for all

One Digital strategy

2025 – 2028

v5 May 2025

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

Introduction

In April 2024, Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) came together in a Group arrangement, called the Lincolnshire Community and Hospitals NHS Group (LCHG), with the goal of improving the care provided to patients across the county.

Being part of a Group enables us to go further faster, for the benefit of our patients. Our fundamental drivers are improving how we deliver services for our patients, improving the population health of the many communities we serve and making it easier for our people to deliver the care they want to provide.

The strategic aims of this collaboration include:

- **Patients** - ensuring we delivery high quality care which is safe, responsive and able to meet the needs of the population.
- **People** - making LCHG the best place to work by enabling our people to lead, work differently, be inclusive, motivated and proud to work within LCHG.
- **Services** - ensuring our services are sustainable, supported by technology and delivered from an improved estate.
- **Partners** - 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.
- **Population Health** - improving physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population.

By working together under unified Group leadership, the Trusts aim to address challenges such as increased demand for services, financial pressures, and workforce recruitment and retention. This integrated approach is designed to deliver sustainable, high-quality healthcare and improve the overall experience for both patients and staff.

Each Trust within the group has a well-established strategic direction, including digital, with strong foundations in digital delivery. This level of digital maturity allows them to effectively support group-level objectives while leveraging their individual strengths in service provision and innovation. However, rather than pursuing separate digital strategies for each Trust, we are now focused on delivering a joint group digital strategy – **one digital**.

Our **one digital** strategy acts as a framework for our collaborative work across both ULTH and LCHS. By working together across ULTH and LCHS we will leverage increased scale, provide a consistent platform to transform care, allowing us to scale innovation faster, support larger and more ambitious research and harness the unique capabilities from each Trust to deliver better outcomes for patients and an improved experience for our staff.

Foreword

The future of sustainable healthcare is digital and data driven. Getting it right will mean better care and outcomes for patients and an improved experience for colleagues. The scale of what we can achieve together is genuinely exciting. We serve over ¾ million people across our Trusts, with a 12,000 strong workforce and a combined turnover of £1 billion.

Our scale as a Group brings real opportunity - whether that is attracting commercial partners, negotiating better contracts, or creating centres of excellence for our health system. By bringing our programmes together underpinned by our **One Digital** approach, we will make a bigger impact for patients, communities, and colleagues, faster.

There are six ways we will do this, which are expanded further through this strategy:

1. **Getting the basics right** - creating reliable, modern digital foundations that support daily operations
2. **Putting users' needs first** - implementing systems that work for our people, reducing complexity, and making delivering and receiving care easier.
3. **Using digital as a tool for transformation** - solving bigger challenges and adopting innovations faster by working together across ULTH and LCHS.
4. **Embracing emerging technology** - taking bold steps with innovative solutions, from artificial intelligence to process mining, placing these at the core of care delivery.
5. **Harnessing strategic partnerships** - increasing our impact through collaboration with NHS organisations, academic institutions, and private sector partners.
6. **Creating and embedding one digital** - delivering a unified approach to digital and data transformation across our organisations.

One Digital brings together ULTH's and LCHS' digital programmes – providing a single banner for how we describe and organise our work. This isn't just a name change - it's a commitment to transforming care together.

We are bringing our digital governance together through shared decision-making forums to align our strategies, share learning, and make the most of our combined resources. It's about making sure we can move quickly and effectively when opportunities arise to work together.

This strategy sets out our high-level ambition for 2025-2028, supported by detailed delivery roadmaps and clear measures of success. Delivering a unified strategy isn't about losing what makes each Trust special. It's about amplifying our impact and creating new opportunities. Whether based in ULTH or LCHS, we have a chance to build something great together. Every improvement we make, every innovation we deliver, and every minute of time we save for our teams - it all adds up to better care for our patients.

Michael Humber
Group Director of Digital Services

Strategy on a page

Harness the power of digital to deliver healthcare services differently, providing a better experience for our patients and colleagues

Getting the basics right

A relentless focus on the basics is the foundation for everything we want to achieve.

We will make systems simpler and more reliable, so they don't get in the way.

Where we are now

Our foundational digital systems are not consistent or robust enough. This is worsened by systems that make people's jobs harder to do. Fragmented technology and inconsistent training mean colleagues often lack confidence in the tools they need. These challenges have led to frustration and hindered progress. To move forward, we must focus on making it easier and safer to deliver and receive care, ensuring a dependable digital foundation that supports colleagues and gives confidence in our ability to deliver.

What we aim to achieve

- Network uptime above 99.9% outside of planned downtime throughout 2025
- Reduced time from device request to delivery from 6 weeks to 1 week
- Standardise digital tools and systems to create an intuitive, seamless experience for all staff.
- Modernised network infrastructure to enhance connectivity, reliability, and performance.
- Ensure a digital experience where devices work reliably, with responsive support resolving urgent issues within an hour and other matters the same day, so staff can work efficiently with minimal disruption.
- Remove obstacles and friction points by carefully studying how colleagues need to work to perform their roles, and ensure digital solutions are optimised to support these more effectively.

How we will do it

We will deliver a strategic, phased approach to unify and modernise our digital infrastructure:

Consolidate and simplify systems

- Reduce complexity by consolidating platforms and enhancing system integration.
- Improve access and collaboration through standardised tools and processes.

Strengthen network, data centre and device infrastructure

- Ensure reliable, high-speed connectivity across sites.
- Provide modern, up-to-date devices with efficient management and timely upgrades.
- Optimise asset availability and performance through enhanced tracking solutions.

Proactive training and support

- Deliver tailored training to meet staff needs.
- Expand peer-to-peer support networks to build confidence and digital capability.
- Engage regularly with staff to promote transparency, gather feedback, and provide reliable support.

Maintain a relentless focus on cybersecurity, clinical safety and data security and protection

- Uphold and ensure compliance with the highest standards of clinical safety and data security and protection.
- Continually enhancing systems and processes to protect against evolving cyber threats.

By focusing on these priorities, we will create a reliable, modern digital foundation that supports daily operations whilst enabling long-term innovation and transformation across our Trusts.

What happens next?

We will set out specific measures by August 2025 which set out how the experience of technology and support will improve.

Putting users' needs first

We are committed to putting people - patients and colleagues - at the heart of digital transformation.

Building on the great success of the previous Digital Strategy, we will continue to implement systems that work for colleagues, reduce complexity, support our sustainability, and make delivering and receiving care easier.

Where we are now

Our digital systems are fragmented, outdated, and often feel like a barrier instead of a help. Our colleagues juggle too many systems—spending up to half their time navigating screens instead of caring for patients. Administrative teams, critical to smooth operations, have often been excluded from design decisions, leaving them with tools that don't meet their needs.

A recent staff survey showed that the majority of respondents feel digital tools make their work harder. We have heard your frustrations: re-entering data, delays in accessing vital information, and a lack of integration are holding us back. We acknowledge this and are committed to fixing it - focusing on tools that work for you, simplifying your tasks, and helping you deliver the best possible care.

What we aim to achieve

- Reduce the number of different systems colleagues have to use by 50% by August 2027.
- Minimise the time spent on administrative tasks, enabling colleagues to focus more on patient care by reducing processes that take hours to minutes.
- Integrate medical and remote monitoring devices to automate data entry.
- Implement technologies and innovations that directly improve the delivery and experience of care, ensuring solutions are user-focused, intuitive, and fit for purpose.
- Remove paper records wherever possible to remove the risk and challenges of using digital systems alongside paper.

How we will do it

User-led design

We will place users - healthcare professionals and service teams - at the centre of decision-making. Through co-design workshops, feedback sessions, and clinical and operational leadership, we'll ensure the tools we create reflect sustainable, real-world needs. All systems will be built to latest web accessibility standards across our digital estate, incorporating adaptive and assistive technologies, while also aligning with national usability priorities. No system will be implemented without clear evidence that users have shaped and approved it.

Streamlined decision-making and continuous improvement

A single prioritisation process led by clinical and operational staff will ensure we focus on the initiatives that have the greatest impact. By consolidating and simplifying systems, we will reduce the number of tools colleagues rely on and make digital workflows faster and more efficient.

Once solutions are live, we will not stop there. Ensuring digital and data solutions remain relevant and highly usable is dependent on ongoing engagement from colleagues. We will establish dedicated teams to make prioritisation decisions and run continuous improvement and optimisation of our systems.

Focusing on results

Everything we do is aimed at making it easier to deliver and receive care. We will measure success by how much time and effort we save for staff, how intuitive our systems are, and how well they support excellent patient care.

What happens next?

We will set out the technology roadmap in September 2025 which clarifies what systems we will use for what and which systems we will turn off.

Digital as a tool for transformation

Digital is our biggest opportunity to transform care and services by rethinking them entirely. Working together we can solve bigger challenges, adopt innovations faster, and create meaningful improvements.

By getting this right, we can make things easier and safer for staff, improve outcomes for patients, and run services more efficiently. This is not just about adding technology – it is about fundamentally improving how we work. Digital needs to be part of every conversation about our future, not an afterthought.

Where we are now

We have observed that the focus on procuring the best of breed technology has propagated system islands and areas of duplication. Whilst certain specialisms prospered by this approach, it has led to increased complexity, higher costs, a lack of interfacing which in turn prohibits systems talking to one another, features we do not fully use, and different tools doing the same job that cannot be supported or optimised effectively. We have already embarked on the investment in tools that fit the attributes needed for cohesive working and service excellence and we will build on this.

What we aim to achieve

- Ensure every technological investment has a clear pathway to meaningful adoption, prioritising purposeful implementation that drives genuine, practical usage.
- Enable Group-level decisions to align priorities and strategies, such as the Electronic Patient Record direction.

How we will do it

Provide a route for teams to get input upfront

We will make it easy for teams to come to Digital with a problem that needs solving and get help identify the right solution. We will prevent people buying or using services (including free solutions) that do not follow this process.

Make critical design decisions

We want to get better at using digital to improve care - and help others to do the same. By choosing the right tools, like our Electronic Patient Records, and making sure they work well for colleagues, we can make a real difference to care. When we find something that works, we will share what we have learned with other NHS organisations.

Reduce health inequalities

Our population is diverse in culture, language, age, and digital literacy. By embedding equity in digital transformation, we will ensure our solutions benefit everyone, for example through improved access to medical records and correspondence via patient portals. Working with communities, colleagues, and partners, we will create sustainable digital solutions that enhance equitable, sustainable healthcare delivery, and reduce our environmental impact.

Recognising digital poverty as a barrier to accessing healthcare we will work with local partners and communities to provide targeted support, resources, and alternative access routes that ensure digital healthcare services are accessible to all, regardless of their digital capabilities or circumstances.

Join up transformation

We will join up digital transformation with other teams leading change to embed digital as the primary means of transformation. Every significant transformation across ULTH and LCHS will consider digital and all digital initiatives will be evaluated for their transformational potential.

Embracing emerging technology

We are ready to take bold steps with emerging technology, placing innovative solutions at the core of care delivery. Our Group's scale allows us to attract world-class partners and lead digital transformation.

Technology must enable care, not hinder it. From Artificial Intelligence (AI) supporting patient care to process mining redesigning pathways, we will adopt, test, and scale tools that deliver maximum value. Smarter systems will eliminate repetitive tasks, streamline workflows, and let all our colleagues focus on delivering.

Where we are now

While we currently use some emerging technologies, we can do more to fully leverage their capabilities across the Group to drive innovation, improve efficiency, and enhance patient care outcomes.

What we aim to achieve

- Leverage emerging technology to improve clinical outcomes and operational efficiency.
- Take bold steps to redesign care pathways using cutting-edge technologies, transforming how care is delivered across all sites.
- Establish ULTH/LCHS as a recognised leader in healthcare innovation, driving the adoption of emerging technologies at scale.

How we will do it

Leverage emerging technologies

Automation and Artificial Intelligence (AI) will reduce administrative burdens, enhance workflows, and provide our colleagues with actionable insights to make informed decisions faster. These advancements will allow our colleagues to spend more time with patients, improving care quality and staff satisfaction.

Invest for innovation

We will take calculated risks on digital tools. This means balancing investment in proven systems with emerging technologies. By allocating resources to learn fast on promising innovations we can accelerate unlocking efficiency gains, and quickly explore new care delivery ideas to transform services for our patients and staff.

Partnerships for impact

We will identify and work with the best partners to deliver inward investment and become a proving ground for emerging technology. We will do this alongside fostering a reputation for a safe and responsible implementation.

Deliver ambitious initiatives

We will integrate emerging technologies such as AI, mobile solutions, voice recognition, smart buildings, robotic process automation, and genetic testing to streamline workflows, improve communication, enhance administrative efficiency, and advance personalised medicine.

Build the ULTH/LCHS AI Academy

We will create an AI Academy to train staff, ensure safe and effective adoption of technology, and foster innovation. This will empower staff to explore new ways of delivering care and create a Group-wide centre of excellence for digital transformation.

What happens next?

We will set out specific strategy and resourcing plan for emerging technology by September 2025.

Harness strategic partnerships

We recognise the power of collaboration to amplify impact and drive innovation strategy.

By forging strategic partnerships with NHS organisations, academic institutions, private sector partners, and community organisations, we aim to enhance healthcare delivery, accelerate digital transformation, and explore commercial opportunities that benefit our Group and the broader health ecosystem.

Where we are now

ULTH and LCHS have actively pursued partnerships with various NHS and non-NHS organisations to enhance patient care, education, and research both regionally and nationally and are already achieving success from our partnerships. We are working as part of the East Midlands Acute Provider Digital Design Collaborative (EMAP DDC) on the region wide deployment of the Nervecentre Electronic Patient Record (EPR) system.

We are piloting a first-of-type AI ambient voice solution within pre-op in anaesthetics. Produced an RPA process to mimic a reporter to clear the backlog of legacy events in the ULTH Radiology systems. We have also automated scripts to auto report all Radiotherapy CT scans so to keep the unreported counts down.

We have been focused on using these partnerships to deliver transformation at lower cost across the Group. The next phase will be to develop these partnerships into routes to generate revenue for ULTH and LCHS.

What we aim to achieve

- Partner with other NHS Trusts, technology providers, research institutions and collaborative initiatives to co-develop and scale innovative solutions and lead on best practice.
- Once or EPR is in place we will market anonymised, aggregated data to researchers, pharmaceutical companies, or health-tech startups for research and development purposes.
- Use RPA to further improve efficiencies and improved care such as blue light transfers via the image Exchange Portal out of hours without the need for human interactions improving services to clinical teams and patients.
- Also introduce AI to further improve efficiencies and improved care such as implementing the AI Diagnostics Funded Annalise Chest AI with to improve diagnostic accuracy and increase diagnostic efficiency.

How we will do it

- Engage with NHS England, the FDP, and other national bodies to align with strategic goals.
- Develop strong foundational capabilities in EPR and Electronic Document Management (EDM).
- Pioneer first-of-type technology, be an accelerator site for digital projects, pilot new technologies and workflows, iterating and improving as we test and learn, scaling what works best.
- Pursue and secure funding streams through collaboration with partner Trusts and national healthcare bodies.
- Partner with universities, pharmaceutical companies, and research institutions to use anonymised data for clinical trials, drug development, and health research.

Create and embed **one digital**

One digital represents a unified approach to how digital works across ULTH and LCHS, in essence how we deliver everything described in our strategy.

Our mission is to form a cohesive Digital team dedicated to supporting staff. By encouraging colleagues to draw on our expertise, we aim to solve problems together and deliver meaningful, joined-up solutions that meet the needs of the entire organisation.

Where we are now

Working at Group level to deliver **one digital** priorities across ULTH/LCHS is in its infancy and needs time to mature. A clear governance structure and delivery framework are not fully established, making it harder to align priorities, ensure accountability, and deliver digital initiatives effectively. While collaboration across the Group is starting to develop, it remains limited.

What we aim to achieve

- Foster a Group-wide culture of collaboration and shared responsibility for digital transformation.
- Design and implement a comprehensive delivery framework to drive alignment and accountability across ULTH and LCHS.
- Establish a clear and robust governance structure to streamline decision-making and ensure effective prioritisation.

How we will do it

Fostering a unified culture and workforce enablement

To support digital transformation, we will help colleagues deliver their critical work more effectively. Our digital teams are here to support and collaborate with colleagues, making daily tasks easier and more efficient.

We will encourage colleagues to share challenges with digital teams so we can solve them together, rather than in isolation. By breaking down silos and empowering teams, we will promote collaboration and ensure our digital initiatives meet the needs of the whole organisation.

Enhancing responsiveness and continuous improvement

Digital teams will focus on solving problems quickly and delivering real, practical results. By working together, we will address challenges directly, improve workflows, and adjust processes as needed. This step-by-step approach will reduce inefficiencies, speed up delivery, and ensure consistent value. By learning from each challenge, we will be better prepared for the next.

Establishing a Group PMO structure, streamlining governance and processes

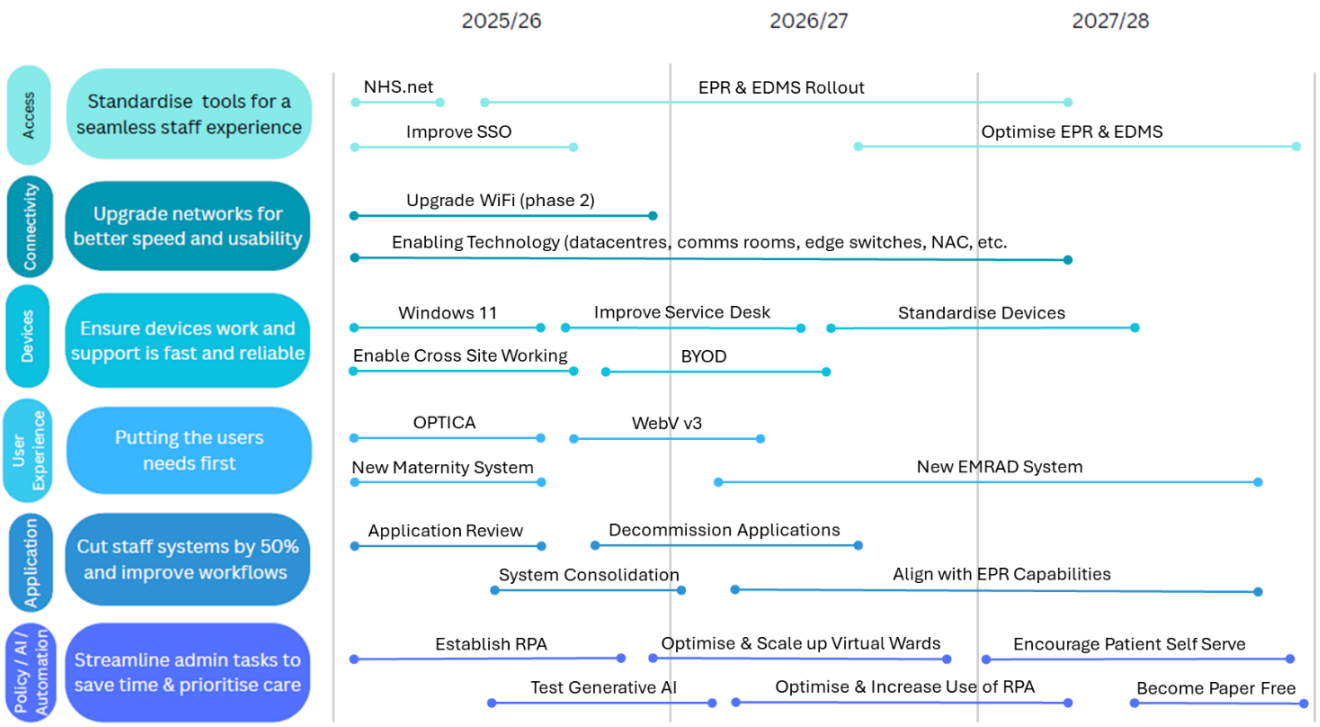
We will create a unified **one digital** Programme Management Office (PMO) to ensure clear decision-making and shared priorities across ULTH/LCHS. This approach will improve predictability, transparency, and delivery speed by focusing on fewer, high-impact initiatives. Data-driven decisions will guide resource use, ensuring that all systems are safe and consistently effective.

By standardising processes, we will reduce silos, improve procurement, and align transformation efforts. Streamlined workflows will make collaboration easier, increase efficiency, and ensure all digital projects deliver safer and better service outcomes for the Group.

Capability roadmap 2025 - 2028

Our strategy requires fundamental shifts in how we build, deploy, and maintain **one digital** services across our Trusts. This roadmap outlines how we will move from site-specific solutions to group solutions, and maintaining operational effectiveness. By focusing on shared capabilities first, we can rapidly demonstrate value while building the foundations for more complex integrations.

The roadmap balances releasing immediate benefits against strategic initiatives that will transform how we deliver digital services across the group



How we will monitor progress

This strategy will be underpinned by a roadmap detailing a broad range of programmes, initiatives and enablers associated with each goal and objective. Delivery progress and performance will be overseen by our **one digital** Programme Management Office (PMO), reporting to the Digital Oversight Group.

All initiatives will be financed through a combination of funding sources, including the allocated 2025/26 digital budget, match-funding programs such as the Frontline Digitalisation Funding Programme, strategic partnerships with third-party vendors, and central NHSE funding streams, such as the Digital AI Programme and Digital Productivity Funds. To effectively measure our digital transformation journey, we will track progress through established industry frameworks and key performance indicators. This includes monitoring our digital maturity scores using recognised standards, alongside measuring patient and staff satisfaction and digital confidence through regular surveys. We will particularly focus on system usability metrics for core platforms like our Electronic Patient Record (EPR), aiming to demonstrate measurable improvements in both technical capabilities and user experience over the strategy period. These quantitative and qualitative measures will provide objective evidence of our progress and help identify areas requiring additional focus or support.

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	*1st July 2025*
Item Number	*11*

Performance Report for May 2025 (ULTH)

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Daren Fradgley, Group Chief Integration Officer*
Author(s)	*Liam Buchan, Data Analyst*

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 decreased in May at 12.2% against a trajectory of 10.7% compared to 13.6% in April.*
- *Duty of Candour for verbal and written compliance in April has improved to 94%, compared to 79% in March.*

Performance

- *The annual performance target for the 4-hour wait time has been established at 78%. The full UEC combined Type 1, Type 3 (both co-located and separate sites) achieved 75.86% in May signifying a 1.46% decline compared to April 2025.*
- *11.09% of patients (T1 only) exceeded 12 hour wait in department in ED.*
- *Average response time for Cat2 ambulance conveyances in May was approximately 34.08 minutes reflecting a increase of 3.39 minutes compared to April 2025 and remaining above the targeted 30 minutes.*
- *Long Waiters - at the end of April, the Trust reported 0 patients waiting longer than 104 weeks; 0 patients waiting over 78 weeks, 14 patients waiting over 65 weeks.*
- *Performance for DM01 in May showed a slight improvement to 73.01% from 67.47% in April. 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.

- *28-day Faster Diagnosis Standard (FDS) in April achieved 72.5% which is slight deterioration from March 78% and has fallen below trajectory for the first time in months.*

- *62-day classic treatment performance for April was 61.7%, a deterioration from the March position of 71.3%.*

- *104+ day waiters increased to 98 as of 11th June compared to 71 as of 14th May, the highest risk specialities are colorectal, head & neck and lung.*

Finance (is now reported for the Group)

The Group has a planned breakeven position for 2025/26 inclusive of a £79.3m cost improvement programme.

- *Revenue position*
  The Group's YTD position is a £8.1m deficit, which is £0.1m favourable to the planned £8.2m deficit.

- *Capital position*
  The Group YTD has delivered capital expenditure of £3.3m, which is £1.7m lower than planned capital expenditure of £5.0m.

- *CIP position*
  The Group YTD has delivered CIP savings of £5.9m, which is £0.2m favourable to planned CIP savings of £5.7m.

- *Cash position*
  The Group's cash balance is £39.1m, which is £2.3m higher than the planned cash balance of £36.8m.

Workforce

- *Mandatory training for May is 92.83% against a plan of 90%*

- *May sickness rate is 5.29% against Q1 target of 4.60%*

- *Staff AfC appraisals at 76.68% for May against Q1 target 80.00%*

- *Staff turnover at 9.14% for May against Q1 target of 9.00%*

- *Vacancies at 6.05% for May against Q1 target of 7.01%*

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 LCHG strategic aims & objectives	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings	*X*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	*X*
2b: Empower our people to continuously improve and innovate	*X*
2c: Nurture compassionate and diverse leadership	*X*
2d: Recognising our people through thanks and celebration	*X*
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*X*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	
3c: Enhance our digital, research & innovation capability	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	

Executive Summary

Quality

Pressure Ulcers

There have been 45 category 2 pressure ulcers in May. The number of Category 2 incidents in May has increased by 5 from April 2025. 5 of these incidents were device related, which is a decrease of 4 device incidents from April. Quality Matron and Tissue Viability team provide support to areas with increased number of incidents.

VTE

In May, compliance remained below the 95% target, reaching 93.62%. While this may indicate that assessments are not being completed in the 14-hour timeframe, a key issue is the discrepancy between the actual time of assessment completion and the time recorded in Careflow. Currently, the time recorded in Careflow reflects when ward clerks input the data rather than when the assessment was completed. Since ward clerks are unable to amend the recorded time, this results in an inaccurate representation of compliance. Additionally, the only system that accurately captures the assessment time is ePMA, where the timestamp reflects the actual time of completion. However, not all clinicians use ePMA for VTE risk assessment, leading to inconsistencies in data accuracy. The Team are engaging with the Digital Transformation Team to explore technical solutions that would prevent clinicians from bypassing or overriding the VTE risk assessment requirement within ePMA. This will support consistent practice and ensure accurate, real-time data capture.

Medications

Medication incidents reported as causing harm has decreased to 12.2% against a trajectory of 10.7%. Many of the 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 no Safety Alert with a deadline for completion in May. 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. Use of Dashboards for monitoring compliance on Alerts

Module on DatixIQ.

SHMI

The Trust SHMI has decreased slightly to 109.34 for May but remains within expected limits. Any diagnosis group alerting is subject to a case note review. HSMR is at 100.24 (as expected). Due to the change in methodology, the Trust is seeing a slight increase and work is being undertaken to understand the reasons for the increase. Clinical Governance & Clinical Coding met with Telstra Health UK for a greater understanding into the recent increases in the Trust's HSMR/SHMI. Reviewing specific areas such as the 'Global Frailty Index' and 'Elixhauser-Bottle Comorbidity Index'. The team are also reviewing the diagnosis groups with trend increases.

eDD Compliance

eDD Performance continues to be below the 95% target, currently at 91%. 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 April data

The **screening compliance for inpatient child** increased to 98% (target 90%). 43 children out of 44 that had PEWS of 5 or above were screened for sepsis within 60 minutes. There was 1 patient with delayed sepsis screening. This child was diagnosed with a Lower Respiratory tract infection and was treated with oral antibiotics.

IVAB ED Children – The administration of IVAB for children in ED increased to 67% (target 90%). 6 children out of 9 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.

Duty of Candour (DoC) – March Data

DoC compliance in April for verbal and written increased to 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 May 2025.
In May, there was a notable increase in attendance across the Urgent and Emergency Care (UEC) pathways, reflecting a 7.01% rise compared to the average attendance recorded during May for the years 2022, 2023, and 2024. Furthermore, an upward trend in patient acuity was observed, with 12.66% 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 13.49% in comparison to the average attendance for May across the years 2022, 2023, and 2024, which corresponds to an increase of 207 patients. Seasonal infections continue to exert pressure on our services. By the conclusion of May, the Trust had documented 12 PCR confirmed inpatients with positive COVID-19 test results, which represents an decrease of 3 cases compared to the previous year.

Throughout the month, a total of 628 flu tests were administered, indicating a 62.27% increase relative to May 2024. Of these tests, 21 yielded positive results, resulting in a positivity rate of 3.34%. In comparison, among the 586 patients tested for respiratory syncytial virus (RSV), 8 were found to be positive, leading to a positivity rate of 0.51%. Additionally, the month of May witnessed a 70.85% 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 May 2025, the trust recorded a performance rate of 75.86%, signifying a 1.46%% decline compared to April 2025 however a 4.14% increase to May 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.

Unfortunately, both departments have observed a decline in Type 1 performance, with the Lincoln Emergency Department demonstrating a decrease from 63.41% to 61.91%. Similarly, the Pilgrim Emergency Department experienced a drop from 63.68% to 58.41%. Overall, Type 1 performance achieved a final performance rate of 60.41% which is a 3.12% decrease to April 2025.

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, 11.09% of patients exceeded the 12-hour benchmark (Type 1 only); this figure indicates a 0.35% increase compared to April 2025, equating to 182 more patients surpassing this threshold.

In May, the average mean response time for Category 2 cases was approximately 34.08 minutes, reflecting a increase of 3.39 minutes compared to April 2025 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 21% 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, 26.75% of paediatric patients arriving via the East Midlands Ambulance Service (EMAS) scored 4 or greater, while the percentage for adult patients was 21.26%.

Fractured Neck of Femur 48hr Pathway (#NOF)
Trauma demand has been at its highest level to date, putting continued pressure on access to theatres and May saw a slight reduction in performance with 46.67% of patients making it to theatre within 48 hours.

Length of Stay
In May, the Non-Elective Length of Stay experienced a decrease of 0.06 days compared to April 2025, with the current performance level recorded at 4.55 days, which surpasses the maximum threshold by 0.05 days. The average bed occupancy rate, with respect to "Core General and Acute," stood at 92.17%. To maintain safe and efficient operational flow within acute care settings, an average of 16 escalation beds or boarding spaces has been allocated, resulting in an occupancy to escalation ratio of 90.69%, which complies with the national standard of less than 92%. Additionally, approximately 44 beds have been ringfenced for elective patient flow at Grantham. Excluding this facility from the metrics indicates that the core occupancy would result in 94.74%, while the core plus escalation occupancy would yield 93.07%.
The identification of timely support to facilitate discharges from the acute care setting for pathways 1 to 3 continues to pose significant challenges for System Partners. In response, the Trust has implemented several new processes aimed at addressing the needs of both recently admitted and long-waiting patients, emphasizing the importance of identifying reasons for delays and escalating issues earlier when appropriate. Additionally, System Partners are now provided with daily updates regarding new admissions that could potentially lead to prolonged stays. This proactive approach allows for the realignment of base packages of care to accommodate new patients in a timely manner, thereby ensuring a continuous flow of service provision.

Referral to Treatment
After a slight dip in March, April performance returned to an improving trajectory and delivered a performance of 53.8% compared to 53.46% in March. The Trust continues to report patients waiting over 104, 78, 65 & 52 weeks. At the end of May, the Trust reported zero patients waiting longer than 104 weeks. The trust exited May with 0 patient waiting more than 78 weeks and 14 patients waiting over 65 weeks.

The trust was an early adopter of the Further Faster programme which is a national initiative to reduce patients waiting over 52 weeks. At the end of April the Trust reported 1,775 patients waiting over 52 weeks which is a second monthly increase after five consecutive months of improvement.

Waiting Lists
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. The waiting list started to reduce in November 2024 with April recording 70,044

DM01
The report for DM01 in May showed an improvement to 73.01% 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
May outturn for cancelled operations on the day Improved for a third consecutive month to 1.13%. Lack of time and lack of theatre staff were again the main reasons for cancellations.

Included in the 1.13% of on the day cancellations, 27 patients were not treated within the 28-day standard and this continues to be driven by the pressure to date long waiters and Cancer patients.

The continuous review of the effectiveness of the 6:4:2 theatre scheduling meetings continues along with the pre-op improvement work stream, both of which are expected to drive down on the day cancellations.

Cancer

28-day Faster Diagnosis Standard (FDS) for April sat at 72.5% and has fallen below trajectory for the first time in recent months.
31 day performance for April deteriorated slightly to 89.8%.

62-day classic performance for April decreased to 61.7%.

104+ day waiters increased to 98 due to a high number of complex patients. 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 May 2025 Core Learning Rate is 92.83% 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 as we move into 2025/26 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. 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 May 2025 Sickness Rate is 5.29% against a Q1 Target of 5.28%. This is within tolerance and currently on track to meet target. Health and wellbeing will continue to be a focus in 2025/26 and supporting staff to remain well and at work will be a priority.

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 May 2025 appraisal rate is measured against a Q1 Target of 80.00%, and in month we have achieved a Trustwide position of 78.28%. This is a slight decrease when compared to the previous month, but is expected as we have moved into an appraisal window for Agenda for Change staff. t. It is the Agenda for Change appraisals which require the focus. The move in 2025/26 to an appraisal window in Q1 is expected to support attaining the target and sustaining in year.

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.

Staff Turnover – Our May 2025 Turnover Rate is 9.14% against a Target of 9.00%, this is within the tolerance levels and on track to meet target. It should be noted that we have seen reduced levels of turnover that we have seen within previous months. 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 will continue to work closely with Divisional colleagues to reduce the impact of staffing and associated operational pressures.

Vacancies – Our May 2025 Vacancy Rate is 6.05% which has increased slightly in month although this is to be expected with the Vacancy Control Processes we have in place. We are exceeding target overall in month. Our recruitment levels have continued to be consistent during 2024/25, and we will continue to monitor in 2025/26 to ensure we are recruiting to the roles/services which are directly impacting patient care.

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 a planned breakeven position for 2025/26 inclusive of a £79.3m cost improvement programme.

Revenue position - The Group's YTD position is a £8.1m deficit, which is £0.1m favourable to the planned £8.2m deficit.

CIP position - The Group YTD has delivered CIP savings of £5.9m, which is £0.2m favourable to planned CIP savings of £5.7m.

Capital position - The Group YTD has delivered capital expenditure of £3.3m, which is £1.7m lower than planned capital expenditure of £5.0m.

Agency position – The Group YTD has expenditure of £3.4m on agency staffing, which is £0.8m higher than planned agency expenditure of £2.7m.

Cash position - The Group's cash balance is £39.1m, which is £2.3m higher than the planned cash balance of £36.8m.

Month 2 Position	Group performance			LCHS performance			ULTH performance		
	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)	(8.2)	(8.1)	0.1	(1.1)	(1.0)	0.1	(7.1)	(7.1)	0.0
CIP Delivery	5.7	5.9	0.2	0.5	0.7	0.2	5.2	5.3	0.0
Capital Spend	5.0	3.3	(1.7)	1.5	1.2	(0.3)	3.5	2.1	(1.4)
Agency Spend	(2.7)	(3.4)	(0.8)	(0.1)	(0.3)	(0.2)	(2.6)	(3.2)	(0.6)
Cash Balance	36.8	39.1	2.3	25.7	25.1	(0.6)	11.1	14.0	2.9

Daren Fradgley
Group Chief Integration Officer
June 2025

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.

Caring and building a healthier future for all

Performance Overview - Quality

NHS
Lincolnshire Community and Hospitals NHS Group

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-25	Apr-25	May-25	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	9	9	5	14	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	1	0	1	1	?	
	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	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	0.05	0.03	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	0.05	0.11	0.11	0.11	P	L
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	7	1	0	1	?	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	1	0	1	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	92.56%	92.56%	93.62%	93.09%	F	
	Never Events	Safe	Patients	Director of Nursing	0	1	0	0	0	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	4.66	5.01	4.20	4.61	?	

Caring and building a healthier future for all

Performance Overview - Quality

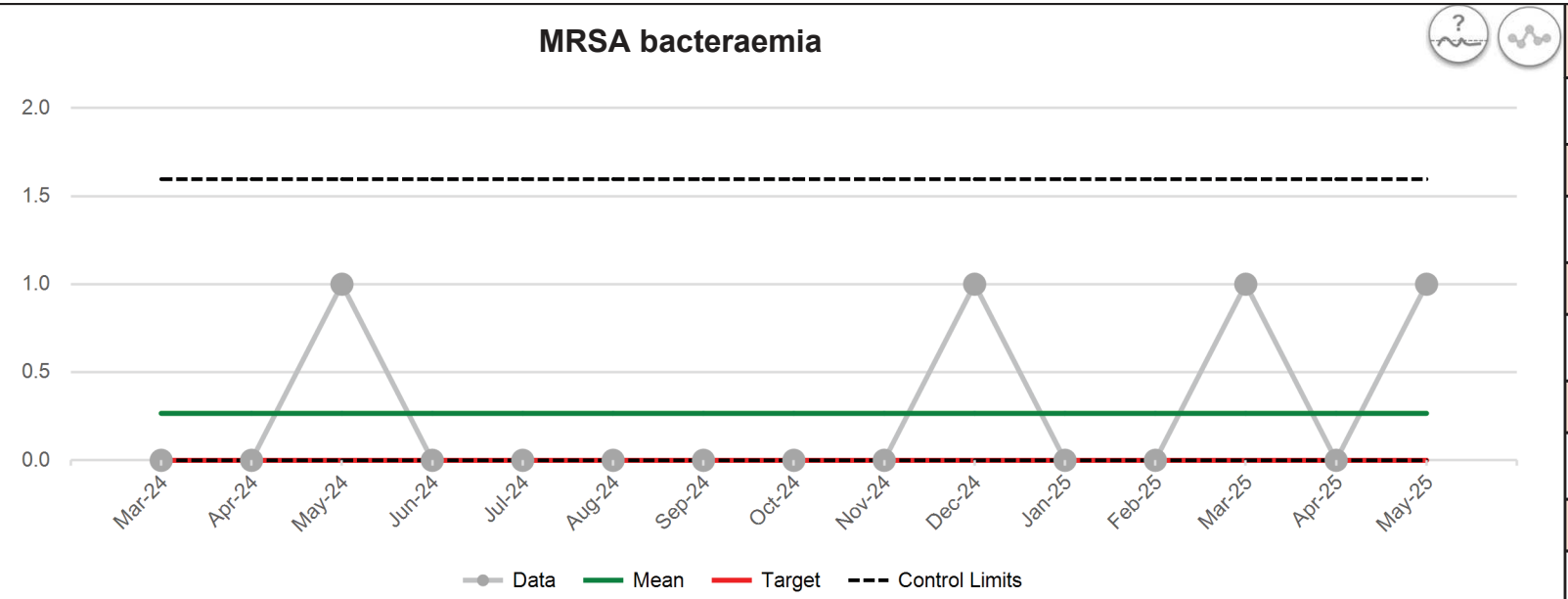
NHS
Lincolnshire Community and Hospitals NHS Group

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-25	Apr-25	May-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%	10.50%	13.60%	12.20%	12.90%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	0.00%	0.00%	None due	0.00%	F	
	Hospital Standardised Mortality Ratio - HSMR+ (basket of 41 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	98.98	100.66	100.24	N/A		
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 5 month time lag)	Effective	Patients	Medical Director	100	109.35	109.99	109.34	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	
	eDD issued within 24 hours	Effective	Patients	Medical Director	95.00%	88.60%	90.10%	91.00%	90.55%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	93.52%	91.86%	Data Not Available	91.86%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	89.00%	98.00%	Data Not Available	98.00%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	95.06%	97.43%	Data Not Available	97.43%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	100.00%	100.00%	Data Not Available	100.00%	P	H
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	95.27%	93.61%	Data Not Available	93.61%	P	

Performance Overview - Quality

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-25	Apr-25	May-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%	91.00%	93.00%	Data Not Available	93.00%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	93.70%	95.64%	Data Not Available	95.64%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	62.00%	67.00%	Data Not Available	67.00%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	3.18	2.97	2.75	2.86	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%	79.00%	94.00%	Data Not Available	94.00%	?	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	79.00%	94.00%	Data Not Available	94.00%	F	

Performance Overview - Quality



May-25
1
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of Nursing

Background:
MRSA Bacteraemia

What the chart tells us:
The Trust is over the target by 1 case for the current reporting year.

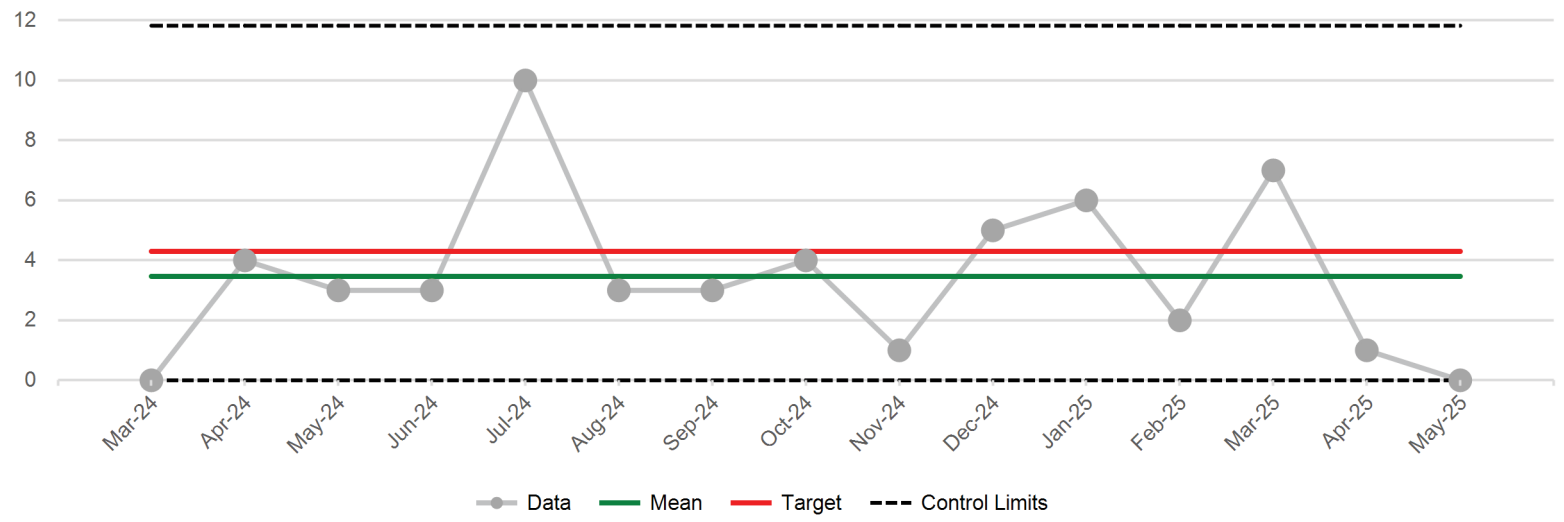
Issues:
There was a HOHA case this month- this was an elderly gentleman, admitted from a Care Home, with multiple co-morbidities and at end of his life. Source of bacteraemia was unknown and the case was not preventable.
He was found to be colonised with MRSA, but was not screened on admission to the Trust, as per policy. There was a delay in prescribing decolonisation treatment. Patient has now been discharged to the Care Home on end of life care.

Actions:
Appropriate screening of patients and decolonisation of patients has been discussed with ward staff at Safety huddles.

Mitigations:
Being discussed at the Medicine IPC Focus Group meeting this week for learning and areas for learning were discussed at the IPC site meeting.

Performance Overview - Quality

Pressure Ulcers category 3



May-25
0
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 0 Category 3 incident against a target of 4.3 per month.

Issues:
The number of Category 3 incidents in May have decreased by 1 from April 2025.

Themes identified as areas of focus for improvement are:
• Continue to ensure teams utilise best practice skin integrity management plans to prevent patients skin deteriorating to Category 3 or 4 pressure ulcers.

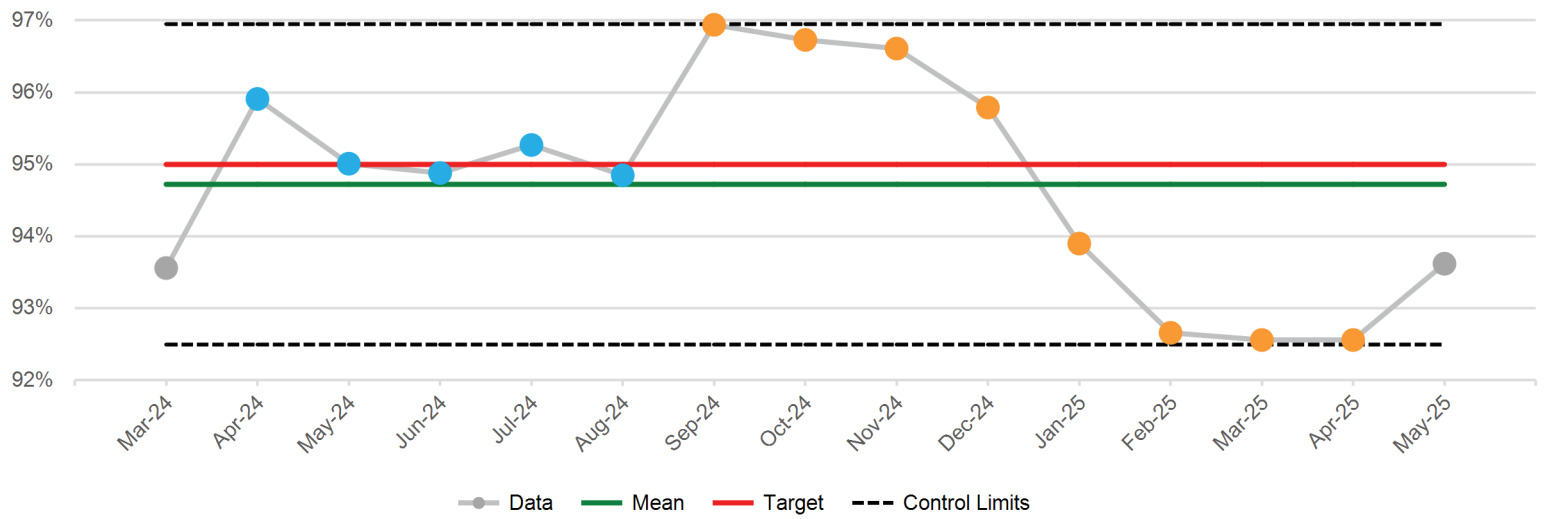
Actions:
All Category 3 incidents will be reviewed at the weekly Pressure Ulcer Support and Supervision Panel meeting.

The Tissue Viability and Quality Matron Team undertake a detailed review of these incidents to identify any additional learning.

Mitigations:
Quality Matron and Tissue Viability team provide support to areas with increased number of incidents.

Performance Overview - Quality

Venous Thromboembolism (VTE) Risk Assessment



May-25
93.62%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
VTE risk assessment within 14 hours of admission continues to be a key patient safety standard. In May, compliance was recorded at 93.62%, still below the 95% target.

What the chart tells us:
This figure represents the proportion of risk assessments completed within the required timeframe based on current data sources.

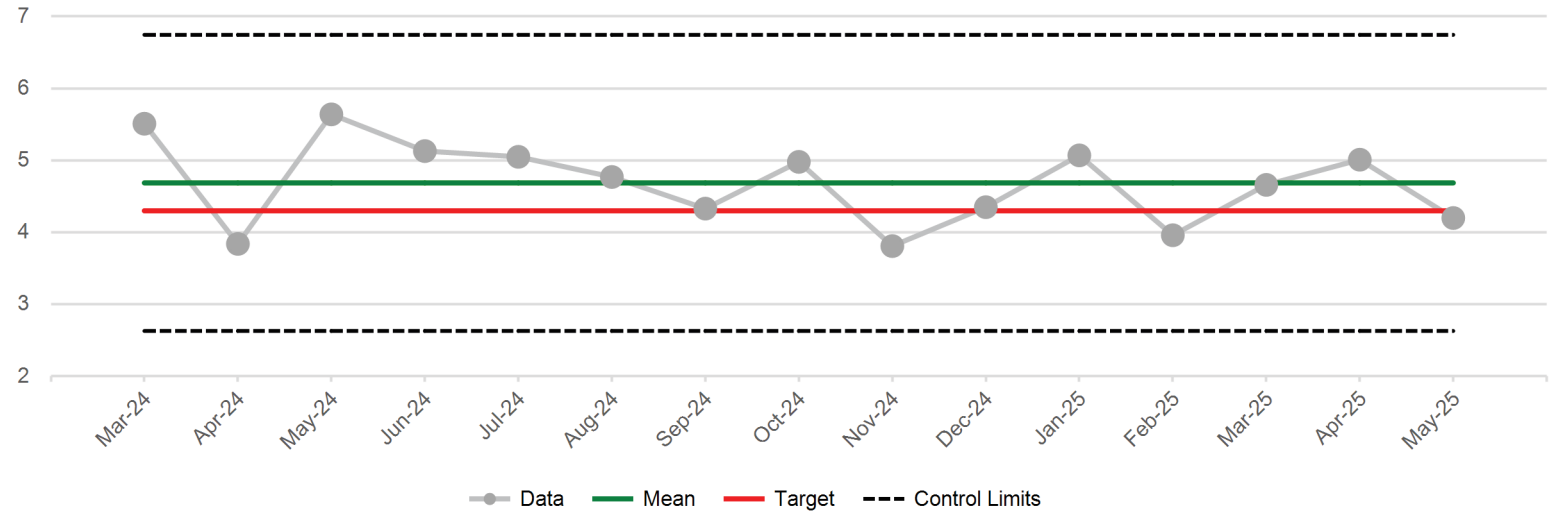
Issues:
A recurring issue remains the accuracy of the recorded completion times, particularly in Careflow. The system logs the time when ward clerks' input the data, not the actual time of assessment completion and ward clerks cannot amend this. This often results in underreported compliance. In contrast, ePMA automatically records the true time of assessment but is not consistently used by all clinicians. These discrepancies continue to affect the integrity of the reported data.

Actions:
To address this, we currently using both Careflow and ePMA to collect data. For better transparency, we have begun monitoring compliance from each system separately. While the long- term intention is to transition using ePMA data exclusively – due to its accuracy – we will continue dual monitoring in the interim.
We have also initiated tracking of assessment completion timelines to better understand when VTE assessments are being performed relative to admission. To support this, a targeted audit is planned for the beginning of July, led by the Chair of VTE Committee and the VTE Nurse Specialist. This will involve a review of patients notes, both Careflow and ePMA to verify actual completion times and evaluate how well they align with recorded data.

Mitigations:
We continue to work closely with the Digital Transformation Team to explore options for improving ePMA utilisation and limiting the ability to bypass VTE assessments prompts. We are also working with the Information Systems Manager to improve data capture processes, enhance reporting accuracy and reduce reliance on retrospective data entry.

Performance Overview - Quality

Reported medication incidents per 1000 occupied bed days



May-25
4.20
Variance Type
Common cause variation
Target
4.30
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Medical Director

Background:
Reported medication incidents per 1000 occupied bed days

What the chart tells us:
In the month of May the number of medication incidents reported was 155. This equates to 4.20 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 12.2 % which is above the national average of 11%.

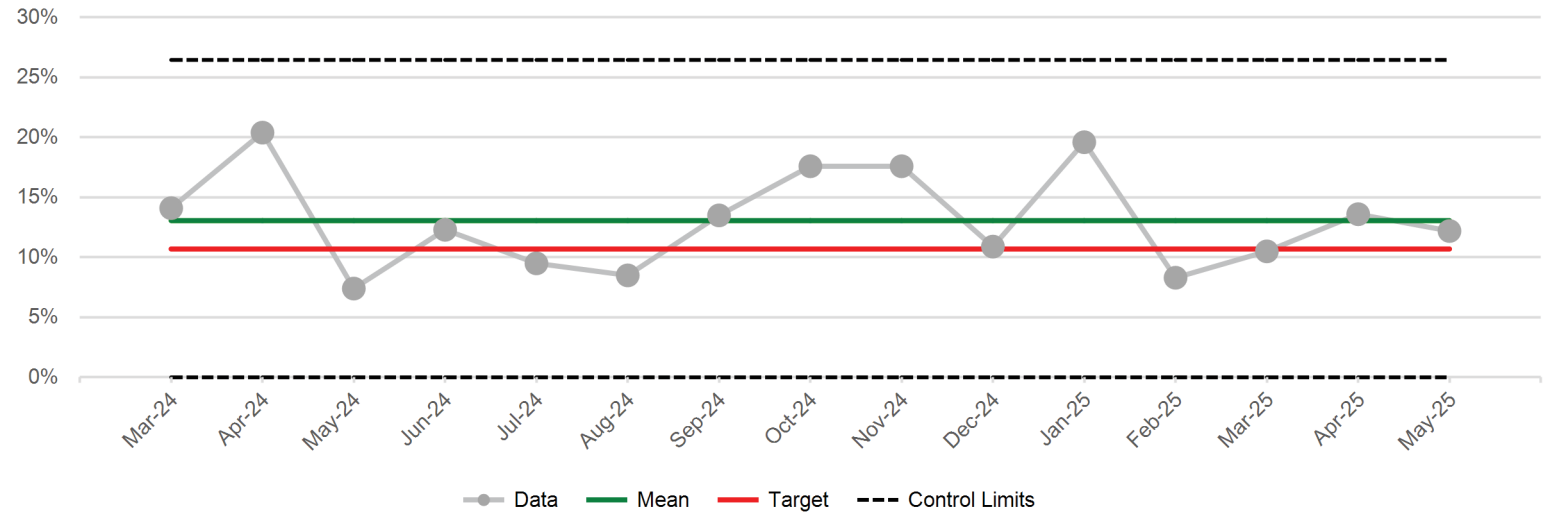
Issues:
The majority of incidents are at the point of prescribing and administration of medication and the main errors are omitting medicines.

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

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



May-25
12.20%
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 May the number of medication incidents reported was 155. This equates to 4.20 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 12.2 % which is above the national average of 11%.

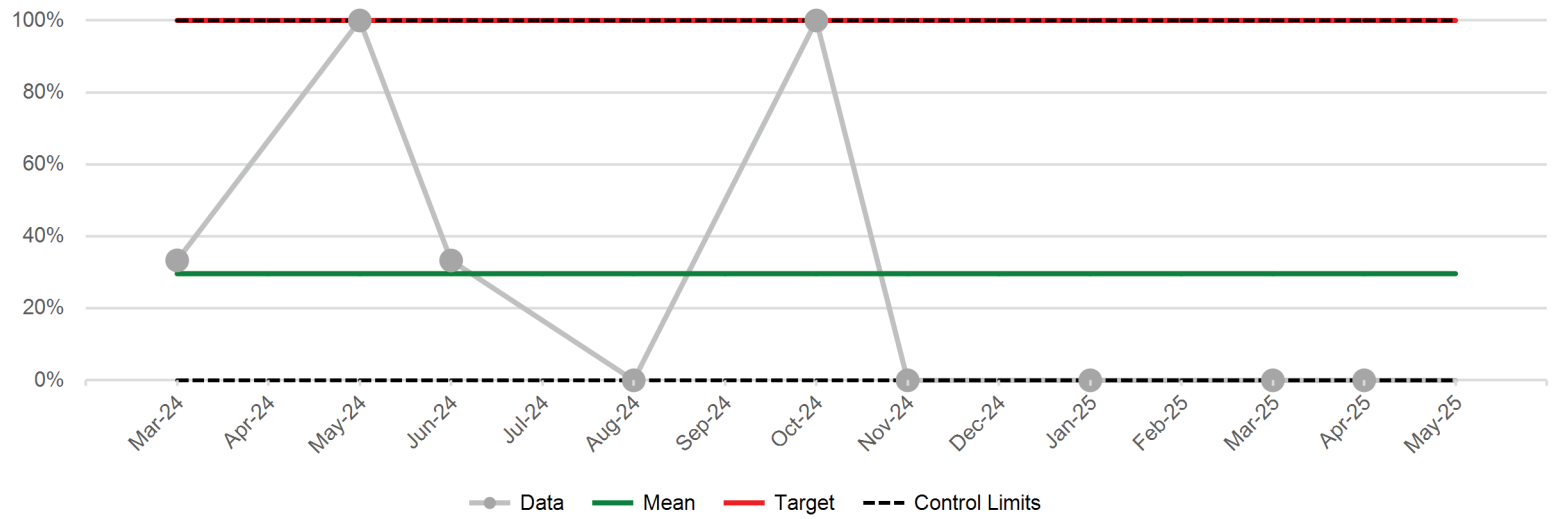
Issues:
The majority of incidents are at the point of prescribing and administration of medication and the main errors are omitting medicines.

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

Patient Safety Alerts responded to by agreed deadline



May-25
None Due
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Patient safety alerts responded to by agreed deadline.

What the chart tells us:
There were no Patient Safety Alerts due for closure in May 2025.

Deviances still 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 and escalation where appropriate to Divisions for overdue actions.

Compliance is monitored on DatixIQ 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 to Divisions and Patient Safety Group for upward reporting to Quality Committee.

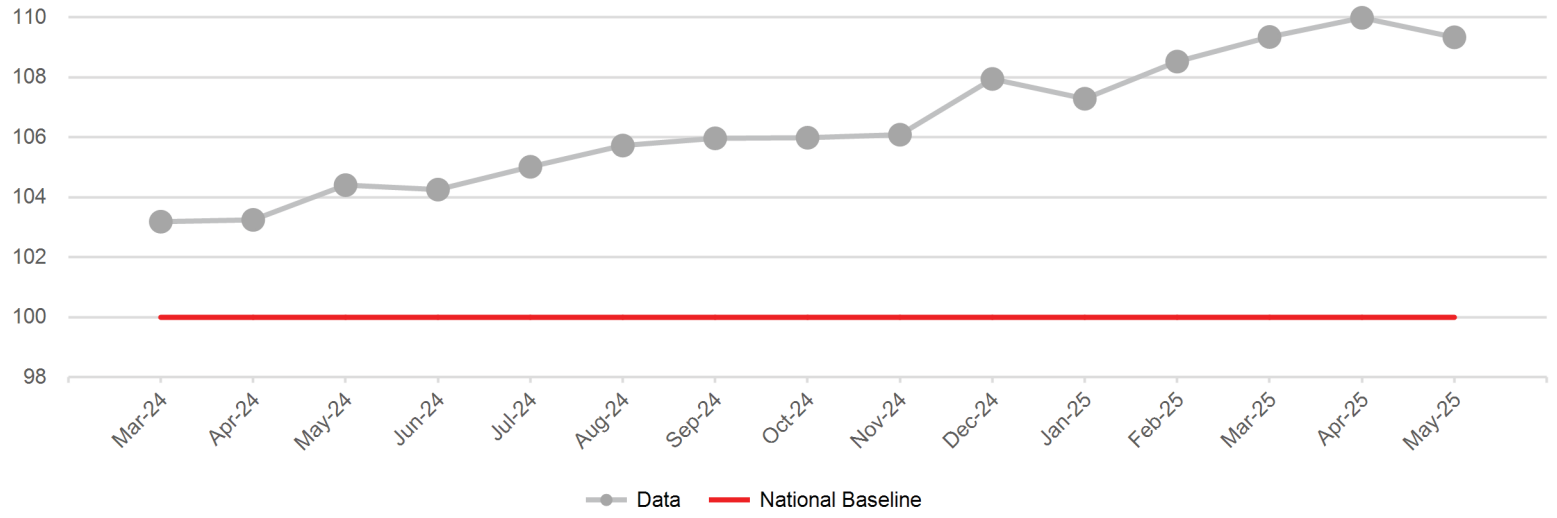
Mitigations:
Compliance is discussed monthly at Patient Safety Group, and a monthly escalation report highlights Alerts with upcoming deadlines for Leads to action and outstanding actions for overdue Alerts.

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

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



May-25
109.34
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.

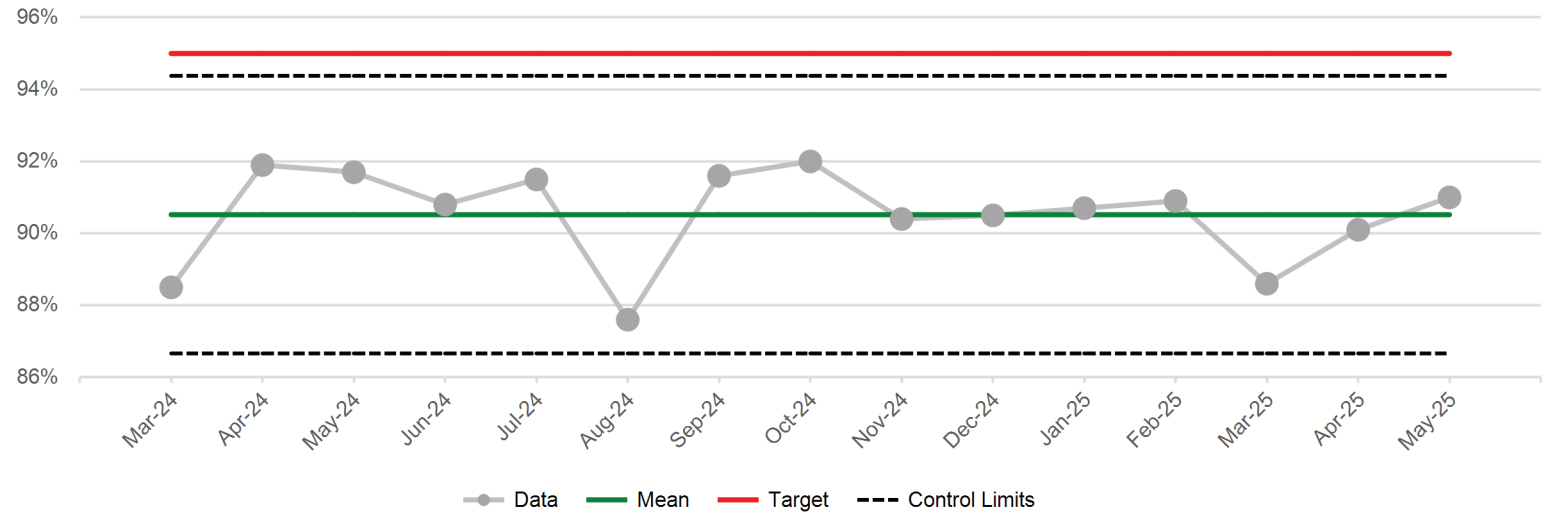
The SHMI methodology has changed, the data is being reviewed as the Trusts SHMI has increased.

Actions:
Clinical Governance & Clinical Coding met with Telstra Health UK for a greater understanding into the recent increases in the Trust's HSMR/SHMI. Reviewing specific areas such as the 'Global Frailty Index' and 'Elixhauser-Bottle Comorbidity Index'. We are also reviewing the diagnosis groups with trend increases.

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

Performance Overview - Quality

eDD issued within 24 hours



May-25
91.00%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
eDD Performance continues to be below the 95% target, currently at 91%.

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

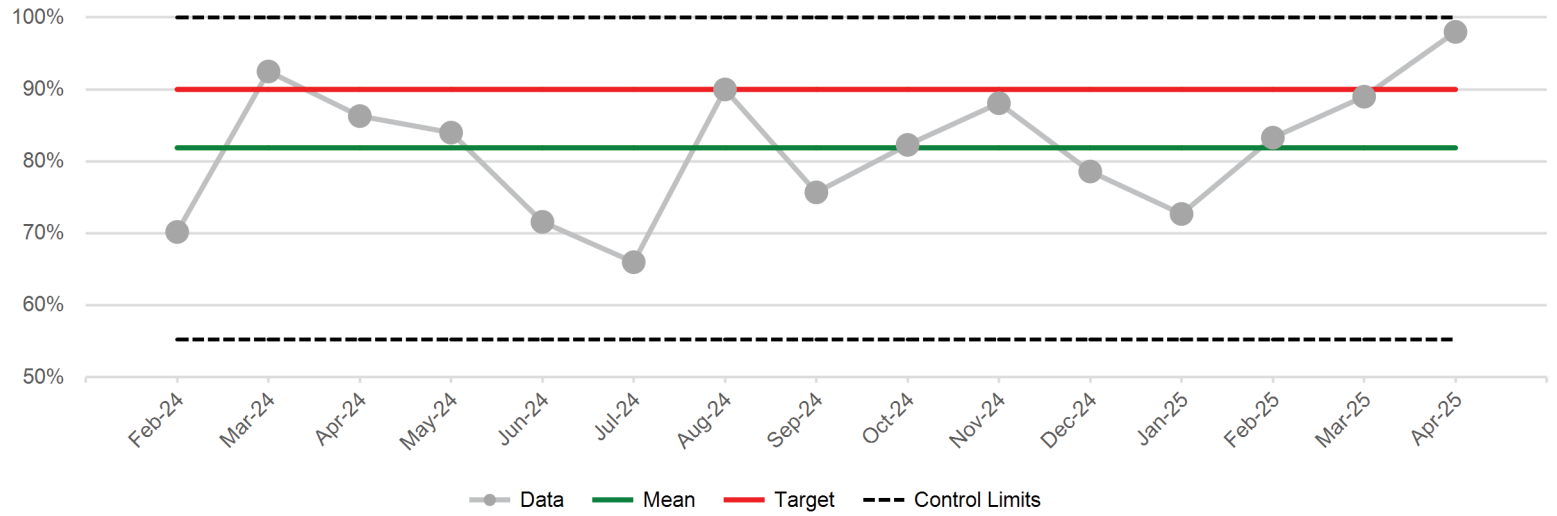
No Narrative owner

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)



Apr-25
98.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The Sepsis screening compliance this month was 98%, which is above the 90% target. 43 of 44 patients were screened within the 60-minute timeframe.

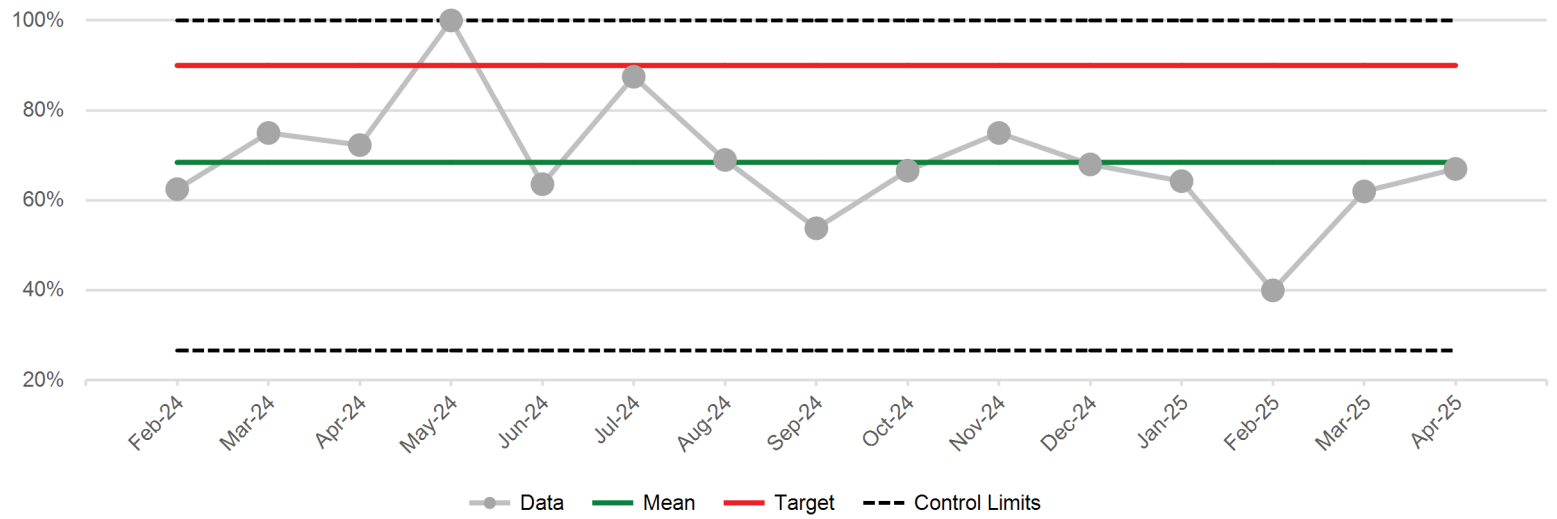
Issues:
There was 1 patient this month with delayed sepsis screening. This child was diagnosed with a Lower Respiratory tract infection and was treated with oral antibiotics.

Actions:
Sepsis Practitioner is currently pulling notes and completing any harm reviews. These are then discussed at monthly Sepsis compliance meetings
Sepsis training completed for Pilgrim medics on 20/05/2025.
Sepsis incorporated into all sim training.
Aim now is to maintain this compliance .

Mitigations:
No Harm found in harm reviews done. Patients found to have been treated appropriately.

Performance Overview - Quality

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



Apr-25
67.00%
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)

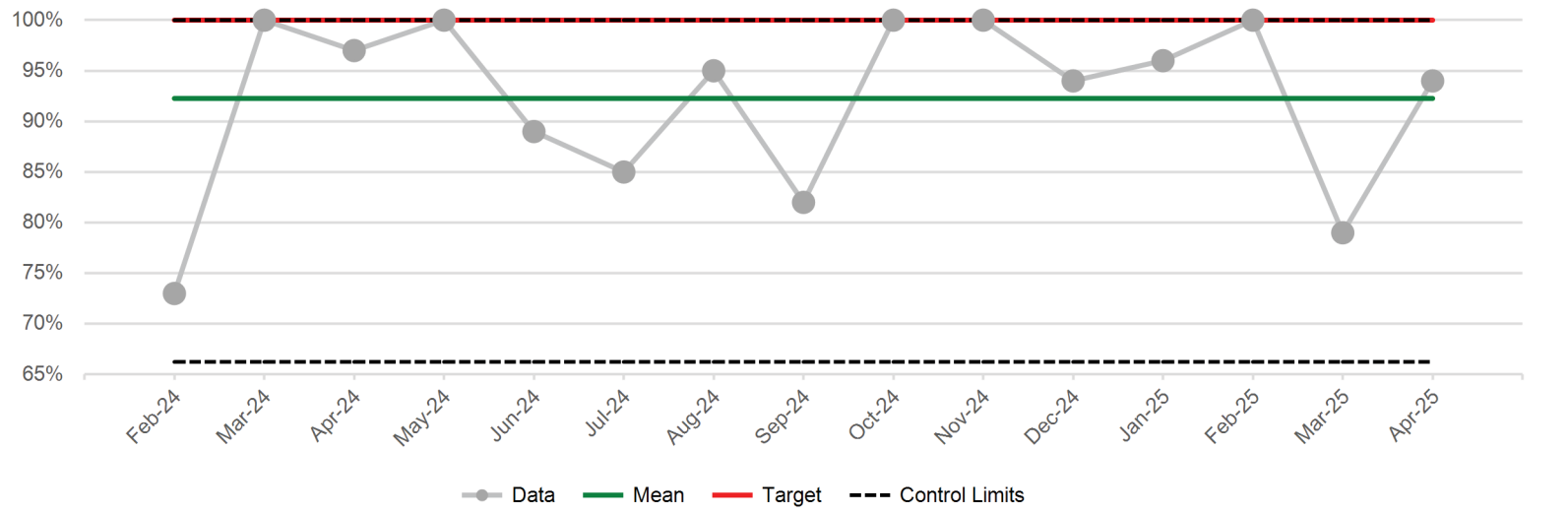
What the chart tells us:
The compliance for administration of IVAB within one hour was 67%, which, although an improvement, is well below the 90% standard. 6 out of 9 patients received their antibiotics within a timely manner.

Issues:
There were 3 patients this month with delayed Sepsis treatment.
- One patient appeared to have Asthma but underlying pneumonia was found on X-Ray – antibiotics given at 80 minutes.
- 1 child had bloods done and cannula sited by ED staff but decision to start antibiotics was delayed until seen by paediatric team.
- 1 baby with previous E.coli UTI- decision made to treat in department but nothing done until transferred to ward – delay of 8hours

Actions:
Themes escalated to ED manager, Sepsis link nurses and Consultant. Paediatric teams are planning some joint training with ED team.
Planned simulation training was cancelled due to High Patient numbers / workload
Harm reviews completed by Sepsis practitioner and findings fed back to ED team.

Mitigations:
Harm reviews completed for all patients with delayed treatment – No harm found. IR completed for patient who had significant delay.

Performance Overview - Quality



Apr-25
94.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates inconsistently passing and 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 high.

Issues:
The non-compliance figures for this period has been escalated.

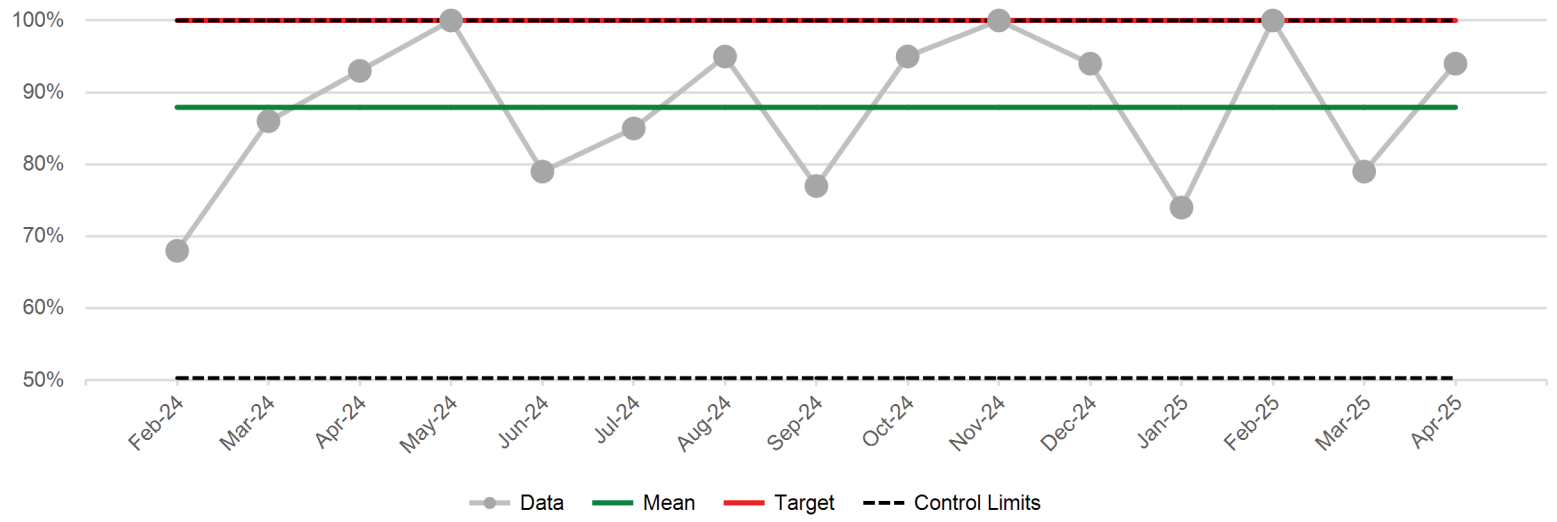
Actions:
Care group position for each service now provided and business partners working with divisions to complete and monitor ongoing compliance.

Weekly tracking in progress by the incident team.

Mitigations:
Dedicated members of the incident team have been aligned to care groups which has improved compliance.

Performance Overview - Quality

Duty of Candour compliance - Written



Apr-25
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 high.

Issues:
The non-compliance figures for this period has been escalated.

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.

Caring and building a healthier future for all

Performance Overview - Operational Performance

NHS
Lincolnshire Community and Hospitals NHS Group

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-25	Apr-25	May-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.20%	0.24%	0.24%	0.24%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	78.00%	78.21%	77.32%	75.86%	76.59%	78.00%	F	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	573	969	942	1,911	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	78.25%	79.38%	74.80%	77.09%	88.50%	F	
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	1,629	1,775		N/A	N/A	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	10	17		N/A	N/A	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	53.46%	53.80%		53.80%	84.10%	F	H
	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	71,582	70,044		N/A	N/A	F	
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	78.00%	72.50%		72.50%	75.00%	P	
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	71.30%	61.70%		61.70%	85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	90.00%	76.50%		76.50%	93.00%	F	

Performance Overview - Operational Performance

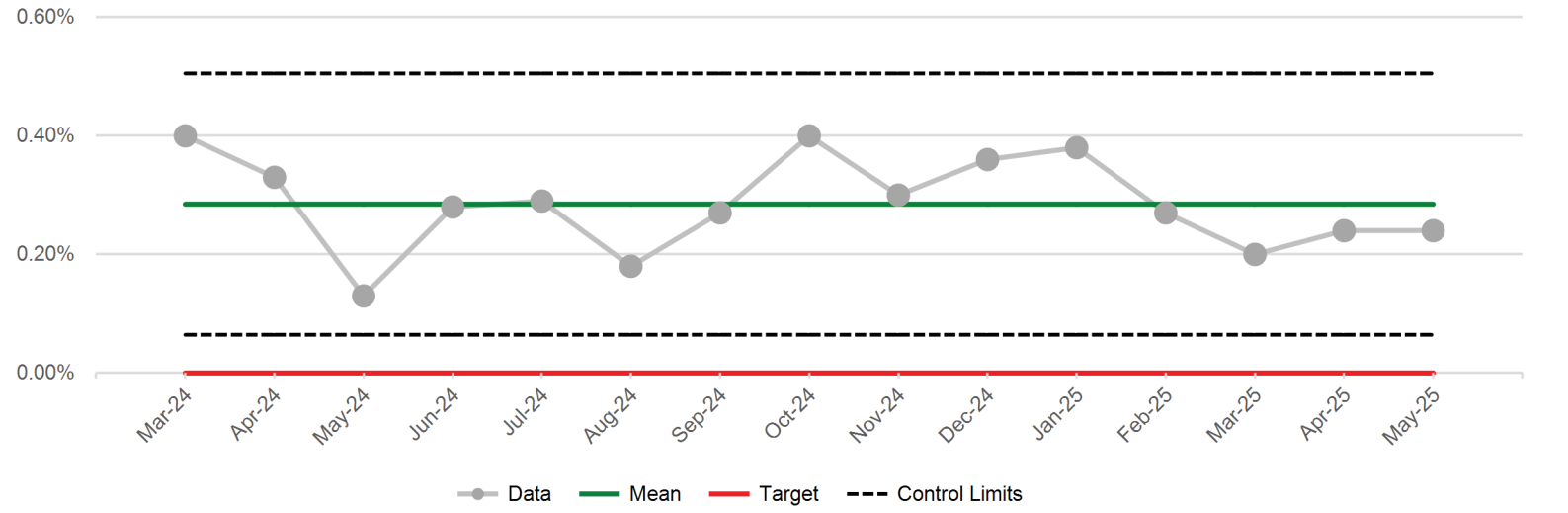
5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-25	Apr-25	May-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	79.50%	68.10%		68.10%	93.00%	F	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	91.60%	89.80%		89.80%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	95.70%	98.40%		98.40%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	70.60%	73.10%		73.10%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	77.40%	71.30%		71.30%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	64.70%	83.30%		83.30%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	76.40%	74.10%		74.10%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	68.34%	67.47%	73.01%	70.24%	99.00%	F	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.70%	1.41%	1.13%	1.27%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	29	34	27	61	0	F	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	55.26%	48.00%	46.67%	47.34%	90.00%	F	L

Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-25	Apr-25	May-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	38.16%	28.00%	27.78%	27.89%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,521	4,511	4,907	4,709	4,657	P	
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	128	217	413	315	0	F	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	78	71	98	N/A	N/A	F	H
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.85	2.61	2.96	2.79	2.80	?	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.52	4.61	4.55	4.58	4.50	F	L
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.50%	Submission suspended	Submission suspended	Submission suspended				
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	37,147	37,969	38,948	38,459	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	36.67%	37.16%	38.70%	37.93%	45.00%	F	

Performance Overview - Operational Performance

% Triage Data Not Recorded



May-25
0.24%
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

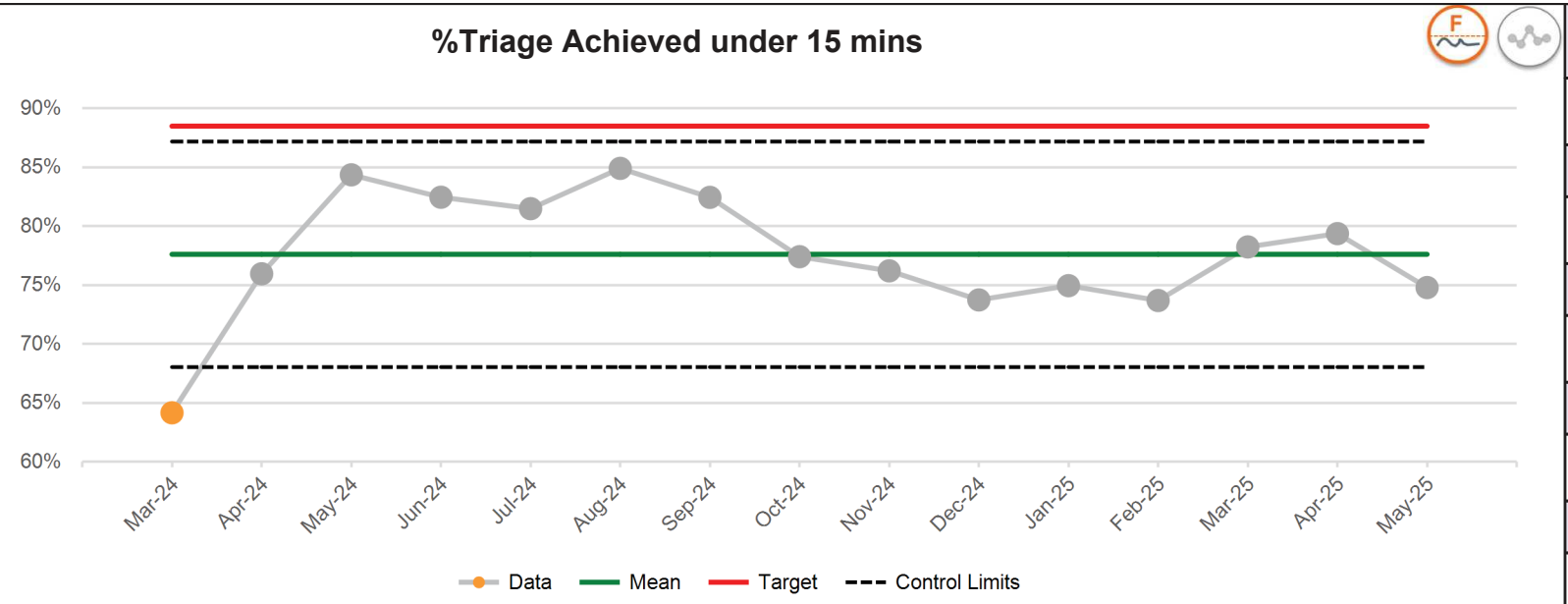
What the chart tells us:
May reported a non-validated position of 0.24% of data not recorded versus the target of 0%. To note, 85% of those without a triage recorded “did not wait” to be seen or diverted to UTC. Of those who did not wait to be seen they waited an average of 45 minutes.

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:
- 3 daily capacity and performance meetings to identify recording delays early, along with confirmation through tailored daily updates from the (UEC) team.
- Twice-daily staffing reviews to ensure the appropriate allocation of the Emergency Department (ED) workforce to meet performance indicators.
- The Urgent and Emergency Care Clinical Business Unit is continuing to perform daily interventions to ensure compliance with recording and operational requirements.

Performance Overview - Operational Performance



May-25
74.80%
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

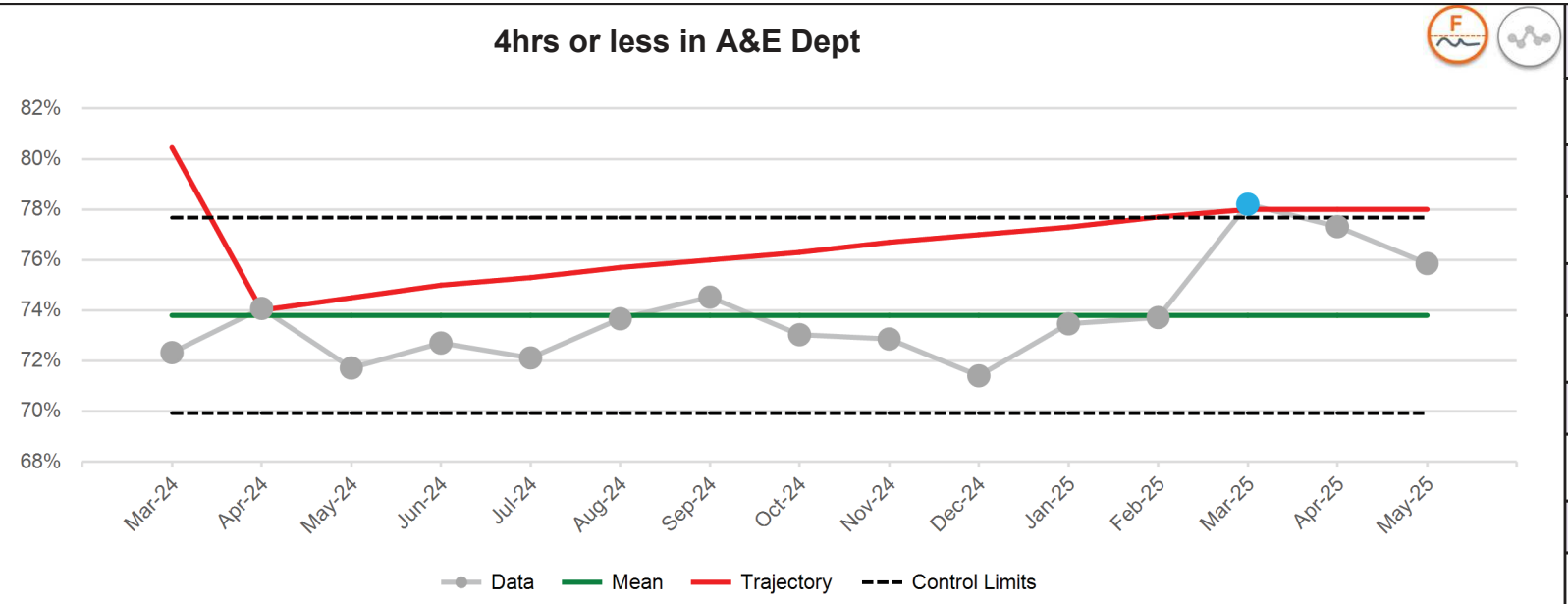
What the chart tells us:
Mays outturn was 74.80%, compared to 79.38% in April (validated). This represents a negative variance of 13.7% from the target of 88.50%. Mays performance shows a 9.57% decline compared to the same month in 2024.

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.

Performance Overview - Operational Performance



May-25
75.86%
Variance Type
Common cause variation
Trajectory
78.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
The 25/26 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 75.86%, representing a decline over April's performance of 77.32%. It is important to note that the chart does not account for the increased volume and acuity of presentations to the department.

Issues:
In May 2025, Type 1 witnessed an average daily patient volume of 559, reflecting an 3.36% increase from the 540 patients attended to in April 2025.

ED encountered a deficiency in discharges from the wards, with an average of 30 fewer patient discharges per day than necessary to meet the demand. This led to extended wait times for inpatient beds during the night. Additionally, delayed identification of patients eligible for prolonged stays in the ED was noted, with over 60% of patients being identified only after 4 pm daily.

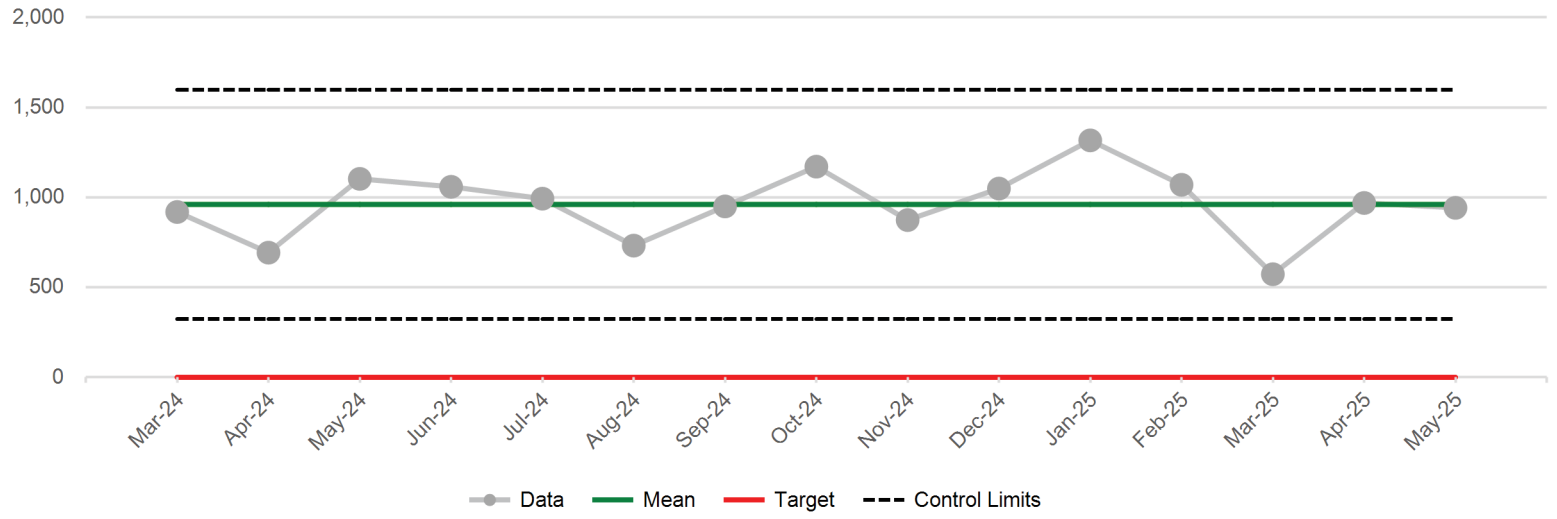
Type 3 (All locations) observed an average of 433 daily patients, representing a 1.01% increase to the preceding month.

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



May-25
942
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:
May experienced 942 breaches, a improvement from 969 in April, marking a variance of 2.79% (27 less patients). The 942 breaches accounted for 5.44% of all type 1 attendances. Additionally, the chart did not capture the adhoc internal decisions made to prioritise total time in the Emergency Department, aimed at minimising exposure risk and mortality rate.

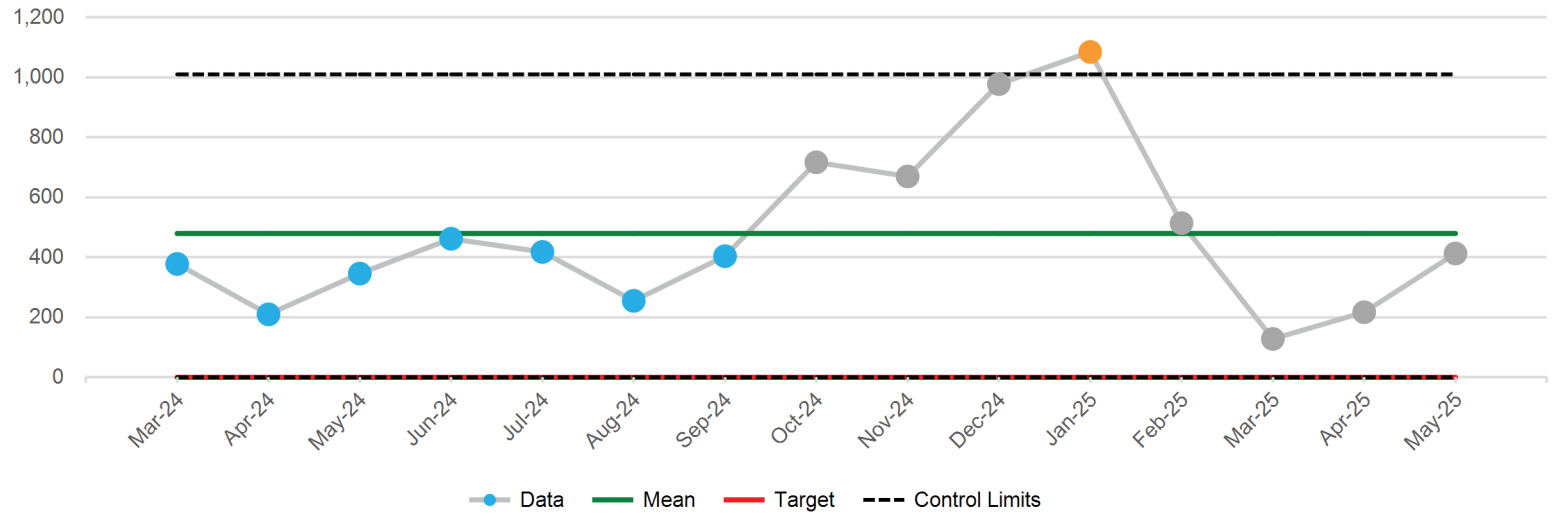
Issues:
Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings.

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

Mitigations:
A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support.
A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.
An additional consultant shift was funded by winter monies to review all DTAs every day to ensure that they still require admission
Rapid Assessment and Treatment consultant shifts are in place at both ED front doors to assist with length of stay in department and appropriateness of referrals/navigation.

Performance Overview - Operational Performance

EMAS Conveyances Delayed >59 mins



May-25
413
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Delays in offloading patients following a conveyance has a known impact on the ability of EMAS to respond to outstanding calls

What the chart tells us:
Ambulance handovers exhibited a deterioration in May with 413 arrivals recorded in contrast to the 217 arrivals documented in April. This accounted for 8.4% of all handovers in May 2025. 21.61% of patients arriving were already scoring above 4 on (NEWS) at the time of presentation.

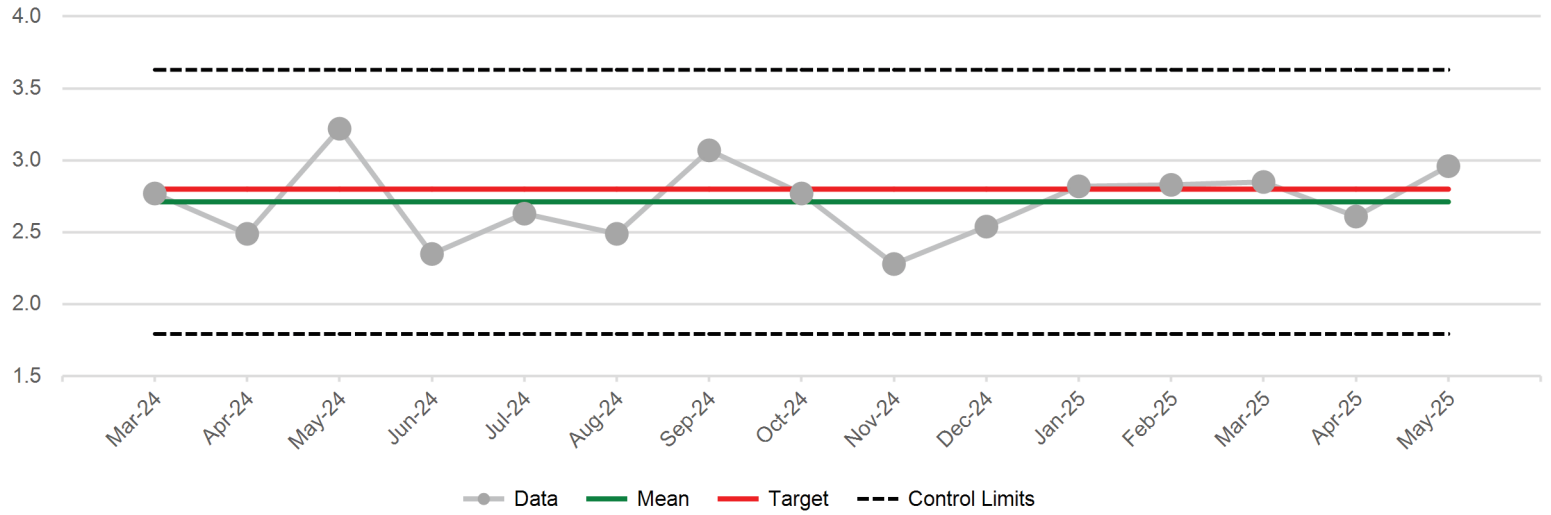
Issues:
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number 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.

Performance Overview - Operational Performance

Average LoS - Elective (not including Daycase)



May-25
2.96
Variance Type
Common cause variation
Target
2.80
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Chief Operating Officer

Background:
The average length of stay for Elective inpatients

What the chart tells us:
The average LOS for Elective stay has increased to 2.96 days compared to 2.6 days in the preceding month. This represents a negative variance of 0.16 days against the agreed target.

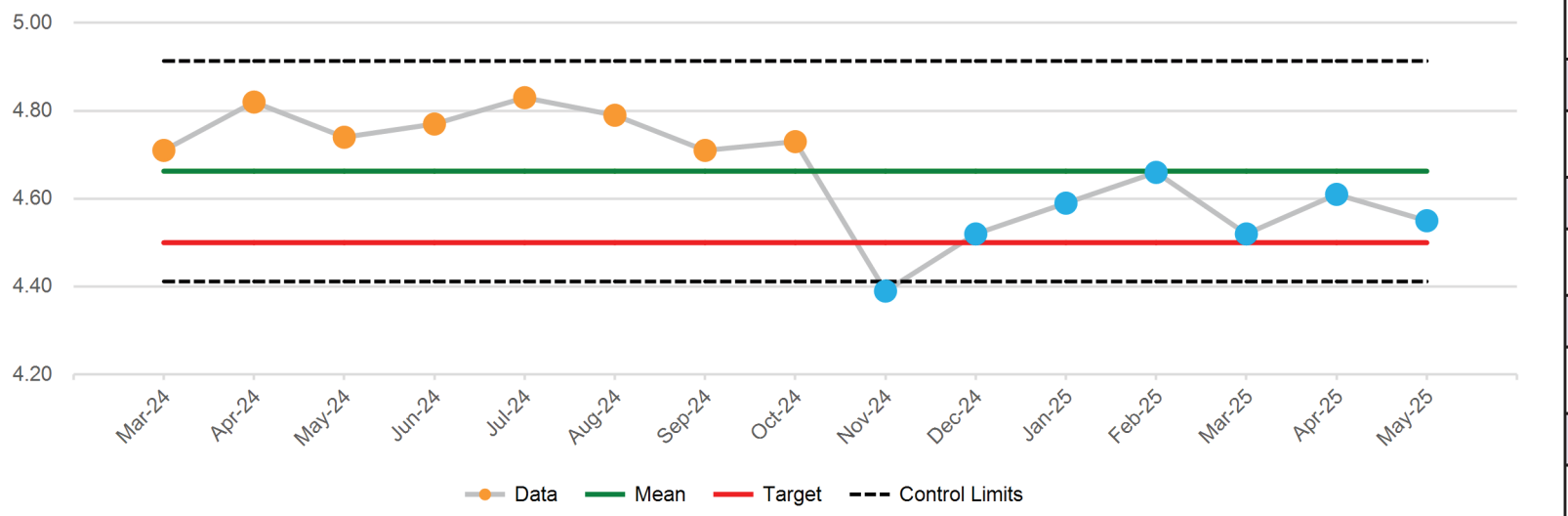
Issues:
The complexity of patients currently being admitted is rising, which will have implications for post-operative recovery and length of stay (LOS). There has also been an increase in the number of elective patients within pathways 1, 2, and 3. Furthermore, the data concerning outliers in the previously designated elective beds and coding has been skewed.

Actions:
The reduction in waiting times is being assessed on a weekly basis. Our attention is directed towards specialty waiting lists, particularly for patients who have been identified as experiencing increased morbidity, as this condition may result in an extended length of stay (LOS). Moreover, we are prioritizing the timely transition of patients from Intensive Care Unit (ITU) level 2 care to level 1 "wardable" care.

Mitigations:
The weekly 6-4-2 theatre scheduling meetings will identify patients who may require an extended length of stay (LOS) and will consider strategies for increased optimization to reduce the predicted LOS.

All elective areas are now required to pre-operatively escalate any post-operative needs that could lead to an extended LOS beyond what is typically expected.

Performance Overview - Operational Performance



May-25
4.55
Variance Type
Special cause variation - improvement (Indicator where low is good)
Target
4.50
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Average length of stay for non-Elective inpatients

What the chart tells us:
May outturn of 4.55 is a improvement of 0.06 days and a 0.05-day negative variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (0.9) less days
Pathway 1 (1.1) more days
Pathway 2 (5.8) more days
Pathway 3 (3.3) more days

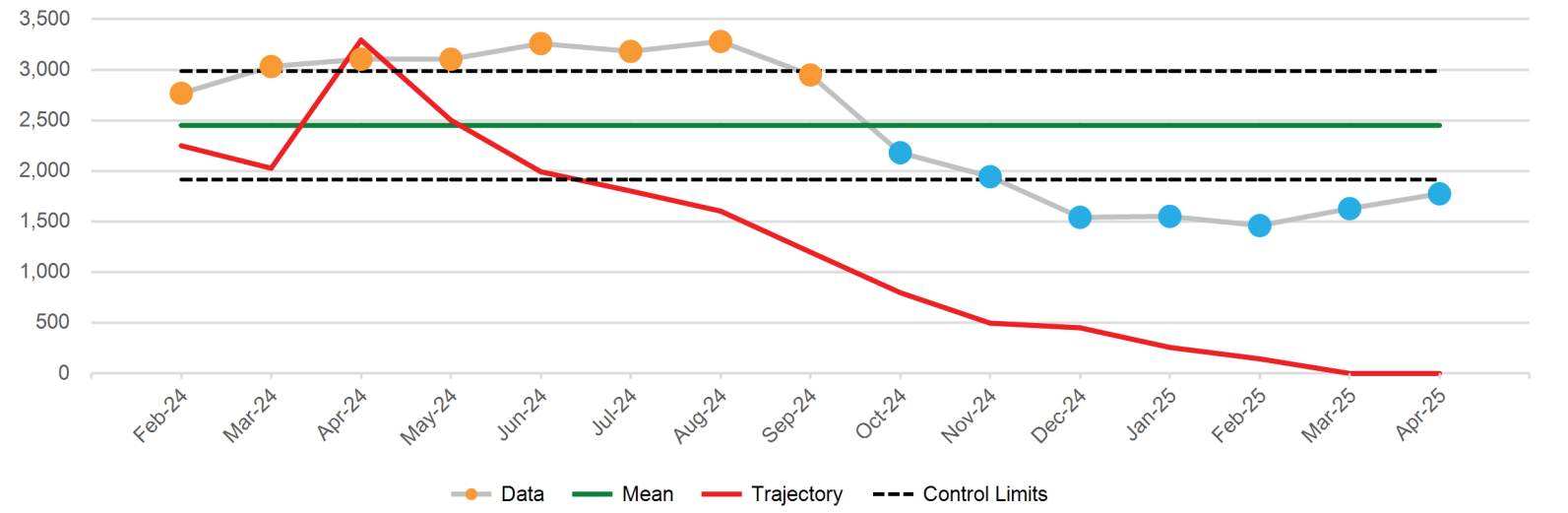
Issues:
In May, there was a decrease in performance in the number of super-stranded patients, with the daily average increasing to 144 from 132. However, with the number of stranded patients (14 days) remaining static at 218 daily. Weekend discharges consistently remained lower than weekdays, with a 46.63% reduction and an average of 66 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 No Criteria to Reside 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.
- Weekly review of Long Stay Patients
- Daily Updates to ASC regards new admissions whose package of care can be realigned to other patients due to expected spell duration.

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

Performance Overview - Operational Performance



Apr-25
1,775
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 52 weeks for treatment

What the chart tells us:
The Trust reported 1,775 incomplete 52-week breaches for April 2025, an increase of 146 from March's 1,629.

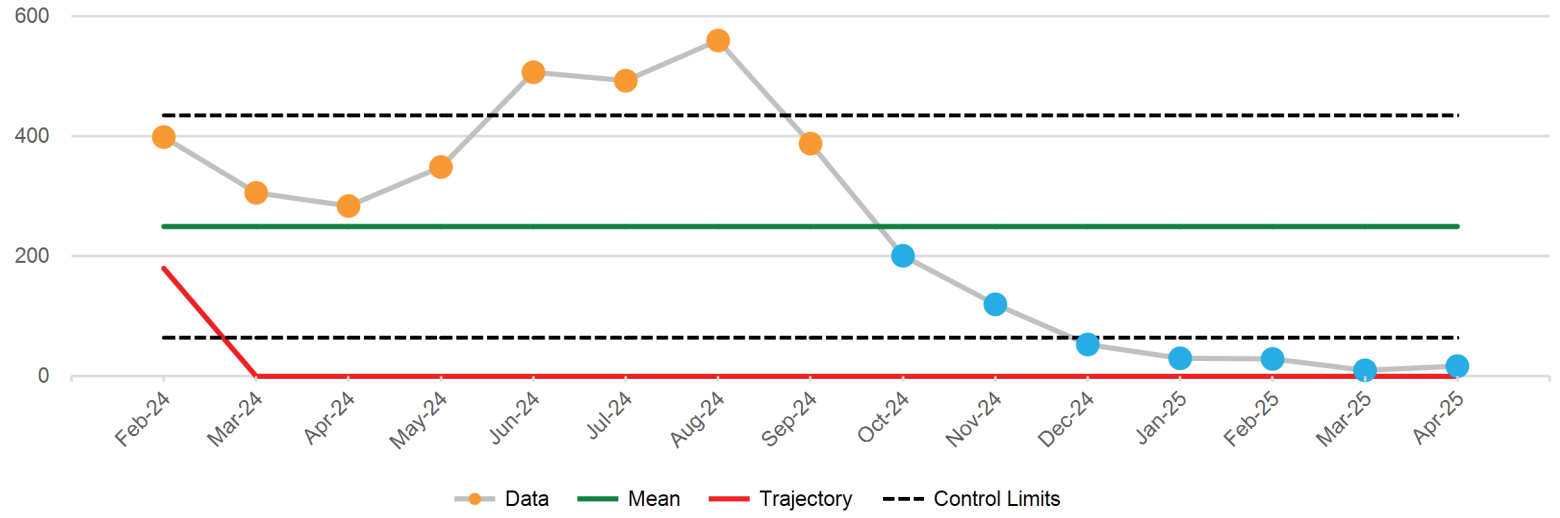
Issues:
As shown above, 52 week waiters are positively performing against trajectory, albeit with an increase in numbers from last month. Both admitted and non-admitted patients sit within this wait band, however, the most significant pressure is in the non-admitted pathways. ENT continues to be the specialty under greatest pressure, which together with audiology, accounts for 46.87% of patients in this wait band. A decrease of 2.73% from last month.

Actions:
Insourcing for additional ENT clinics and additional DMC clinics for Gastroenterology continues. The additional clinics have reduced both total waiting list size and long waiters.
It has been recognised that 52-week performance is deteriorating and is being managed through the Trust's Performance Review Meetings with each division

Mitigations:
ULTH 52 week position in current data (W/E 25th May '25) ranks 5th for this metric within the Midlands region (11 Providers).
The weekly PTL meetings monitor and track patients down to 52w for the majority of specialties.

Performance Overview - Operational Performance

65 Week Waiters



Apr-25
17
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 17 incomplete 65-week breaches for April 2025, an increase of 7 from March's 10.

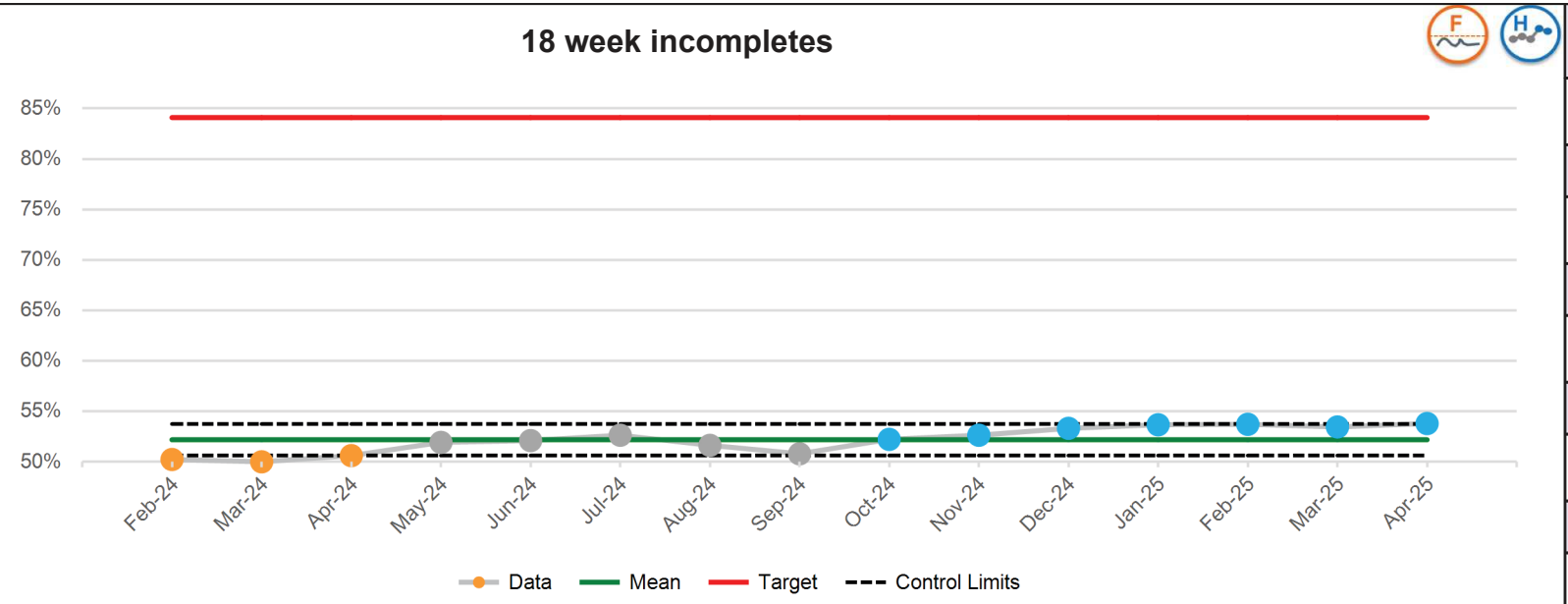
Issues:
ULHT's 104 week wait position was zero for April. As shown above, 65 week waiters have increased slightly this month.

Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through PTL meetings.
This meeting includes particular focus 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:
Current data (W/E 25th May '25) ranks ULTH 2nd for 65w actual metrics within the Midlands region (11 Providers).

Audiology performance recovery paper under development.

Performance Overview - Operational Performance



Apr-25
53.80%
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. April 2025 saw RTT performance of 53.80% against an 84.1% target, which is 0.35% up from March.

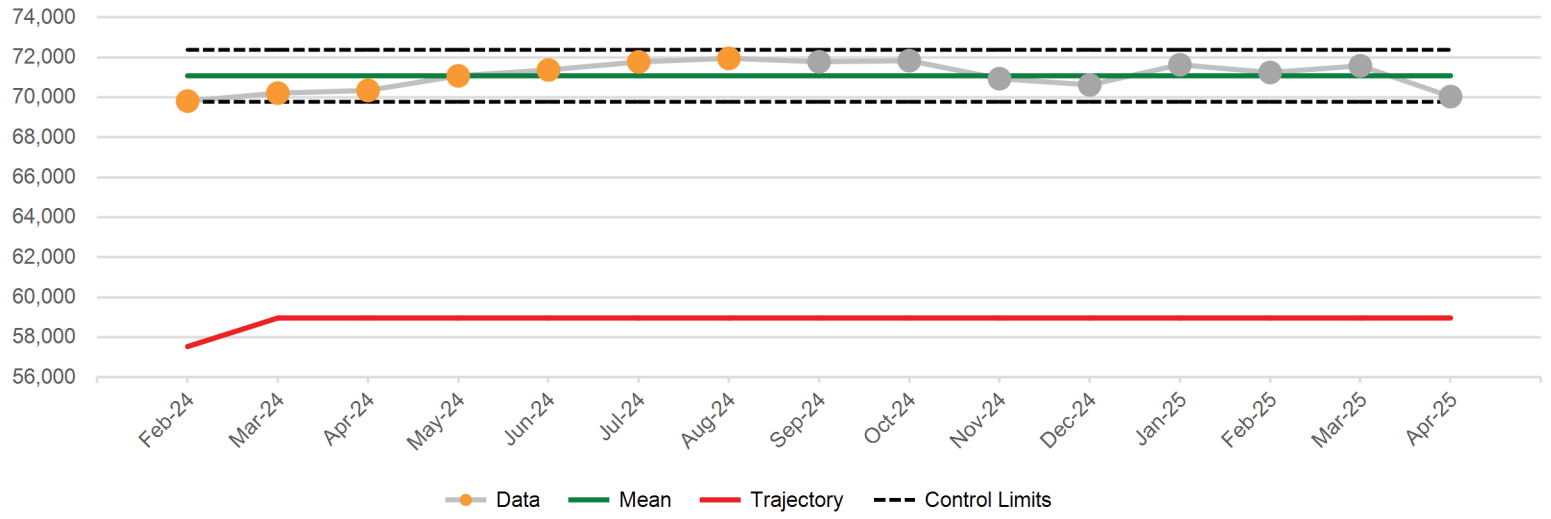
Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:
ENT– 5,706 (decreased by 408)
Gynaecology – 3,112
(decreased by 180)
T&O–2,846 (increased by 164)
Ophthalmology – 2,426 (decreased by 62)
Gastroenterology – 2,231 (decreased by 354)

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;
-Outpatient utilisation
-Tertiary capacity
-Outsourcing/Insourcing
-Use of ISPs
-Reducing missing outcomes

Mitigations:
To support delivery of actions and to maintain drive on recovery,
focus continues on capturing all activity. Current data (W/E 25th May '25) ranks ULTH 9th for RTT performance metrics within the Midlands region (11 Providers).
Ophthalmology and ENT clinic templates and slot utilisation are currently under review to rationalise and ensure efficiency and increase productivity.

Performance Overview - Operational Performance

Waiting List Size



Apr-25
70,044
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 March, with April showing a decrease of 1,538 to 70,044
This is more than double the pre-pandemic level reported in January 2020.

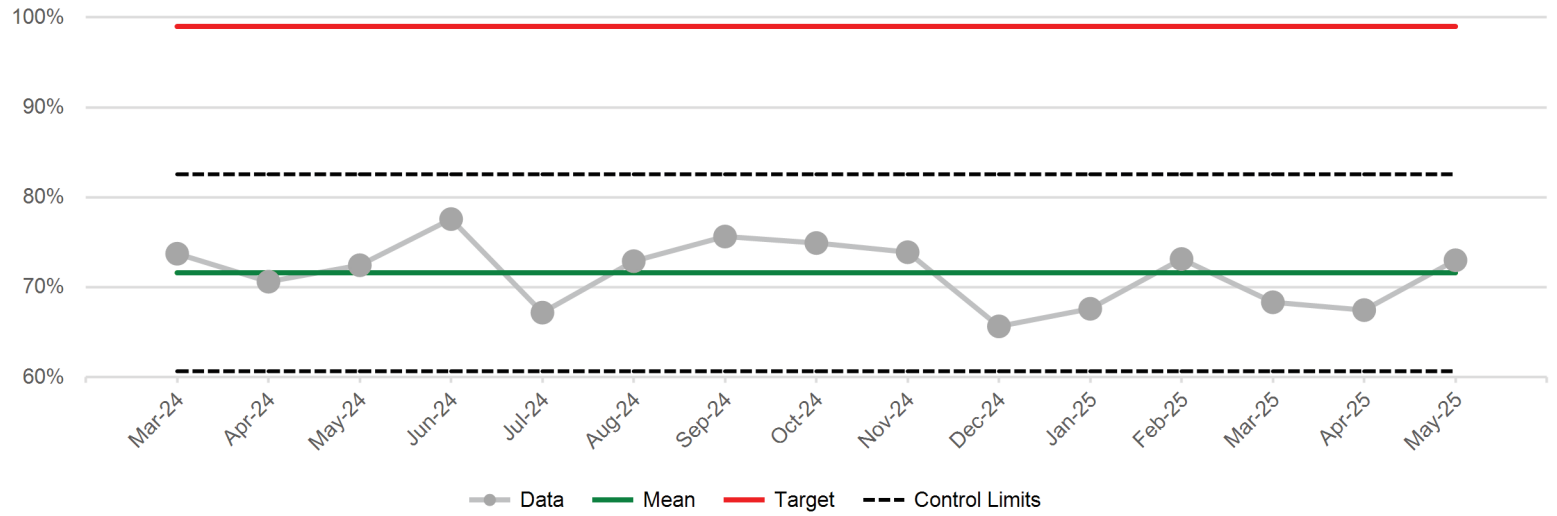
Issues:
Following the backlog increase from the pandemic, there have been additional pressures that have affected capacity, including urgent care pressures.
The five specialties with the largest waiting lists are;
ENT – 9,545
Trauma & Orthopaedics 6,241
Ophthalmology – 6,029
Gynaecology – 5,968
Gastroenterology – 4,849

Actions:
Improvement programmes as described above for RTT performance.
Fortnightly outpatient waiting list CBU meetings.
Outpatient services continue to work with specialties to facilitate extra activity. Improvement team working with specialties to increase PIFU uptake.
The internal validation team in conjunction with the EACH are currently undertaking a National validation sprint involving administrative and technical validation of patient pathways.

Mitigations:
The number of patients waiting over 78 weeks continues to be zero. Current data (W/E 25th May '25) ranks ULTH =1st for this metric and 4th for total waiting list size within the Midlands region (11 Providers)
Appropriate admitted and non-admitted patients continue to be transferred out to ISP's or insourced.

Performance Overview - Operational Performance

Diagnostics achieved



May-25
73.01%
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 May was 73.01% against the 99.00% target.

Issues:
Most 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.

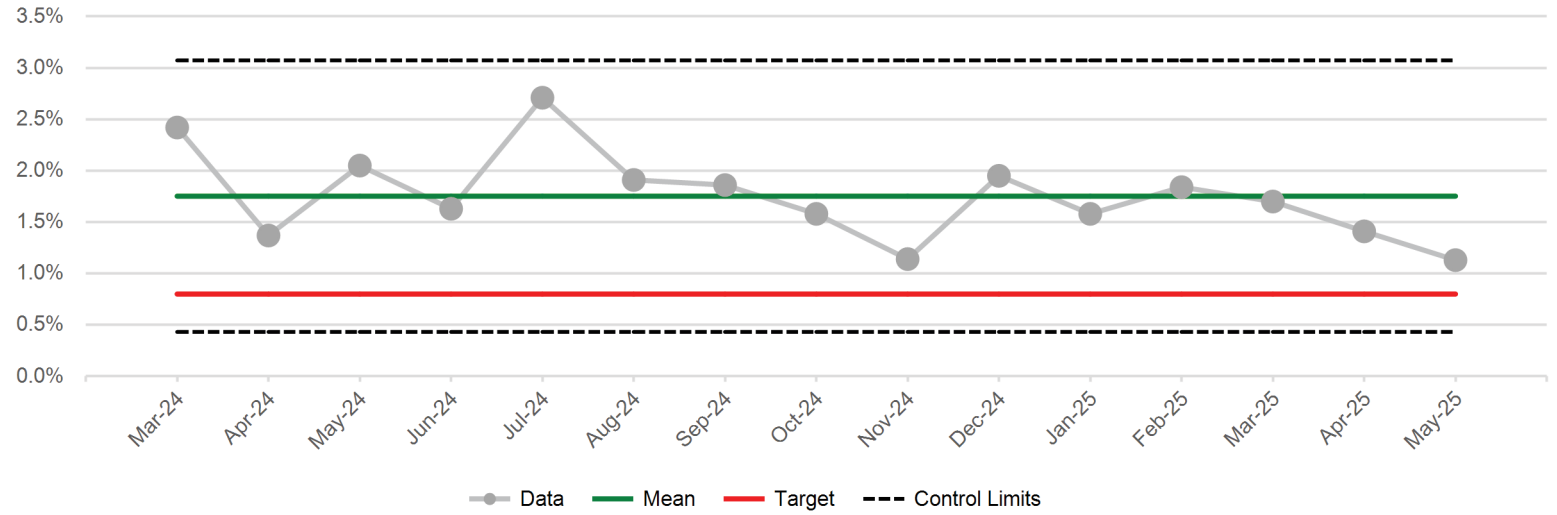
Actions:
Radiology is working to their recovery plans. Ultrasound are using agency where possible and additional shifts,

Audiology have submitted a long-term recovery paper and are awaiting outcomes from the paper.

Mitigations:
Patients are being seen in clinical priority.

Performance Overview - Operational Performance

Cancelled Operations on the day (non clinical)



May-25
1.13%
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 further decrease in the number of non-clinical cancellations in May, though this remains over the 0.80% target.

Issues:
Top 3 theatre cancellations for May were:
Staff unavailable (theatres/anaesthetics/surgeons)
Lack of time
DNA

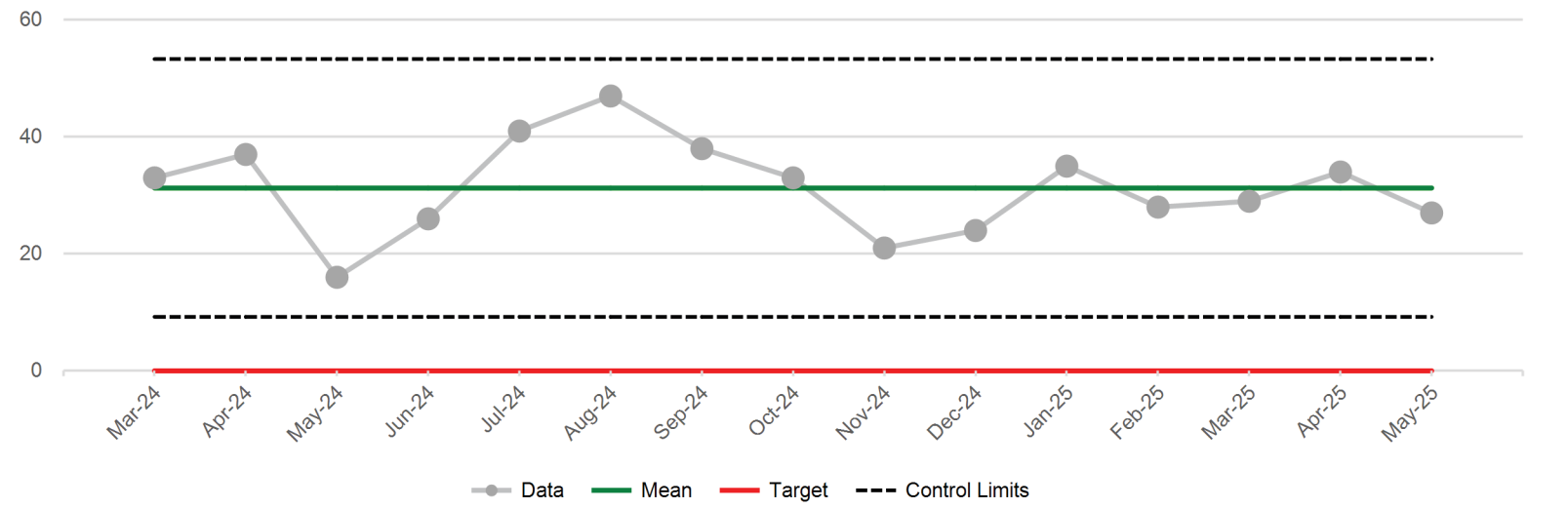
Unavailability of staff was primarily due to theatre staffing and represents significant absences as well as reduction in bank/agency use.

Actions:
Lincoln are introducing a reduced theatre floorplan and we are starting to work with specialties to identify any activity that can be moved to other sites. Estimated start Sept 2025 then will look to replicate this on other sites.

We are also about to start working with EY to improve 642, pre assessment and theatre utilisation.

Mitigations:
Ongoing work around reducing cancellations on the day is improving our position.

Performance Overview - Operational Performance



May-25
27
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There has been a decrease from 34 in April to 27 in May.

Issues:
There continues to be a focus on long waiters and the trauma backlog which both have an impact on elective lists and has made rebooking patients more challenging.

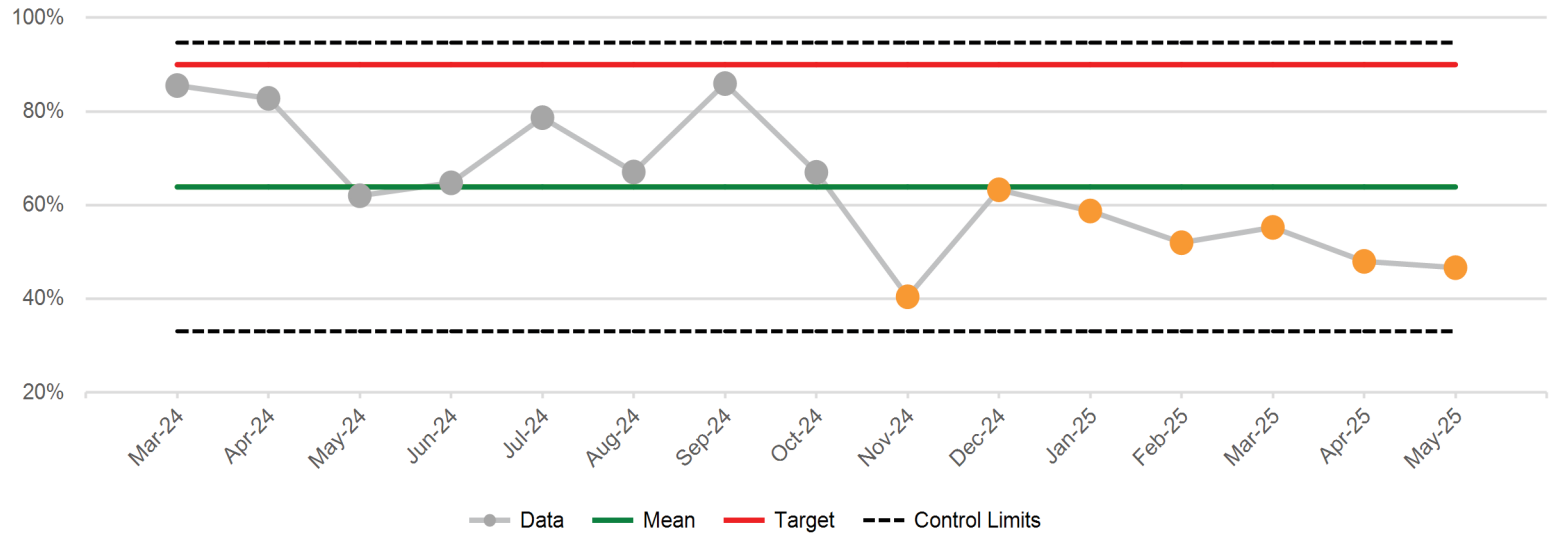
For some specialties, there is delay with clinicians prioritising patients – this is being picked up by CBUs.

Actions:
Focus to remain on improved utilisation on our lists using 642. Pre meets provide actions which are monitored daily within the waiting list and specialty teams.
Implementation of standby patients continues to be pushed in specialities with low utilisation/increased COTD to support reduced breaches however these need to be optimised due to Pre Assessment capacity.

Mitigations:
EY will be on site from 16.6.25 to support improving utilisation including looking at theatre start times, over booking of lists, early and late finishes.

Performance Overview - Operational Performance

#NOF 48 hrs



May-25
46.67%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
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 May was 46.67%

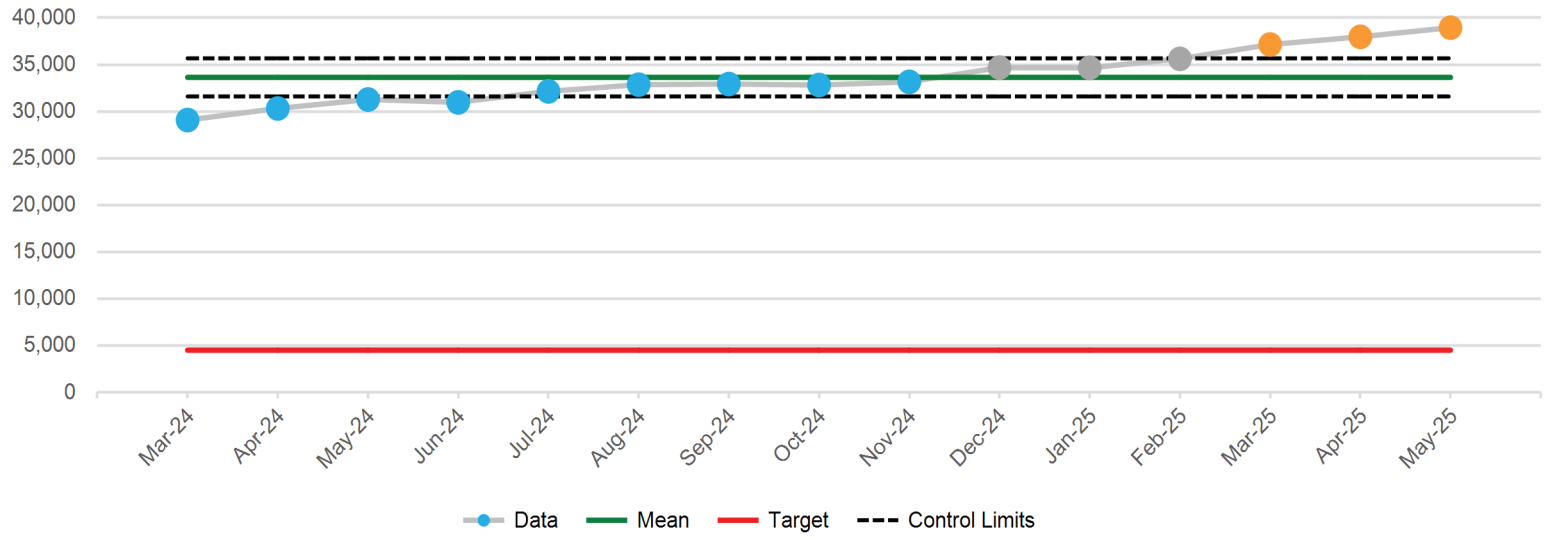
Issues:
- Lack of theatre space to accommodate Femur fractures.
- ULHT continue to have a high demand of trauma patients admitted with one trauma list planned daily on both sites.
- Lack of theatre staff to provide additional trauma capacity.
- ULHT breaching the NHFD best practice tariff for femur fractures.
- 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



May-25
38,948
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

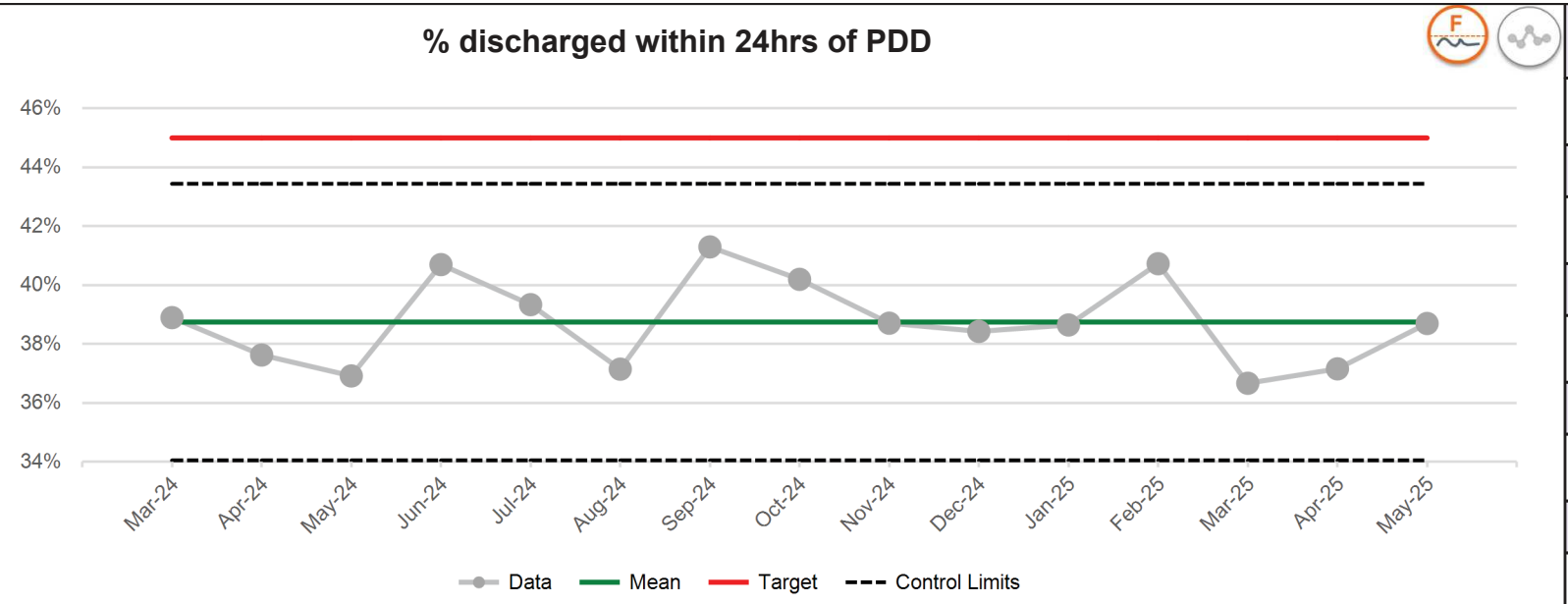
What the chart tells us:
Currently at 38,948 against a target of 4,524. During Covid the number of patients overdue significantly increased and the trend has seen a steady increase since, an exception being Aug 23 – Nov 23 and Oct 24, since when the number of overdue patients has continued to increase.

Issues:
The organisation has several competing priorities. The current focus is on the long waiting patients (> 65 and >52 weeks) and potential cancer patients The current PBWL demand outweighs the current capacity which is being impacted by available capacity 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 clinic process has been revised to improve capacity and vacant slots. Clinic Scheduler x 2 in post. 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, 52-week and urgent suspected cancer patient cohort.

Performance Overview - Operational Performance



May-25
38.70%
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 Predicted Date of Discharge

What the chart tells us:
The current performance metrics reveal a improvement in comparison to April's sharp improvement. Resulting at 38.70%.

Issues:
The delivery team initially provided support to the wards to enhance compliance with WebV. However, following the discontinuation of this support and the transition of responsibilities to Business As Usual (BAU), there had been a marked decline in performance. Furthermore, the cessation of involvement from SAFER Practitioners raises concerns that compliance may regress if BAU defaults to previous standards.

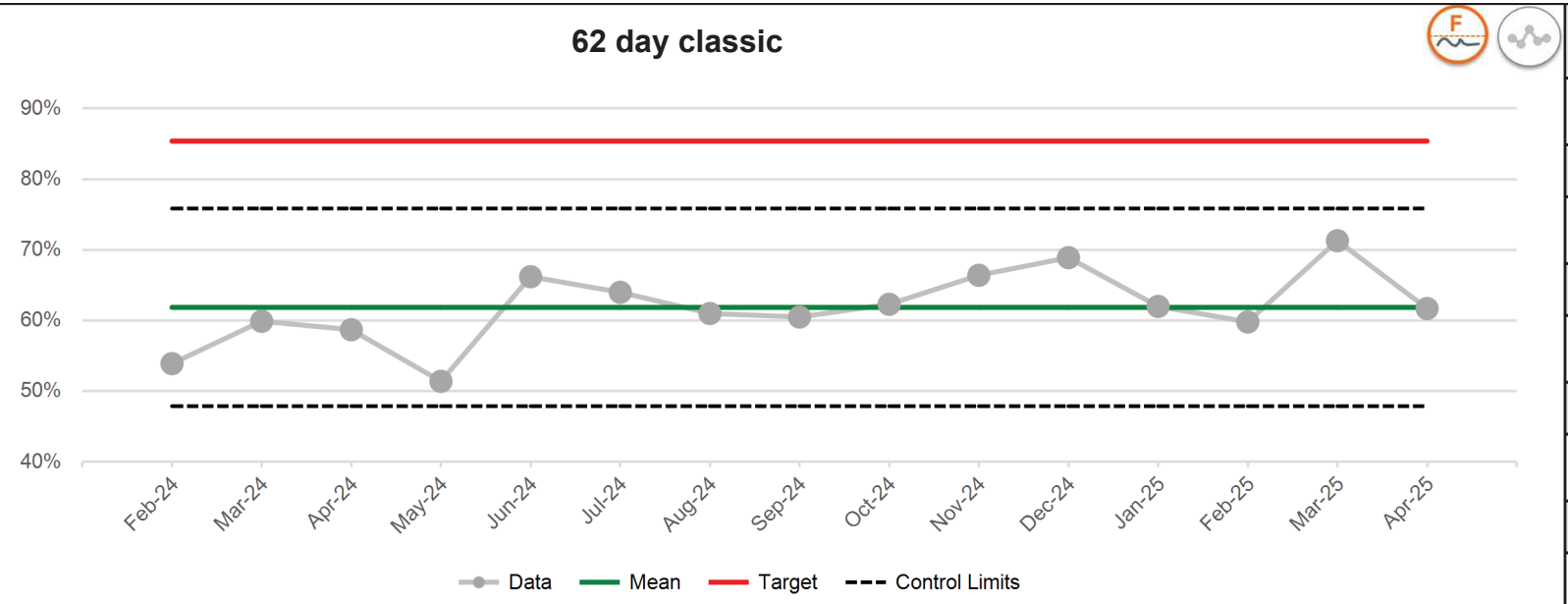
Issues related to staff compliance, competence, and resource allocation persist, particularly during weekends when there is an increased reliance on bank and agency personnel in the wards. Consequently, several WebV fields are not updated with the same accuracy or frequency on weekends as they are during weekdays.

Actions:
Ongoing weekly monitoring is being executed, and any identified areas of concern are communicated to the ward sisters and matrons to facilitate performance improvement.

New processes have been established in conjunction with the weekly non-criteria to reside situational reports to ensure that the data recorded regarding the wards accurately reflects the patients' true conditions. Additionally, themes and trends are identified in real-time to enable timely interventions.

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.

Performance Overview - Operational Performance



Apr-25
61.70%
Variance Type
Common cause variation
Target
85.39%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients to start a first treatment within 62 days combined

What the chart tells us:
We are currently at 61.70% 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 75% compliance in the 62 day combined standard by the end of March 2026.

Please also see Issues on accompanying pages.

Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing, consultant due to starts June 2026.
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 increased from 2 to 3 slots per day starting from July.

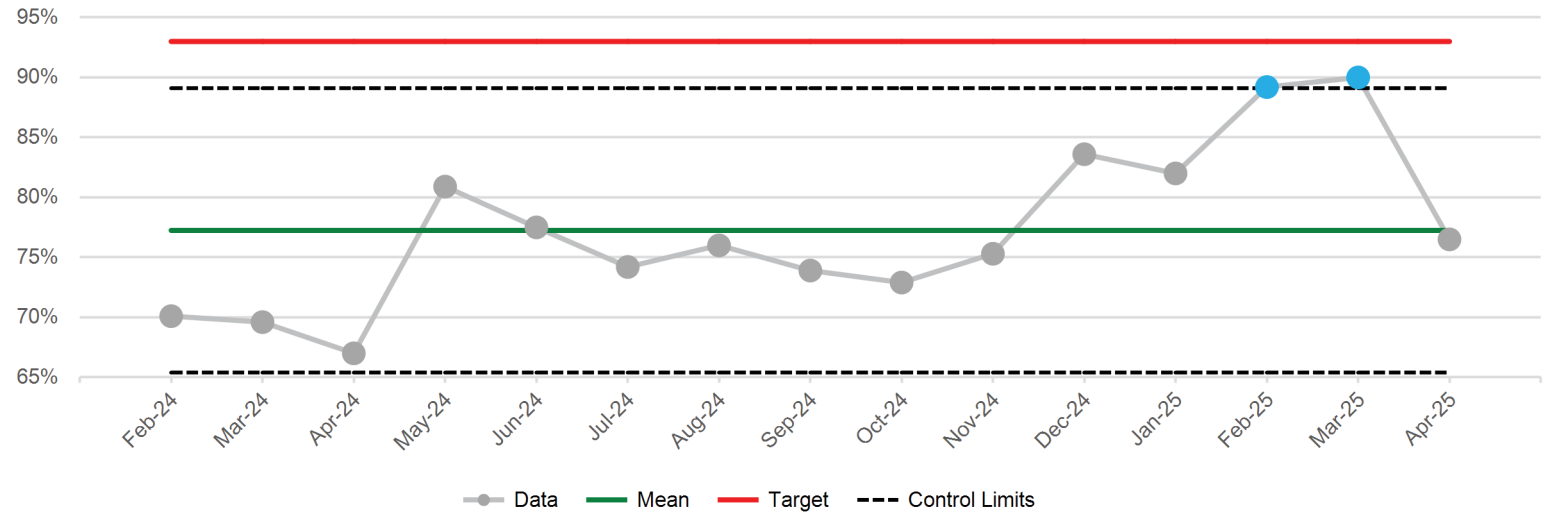
Please also see Actions on accompanying pages.

Mitigations:
A process is now in place to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

2 week wait suspect



Apr-25
76.50%
Variance Type
Common cause variation
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 76.50% against a 93% target.

Issues:
Patients not willing to travel to where our service and/or capacity is available.
The Trust's 14-day performance remains affected by the ongoing alignment issues in Breast Service One-Stop appointments, due to clinician capacity.
Breast accounted for 10.73% of the Trust's 14 day breaches which is an improvement on recent months.
Additionally, Gynaecology speciality were responsible for 15.77% of the Trust's 14 day breaches in April.
Skin tumour site accounted for 52.20% of the Trust's 14-day breaches in April. We have started to see a seasonal increase for referrals which will likely continue through to Autumn.

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 September 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 is established in post.

Please also see Actions on accompanying pages.

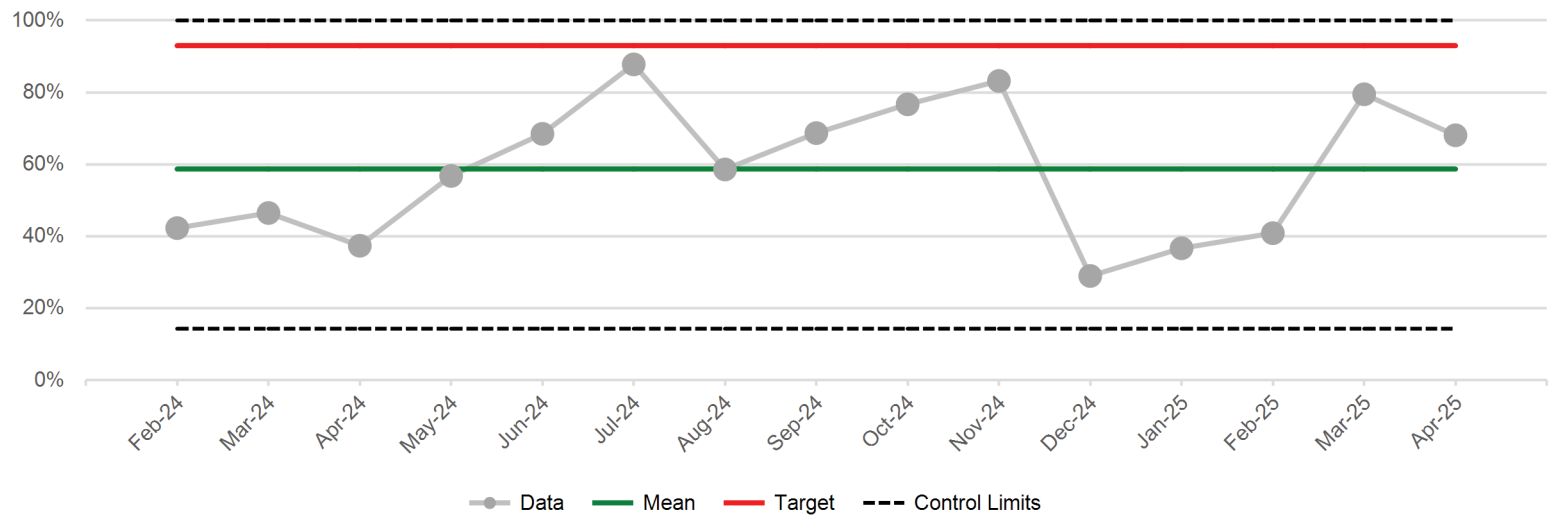
Mitigations:
Haematology is in fragile services due to vacancy/capacity. Issues with inappropriate referrals and GP engagement continue to be escalated and supported by the ICB and Cancer Navigators will be able to streamline this process.
Delays in the booking and utilisation of appointment slots which continue to be addressed with C&A and the Divisions.
In Gynae, the urgent PMB pathway progress and impact is being monitored. An HRT programme of work is underway with support from ICB colleagues.

The process to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention / support is currently being reviewed.

Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

2 week wait breast symptomatic



Apr-25
68.10%
Variance Type
Common cause variation
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients urgently referred for breast symptoms (where cancer was not initially suspected) seen within two weeks of referral

What the chart tells us:
We are currently at 68.10% 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.

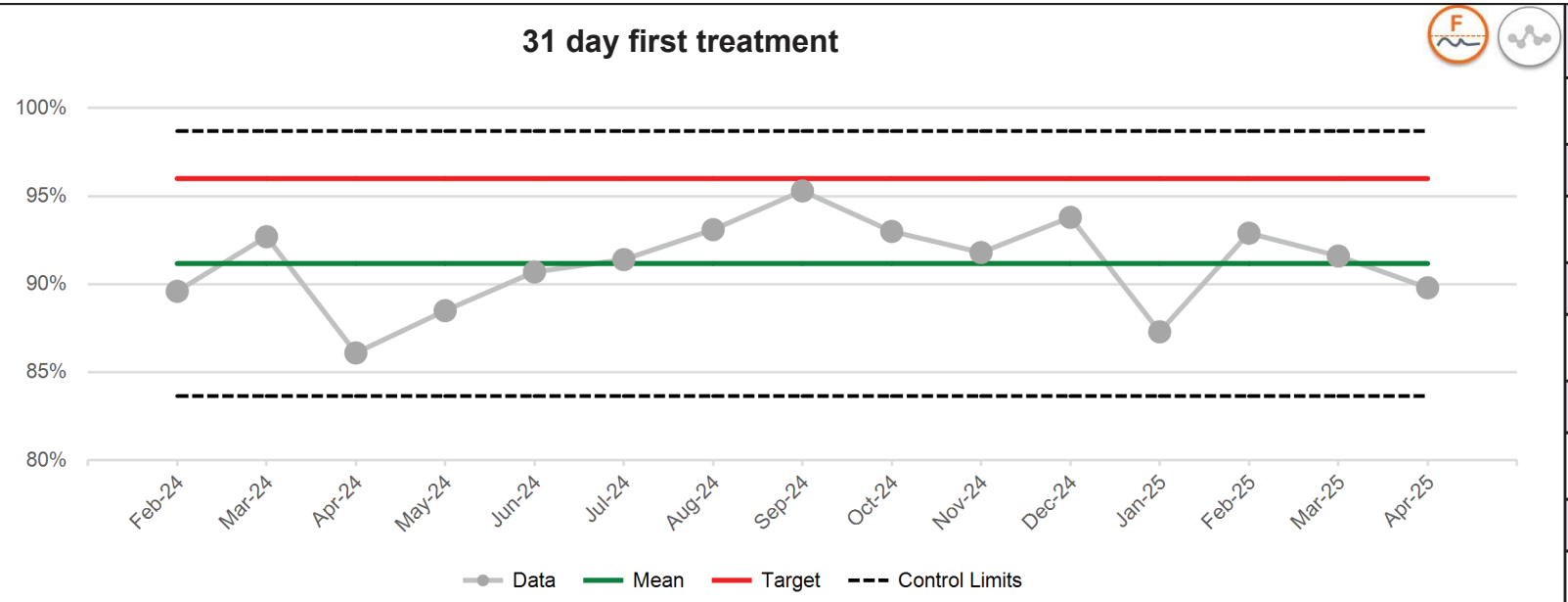
Actions:
Referral process have now returned to C&A, the division continue to monitor to ensure a streamlined transition.
Processes – SOPs relating to DNAs, multiple cancellations and Escalation's are currently being developed and taken through CBU Governance processes for approval.

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



Apr-25
89.80%
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 89.80% against a 96% target.

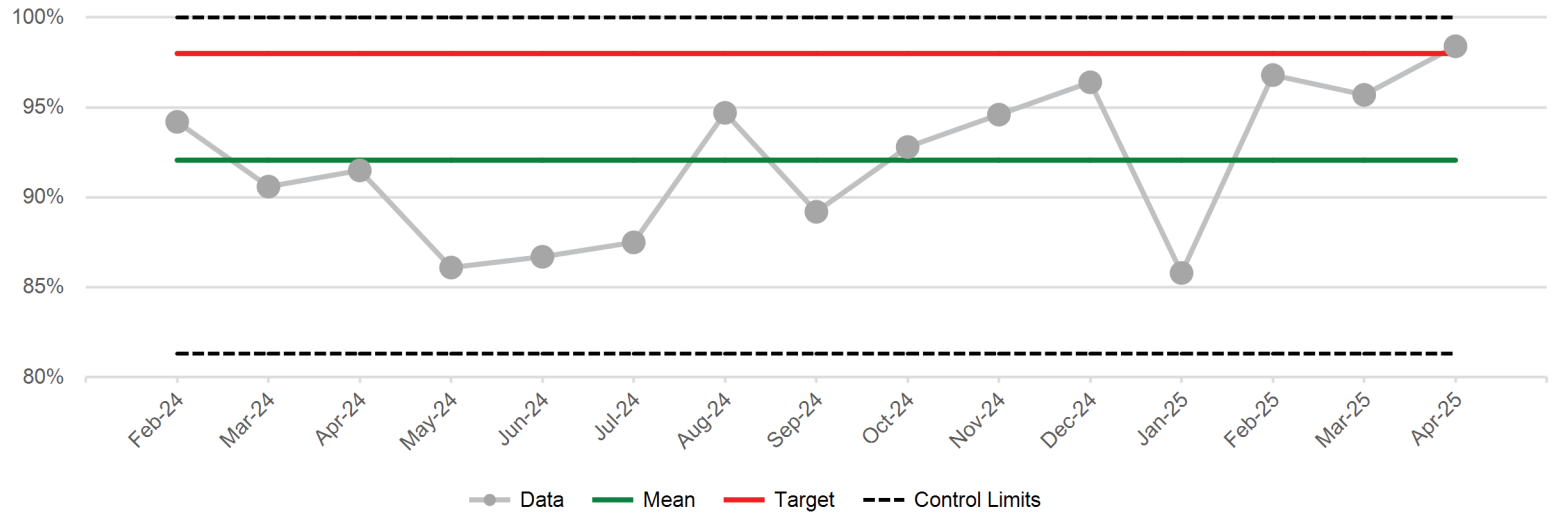
Issues:
The failure of the 31 Day standards was primarily attributed to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment 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, consultant starts June 2026.
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.
A report has been implemented across the Trust to identify those patients at risk of breaching the 31 day standard to bring TCI's forward where possible.

Performance Overview - Operational Performance

31 day subsequent drug treatments



Apr-25
98.40%
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 98.40% against a 98% target.

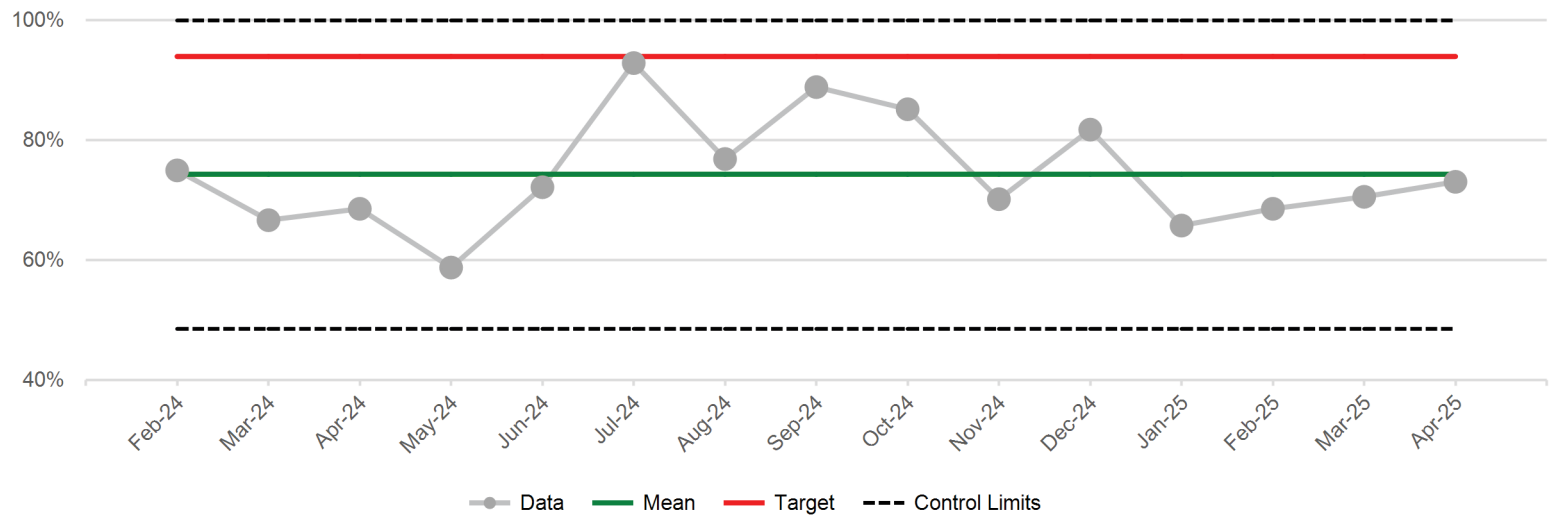
Issues:
In Chemotherapy, staffing shortages, treatment capacity and recent pharmacy staffing shortages have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce is ongoing, consultant starts June 2026.
An ongoing process is underway to ensure shared access to information to ensure breach reasons and adjustments are recorded accurately.

Mitigations:
A report has been implemented across the Trust to identify those patients at risk of breaching the 31 day standard to bring TCI's forward where possible.

Performance Overview - Operational Performance

31 day subsequent surgery treatments



Apr-25
73.10%
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 73.10% against a 94% target.

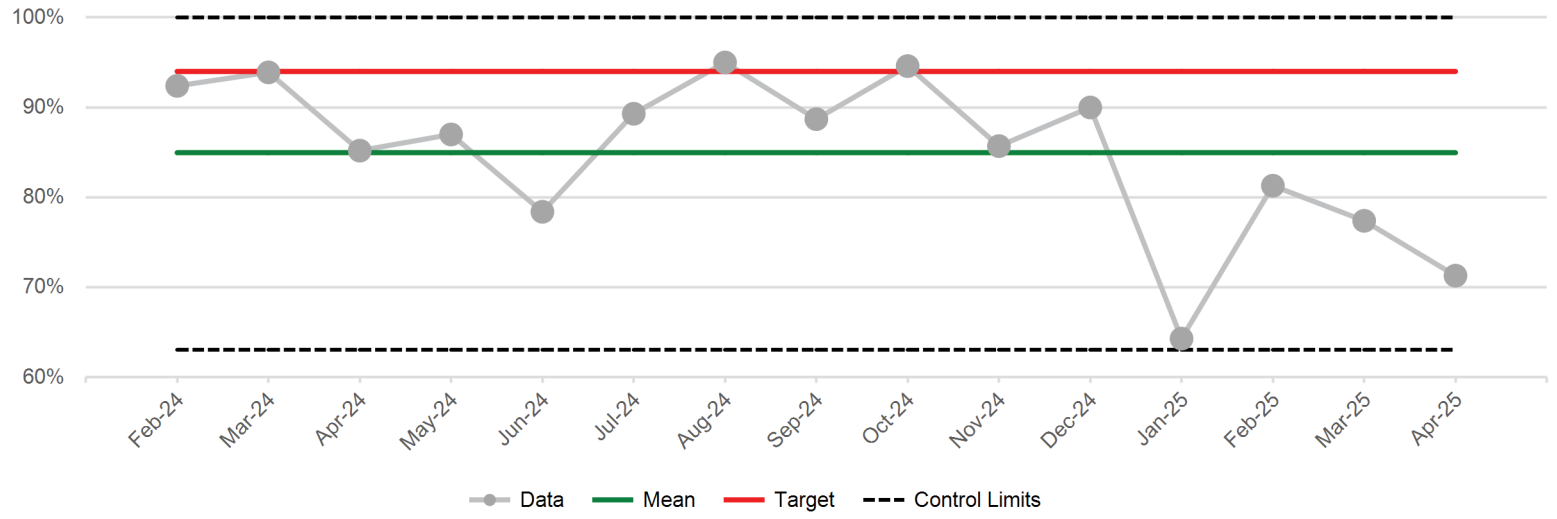
Issues:
The failure of the 31 Day surgery standard was due to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
Colorectal – Current activity complexity is causing delays in allocating surgery dates, e.g. the increase in anterior 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.

Performance Overview - Operational Performance

31 day subsequent radiotherapy treatments



Apr-25
71.30%
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 71.30% against a 94% target.

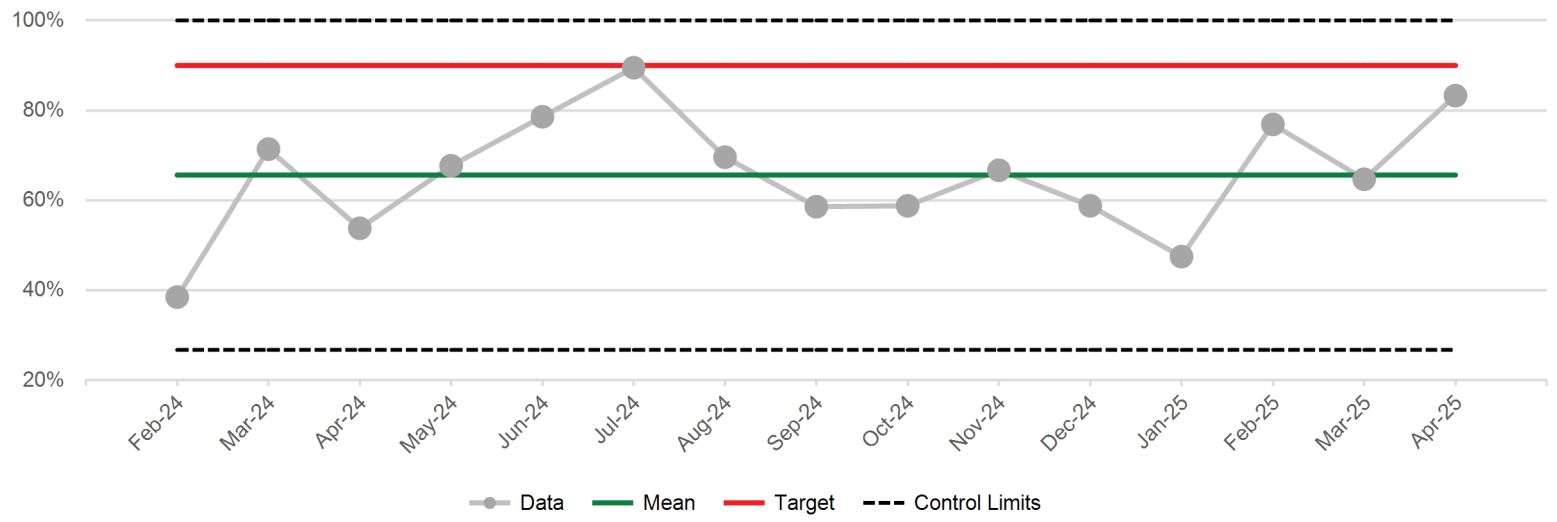
Issues:
Radiotherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce is ongoing, consultant starts June 2026.
A deep dive is being undertaken to ensure shared access to information to ensure breach reasons and adjustments are recorded accurately.

Mitigations:
A report has been implemented across the Trust to identify those patients at risk of breaching the 31 day standard to bring TCI's forward where possible.

Performance Overview - Operational Performance

62 day screening



Apr-25
83.30%
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 83.30% 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 75% compliance in the 62 day combined standard by the end of March 2026.

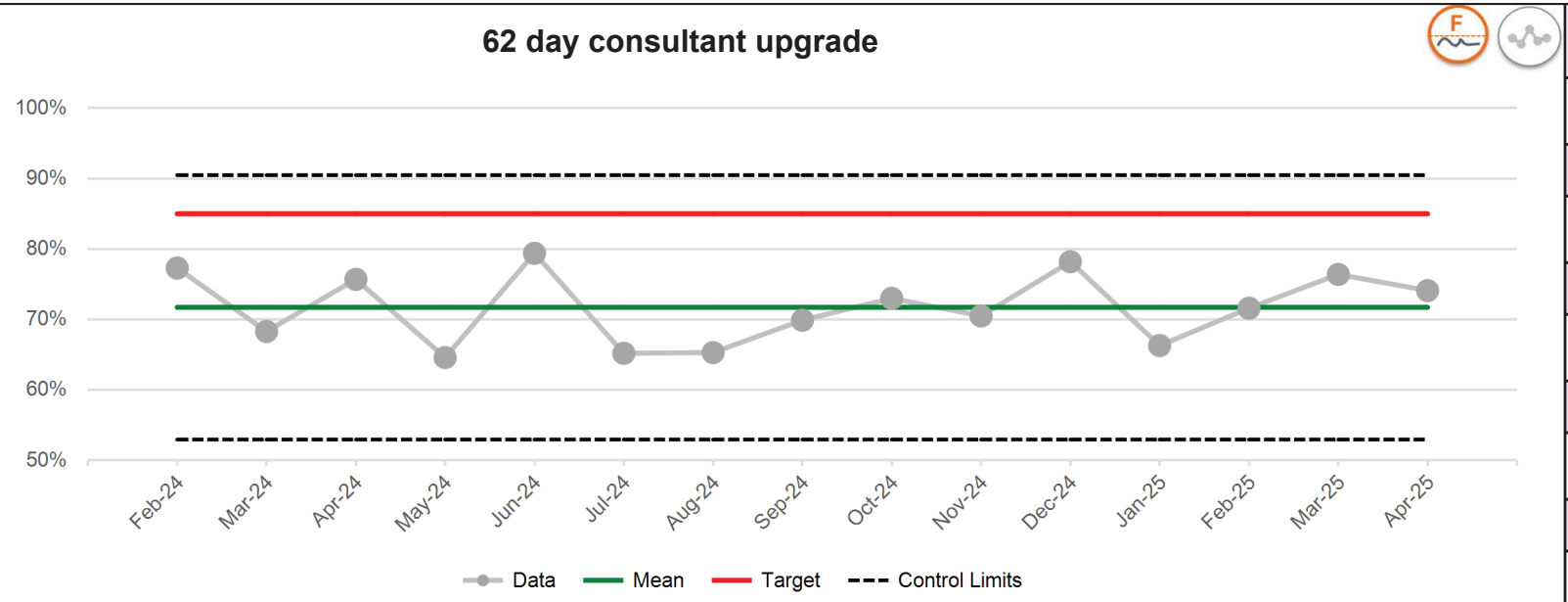
Please also see Issues on accompanying pages.

Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing, consultant to start June 2026.
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 24.

Please also see Actions on accompanying pages.

Mitigations:

Performance Overview - Operational Performance



Apr-25
74.10%
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 74.10% against an 85% target.

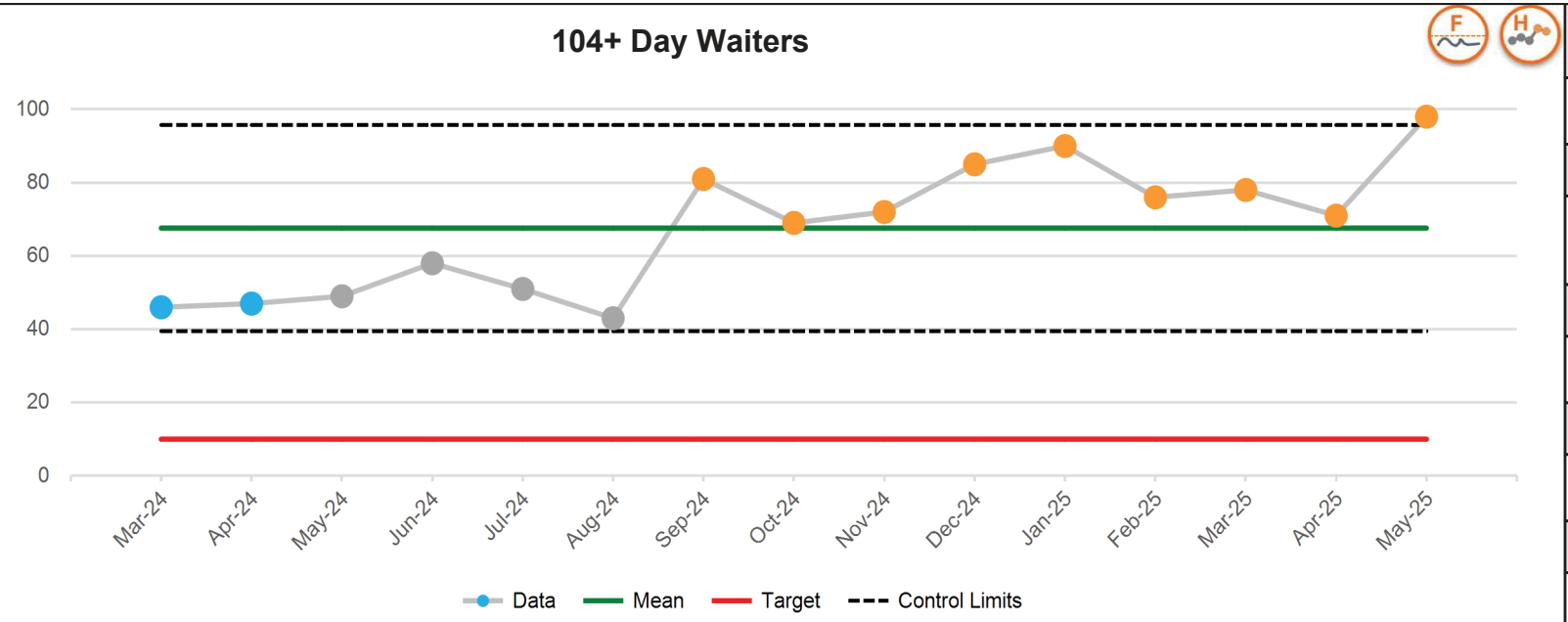
Issues:
Limited theatre capacity continues to impact cancer pathways across the Trust and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice. In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment start dates. NHSE led target to achieve 75% compliance in the 62 day combined standard by the end of March 2026.

Please also see Issues on accompanying pages.

Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing, consultant to start June 2026.
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 24.
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 75% by March '26.

Mitigations:

Performance Overview - Operational Performance



May-25
98
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 11th June the 104 Day backlog is at 98 patients.
There are 3 main tumour sites of concern:-

Colorectal 34
Head and Neck 20
Lung 16

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 14.29% 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.

Caring and building a healthier future for all

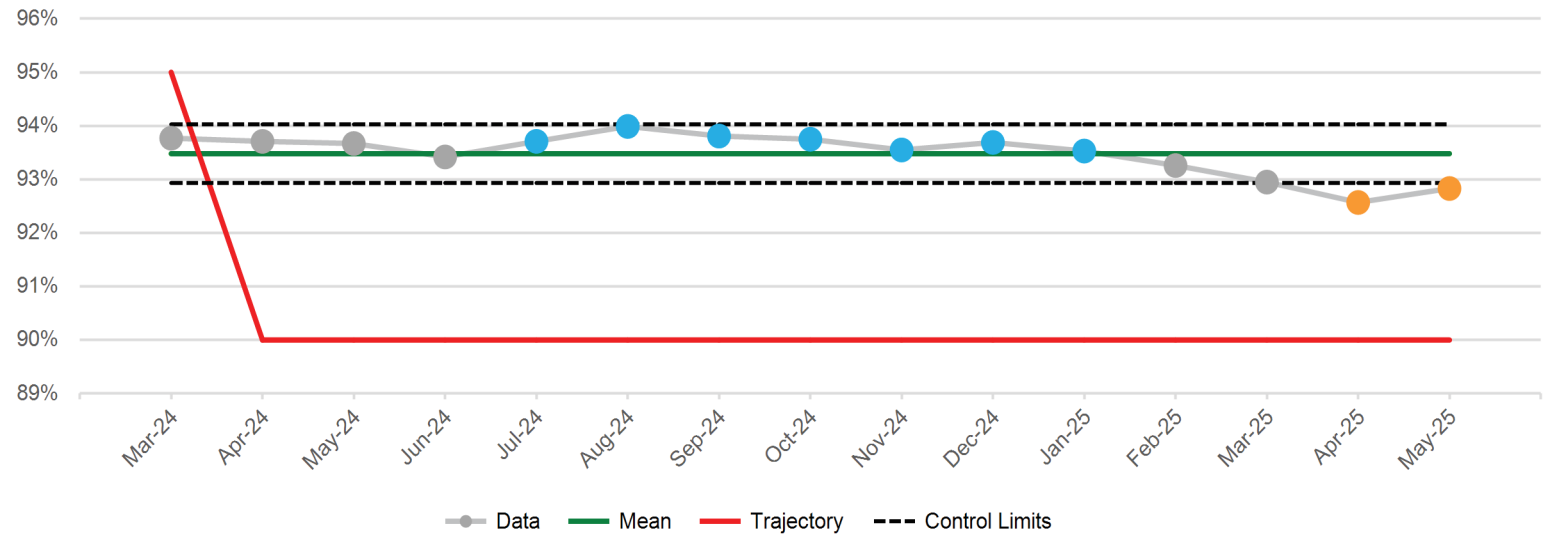
Performance Overview - Workforce

NHS
Lincolnshire Community and Hospitals NHS Group

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Mar-25	Apr-25	May-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%	92.95%	92.57%	92.83%	92.70%	90.00%	P	L
	Number of Vacancies	Well-Led	People	Director of HR & OD	7.01%	6.21%	5.98%	6.05%	6.02%	7.01%	F	
	Sickness Absence	Well-Led	People	Director of HR & OD	4.60%	5.31%	5.31%	5.29%	5.30%	4.60%	P	L
	Staff Turnover	Well-Led	People	Director of HR & OD	9.00%	9.40%	9.19%	9.14%	9.17%	9.00%	F	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	80.00%	76.50%	75.02%	76.68%	75.85%	80.00%	F	

Performance Overview - Workforce

Overall percentage of completed mandatory training



May-25
92.83%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
Trajectory
90.00%
Achievement
Variation indicates consistently passing the target
Executive Lead
Director of HR & OD

Background:
May 2025 reported Core Learning Rate is 92.83% against a target of 90.00%

What the chart tells us:
That there has been a reduction in month when compared to the previous, although still within target.

Issues:
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.

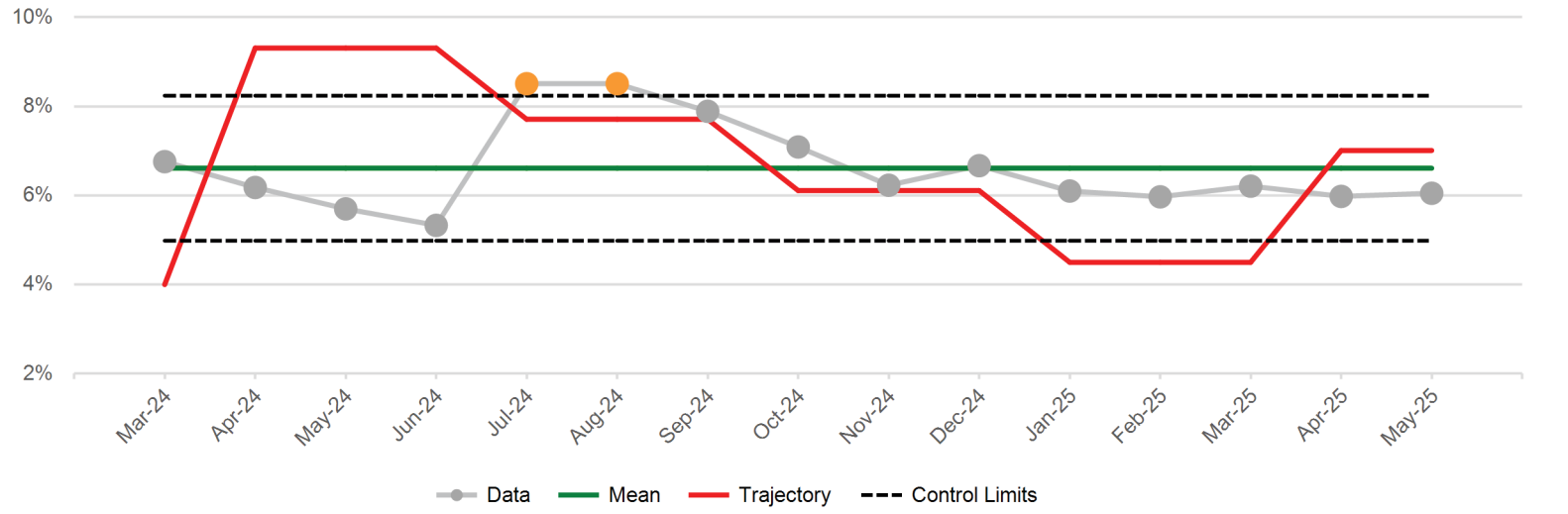
Actions:
• Report compliance rates in monthly performance meetings.

• Carry out deep dives where required to further understand trends.

Mitigations:
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).

Performance Overview - Workforce

Number of Vacancies



May-25
6.05%
Variance Type
Common cause variation
Trajectory
7.01%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
May 2025 reported Vacancy Rate is 6.05% against a Q1 target of 7.01%

What the chart tells us:
That we are within the Q1 target.

Issues:
• 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.

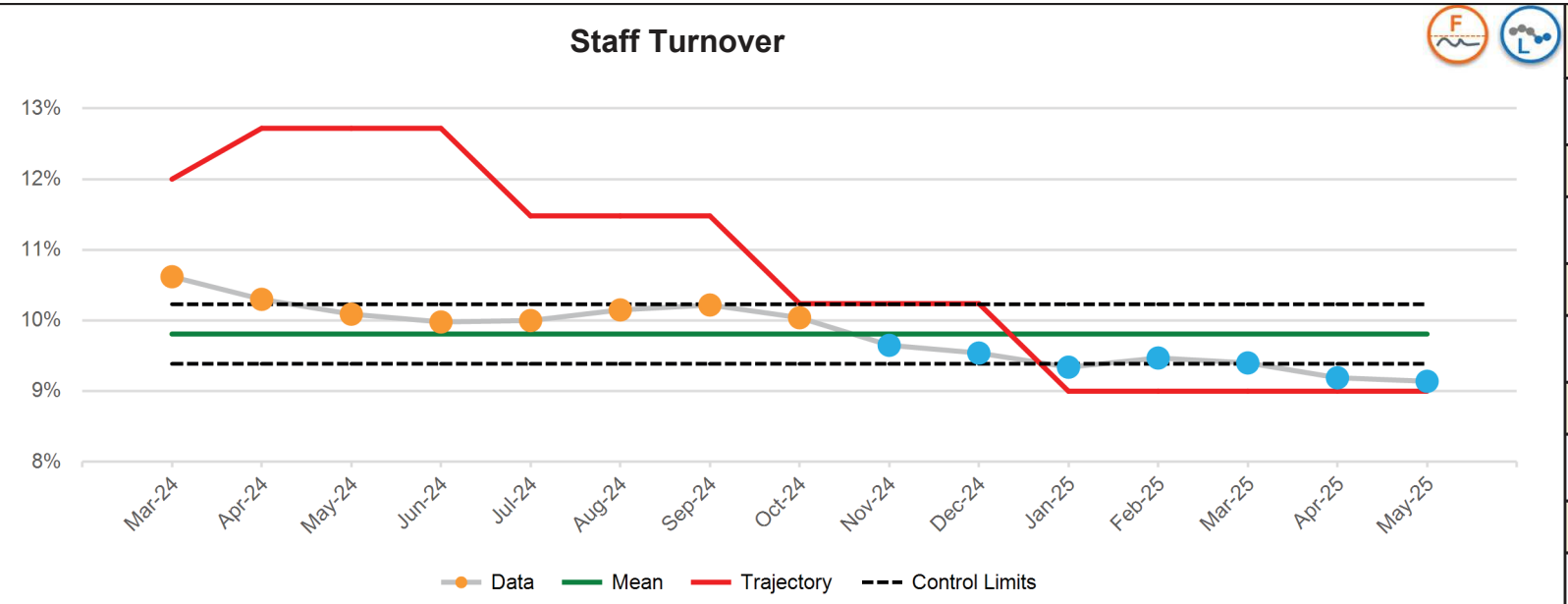
• AHP recruitment remains an area of focus in response to the implementation of Community Diagnostic Centres.

Actions:
• Work is in progress to review our overall establishment with our Divisional Teams as we support delivery of services in line with the 2025/26 National Planning Guidance.

• Continued focus within key roles where the vacancy rate is largest.

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.

Performance Overview - Workforce



May-25
9.14%
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
9.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
May 2025 reported Turnover Rate is 9.14% against a Q1 target of 9.00%

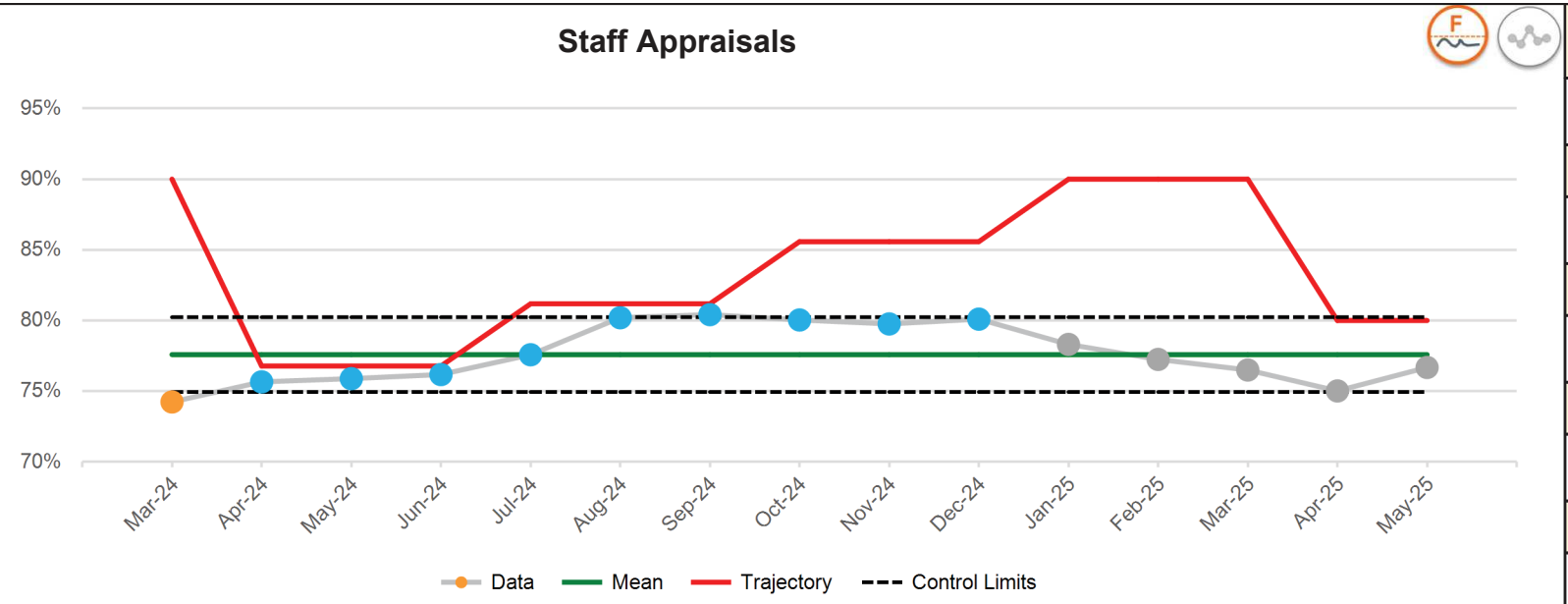
What the chart tells us:
That we have not achieved the target in month although are within tolerance levels.

Issues:
Operational pressures, staffing and culture are continued challenges.

Actions:
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.

Mitigations:
Continue to monitor Turnover rate in lien with plan.

Performance Overview - Workforce



May-25
76.68%
Variance Type
Common cause variation
Trajectory
80.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
May 2025 completion is currently 76.68% for Agenda for Change staff which is outside of the Q1 target of 80.00%

What the chart tells us:
We are not meeting the quarterly target for AfC appraisal in month, but we have seen an improvement since last 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:
- 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.
- Move to an annual cycle in line with other Trust Reporting and Planning has commenced.
- Contacting staff and team managers who are <50.00% for compliance.

Mitigations:
See actions, and continued focus with Divisions through robust monthly monitoring.

In addition, in 2025/26 we will be introducing an appraisal cycle window which supports staff having their appraisal in Quarter 1. This is expected to improve the position, and mirrors best practice seen within our Group Model.

NHS
Lincolnshire Community and Hospitals NHS Group

LCHS Integrated Performance Report (May Data)

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*Tuesday 1st July*
Item Number	*11*

LCHS Integrated Performance Report

Accountable Director	*Daren Fradgley, Group Chief Integration Officer/Deputy Group CEO*
Presented by	*Daren Fradgley, Group Chief Integration Officer/Deputy Group CEO*
Author(s)	*Ben Storer*
Recommendations/ Decision Required	*The Board is asked to:- **NOTE** the performance position*

How the report supports the delivery of the LCHG strategic aims & objectives	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	
2b: Empower our people to continuously improve and innovate	*X*
2c: Nurture compassionate and diverse leadership	
2d: Recognising our people through thanks and celebration	
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*X*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	*X*
3c: Enhance our digital, research & innovation capability	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	

Executive Summary

Performance up until the end of May is set out in the report. The Quality Committee and Finance, Performance, People, and Innovation Committee reviewed March performance in their May meetings.

The number of metrics in each cell in the SPC grid is as follows:

Target Capability	SPC Variation: Special Cause Improvement	SPC Variation: No Variation	SPC Variation: Special Cause Deterioration
Consistently Capable	2	7	5
Inconsistently Capable	1	11	3
Not Capable	0	3	0
No Target	4	19	1

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

1. Home Visiting

   Following the implementation of the pilot which commenced on 15.04.25 whereby UCR and Home visiting are integrated with regards to the response that is offered to patient's requiring a 2-hour response. The initial clinical triage is completed in CAS with the appropriate pathways available. As a result of the pilot the data has been combined to demonstrate the impact of the pilot. The 2-hour response for May is sat at 90% against 1535 cases/visits requiring a 2-hour response. The pilot will continue, and we hope to see the compliance and activity reflective of the success.

2. Ethnicity recording in A&E data sets.

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.

3. Patient Incidents

The graph shows LCHS patient safety incidents per 1000 WTE from 1 November 2023 to 31March 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.

8 indicators are showing special cause deterioration currently:

1. Ops Centre Calls: Abandoned
2. Ops Centre: Priority Calls Answered In 2 Minutes
3. Ops Centre: Standard Calls Answered Within 10 Minutes

May 2025 saw 17,815 calls come through the Ops Centre, compared to 15,868 in May 2024 – a 13% increase as well as this we saw 7,885 emails into ops compared to 6,935 May 24 which is a 14% increase YoY.
Our average daily contacts were 829 in May 25, compared to 710 in May 24 a 17% increase.
Priority calls were answered at 69% within SLA and Standard calls were above the SLA and achieved a strong month 87% within SLA abandonment rate increased due to the sheer

volume of calls coming in (up to 12%) whilst all email contacts achieved the SLA. (100% within SLA) average email handling time of 05:48.
Focus continues to be around how we can work differently and more efficiently without the ability to mitigate the impact of the current vacancies on performance.

4. UTC Discharge Summaries

UTC Discharge Summaries has moved into Special cause deterioration in March 2025; however, it is constantly capable of meeting the 98% target.

5. Mandatory Training Compliance

The overall mandatory training compliance rate which includes all core and role specific modules has increased to 89.85 % which is just below the local and national target of 90%. One month of the mandatory update season remains, so this is expected to return to above target following 30th June.

6. Vacancy Rate

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.

7. Combined Home Visiting – 2 Hour Compliance

Following the implementation of the pilot which commenced on 15.04.25 whereby UCR and Home visiting are integrated with regards to the response that is offered to patient's requiring a 2-hour response. The initial clinical triage is completed in CAS with the appropriate pathways available. As a result of the pilot the data has been combined to demonstrate the impact of the pilot. The 2-hour response for May is sat at 90% against 1535 cases/visits requiring a 2-hour response. The pilot will continue, and we hope to see the compliance and activity reflective of the success.

8. Transitional Care Activity

May 2025 saw 17,815 calls come through the Ops Centre, compared to 15,868 in May 2024 – a 13% increase as well as this we saw 7,885 emails into ops compared to 6,935 May 24 which is a 14% increase YoY.
Our average daily contacts were 829 in May 25, compared to 710 in May 24 a 17% increase.
Priority calls were answered at 69% within SLA and Standard calls were above the SLA and achieved a strong month 87% within SLA abandonment rate increased due to the sheer volume of calls coming in (up to 12%) whilst all email contacts achieved the SLA. (100% within SLA) average email handling time of 05:48.
Focus continues to be around how we can work differently and more efficiently without the ability to mitigate the impact of the current vacancies on performance.

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

1. GU Patients seen within 2 working days;
2. Staff Turnover;

3. Virtual Wards: Cardiology Referrals
4. Agency Expenditure
5. Ops Centre – Emails Offered
6. Discharge to Assessment – Distinct Patient Contacts
7. Combined Home Visiting & UCR Cases

Lincolnshire Community Health Services NHS Trust

INTEGRATED PERFORMANCE REPORT

May 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	Environmental Cleanliness Community Hospital Bed Occupancy Community Hospital Falls per 1000 OBDs MRSA Screening Completion of NHS Numbers for A&E Data Sets Chlamydia Screening Positivity Compliance Ops Centre- Emails answered Witin 24 Hours	UTC Discharge Summaries Mandatory Training Compliancy Vacancy Rate Combined Home Visiting & UCR - 2 Hour Compliance OPs Centre - Standard Calls answered within 10 Minutes
Inconsistently Capable	Agency Expenditure	Sickness Absence Complaints - Rate per 1000 WTE Friends & Family Test Long Term Sickness Community Hospital Discharge Summaries Average Length of Stay 15 Minute Ambulance Handover Better Payment Practice Code UTC 4 Hour UTC 15 Minute Assessment Ops Centre Call: Answered in Timesc	Vacancy Rate Ops Centre Calls Abandoned Ops Centre - Priority Calls Answered In 2 Minutes
Not Capable		Home Visiting Compliancy Patient Incidents Per 1000 WTE Ethnicity In A&E Data Sets	
No Target	Virtual Wards: Cardiology Referrals Ops centre - Emails offered Discharge to Assessment: Distinct Patient Contacts Combined Home visiting & UCR Cases	Complaints CHPPD Total Falls Overdue Datix Total Medication Incidents Compliments Children in Care Community Pressure Ulcer - Rate per 1000 contacts (C2, C3 & C4 Community Hospital Injurious Falls per 1000 OBDs Community Hospital Pressure Ulcers - Rate per 1000 OBDs (C2, C3 & C4 Urgent Commuit Response - Accepted Referrals Discharge to Assess - Accepted Referrals Ops Centre Calls Answered Ops Centre Calls Offered UTC Activity Out Of Hours and CAS Cases Closed Home Visiting Activity Cas Activity Virtual Wards: Frailty Referrals	Transitional Care Activity

Executive Summary

Safe

✓ Total LCHS Patient Medication Incidents has reduced this month from 46 in April to 33 in May

✓ Total Community Hospital Falls performance rates per 1000 OBD has decreased from 3.95 in April to 1.61 for May.

✓ Injurious Community Hospital Falls performance rates per 1000 OBD is 0 for May

✓ MRSA compliance achieving target.

✓ patient Incidents Community Rate per 1000 WTE decreased from 305.63 in April to 238.81 in May

Caring

X FFT scores not achieving 95% target.

X Complaints have increased from previous month.

Responsive

✓ Performance against the UTC targets-4-hour waits is achieving the 95% target.

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

X 15-minute Ambulance Handover is not achieving it's 95% target.

✓ Combined Home Visiting & UCR is achieving 80% target for 2-hour response compliance

X Ops Centre Calls Answered in Timescale is not achieving 90% target.

X Ops Centre Calls Abandoned is not achieving 8% target.

X Discharge Summaries – Community Hospitals, not achieving target of 98%

✓ Discharge Summaries – Urgent Treatment Centres achieving target

Effective

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

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

X Community Hospitals Pressure Ulcers rate per 1000 OBDs – slight decrease from 3.92 to 2.58

✓ Environmental Cleanliness achieving target.

✓ Bed Occupancy rate achieving 89% while the target is at 85%.

X Average Length of Stay is not achieving the 16 Day target

Well-Led

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

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

✓ Staff Turnover is within the 15% target.

✓ Year to date agency expenditure is within plan.

✓ Month 02 position is 44k favourable to plan.

✓Overall efficiency (CIP) ahead of plan.

✓ Cash balances are in line with 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.

X Training Compliance is not achieving the 90% target.

✓ Total Sickness Absence is achieving the 5% target.

✓ Long-Term Sickness Absence is achieving 3% target.

Medicine-related Incidents

Background

Medication is one of the most common medical interventions. LCHS deals with medicines on a day-to-day basis. LCHS has robust polices, training programmes and audit to ensure medicines are managed safely. Due to the high volume of activity involving medicines, complexity of the procedures and the human component, some medicine-related incidents do occur.

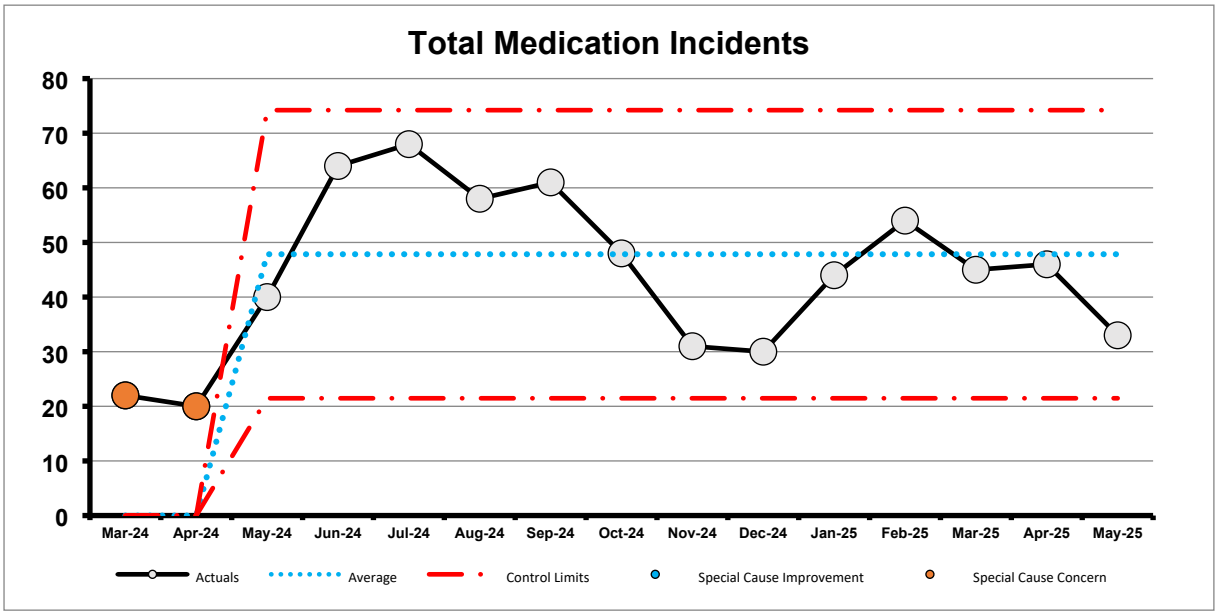
A medicine-related incident can pose a threat to the patient as well as the organisation. The member of staff who made the error can also be affected. Broadly speaking, medicine-related incidents encompass prescribing, preparation, dispensing, administration, and monitoring.

Reducing medicine-related incidents across the Trust remains an ongoing improvement priority.

Benchmark / Target

NHS Benchmarking have not yet published the community dataset for the reporting period.

Current Performance



Narrative

In LCHS, Co-operative pharmacy is the contracted pharmacy service provider to our community hospitals. There is an emerging theme around administration of time critical medication. To mitigate this, the in-house medicines management pharmacy team supported the community hospitals and the contracted pharmacy service provider to develop and implement processes to ensure that time critical medications are administered within a defined time frame. Work has commenced to strengthen the guidance within the medicines policy and introducing fit for purpose audits within community hospitals that will track practice. Clinical staff have been encouraged to complete a Datix whenever time critical medications are administered outside the defined time frame. This has led to a significant increase in the number of incidents reported in June & July when compared to previous months. Administration of time Critical medicine incidents will continue to be tracked to ensure that improvement is embedded & sustained. Examples of time critical medicines include antiparkinsons, psychotropics, blood thinners such as warfarin and antiepileptics.

The inhouse pharmacy team has worked closely with the effective practice facilitator to ensure that time critical medicines are covered in the medicines management training.

LCHS have employed an Associate Chief Pharmacist who is also the trusts medicines safety officer. Part of this role entails improving the reporting and learning from medication incidents. He has been attending various steering groups reiterating and reinforcing the importance of encouraging staff to report medicines related incidents. He also supports teams with action plans ensuring that learning is cascaded and used to improve practice.

SPC

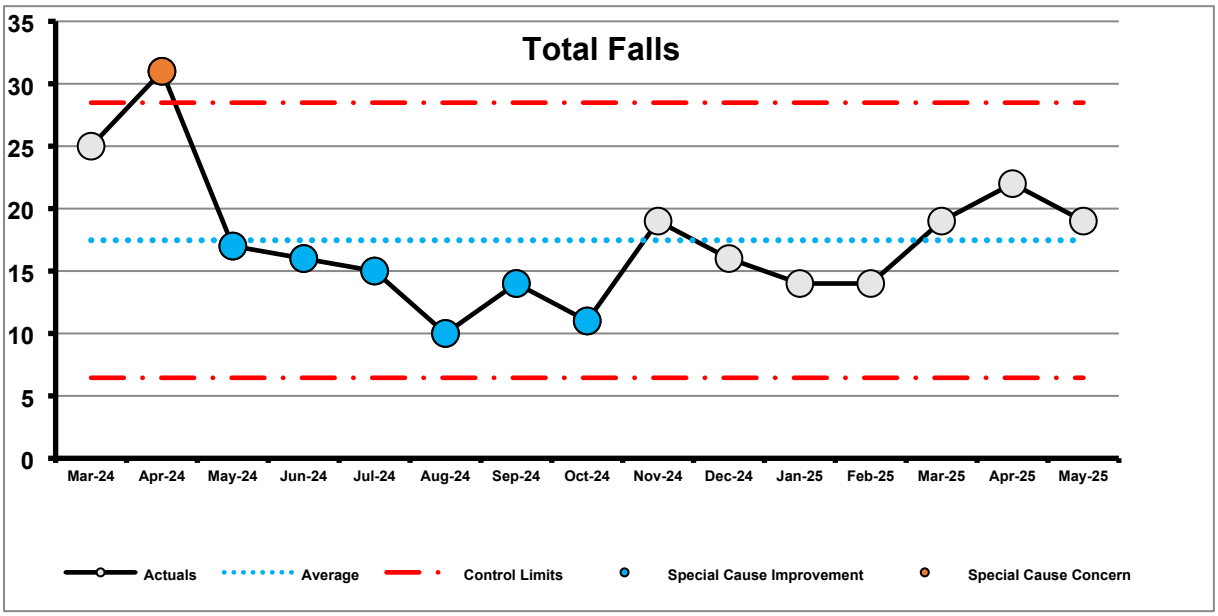
SPC shows that the Trust's total medication incidents have not varied significantly in the period.

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.

SPC

SPC shows that the Trust’s total falls have not varied significantly in the period. Showing common cause no variation.

Falls in Community Hospitals

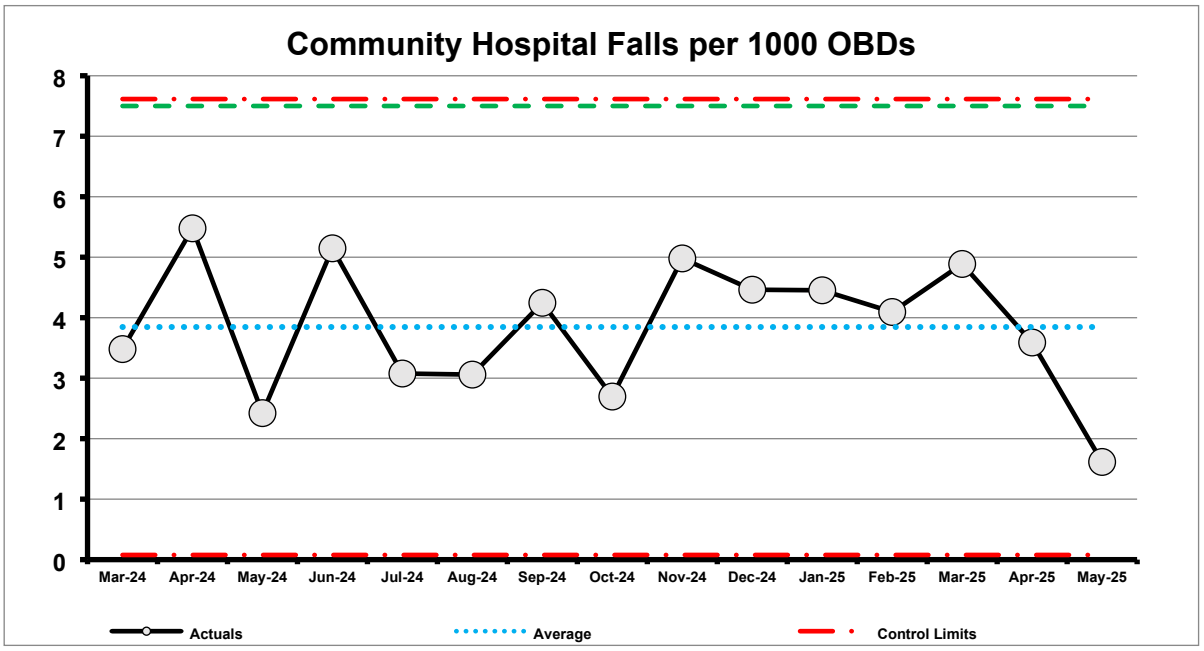
Background

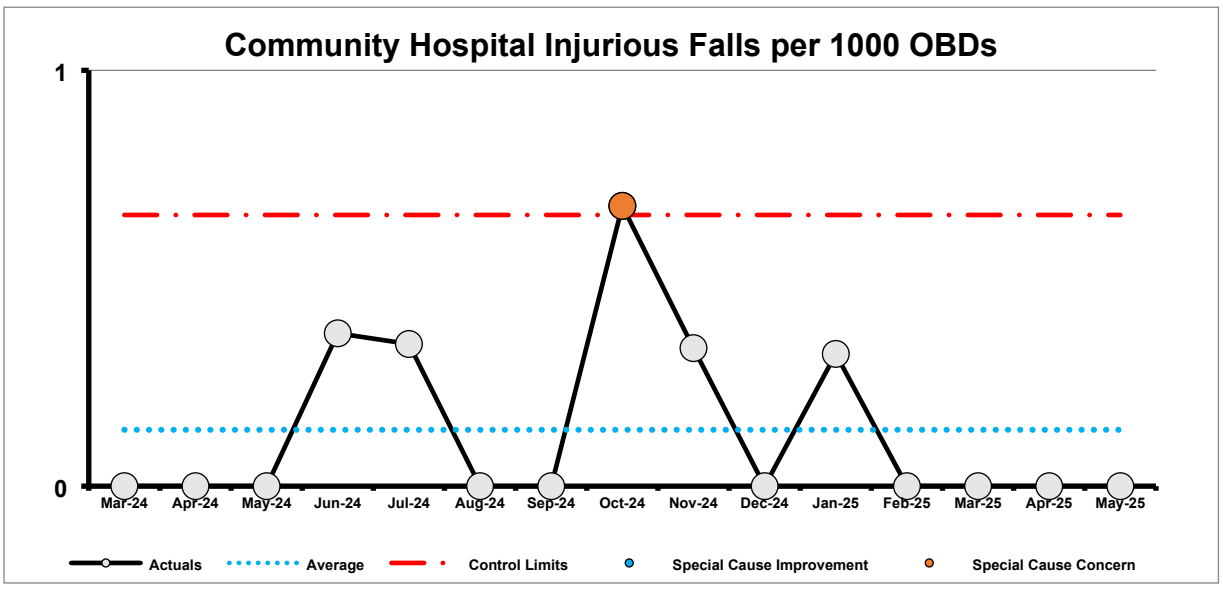
Falls take place in many services, but most falls take place in our community hospitals where the patients have additional levels of frailty and health related conditions which pose additional risk of falling whilst unwell and in an unfamiliar environment.

Falls are categorized 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)

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. Whilst falls track consistently at baseline steering group and other quality groups show there is room for improvement. A focused quality improvement plan for falls is in draft format.

SPC

Community Hospital Falls per 1000 OBDs

SPC shows the Community falls per 1000 OBDs have not varied over the period, showing a decrease from the previous month.

Community Hospital Injurious Falls per 1000 OBDs

SPC for Community Hospital Injurious falls per 1000 OBDs shows common cause no variation for May 2025. It remains consistently below average.

MRSA Screening

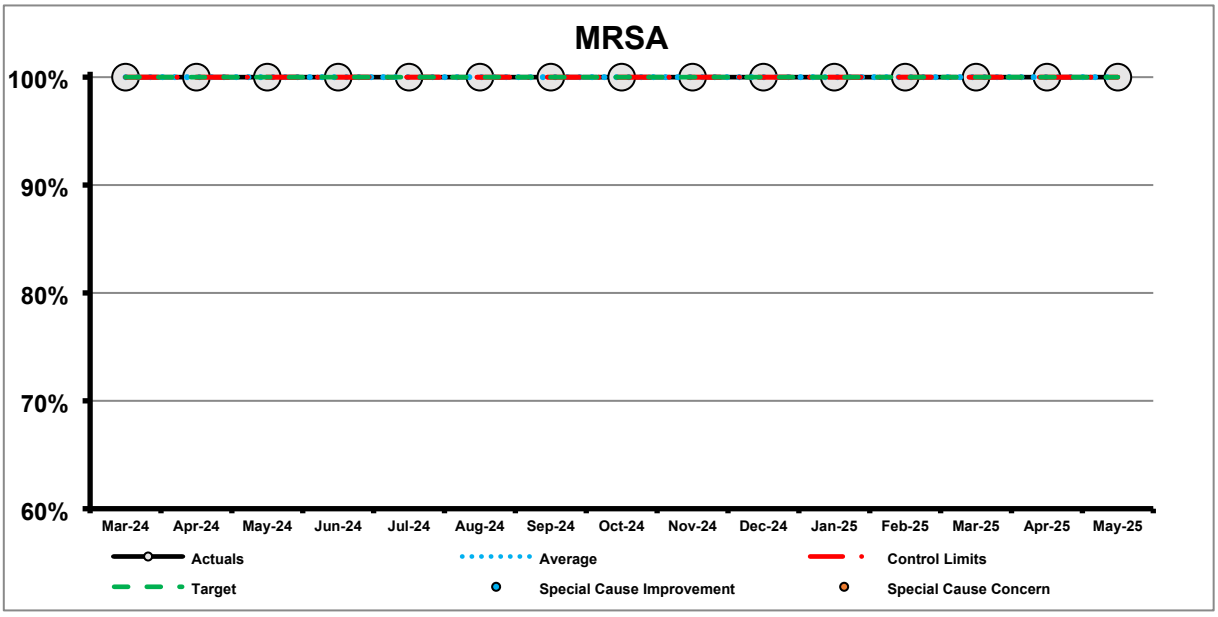
Background

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 141 patients admitted across all sites, 8 patients were eligible for MRSA screening, of which all 8 were screened.

SPC

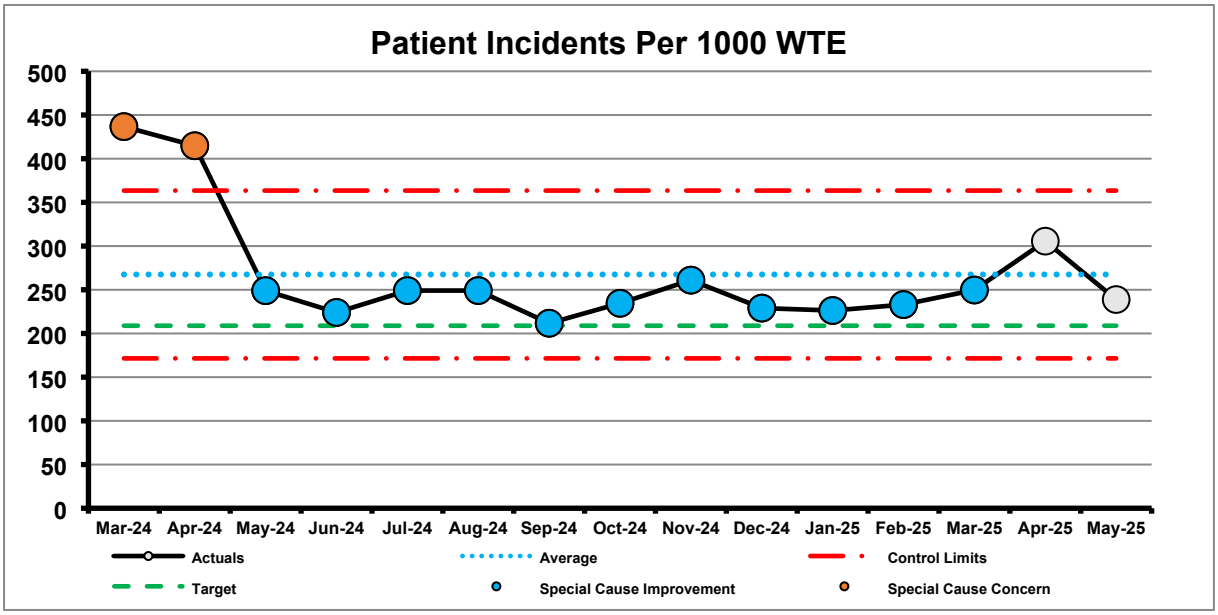
SPC shows MRSA screening compliance has not varied over the period.

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.

Current Performance



Narrative

- The graph shows LCHS patient safety incidents per 1000 WTE from 1 November 2023 to 31March 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 implemented to bring LCHS in line with ULHT partners.

SPC
Patient Incident SPC has not varied significantly in the period.

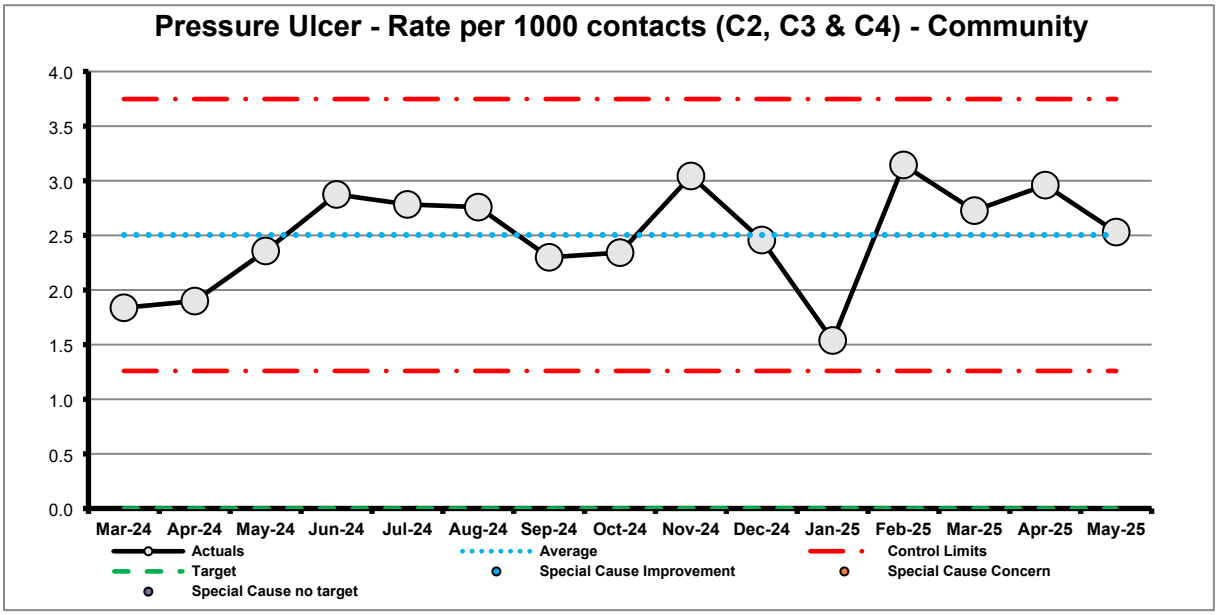
Community Pressure Ulcers – Rate per 1,000 contacts

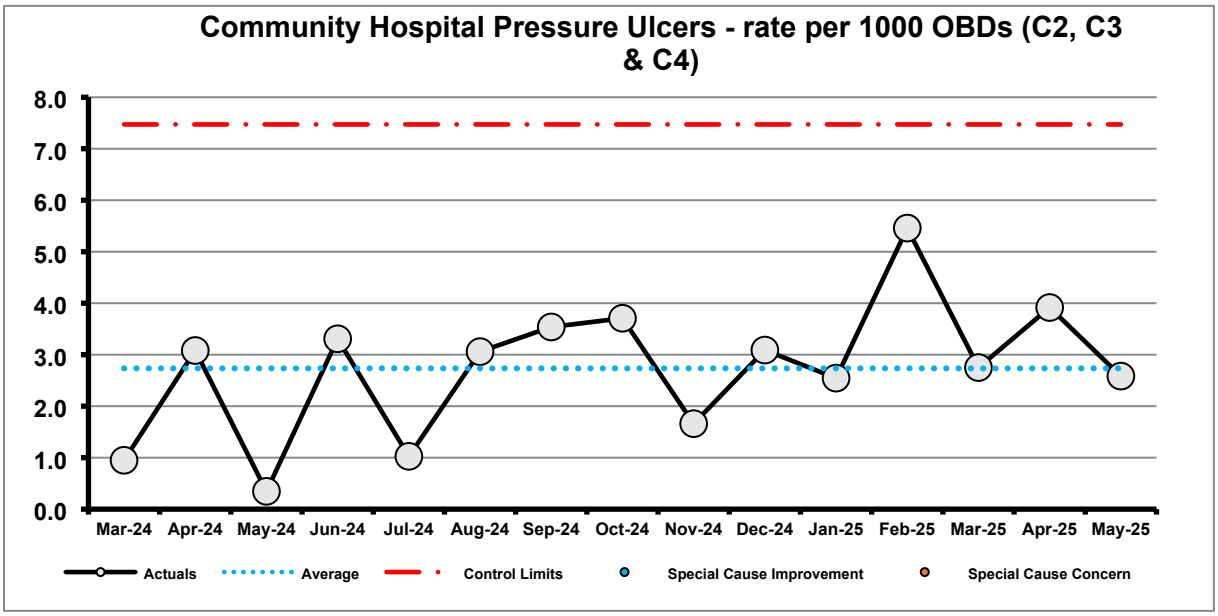
Background
All pressure ulcers grade's 3 and 4 are classified and recorded as serious incidents. There is no distinction between avoidable and unavoidable in cause.

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.

Current Performance





Narrative for Community:

There has been increased focus on the number of Pressure Ulcers within the Community and across all healthcare settings. There has been a slight decrease in incidents this month. Steering groups across the county have evidenced improvements in care.

Narrative for Community Hospitals:

Like falls consistent deep dives do show room for improvement for pressure ulcer care in Community Hospitals with the service not making marked improvements over the last few months. A pressure ulcer care quality improvement plan is to be published. In addition to this we are seeking to be able to report on healing rates in Community Hospitals.

SPC

Pressure Ulcers - rate per 1000 contacts (C2, C3 & C4) – Community
SPC for Pressure Ulcer rate/1000 there has been a slight decrease for the reporting month of May and shows 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 a decrease during the reporting month, showing common cause no variation.

Care Hours Per Patient Day (CHPPD)

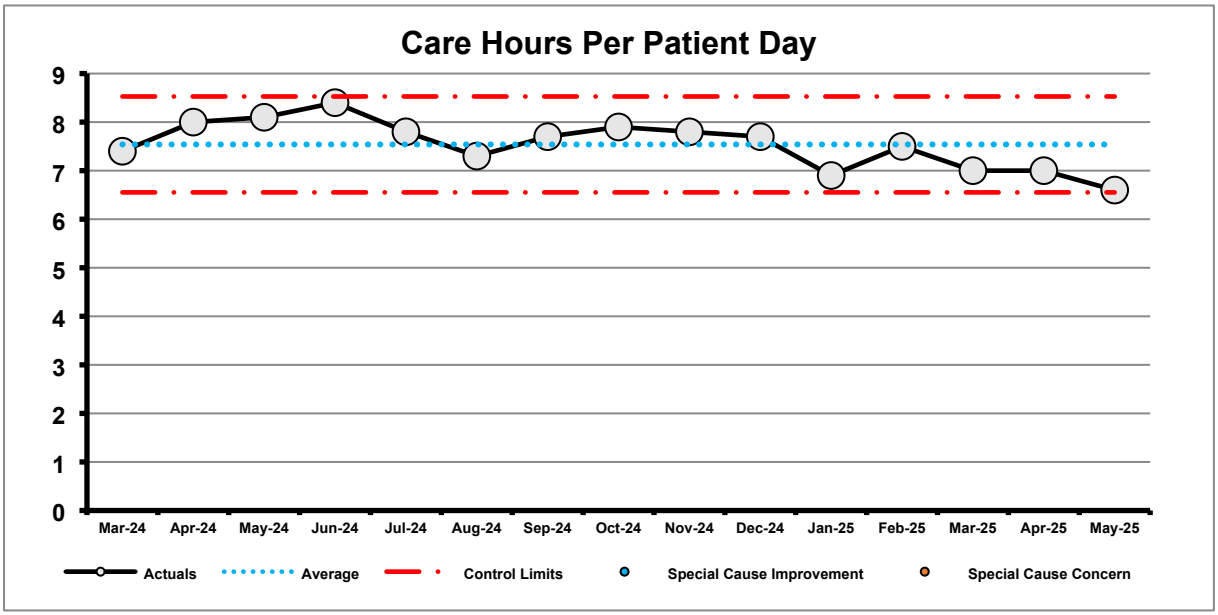
Background
Care Hours per Patient Day (CHPPD) is a simple calculation derived from dividing the number of actual care hours provided by the number of inpatients in a 24-hour period used as measure across inpatient areas.

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.

Target

There is no agreed target, but the CHPPD rate should be considered alongside other quality and safety metrics contributing to safe staffing.

Current Performance



Narrative

CHHPD remains within the control limits. There is no current evidence to suggest a lack of staffing has led to unsafe care been delivered by the Community Hospital Teams.

Actions

A full complement of registered nurse staffing is seen within wards. Louth hospital has increased its bed base to pre COVID levels and is now meeting its contractual obligations.

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

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

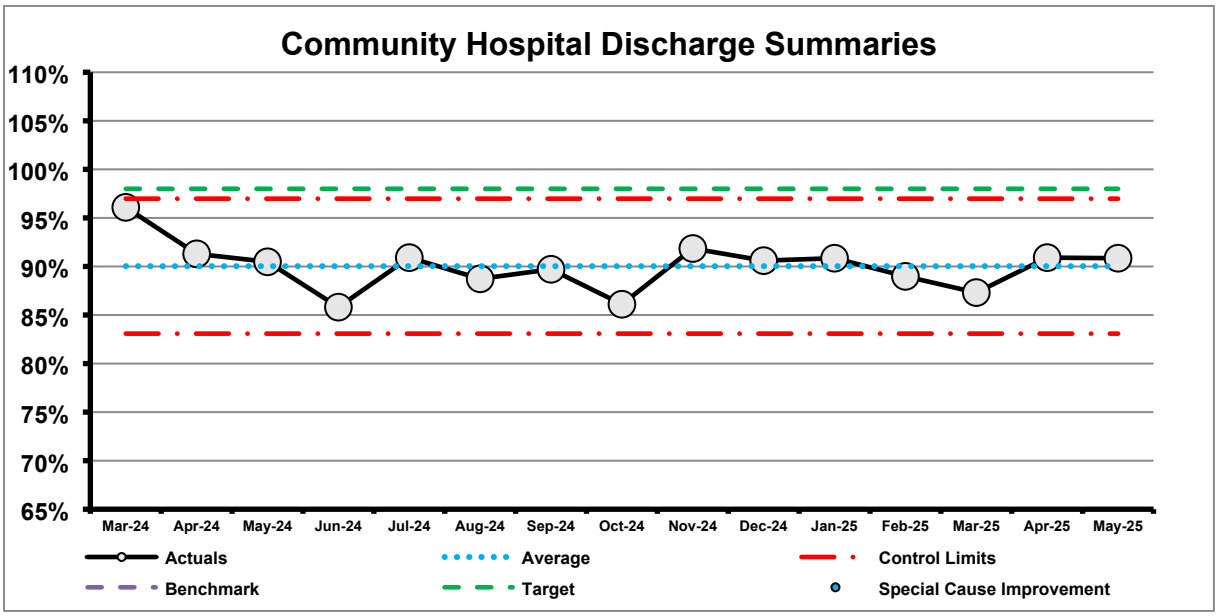
Background

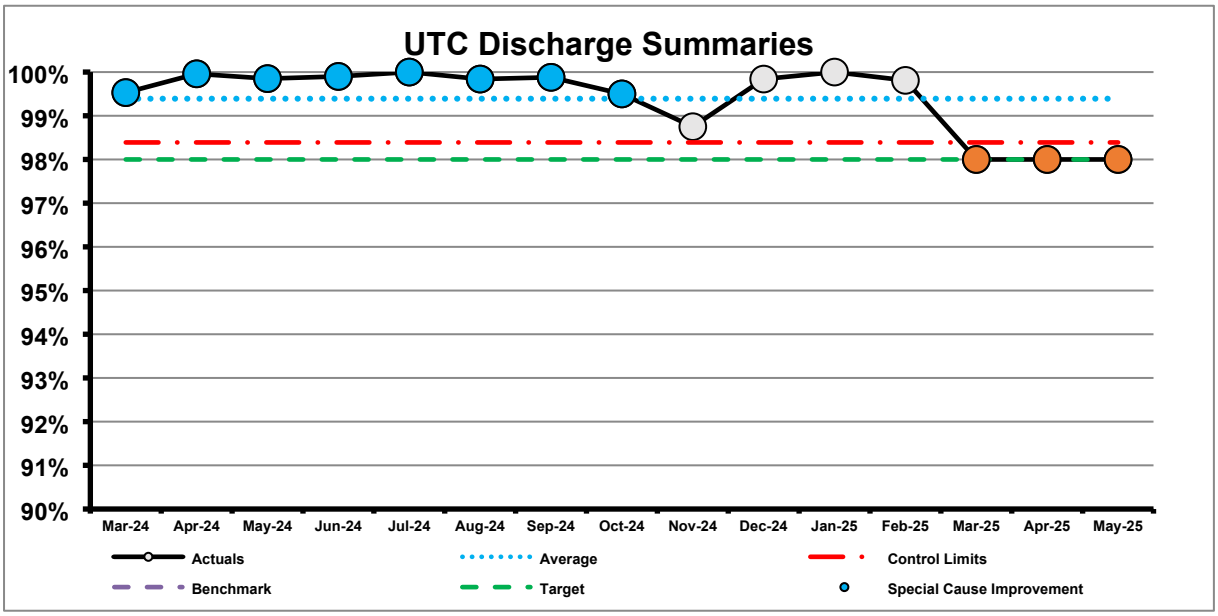
It is a requirement of the Quality Schedule part 6 to the NHS Standard Contract that discharge summaries issued by the ward doctor are issued from Community Hospitals to the patients GP within 24 hours of discharge. As the Trust medical staff currently work Monday to Friday this performance measure is adapted.

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

Continued tracking the baseline for this measure

Urgent Treatment Centres

IUEC continue to ensure patients are safe when discharged from the urgent treatment centres, 98% of GP's getting a discharge letter within a timely manner.

SPC

Discharge Summaries - Community Hospitals

SPC Community Hospital Discharge Summaries has not varied significantly for this period and is showing common cause no variation.

Discharge Summaries – Urgent Treatment Centres

UTC Discharge Summaries has moved into Special cause deterioration in March 2025; however, it is constantly capable of meeting the 98% target.
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Overdue & Reported Datix

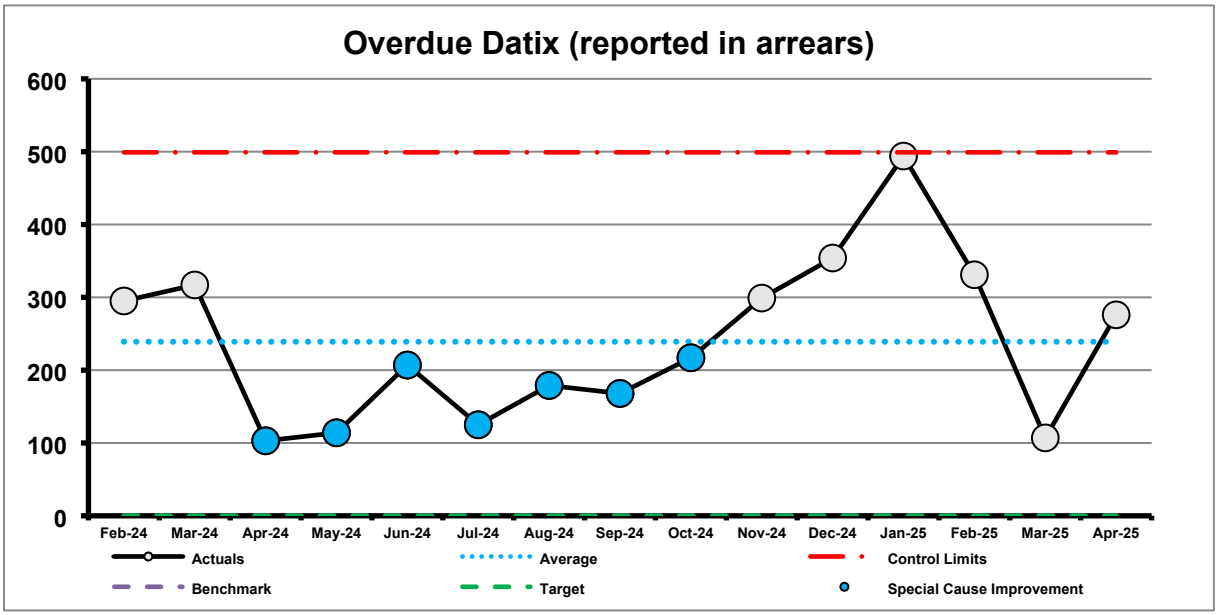
Background
When a Datix is raised to alert or escalate an incident (IR1 form) – it is imperative that the details are reviewed and considered in terms of any immediate actions that have or should be taken particularly regarding patient and staff safety.

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

An incident is marked as over due if it has not been finally approved within 20 working days of the incident being reported. Historically a target of 10% of all reported incidents has been used as the tolerance threshold. As of 1 April 2025, LCHS reports incidents on Datix Web must be closed by the end of quarter 1 2025

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.

SPC
The SPC for Overdue Datix has not varied over the period.

Children in Care (reported one month in arrears)

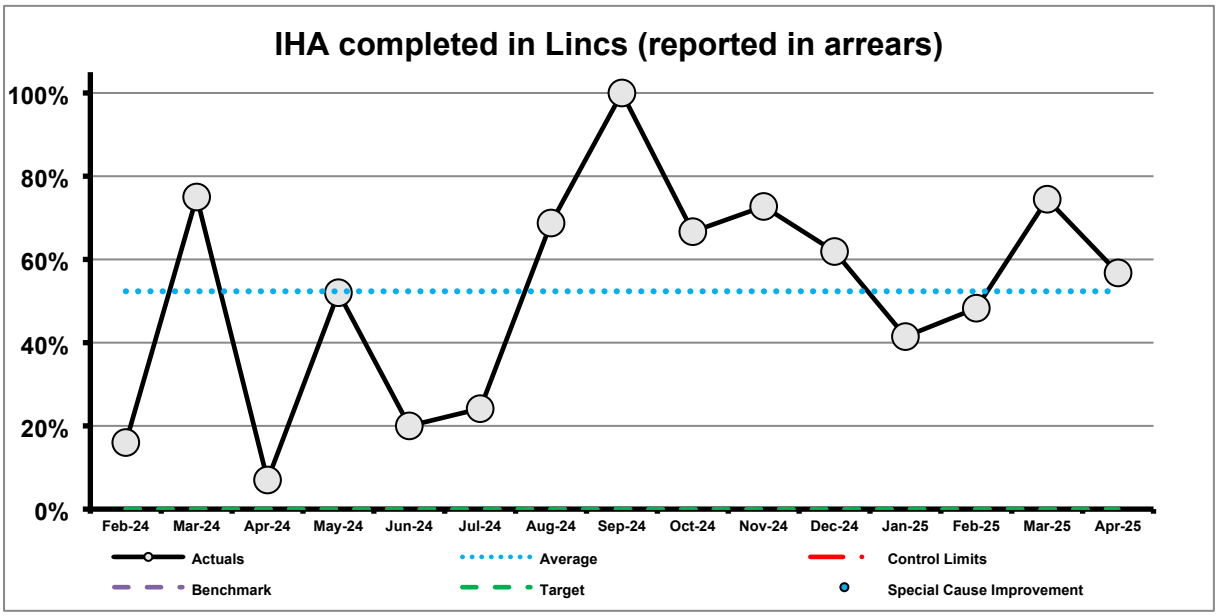
Background

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 reporting logic was updated to reflect children who underwent evaluations during the reporting month, regardless of when they were looked after; instead of children who became looked after within the reporting month and when they had their assessments

In April, 37 children were in cohort to be assessed in Lincolnshire, and 21 received an initial health assessment within 20 working days of them becoming looked after.

SPC

The SPC for IHA Performance is slightly above average in May.

Environmental Cleanliness

Background
The cleaning company contract with provider OCS through NHSPS shared services began in 2022.

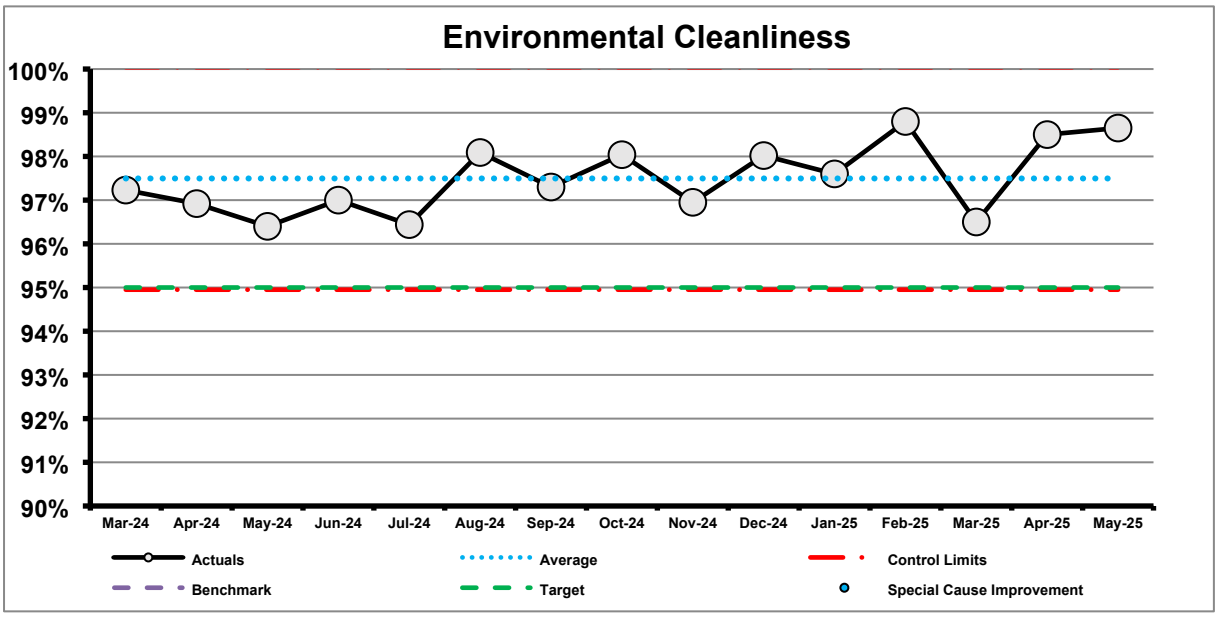
The requirements of the new National Standards of Healthcare Cleanliness that were published at the end of April 2021 have been rolled out across all LCHS community premises by OCS as well as being adopted by NHSPS and the in-house teams at the hospital sites.

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 98.65% 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

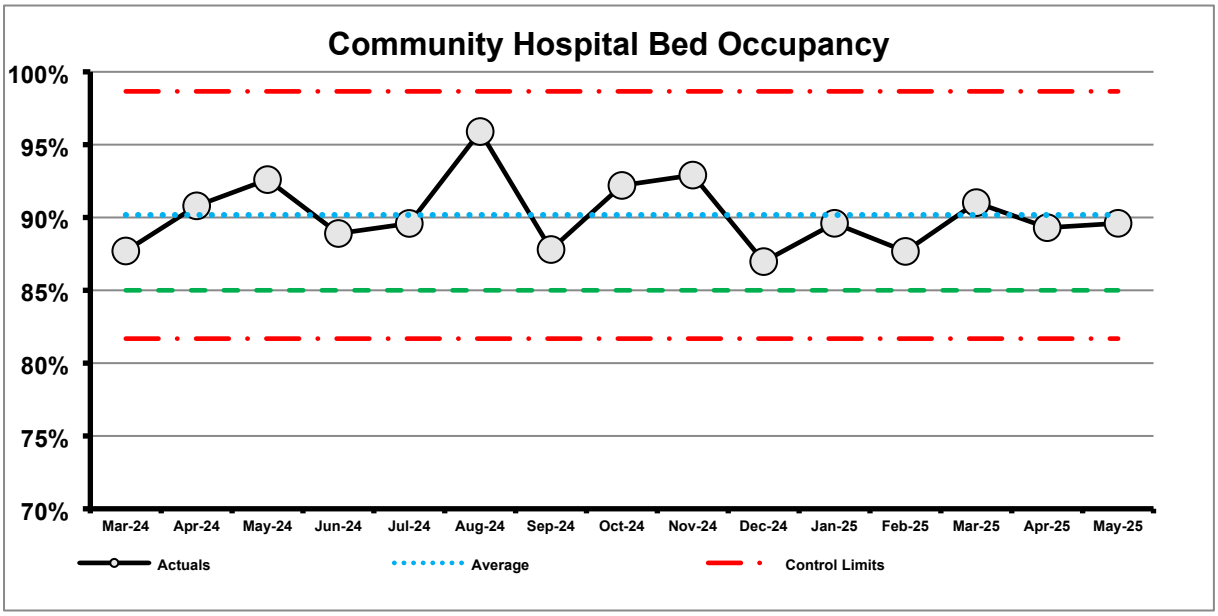
Background

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

Whilst this does show continued very high occupancy for Community Hospitals the way data is collected hides the true occupancy. Occupancy is higher than this, but admissions are so frequently held over from the day before due to issues with transport (either late booking or unavailability) that occupancy is higher than this. These beds have names against them only the patient hasn't arrived by midnight that day.

SPC

SPC shows the Community Hospital bed occupancy performance has not varied significantly over this period and continues to be above the target of 85%.

Average Length of Stay

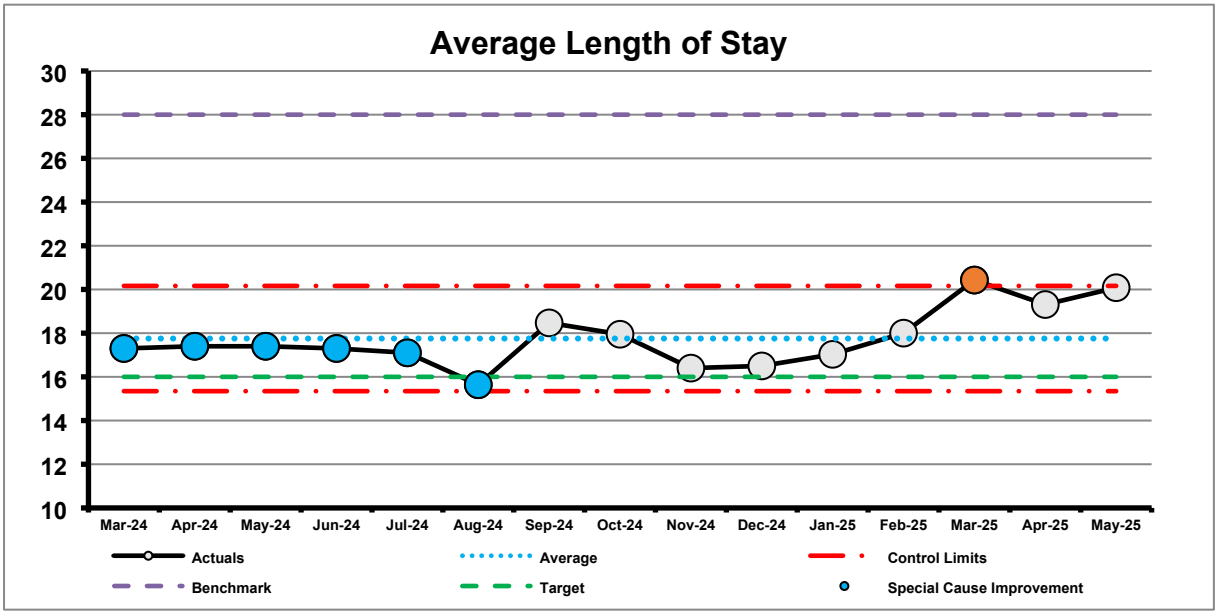
Background

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).

Target

Target length of stay is 16 days.

Current Performance



Narrative

We continue to see this sustained increase in LoS. In addition to the transformational change programme to reduce length of stay in Community Hospital as well as working differently with discharge to assess the leadership of the service are also fully involved in the expansion of Discharge to Assess. Increasing the capacity of D2A should see the chance for more patients to leave hospital earlier and revert length of stay to historic average or better.

SPC

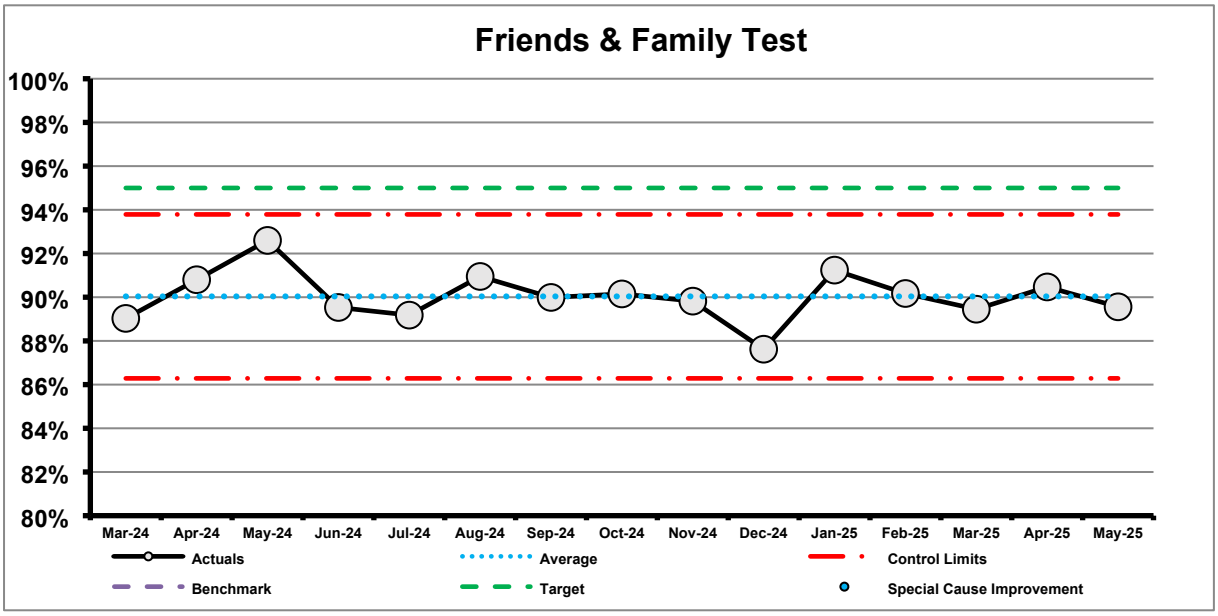
Average length of stay SPC shows special cause no variation. The SPC also shows average length of stay is inconsistently capable of achieving the local target of 16, and the average being above the target means that the target of 16 is missed more often than not.

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 May (90.47%) shows an increase on the previous months performance activity (89.56%).

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

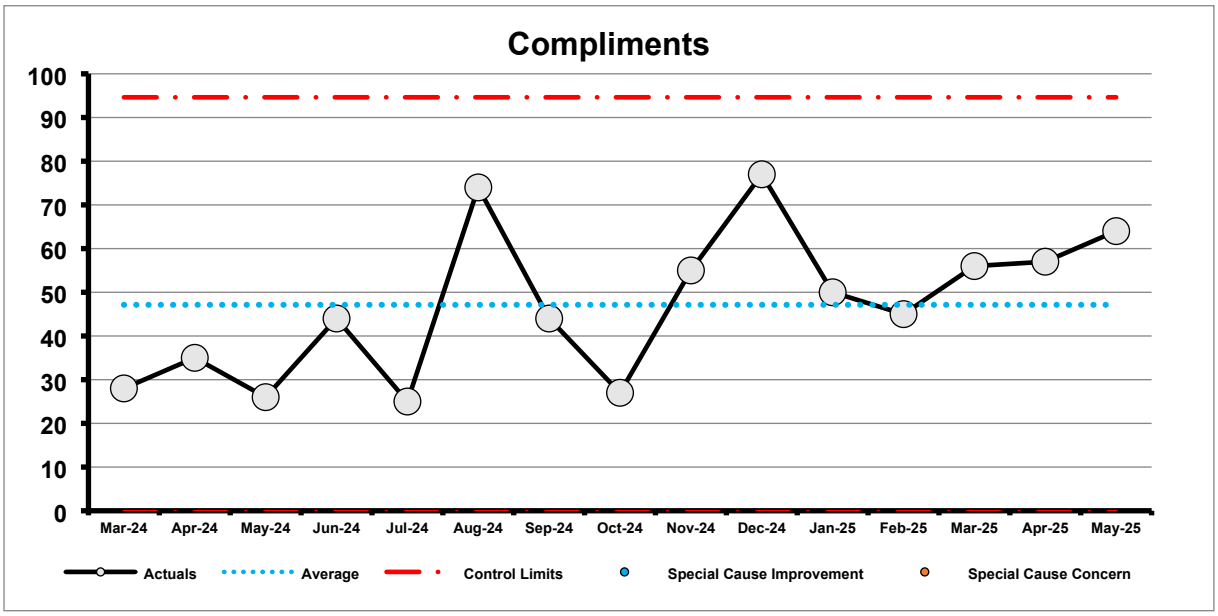
Background

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

Awaiting data and narrative for May

SPC

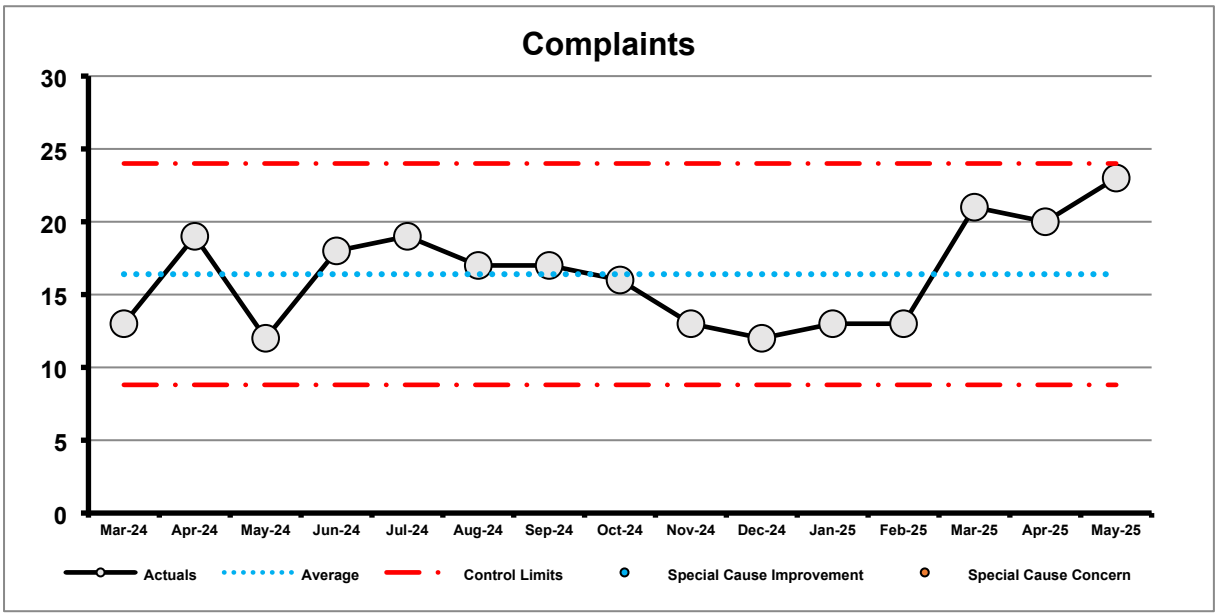
SPC shows that compliments have not varied significantly.

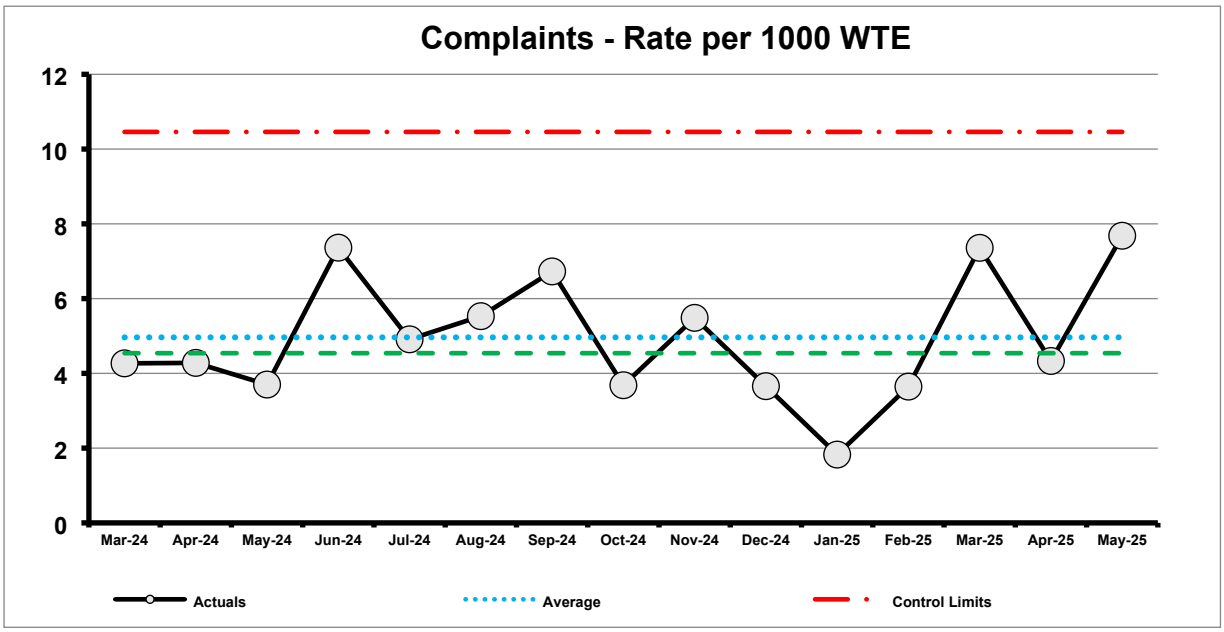
Complaints

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.

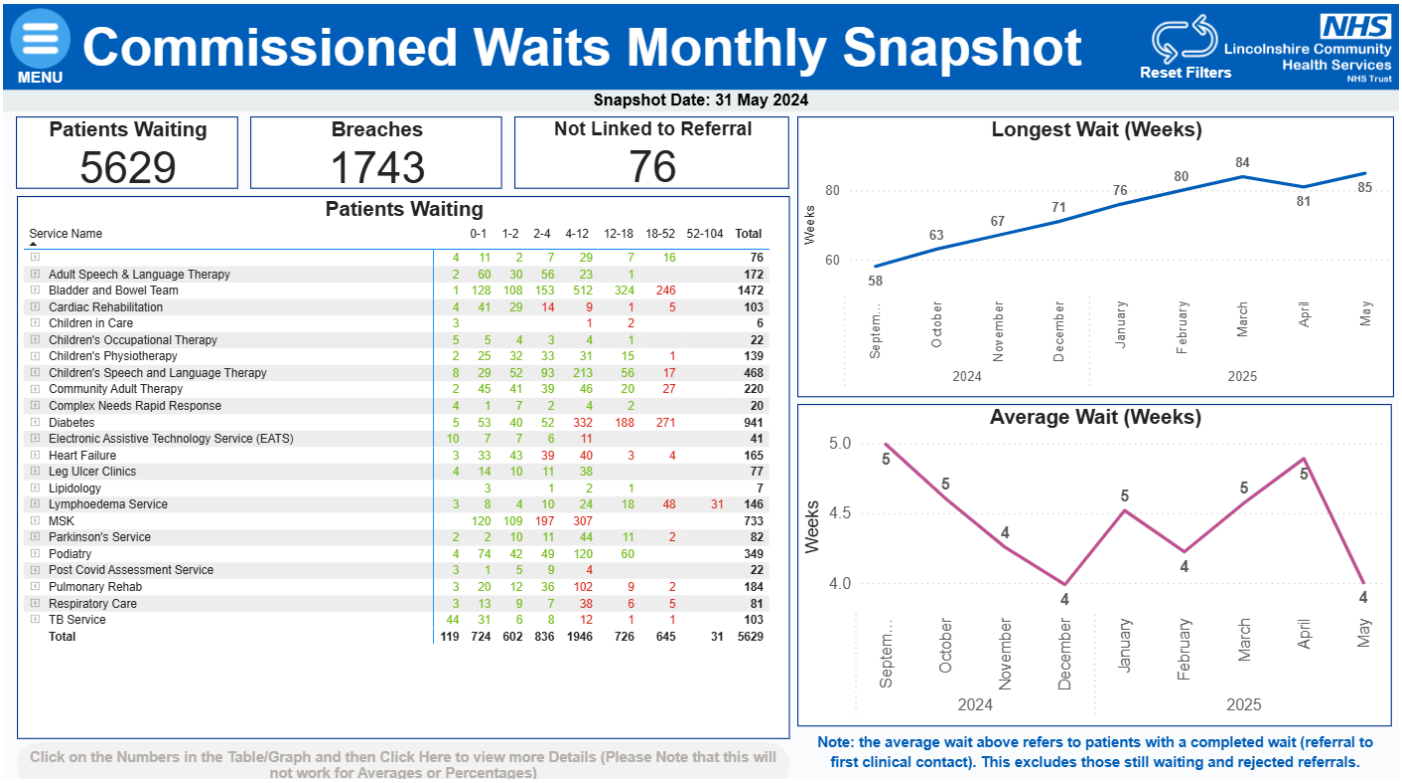
SPC

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 stopped or paused. Each individual service works to their own commissioned wait KPIs which maybe 18 weeks or fewer. All services record referral to initial contact, where that contact includes an element of treatment or advice.

In May 2025, 6 services are offering initial clinical contacts within their service target wait times. The wait in children's physiotherapy that is shown here as breechinig 18 weeks is a data cleansing issue and not a true breech.13 services have patients waiting in excess of the service's maximum target wait time including one service, Lymphoedema, that has 31 patients waiting longer than 52 weeks. 88% of patients are waiting less than 18 weeks.0.55% of patients across services are waiting more than 52 weeks.

Lymphoedema has seen an increase in urgent referrals which has meant that those referred and triaged as routine must unfortunately wait longer. The service has reviewed referral criteria, works collaborative with Essity and is exploring a possible opportunity to expand clinics to Sleaford. All services have Safe Waiting Plans in place including safety netting and harm reviews for patients that have waited longer than commissioned wait times. Services continue to adapt and work flexibly to mitigate challenges at an operational level through prioritisation, skill mix, innovative practice and integrated collaborative working with partners. Business cases for Lymphoedema, TB, Children in Care and Children's Speech and Language Therapy have not been successful in attracting additional resource and services continue to explore ways to manage overwhelming demand and mitigate risks. Adult Community Therapy are exploring significant changes in model, criteria and delivery, identifying potential opportunities for additional resource or capacity in group and opportunities for amalgamation with services such as community hospital therapy and discharge to assess.

The agreed target waits for those services currently utilising the clock are outlined below.

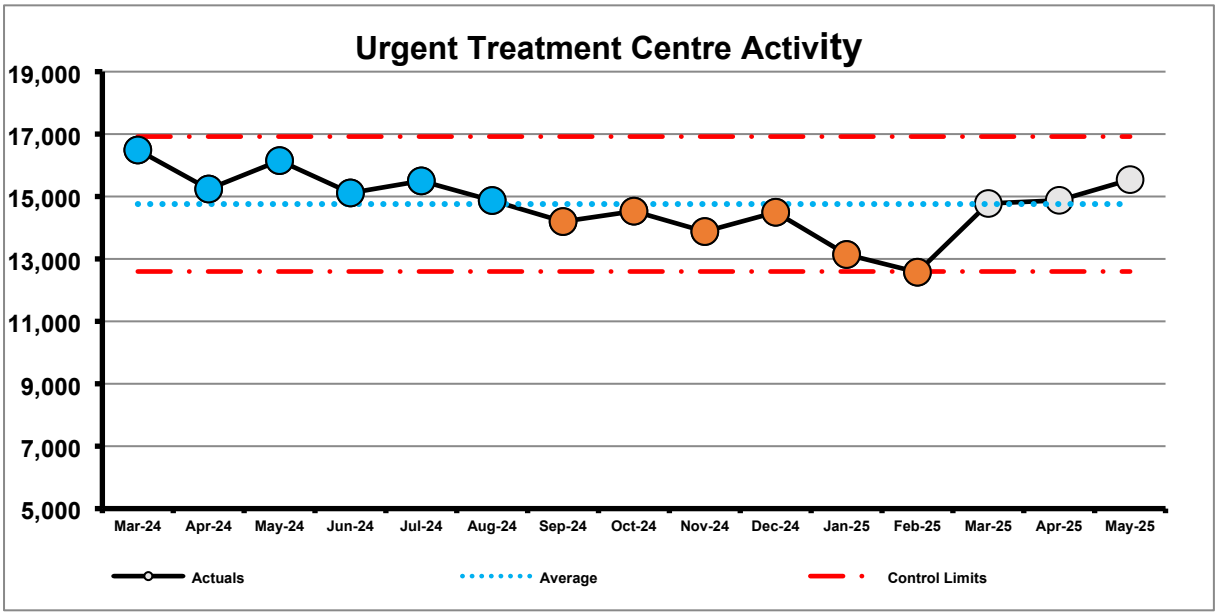
Service	**Target Wait**
Adult Speech and Language Therapy	18 Weeks
Bladder and Bowel	6 Weeks
Cardiac Rehabilitation	10 Working Days
Child Therapy	18 Weeks
Children in Care	20 Working Days
CNS Continence	18 Weeks
Diabetes	4 Weeks
Electronic Assistive Technology Service	6 Weeks
Heart Failure	2 Weeks
Musculoskeletal 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

In May 2025, there has been a modest increase in UTC footfall, consistent with expectations for this time of year. While the number of attendances is higher compared to the previous two months, it remains well within predicted seasonal activity ranges and aligns with the broader national trends observed across urgent care services.

Nationally, UTC attendances continue to fluctuate, with seasonal variations playing a significant role. This seasonal pattern is reflected in our local data, which shows that we are experiencing typical increases in demand as we approach warmer weather. We anticipate a slight rise in activity, especially in our coastal areas, due to the expected summer migration, a trend seen across other coastal regions nationally.

Locally we are closely monitoring attendance patterns to ensure that we can respond dynamically to changes in demand. By identifying peak footfall periods, we can align staffing and resources effectively, ensuring that patients continue to receive timely, high-quality care.

National data shows that urgent and emergency services across the UK saw a 7% increase in attendances in 2023/24, underlining the growing pressures faced by UTCs and other urgent care settings. In local coastal centres, we anticipate a potential 18% increase in activity, highlighting the increasing role of UTCs in managing patient flow and alleviating pressure on emergency departments, particularly during peak periods.

The consistency of UTC activity since September 2024 demonstrates the effectiveness of our long-term planning and proactive approach in managing demand. As we move into the summer months, we remain committed to closely monitoring trends and adjusting resources to ensure we continue to meet patient needs efficiently and effectively.

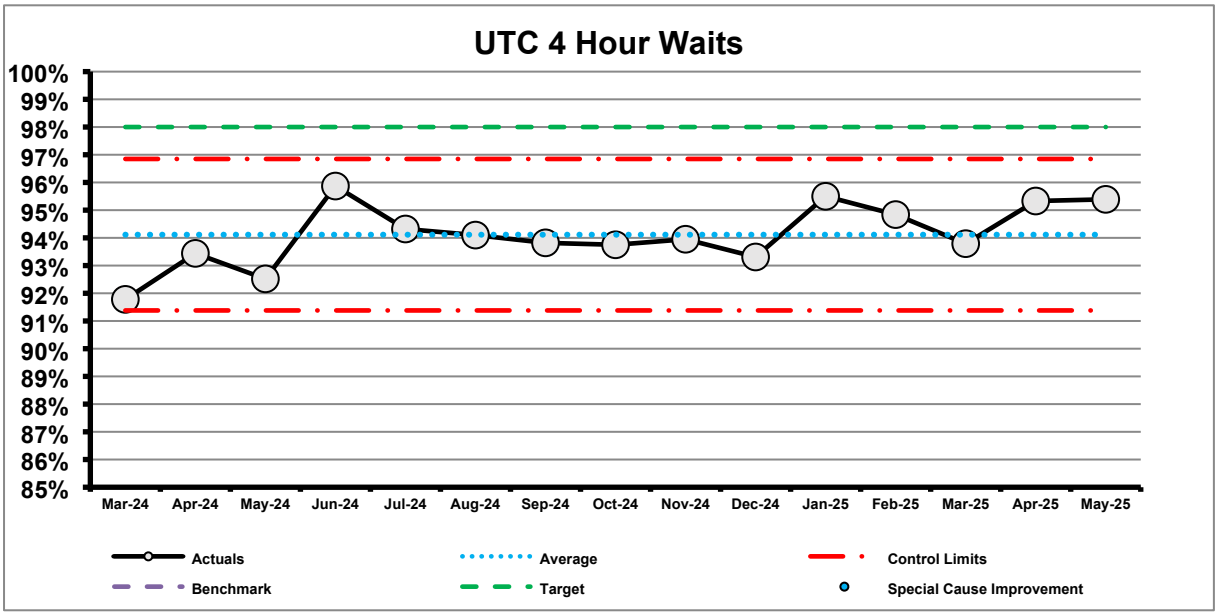
SPC

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

Performance across the Urgent Treatment Centres (UTCs) in May 2025 continues to show a positive trajectory, with 4-hour wait times improving slightly to 95.39%, up from 95.33% in April. While incremental, this improvement is part of a broader, consistent effort to enhance patient flow and care delivery across the system.

A key contributor to this progress has been greater consistency across UTCs, thanks to proactive collaboration and shared learning. Locally, the UTCs are consistently performing above the national average in terms of 4-hour wait time performance—reflecting the strong commitment of clinical and operational teams despite ongoing system pressures.

While the target of 98% remains ambitious, efforts across all sites are intensifying, with teams exploring innovative service models, real-time pathway adjustments, and cross-sector working to improve outcomes. we remain committed to these targets and are making structured, steady progress toward achieving them.

Challenges do persist, particularly at co-located UTC sites in Lincoln and Boston, where performance can be impacted by factors outside the immediate control of the UTC teams. These include:

- Delays in specialty referrals (e.g. orthopedics),
- Limited access to diagnostic services, such as x-rays and blood tests,
- Acute hospital bed pressures, which can delay admission and discharge processes.

These challenges are not unique to the locality and reflect broader system-level constraints observed nationally. However, the UTCs are actively working with acute care partners and system leads to escalate and resolve these issues, with a clear focus on reducing delays and improving patient journeys.

Importantly, this approach includes daily breach validation, early delay identification, and streamlined escalation to specialties. These improvements have been essential in helping maintain a performance level that consistently exceeds the national UTC average, which in many regions remains below 90%.

System-wide collaboration is at the heart of our approach. The aim is to achieve and sustain performance above 76% across the broader urgent care system, and current UTC performance shows we are well-positioned to meet that benchmark with ongoing improvements.

We are also investing in the future, with priority being given to workforce modelling and capacity planning. This will ensure that our services remain resilient, responsive, and ready to meet future demand, particularly as UTC activity remains high and continues to grow.

While the journey toward consistent achievement of the 98% target continues, the underlying data shows a positive direction of travel. The UTCs are increasingly well-placed to deliver timely, high-quality care, and the work being done now will lay the groundwork for long-term, sustainable improvements in urgent care delivery—both locally and as part of the wider NHS landscape

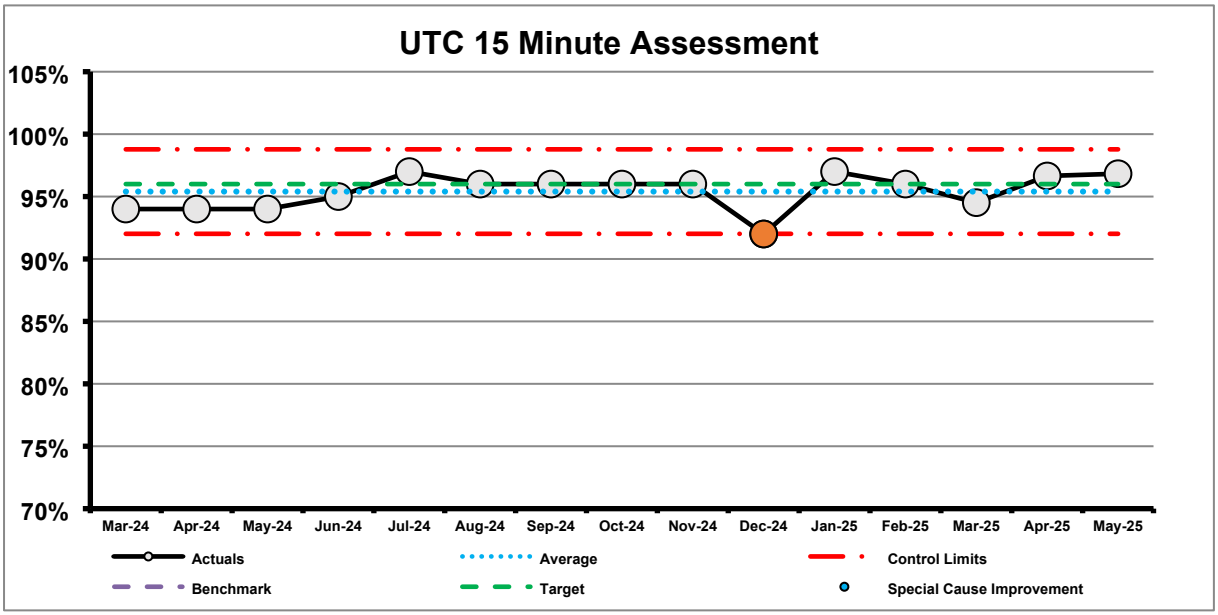
SPC

UTC 4-Hour Wait performance has not varied significantly over the period. UTC 4-Hour Wait performance is inconsistently capable of achieving the new 98% 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

The Urgent Treatment Centres (UTCs) continue to deliver excellent performance in 15-minute initial patient assessments, with April achieving 96.83%, a further improvement from 96.65% in the previous month. This not only exceeds the national target of 95%, but also places our local UTCs ahead of many regions where performance remains more variable.

This sustained upward trend reflects the dedication, efficiency, and clinical excellence of UTC staff, who have shown unwavering commitment to rapid patient assessment and early clinical intervention. Nationally, timely triage remains a key priority, as it plays a critical role in ensuring patient safety and streamlining care pathways—particularly at a time of continued demand across urgent and emergency care services.

Since December 2024, Lincolnshire has seen significant and sustained improvement in this area, marking real progress and highlighting the impact of focused operational efforts and cross-system collaboration. Importantly, our teams are not only maintaining this performance, but actively working to ensure it is sustainable in the long term.

This includes:

- Ongoing staff development and clinical leadership,
- Optimized triage models and assessment tools,
- Daily monitoring and real-time escalation to avoid delays.

These results are a strong indication that local UTCs are among the top performers nationally for early patient assessment—contributing directly to improved patient outcomes, reduced wait times, and more efficient use of healthcare resources.

We are confident that with continued focus and innovation, this high standard of performance will be both maintained and enhanced in the months ahead.

SPC

Since December 2024, there has been significant improvement in UTC's 15-minute assessment performance. Teams remain focused on sustaining this level of performance in the coming months.

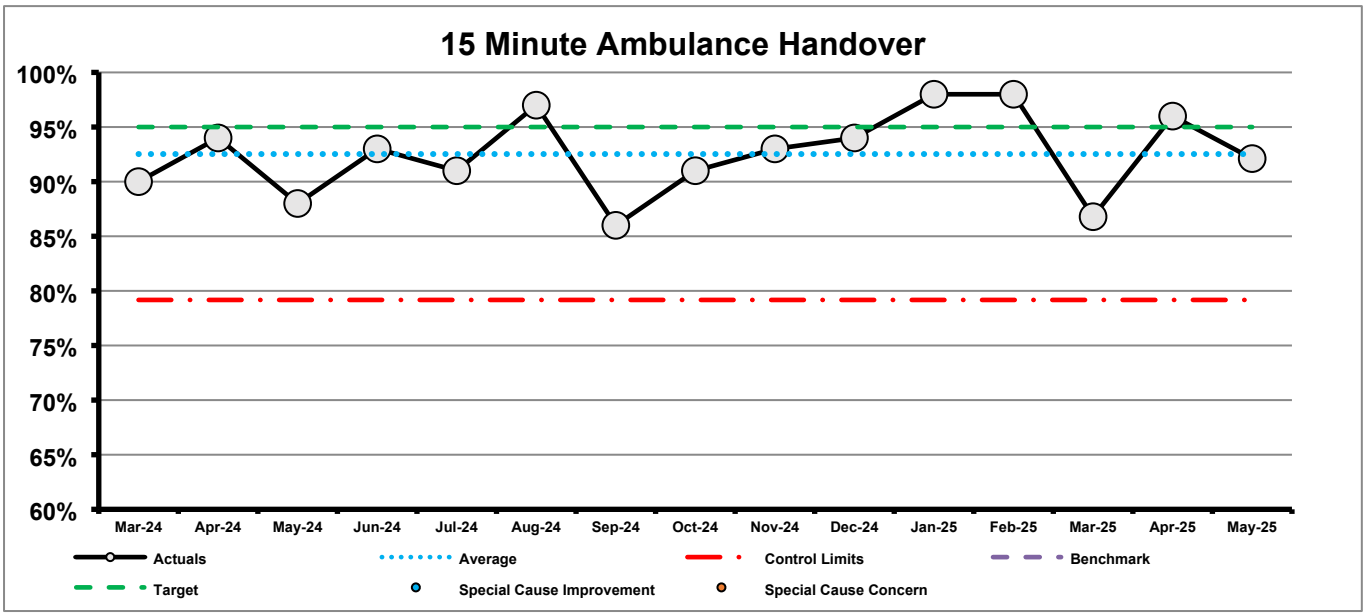
SPC

Since December 2024, there has been significant improvement in UTC's 15-minute assessment performance. Teams remain focused on sustaining this level of performance in the coming months.

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

Locally we continue to demonstrate strong partnership working with East Midlands Ambulance Service (EMAS), focusing on timely handovers and improving patient experience at the front door. In the most recent reporting period, 92.11% of ambulance handovers were completed within 15 minutes, compared to 96% in the previous period. While this represents a slight dip, performance remains consistently above the national average.

Our teams are committed to maintaining our reputation for efficient handover processes. Over the past 12 months, performance has often been near or above the nationally set 95% target, and although there has been some fluctuation, this reflects the real-time operational pressures experienced across urgent and emergency care systems.

We continue to work closely with our EMAS partners through regular joint meetings and collaborative initiatives that focus on admission avoidance, improving patient flow, and enhancing the use of alternative care pathways.

Our shared goal remains clear: to ensure that patients are transferred swiftly, safely, and with minimal delay. This work is being closely monitored, and proactive adjustments are made regularly in response to operational pressures.

While achieving consistent 95% compliance remains a national challenge, the local proactive and system-wide approach positions us ahead of many others, and we are confident that these improvement efforts will continue to yield positive, sustainable results.

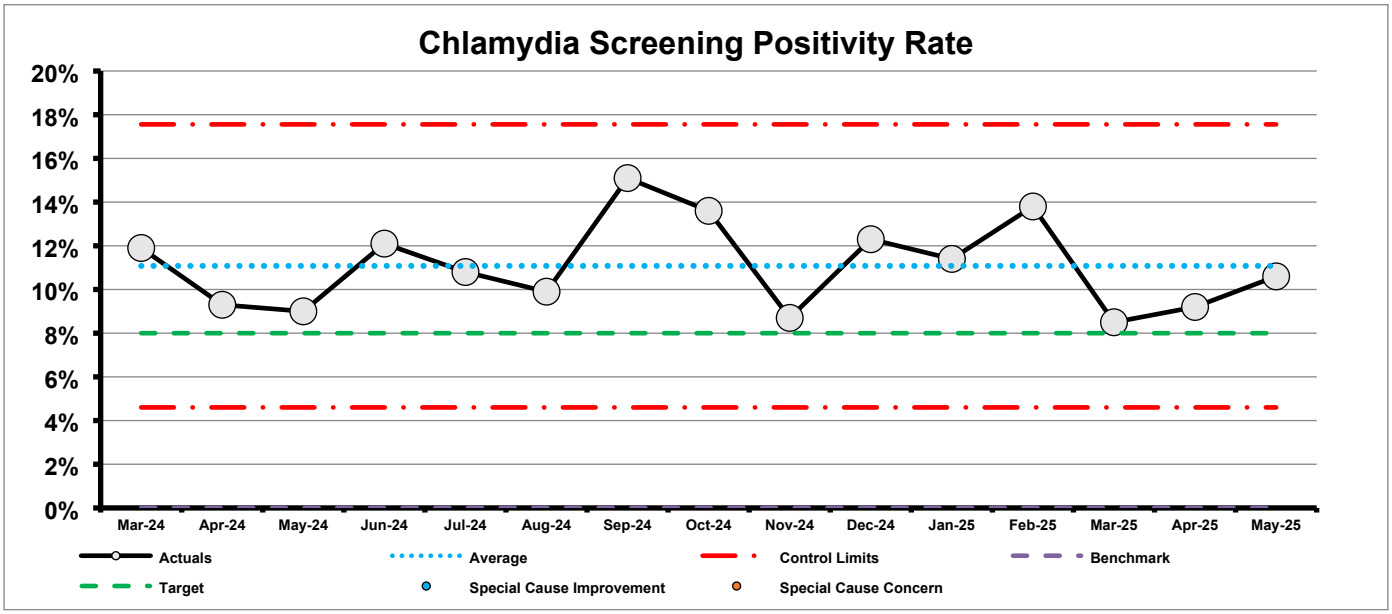
SPC

Although 15-minute Ambulance Handover has inconsistently been capable of achieving the 95% target over the last 12 months, performance continues to be monitored.

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.

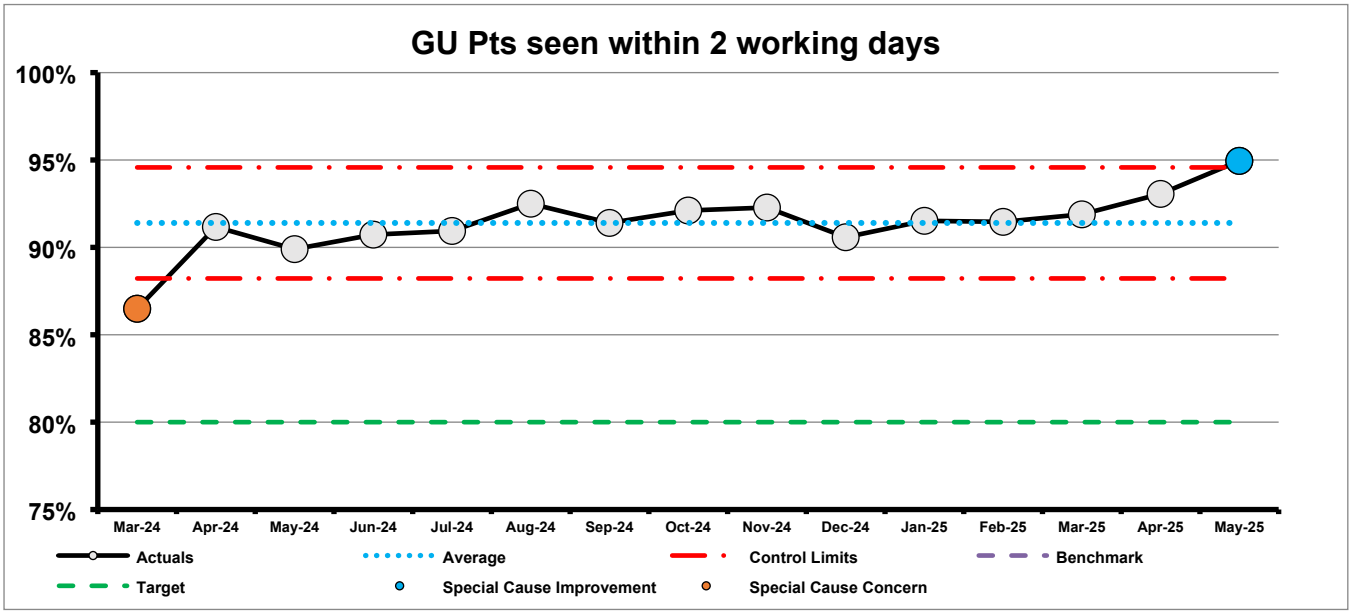
Actions

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 it is consistently capable of achieving the 80% target.

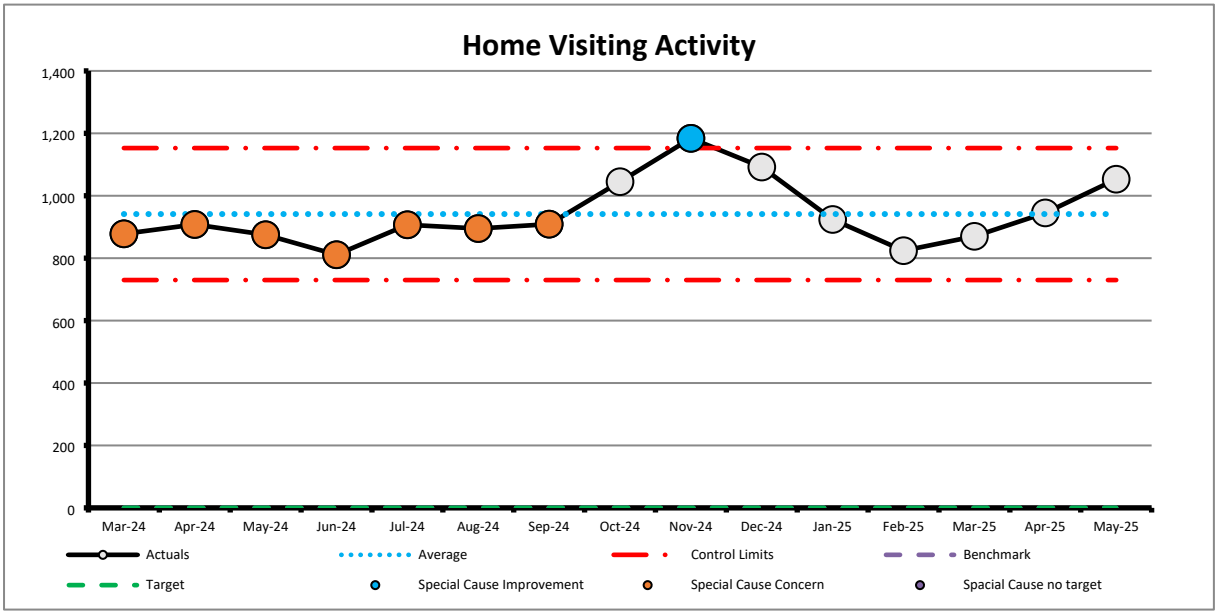
Home Visiting Report

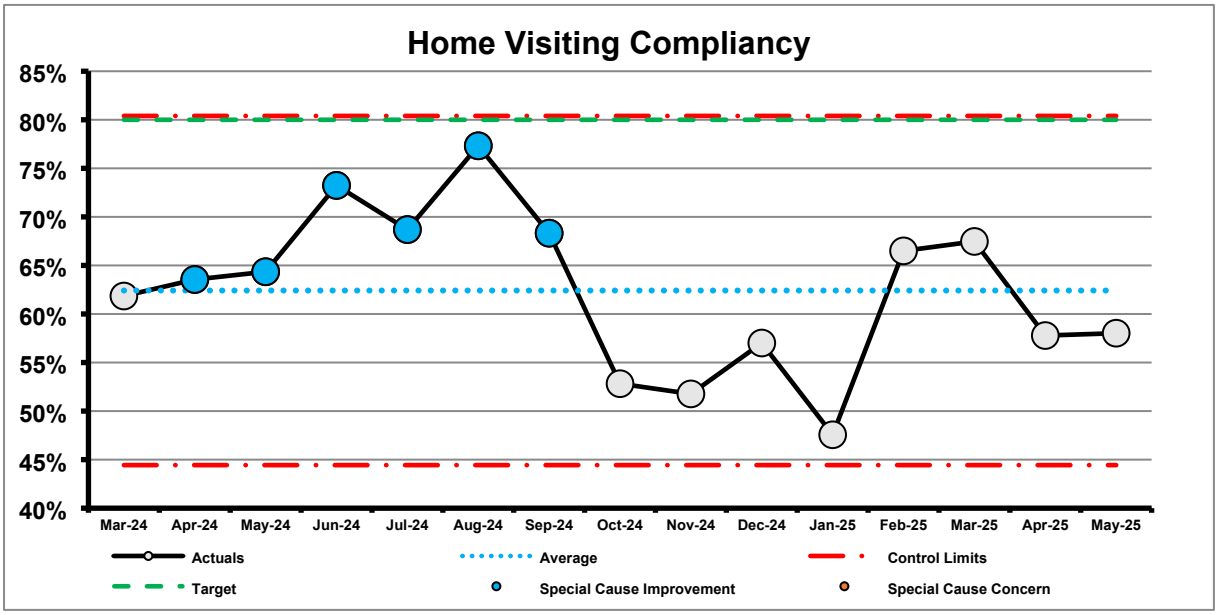
Background

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

Following the implementation of the pilot which commenced on 15.04.25 whereby UCR and Home visiting are integrated with regards to the response that is offered to patient's requiring a 2-hour response. The initial clinical triage is completed in CAS with the appropriate pathways available. As a result of the pilot the data has been combined to demonstrate the impact of the pilot. The 2-hour response for May is sat at 90% against 1535 cases/visits requiring a 2-hour response. The pilot will continue, and we hope to see the compliance and activity reflective of the success.

SPC

Home Visiting activity has not varied significantly over the period.

Compliance has not varied significantly over the period.

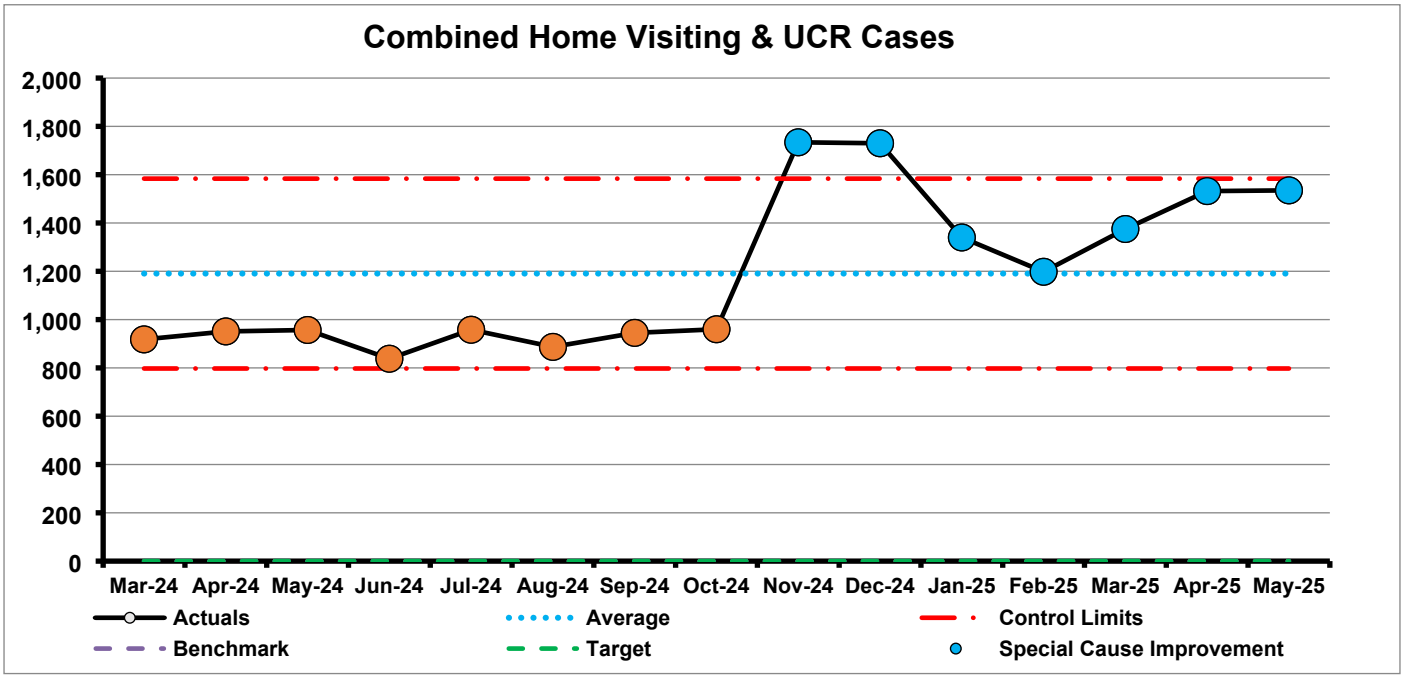
Urgent Community Response

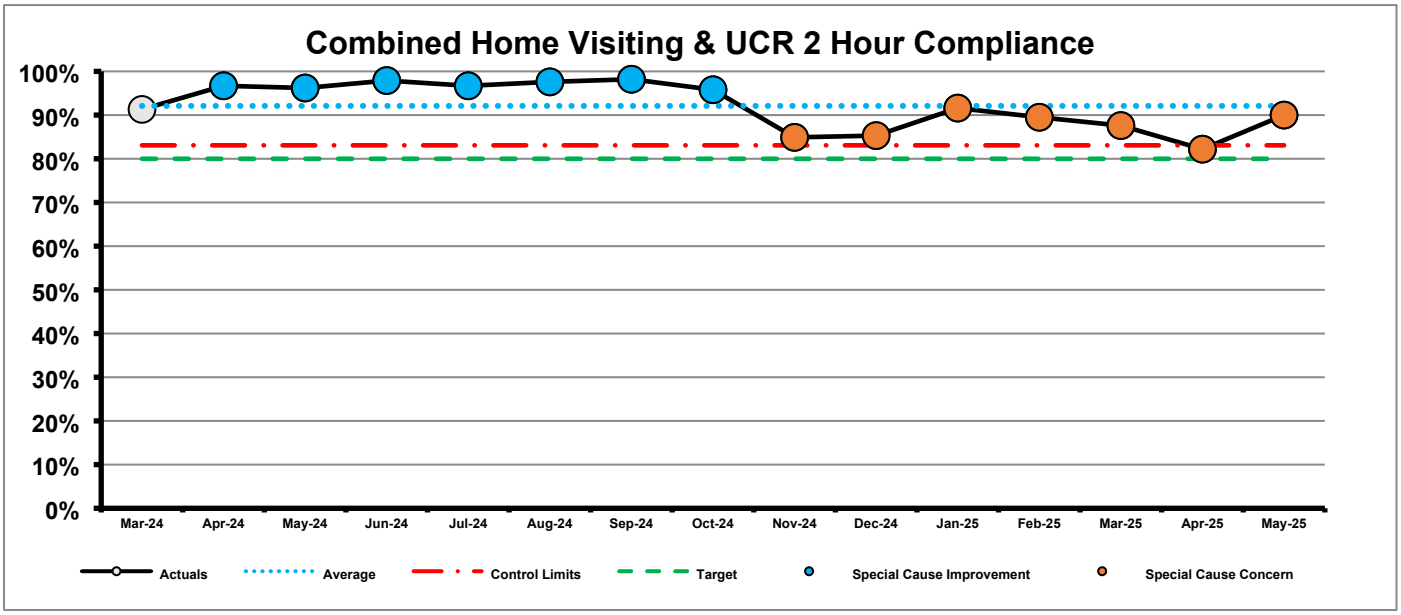
Background

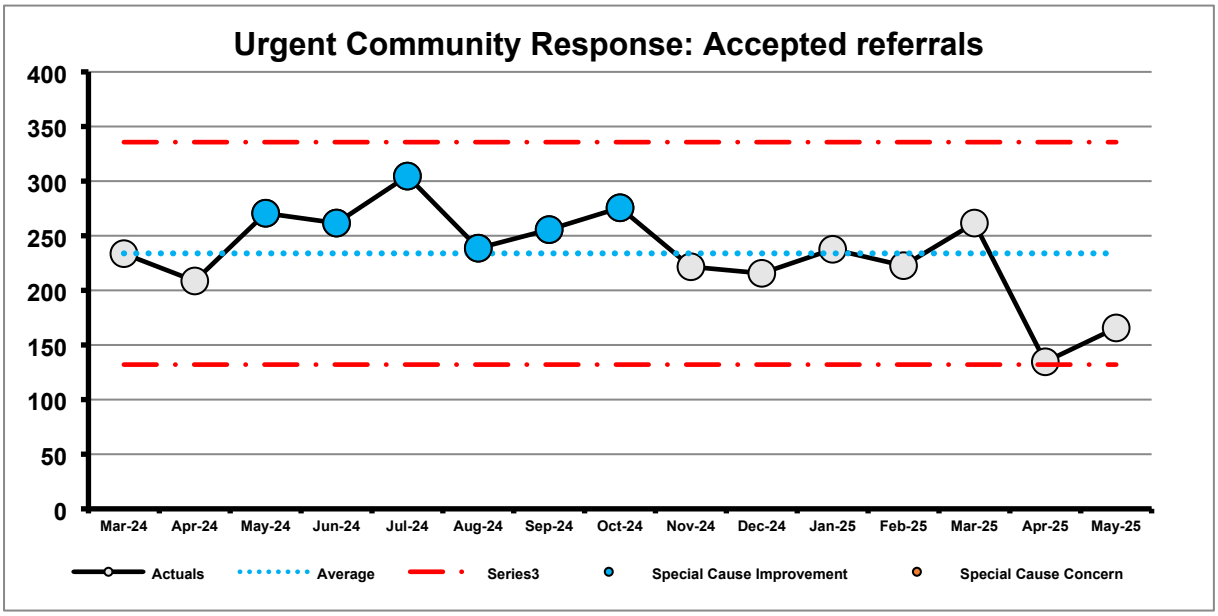
Urgent Community Response is a nationally directed service. The Urgent Community Response Team receives referrals from a variety of sources to support urgent response care services.

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

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SPC

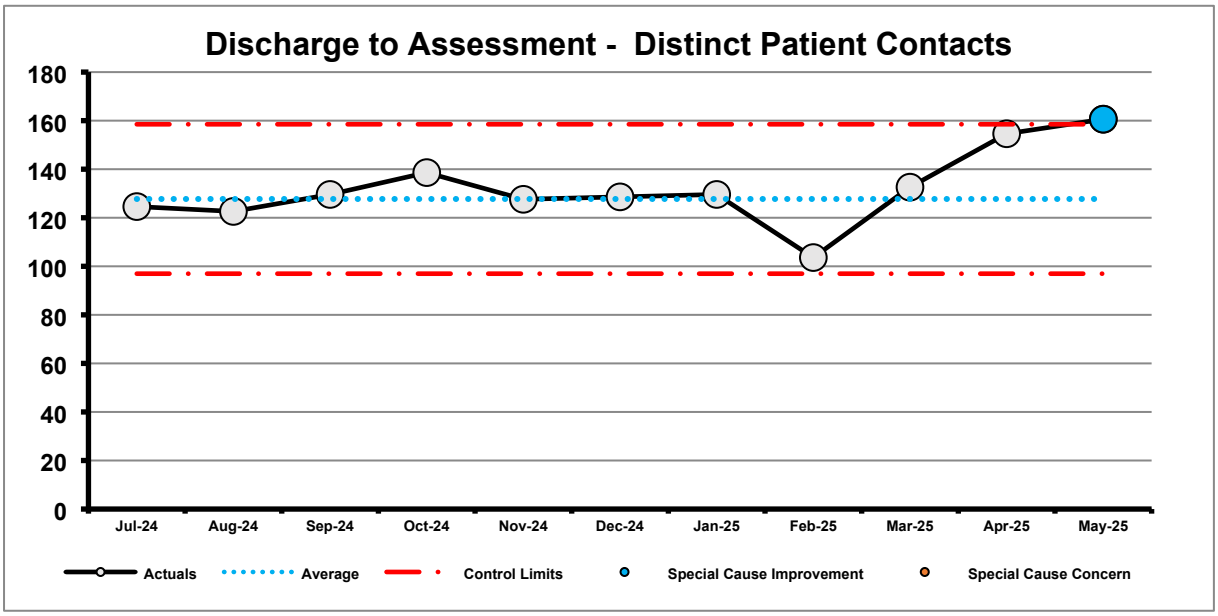
The Combined Home Visiting & UCR 2 Hour Compliance has moved into Special cause deterioration in November 2024; however, it is consistently capable of meeting its 80% target. May 2025 Combined Response measure returned 90% result.

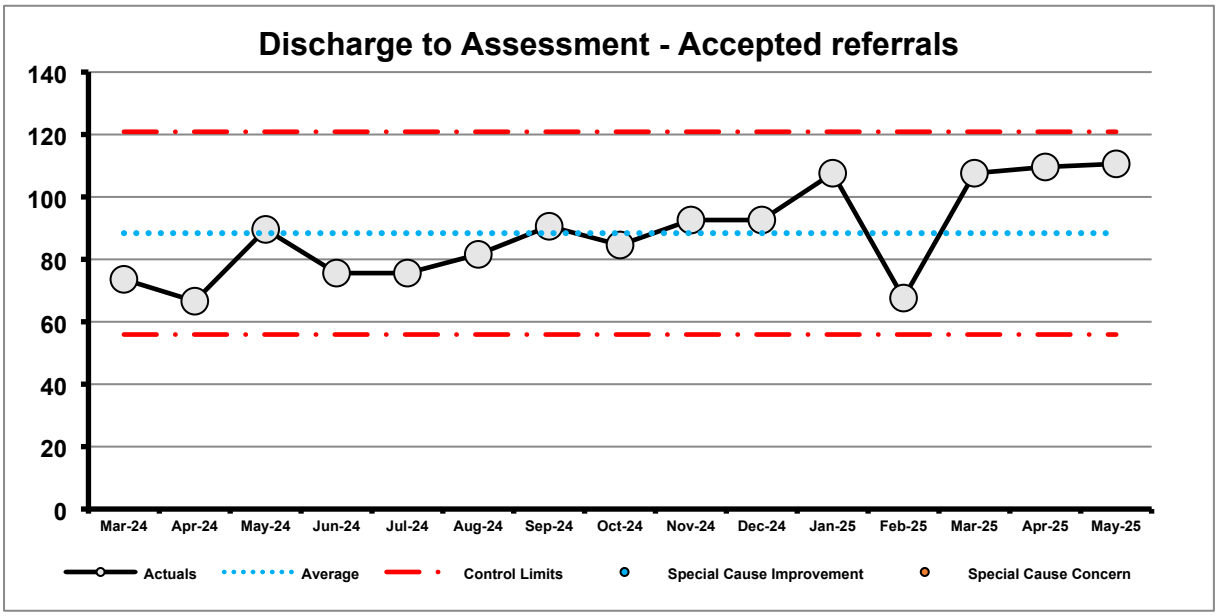
Discharge To Assessment

Background

The Discharge to Assessment programme has been introduced to expedite patients to leave acute care and return to their own home for reablement.

The service works closely with Adult Social Care and supports patients with a wide range of needs.





Narrative

The number of referrals accepted into the Pathway 1 D2A service increased in May and remained within control limits. Continued work with the ULTH Front Door Therapy Service and LCC HBRS service supports the improvement of pathways, in addition to trialling new ways of working between the D2A and LCHS community hospital and discharge hub teams.

Increased number of patients have been supported by D2A with the reduction in the Transitional Care bed numbers currently (see relevant section below).

SPC

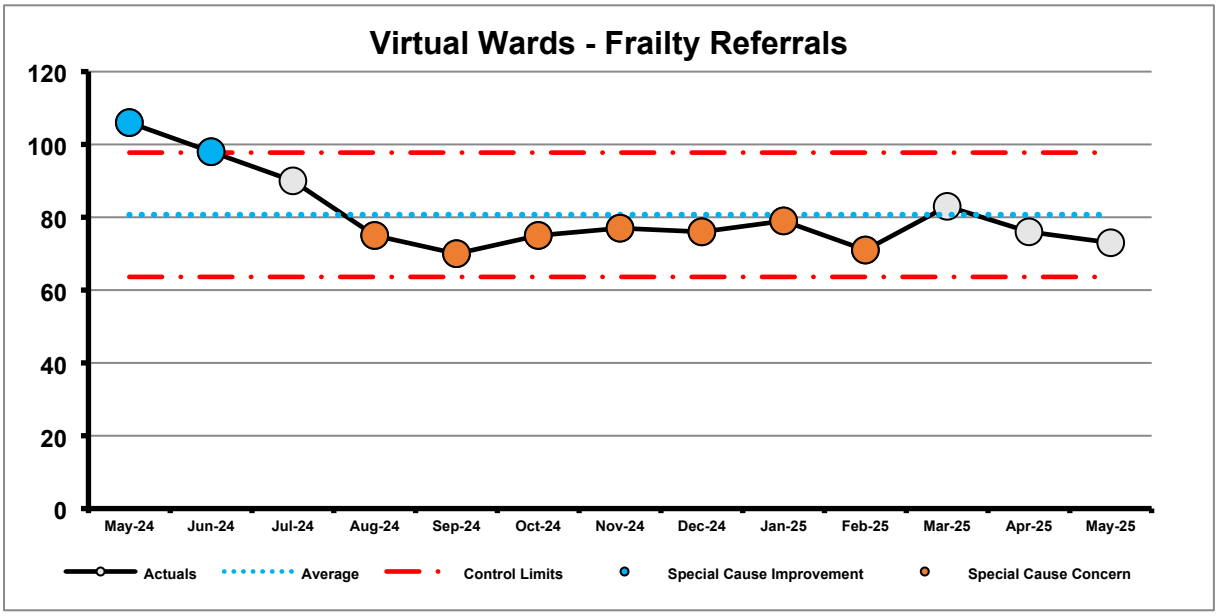
The number of distinct patient contacts has not varied significantly over the period and remains above average.

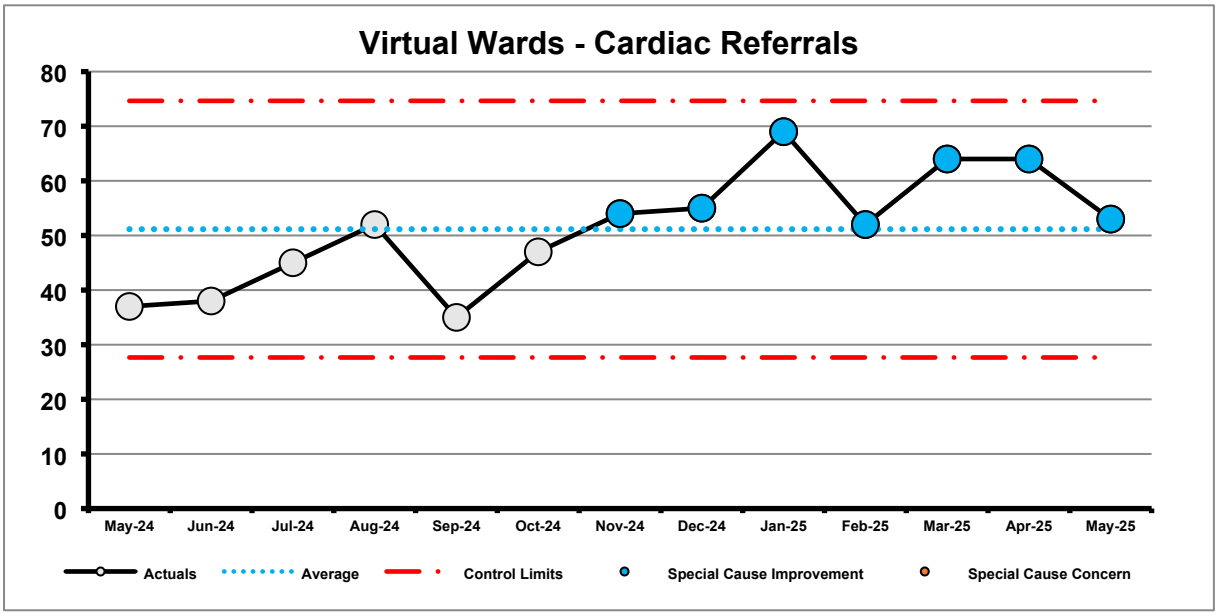
The number of D2A accepted referrals has not varied significantly and remains above average.

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

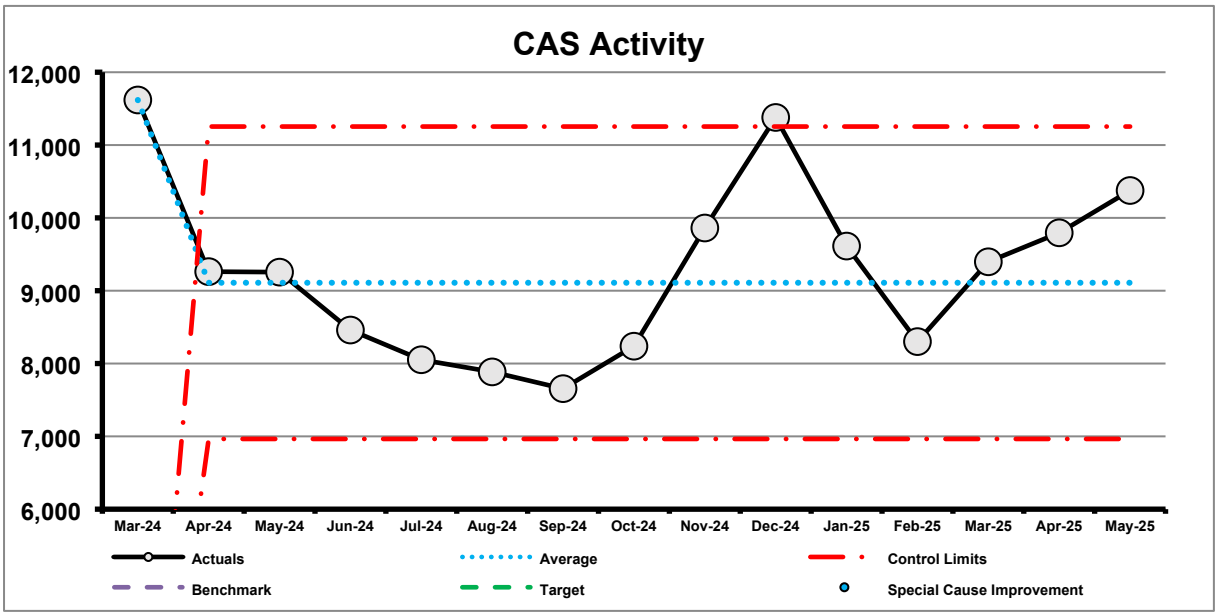
The number of referrals to the frailty virtual ward now shows special cause no variation since March 2025.

The number of referrals to the cardiology virtual ward is sitting just above the average and is showing special cause improvement since November 2024.

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

May activity has shown an increase compared to April and compared to May 2024. Activity has continued on an upward trajectory over the past 4 months. Effective from 21.03.25 CAS supported the UCR service to complete the first clinical assessment/triage to ensure patients are receiving the appropriate outcomes.

There has been significant work within CAS to ensure we are using the established resource and increasing utilisation. This has included various projects.

· The EOC initiative of CAS physically basing themselves within EMAS has now been extended to 7 days a week.

· 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. The ED dispositions are expected to return to CAS during the month of June.

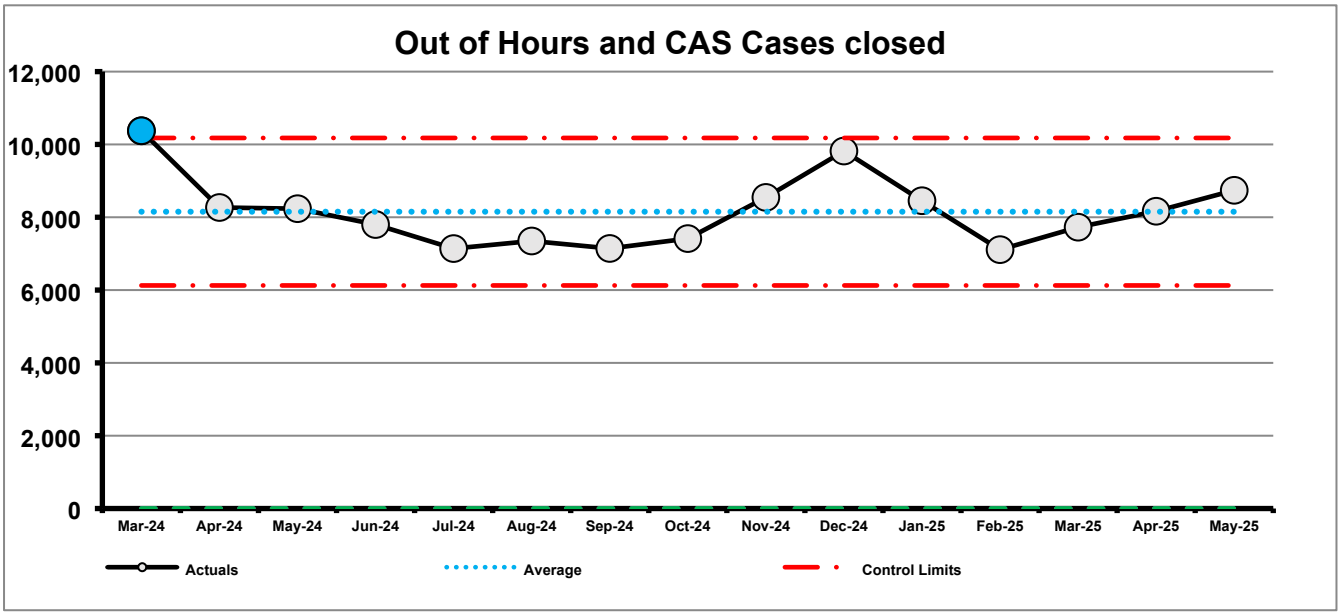
SPC

CAS activity has not varied significantly in the period.

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). May has continued to see a positive trajectory and now sits just above expected average. We are still awaiting DHU contract changes to return to Lincs CAS.

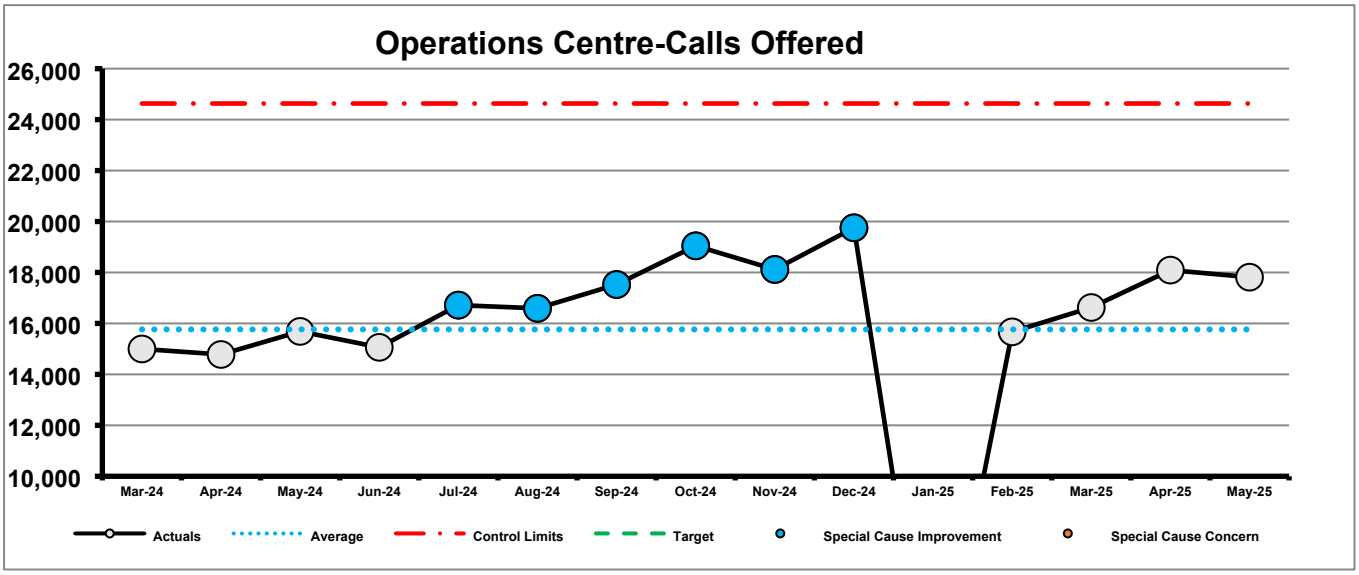
SPC

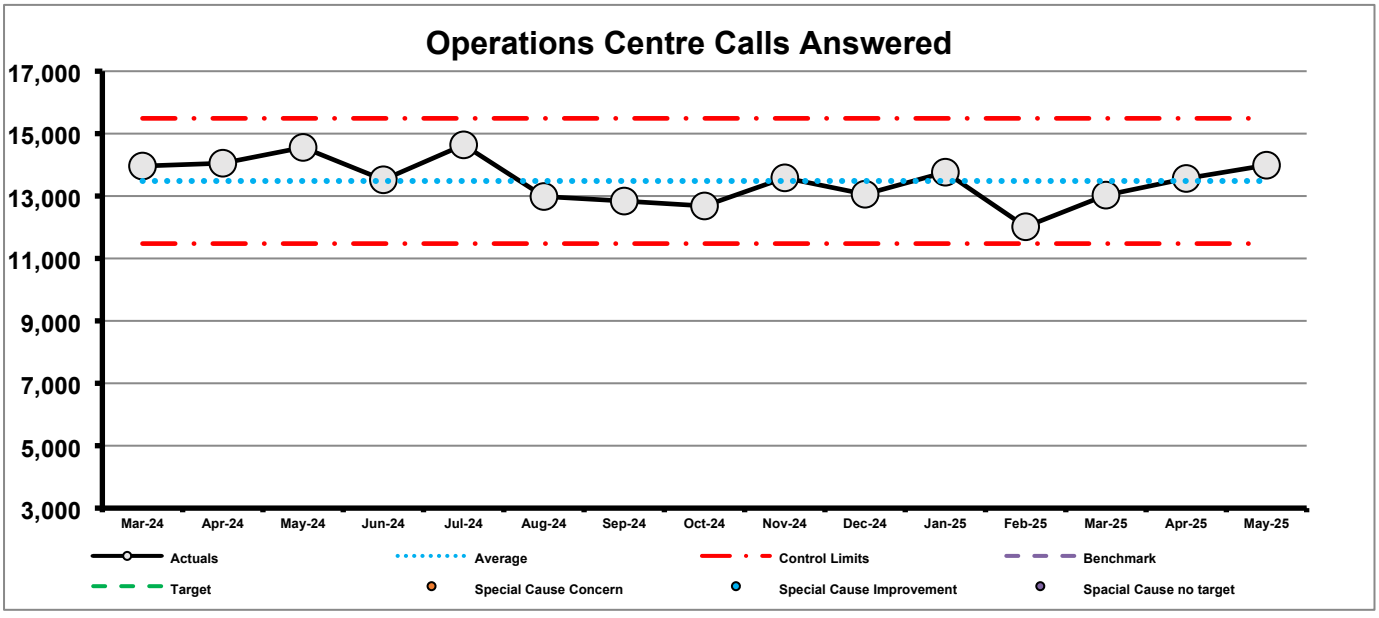
OOH & CAS Cases Closed has not varied significantly in the period.

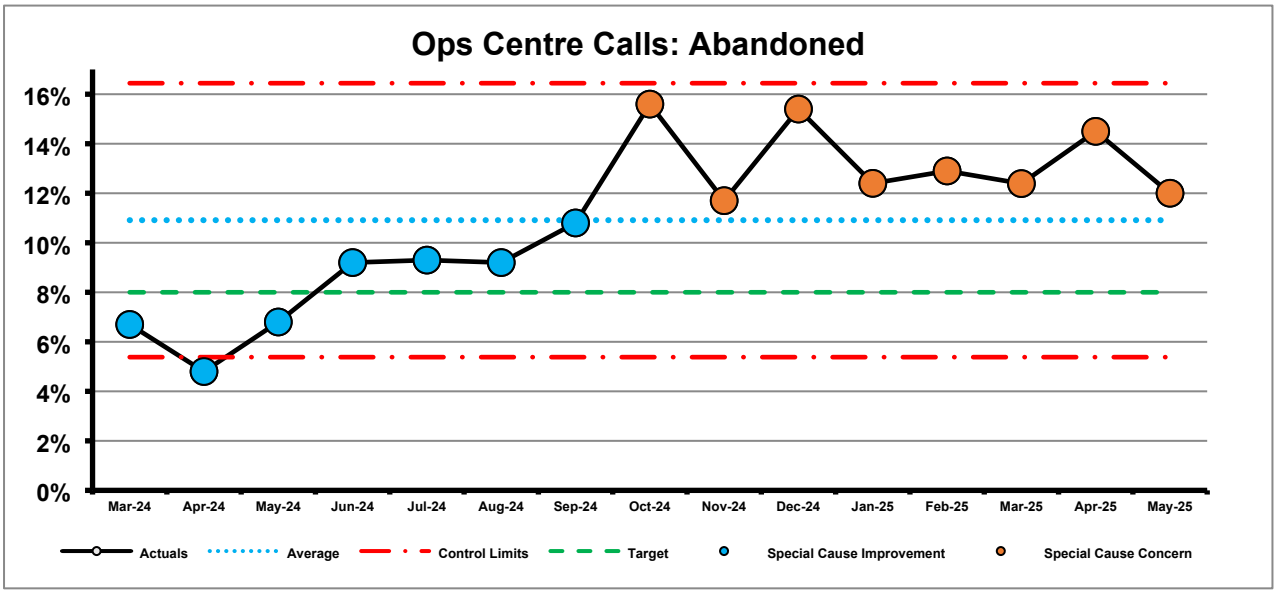
Operation Centre Calls Metrics

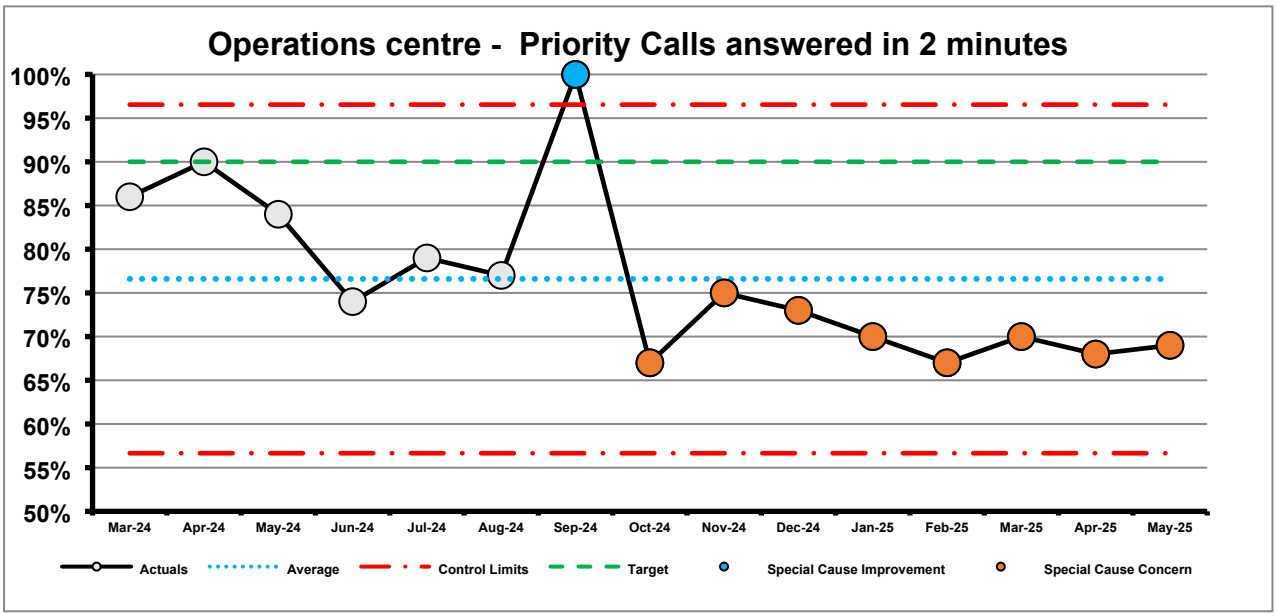
Background

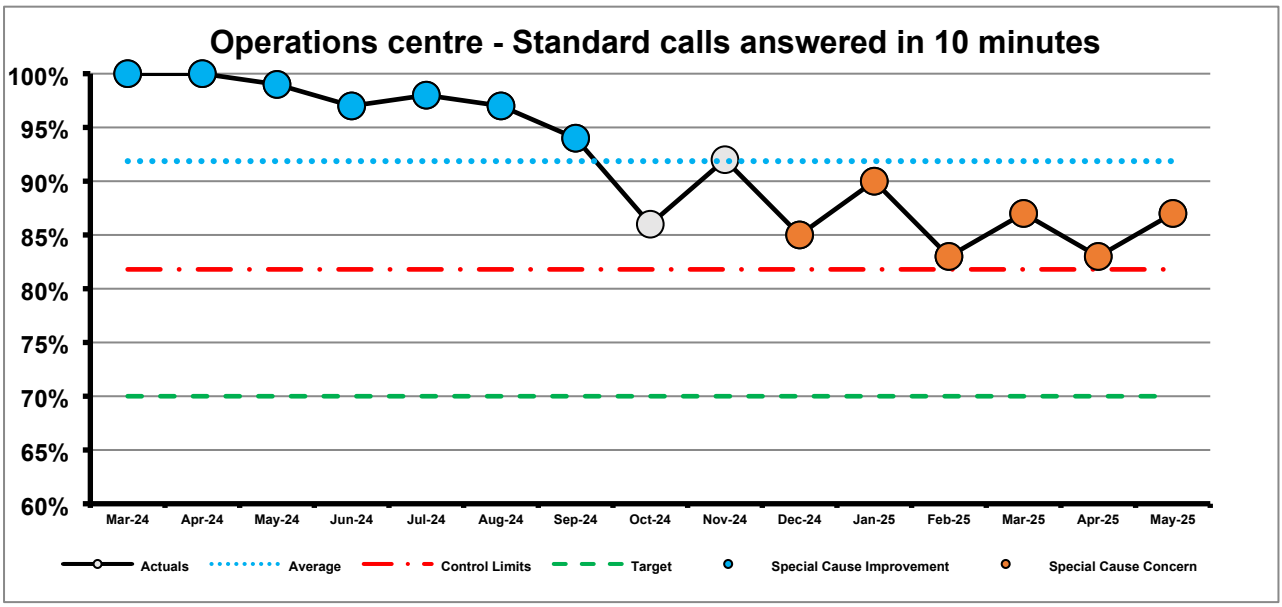
The Operations Centre was opened in December 2016 and provides a 24/7 multi-disciplinary team for LCHS. It was developed on the principle of a 'one call does it all' model and is a critical service that holds the Trust's services together e.g., community nursing, community hospitals, urgent care, transitional care, and our Clinical Assessment Service. The Ops Centre KPIs were amended in December as agreed by Community SLT. The service level was split into two, with standards calls having a target of answering 70% in 10 minutes, and priority calls a target of 90% in 2 minutes.






Ops Centre Calls: Abandoned
16%
14%
12%
10%
8%
6%
4%
2%
0%
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Actuals
Average
Control Limits
Target
Special Cause Improvement
Special Cause Concern


Operations centre - Priority Calls answered in 2 minutes
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Actuals
Average
Control Limits
Target
Special Cause Improvement
Special Cause Concern


Operations centre - Standard calls answered in 10 minutes
100%
95%
90%
85%
80%
75%
70%
65%
60%
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
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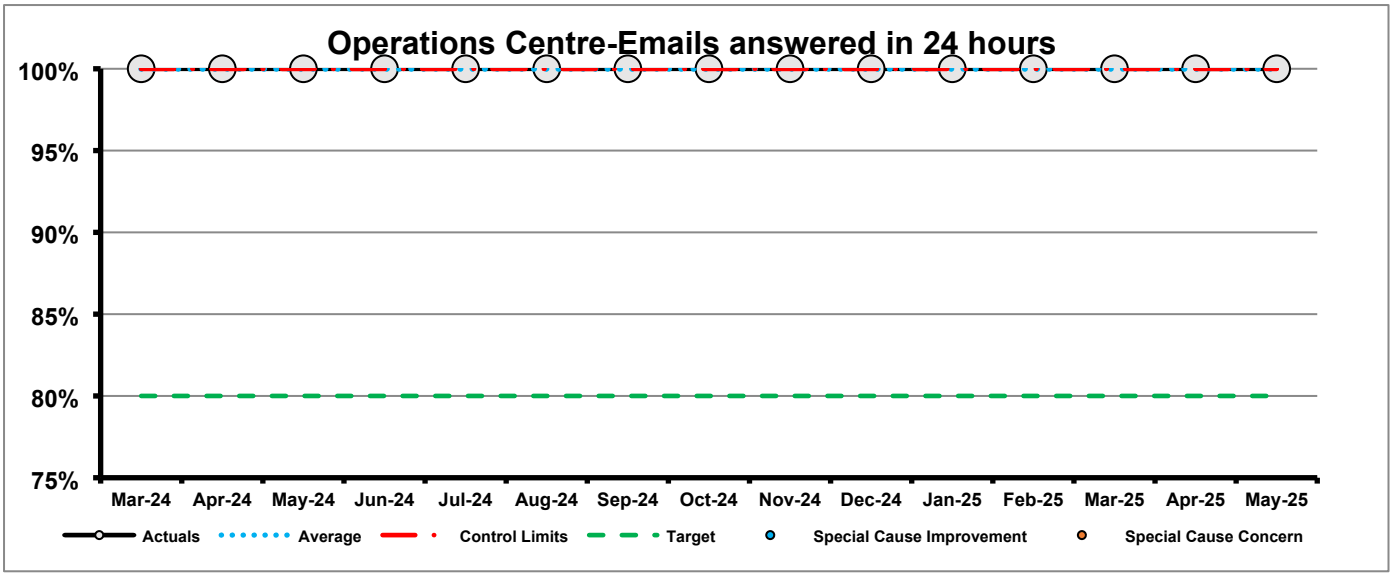
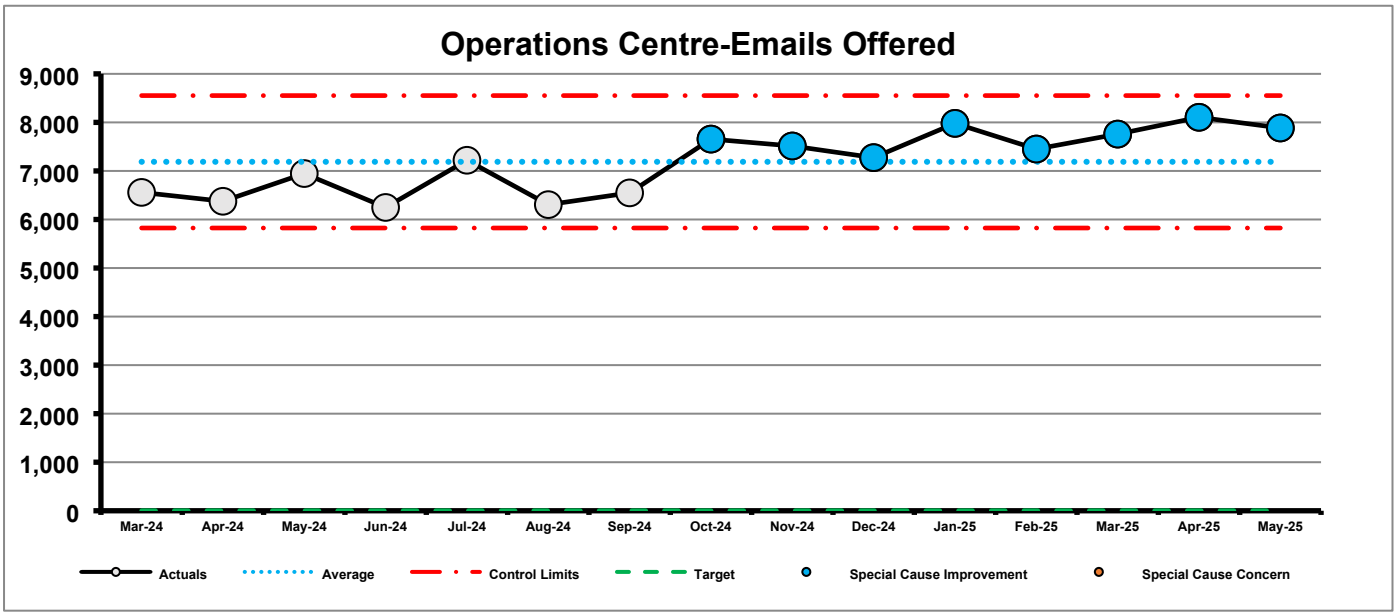
May-25
Actuals
Average
Control Limits
Target
Special Cause Improvement
Special Cause Concern





Narrative

May 2025 saw 17,815 calls come through the Ops Centre, compared to 15,868 in May 2024 – a 13% increase as well as this we saw 7,885 emails into ops compared to 6,935 May 24 which is a 14% increase YoY.

Our average daily contacts were 829 in May 25, compared to 710 in May 24 a 17% increase.

Priority calls were answered at 69% within SLA and Standard calls were above the SLA and achieved a strong month 87% within SLA abandonment rate increased due to the sheer volume of calls coming in (up to 12%) whilst all email contacts achieved the SLA. (100% within SLA) average email handling time of 05:48.

Focus continues to be around how we can work differently and more efficiently without the ability to mitigate the impact of the current vacancies on performance.

SPC

The number of calls answered within the Ops Centre has not varied significantly since August 2024.

Ops Centre Calls Abandoned shows special cause concern since October 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 included for the May report for April data.

Ops centre Priority calls (answered within 2 minutes) are achieving 69% for May 2025.

Ops centre Standard calls (answered within 10 minutes) are achieving 87% for May 2025.

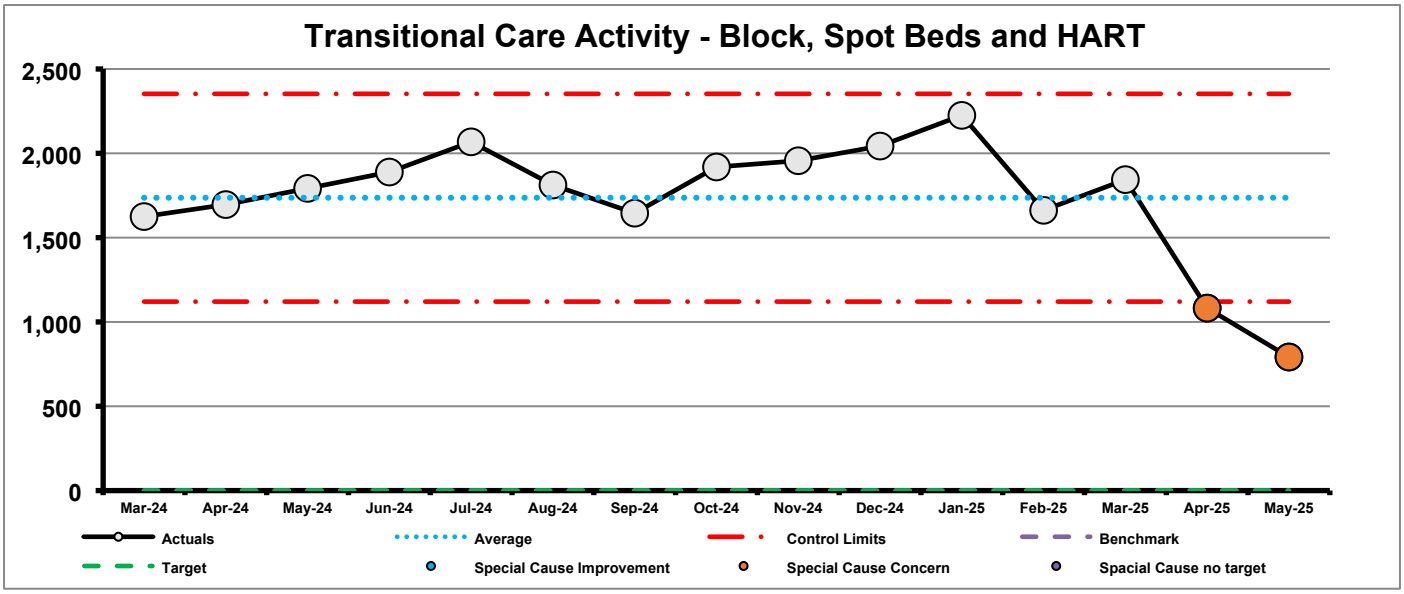
Ops centre Emails answered within 24 hours are achieving 100% for May 2025.

Ops centre Emails offered are 7885 for May 2025.

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

The number of Transitional Care beds procured by LCHS continues to be reduced due to ongoing transformation work and new contracting arrangements being managed with Lincolnshire County Council.

At present, LCHS is working to SPOT purchase beds when required, as continue with the procurement processes, and increasing numbers of patients being supported by the D2A service.

The strategic direction is for the system to commission less transitional care beds overall, and redirect funding into an enhanced D2A service, and so this change is in line with this aim.

SPC

Transitional care activity has reduced in line with this aim from 1082 in April 2025 to 792 within May 2025.

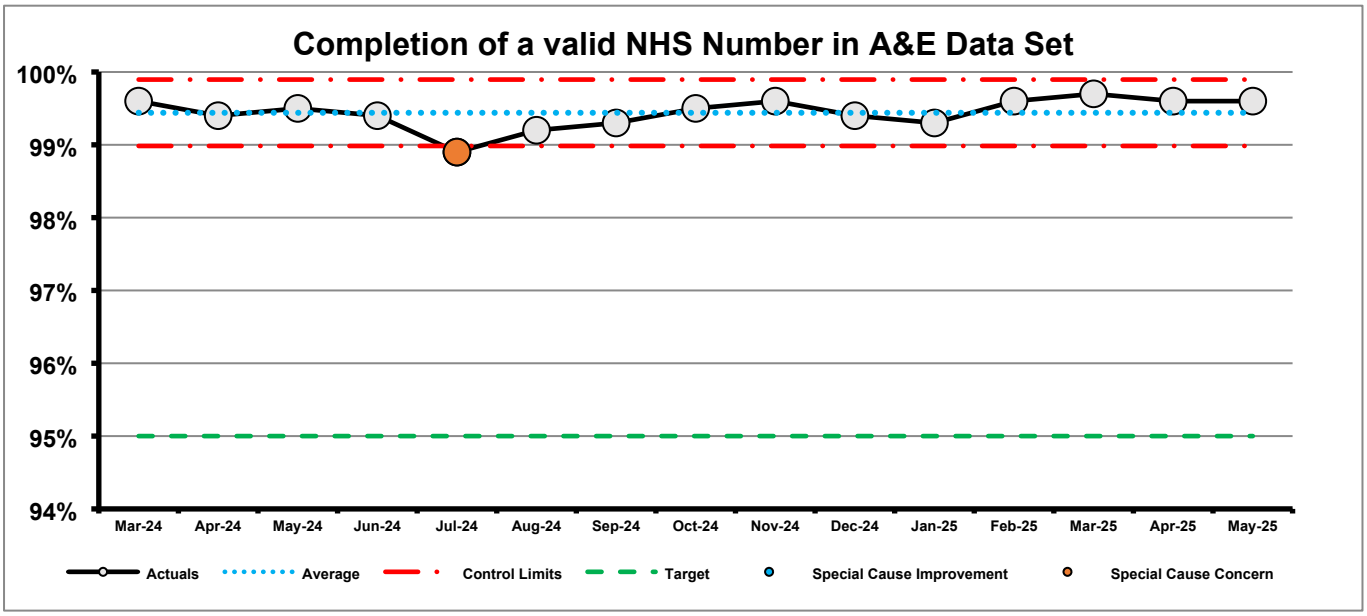
Completion of a Valid NHS Number in A&E Data Set

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

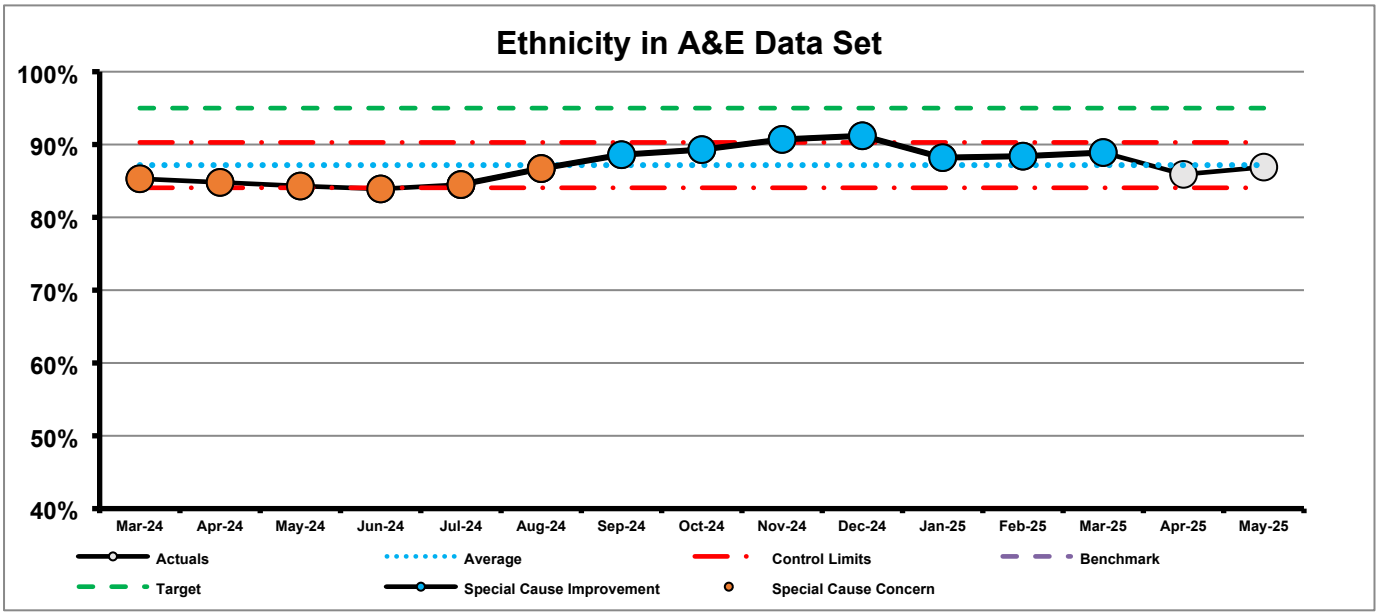
Completion of a valid NHS number for A&E datasets has not varied significantly since June 2024 and is consistently capable of achieving the 95% target.

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.

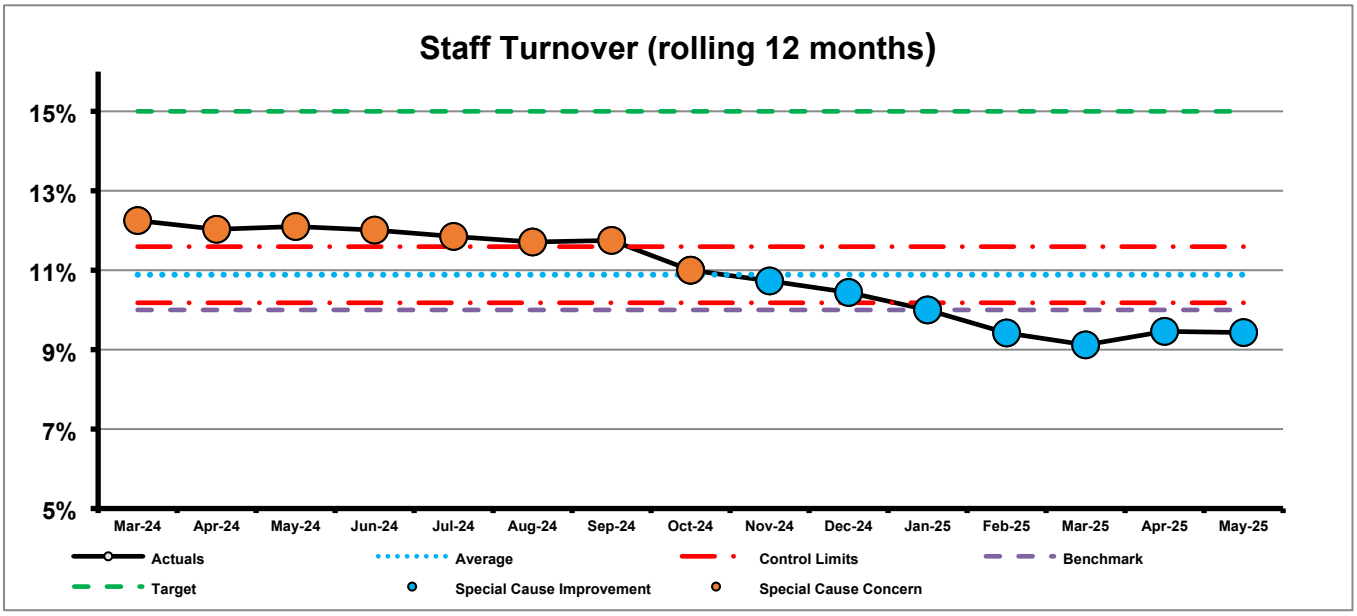
SPC

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.

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 9.43% 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.

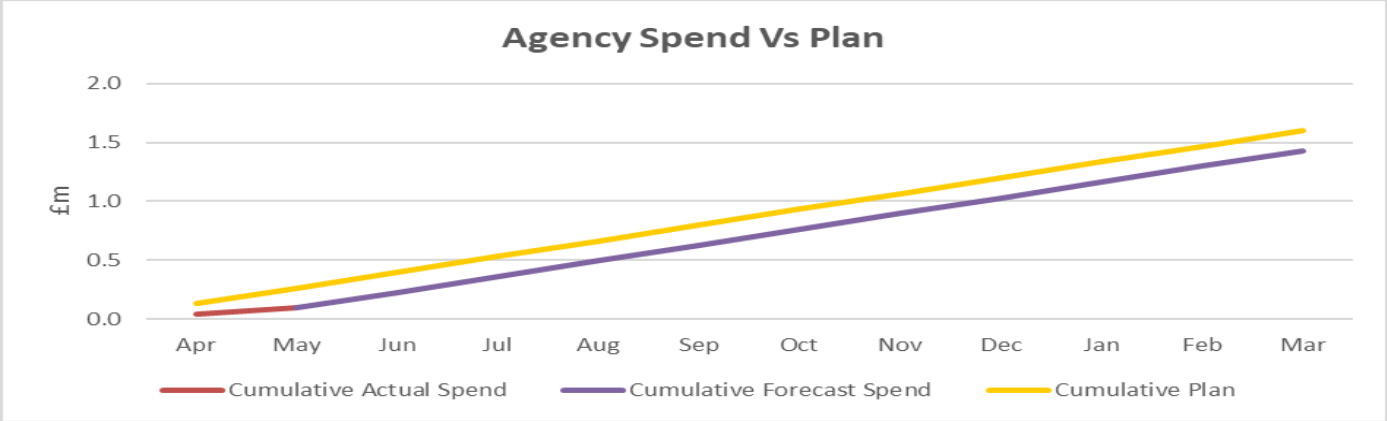
Financial Performance Summary

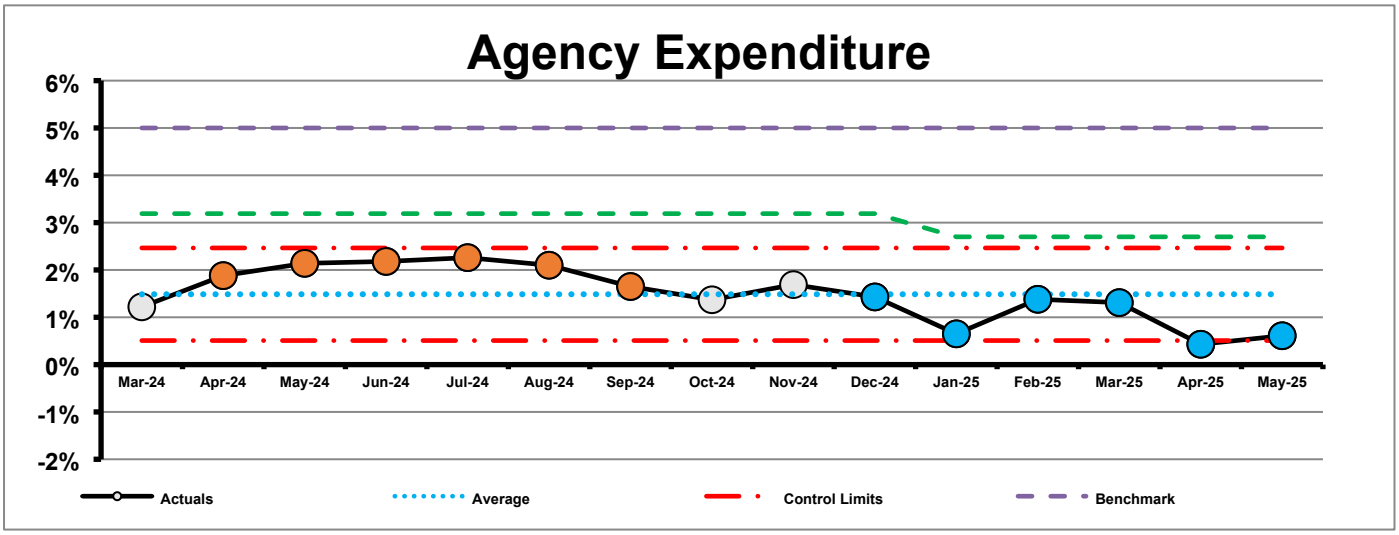
Financial Summary Table (Month 2)	
Description	**Narrative**
Position in May	£-486k deficit
Position YTD	£-985k deficit
Position FOT	Breakeven
CIP in May	£397k against plan of £259k
CIP YTD	£680k against plan of £519k
CIP FOT	£6.7m against plan of £9.5m
Agency in May	£56k against plan of £133k
Agency YTD	£96k against plan of £267k
Agency FOT	£1.4m against plan of £1.6m
Capital in May	£1.2m against plan of £12k
Capital YTD	£1.2m against plan of £1.5m
Capital FOT	£3.3m against plan of £3.3m
Cash	£25.1m against forecast plan of £25.7m

Agency Expenditure

Background

In 23/24 agency spend was £2.6m, the 24/25 outturn represented a 47% reduction in cost of agency in a year, with continued focus on reducing overall temporary staffing spend in 2025/26.





Narrative

- M02 agency spend was £55k compared to £133k plan, this was a favorable result in month.
- Full Year Agency Spend Plan is £1.6m

SPC

Agency expenditure has shown special cause improvement in May 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).

Cost Improvement Headlines

	Plan Month 2 £000	Actual Month 2 £000	Variance Month 2 £000	Plan YTD £000	Actual YTD £000	Variance YTD £000	Annual Plan £000	Forecast £000	Variance £000	Overall Delivery of Savings RAG	Comment on RAG rating
Stock Management	£0	£0	£0	£0	£0	£0	-£110,000	-£110,000	£0	Low	
Overnight Closure of Louth & Skegness UTC	£0	£0	£0	£0	£0	£0	-£274,192	-£274,192	£0	High	Dependent on outcome of ICB/ELT reviews
Vacancy Factor - Ops	-£71,204	-£130,044	-£58,840	-£142,408	-£329,684	-£187,277	-£854,446	-£1,041,723	-£187,277	Low	
Agency/Bank Reduction	-£112,439	-£77,670	£34,769	-£224,878	-£4,922	£219,956	-£1,349,270	-£1,129,314	£219,956	Medium	
Approved Cost Pressures	£13,889	£15,046	£1,157	£27,778	£28,087	£309	£166,667	£166,976	£309	Medium	changes
Bank Sickness Reduction	-£21,917	£0	£21,917	-£43,833	£0	£43,833	-£263,000	-£219,167	£43,833	High	Increases already identified bank savings
Pay T&C's	£0	£0	£0	£0	£0	£0	-£47,000	-£47,000	£0	High	Sprint work - awaiting further detail
DoF Corp Target	£0	-£6,250	-£6,250	£0	-£12,500	-£12,500	-£205,800	-£138,750	£67,050	Medium	Portion remains unidentified
Medical Director Corp Target	£0	£0	£0	£0	£0	£0	-£93,800	£0	£93,800	High	Unidentified
DoO Corp Target	£0	£0	£0	£0	£0	£0	-£124,600	£0	£124,600	High	Unidentified
DoP&I Corp Target	£0	-£27,369	-£27,369	£0	-£66,432	-£66,432	-£827,400	-£214,762	£612,638	High	Unidentified
DoN Corp Target	£0	£0	£0	£0	£0	£0	-£105,483	£0	£105,483	High	Unidentified
Chief Exec Corp Target	£0	£0	£0	£0	£0	£0	-£100,100	-£10,000	£90,100	High	Unidentified
Current unidentified/opportunities	£0	£0	£0	£0	£0	£0	-£1,173,437	-£750,000	£423,437	High	Dependent on TCB project cost savings
Closure of 2x Community Wards	£0	£0	£0	£0	£0	£0	-£921,626	-£921,626	£0	High	Dependent on outcome of ICB/ELT reviews
Vacancy Factor - Corp	-£13,349	-£88,725	-£75,376	-£26,698	-£165,872	-£139,175	-£160,186	-£299,361	-£139,175	Low	
Wholly Owned Subsidiary	£10,000	£10,000	£0	£20,000	£20,000	£0	-£878,932	-£878,932	£0	High	Sprint work - awaiting further detail
1.5% Reduction across services	-£64,243	-£64,657	-£414	-£128,485	-£109,074	£19,411	-£1,541,821	-£1,541,821	£0	Medium	Over 50% awaiting full plans to progress
Bank interest over plan	£0	-£27,376	-£27,376	£0	-£39,285	-£39,285	£0	-£39,285	-£39,285	Low	
2025-26 CIP Programme	**-£259,262**	**-£397,045**	**-£137,783**	**-£518,524**	**-£679,683**	**-£161,159**	**-£8,864,426**	**-£7,448,956**	**£1,415,470**		

Recurrent	-£188,598	-£165,946	£22,652	-£377,197	-£172,928	£204,268	-£8,016,461	-£6,235,563	£1,780,897
Non-Recurrent	-£70,664	-£231,099	-£160,435	-£141,328	-£506,755	-£365,427	-£847,965	-£1,213,392	-£365,427
	-£259,262	**-£397,045**	**-£137,783**	**-£518,524**	**-£679,683**	**-£161,159**	**-£8,864,426**	**-£7,448,956**	**£1,415,470**

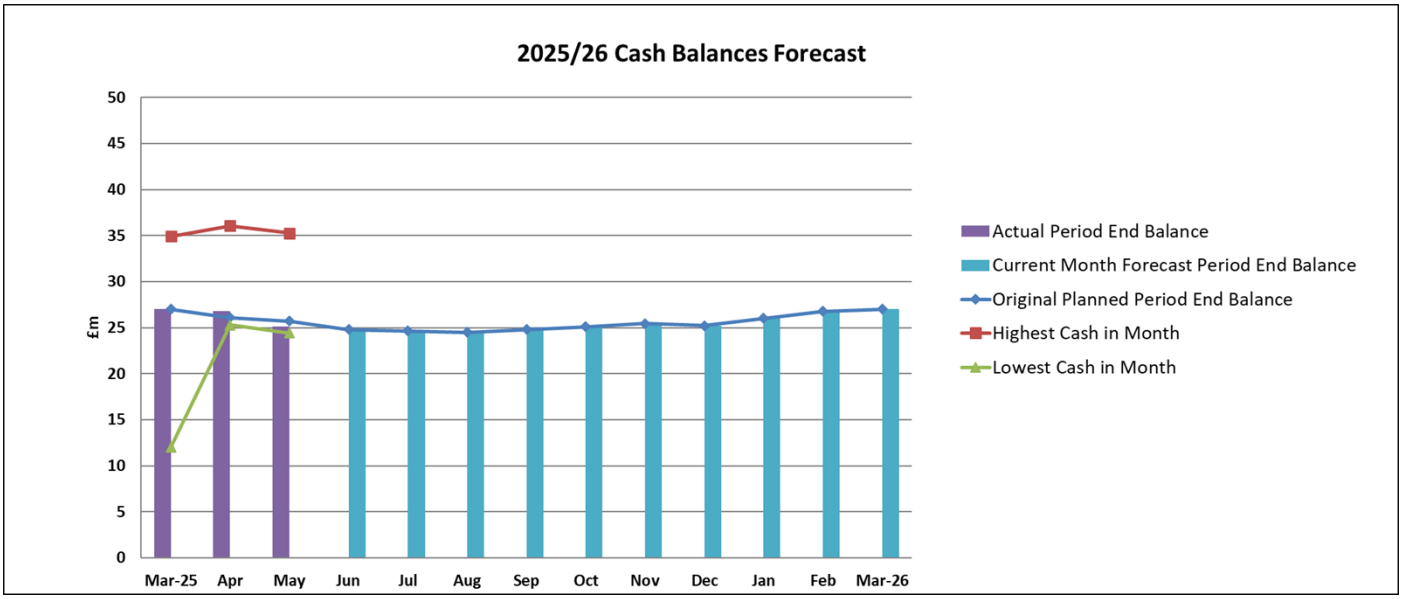
- 2025/26 CIP Target is £9.5m
- Month 2 delivery was £0.1m favourable to plan.
- There are several red schemes at this point in the year, this is partly due to waiting decisions on key schemes from ICB, with the remaining risks of currently unidentified schemes.
- Forecast reflects £1.4m currently unidentified with plans ongoing to develop projects to meet the overall target – this has reduced from M1.

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.

Cash Balances for 2025/26 are as below:



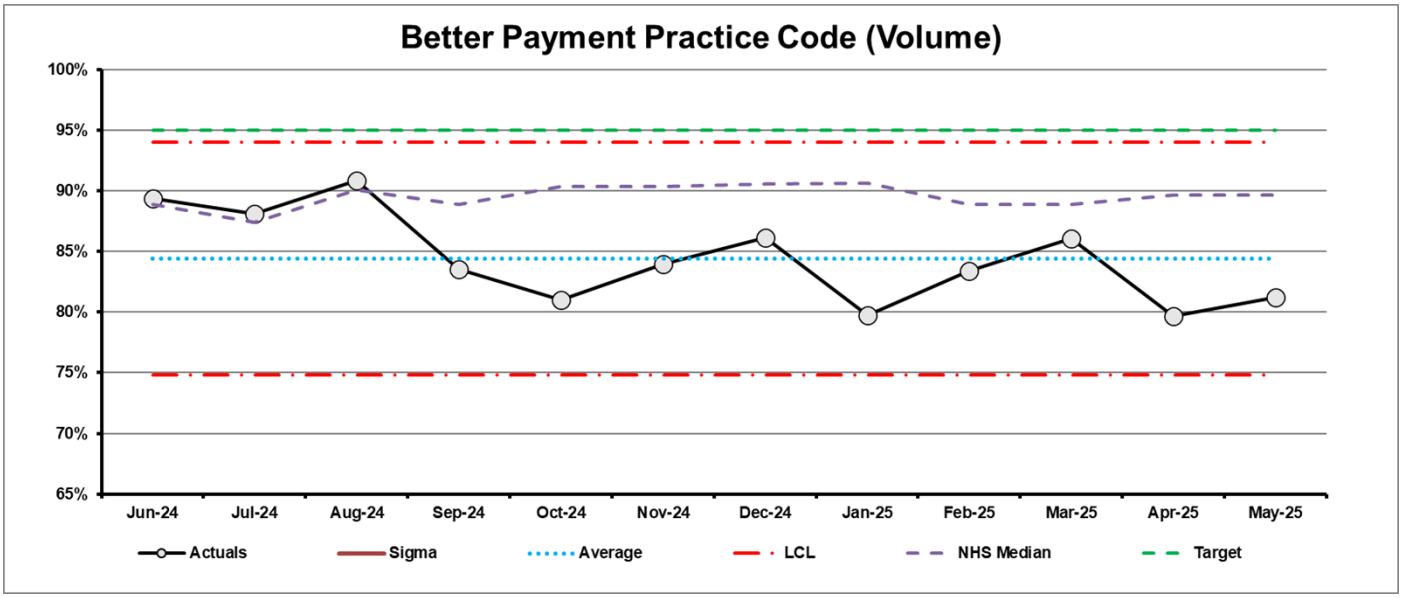
Narrative

- The LCHS cash balance for M2 was £25.1m, this is in line with forecast.
- The lowest cash position in March 2025 related to the support provided for the Group cash position, which was repaid in March 2025.

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

- Number of invoices for May at 81% an increase versus prior month, remaining below the target of 95%
- Finance is continuing to review ASD access considering the structure changes, and staff have been trained to pick up the monitoring of BPPC,
- There is a renewed focus in 2025/26 on achieving 95%. Working closely with ULTH accounts payable team to understand areas of concern and agreed actions to address.

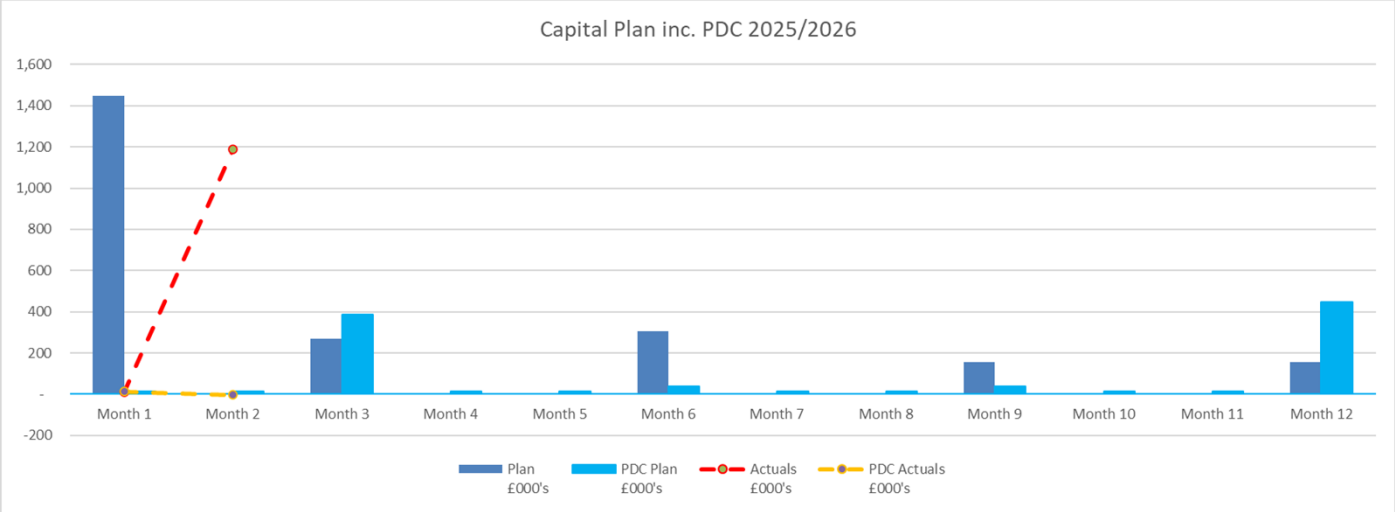
SPC

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

These 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.



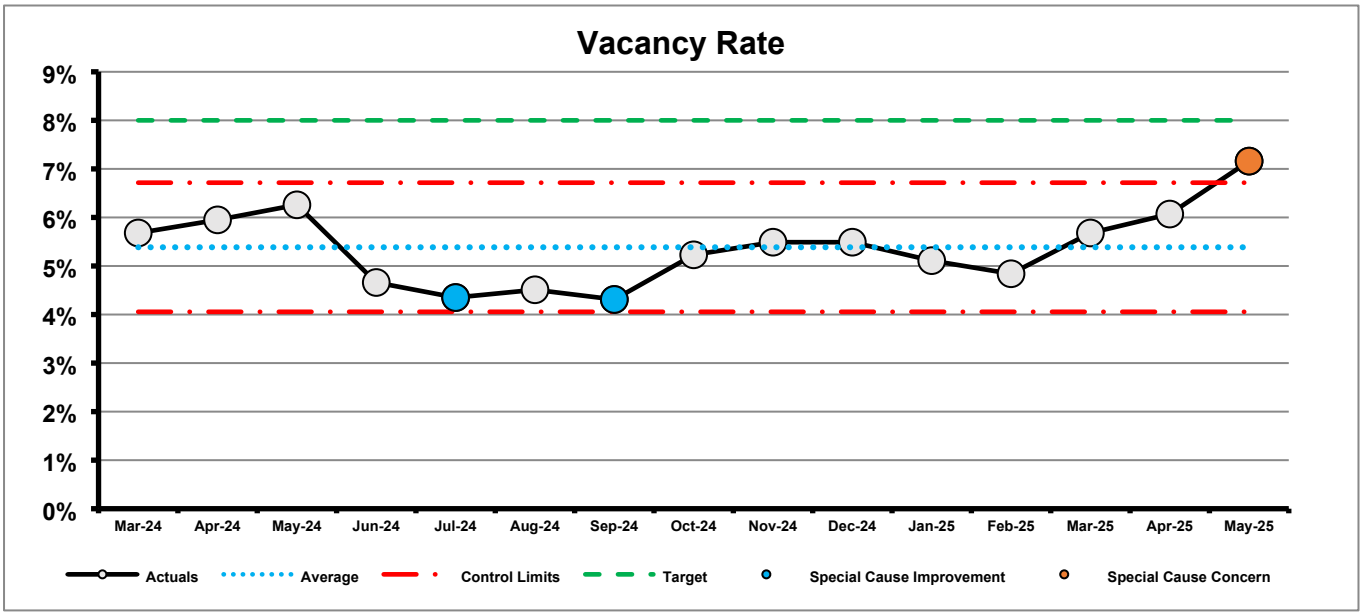
Narrative

- The LCHS capital plan for the financial year totals c£3.3m, £2.3m of capital allocation and £1m of PDC funding.
- Month 2 spend equated to £1.2m. The Plan assumed that the IFRS lease adjustments would transact in Month 1, the forecast was adjusted to Month 2 and has largely been adjusted. The Plan assumes the remaining capital spend would be incurred quarterly.
- There is a YTD underspend (£0.3m) against plan, which largely relates to IFRS16 adjustments and is forecast to be incurred in month 3.
- The year to date spend has been incurred in the following areas (bracketed numbers are full year plan)
    - Information Management & Technology - £8k (£0k)
    - Estates investment schemes - £0k (£0k)
    - Clinical Equipment schemes - £0k (£0k)
    - IFRS16 - £0m (£1.450m)
    - PDC – £68m (£12m)

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.

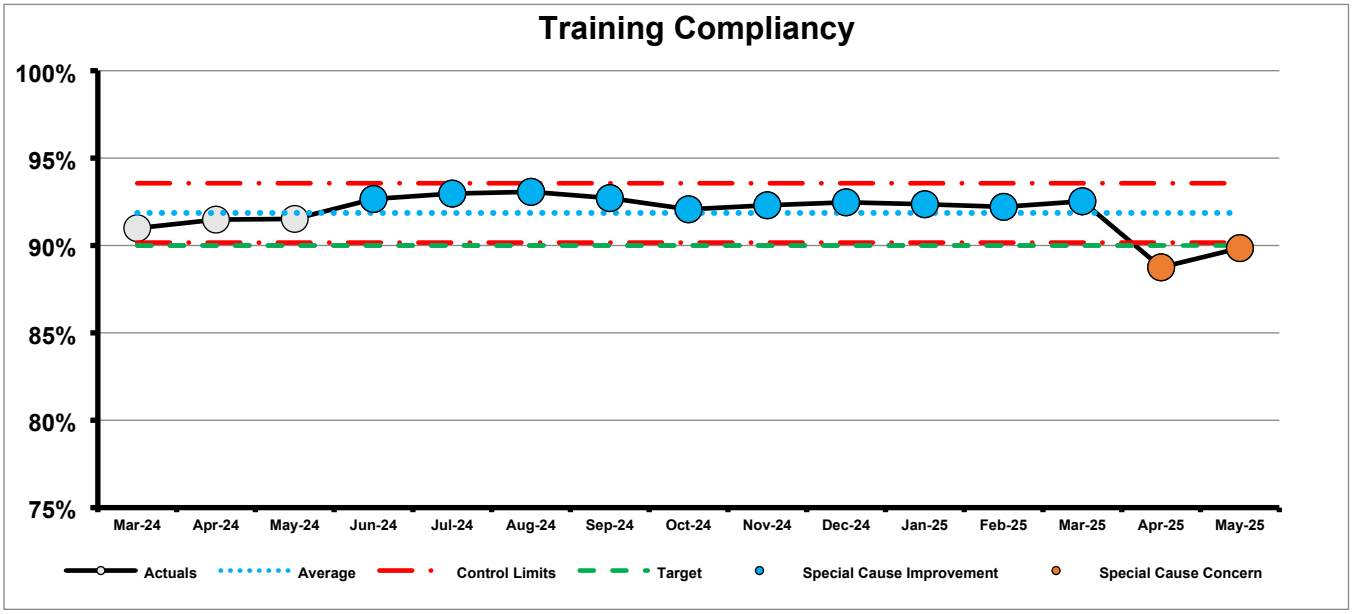
SPC

The vacancy rate shows special cause concern 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 May 2025:

The overall mandatory training compliance rate which includes all core and role specific modules has increased to 89.85 % which is just below the local and national target of 90%. One month of the mandatory update season remains, so this is expected to return to above target following 30th June.

Core mandatory training compliance (requirements for all staff):

Overall compliance for the core mandatory modules has increased to 93.02% which exceeds the national/local target of 90%. A further increase is expected next month for the same reason as outlined above.

The 25-26 Mandatory season, Apr-Jun, commenced on 3rd April. Currently 1861 bookings (1616 people have completed, with an additional 245 bookings) in addition the eLearning module is now live to give a range of delivery methods to suit all, Microsoft Teams, Face to Face and the eLearning module for staff to access at a time of their choice and support those returning to work from long term absence to update during the year. 53 people have completed the eLearning with an additional 58 bookings, which gives an overall increase on all bookings to 88.05% Targeted reminders have been sent to those who have not yet booked.

CYPSS, Corporate, Operational Business Services and System have **overall** compliance remaining above the national/local target of 90% the others are currently under target.

Children's, Young People's, and Specialist Services	92.22%	↑
Collaborative Community Care	89.27%	↑
Corporate Services	94.32%	↑
Integrated Urgent and Emergency Care	85.76%	↑
Operational Business Services	92.70%	↑
Operational Leadership	80.53%	↑
System	91.20%	↓

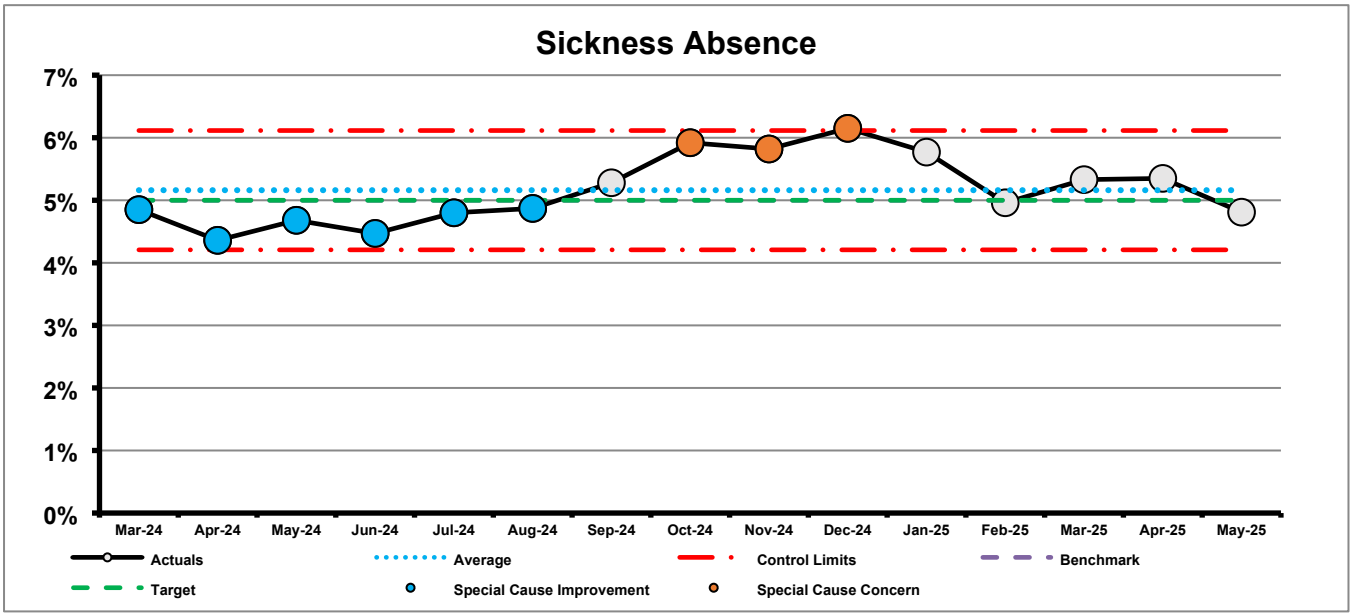
SPC

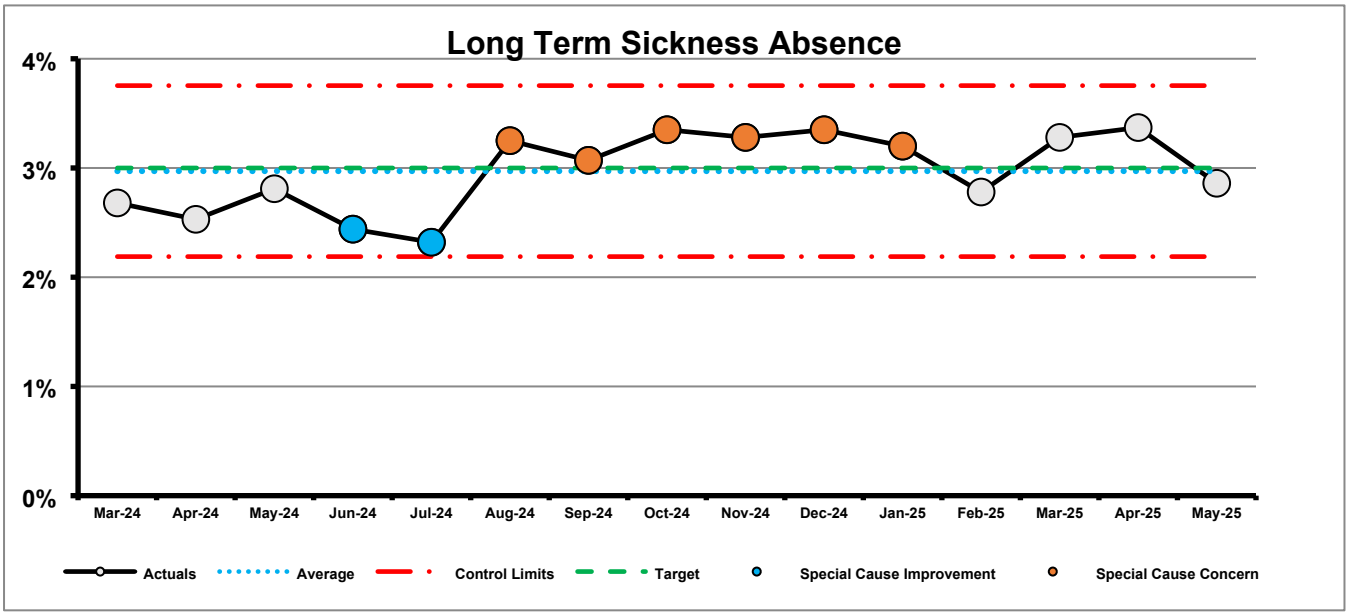
Mandatory Training compliance shows Special Cause Concern in May 2025. The measure is consistently capable of achieving the 90% target.

Sickness Absence

Background

The Trust target for total sickness absence is 5%.





Narrative

The overall sickness levels in May have decreased to 4.81% when compared with 5.27% in April and is exactly equal to the agreed target of 4.81%.

For overall sickness absence, 4 areas are below target leaving 2 areas above target for May: Integrated, Urgent and Emergency care (5.03%), and Collaborative Community Care (5.93%).

The top three reasons accounting for overall sickness absence in May were anxiety, stress, and depression (36.31%), other musculoskeletal (9.99%) and Cold, cough and Flu (8.99%), the top 2 reasons being consistent with previous months.

Long Term

The long-term sickness level in May has also seen a decrease in May to 2.86% from 3.32% in April, which is a green light in accordance with the new workforce targets as it is a reduction on the previous month.

In relation to long term absence, all areas have seen a decrease on the previous month and are therefore green in accordance with the new workforce targets.

The top three reasons for long term sickness absence for May were: Anxiety/stress/depression (44.23%), other musculoskeletal (11.4%) and Cold, Cough and Flu at (8.98%). The top 2 reasons remain consistent with the data for April.

Short Term

The short-term sickness level in May has also decreased to 1.95% from 1.99% in April, which is also a green light against the new workforce targets due to it being a reduction against the previous month.

In respect of short-term sickness, there are 2 areas who have seen an increase against the previous month and are therefore red against the new workforce targets: Children's, Young People and Specialist Services (from 1.81% to 2.08%) and Corporate Services (from 0.66% to 0.87%) all other areas have seen a decrease on the previous month and are therefore green against the new workforce targets.

The top three reasons for short term sickness absence in May were: anxiety/stress/depression (24.69%), gastrointestinal problems (14.77%), cough/cold/flu (12.7%). This has remained consistent with the data for April.

Actions

- The Workforce Strategy Group continues to focus on sickness absence including the number of return-to-work meetings taking place to support staff as well as consideration of the timescales for the various stage sickness absence meetings and whether these happen. This includes where warnings are being issued/not issued and whether this is appropriate, to ensure that the absence policy is being followed in all areas. Divisional leads and HR Business Partners have worked together to hold a number of sickness absence summits with leaders with a focus on different levels of leader's responsibilities and what support is available.

- The HR team continue to offer leaders coaching, advice and guidance in the appropriate and timely management of absence in line with the Your Attendance Matters policy and 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 attendance management workshops are being held bi-monthly.

- 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.

    - The new Group Attendance policy is currently being written to enable both trusts across group be become aligned in their approach to supporting and managing attendance.

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

May2025

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	548.84	500.13	48.71	8.88%	9.25%	0.33%	4.55%	2.08%	2.47%	92.22%	40.46%	91.67%
Collaborative Community Care	759.86	749.60	10.26	1.35%	7.07%	0.35%	5.93%	2.47%	3.46%	89.50%	41.38%	84.43%
Corporate Services	233.38	207.57	25.81	11.06%	17.49%	0.96%	1.96%	0.87%	1.09%	94.32%	16.20%	86.96%
Integrated Urgent & Emergency Care	434.29	372.08	62.21	14.32%	6.72%		5.03%	1.72%	3.32%	85.76%	44.70%	94.94%
Operational Business Services	114.32	104.58	9.74	8.52%	9.79%		4.50%	1.17%	3.33%	92.70%	51.33%	
Operations	14.44	11.18	3.26	22.58%	26.83%		0.45%	0.45%		80.53%	27.27%	50.00%
System	14.00	24.81	-10.81	-77.24%	34.12%	4.03%				91.20%	20.00%	86.67%
Total	**2,119.13**	**1,969.95**	**149.18**	**7.04%**	**9.25%**	**0.37%**	**4.81%**	**1.95%**	**2.86%**	**89.93%**	**39.41%**	**88.65%**

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	233.38	207.57	25.81	11.06%	17.49%	0.96%	1.96%	0.87%	1.09%	94.32%	16.20%	86.96%
Chief Exec	15.07	10.45	4.62	30.63%	38.27%					95.60%	18.18%	
Finance & Business Intelligence	54.20	48.33	5.87	10.82%	23.17%	2.07%	1.26%	1.26%		95.38%	4.00%	
Medical Directorate	24.75	24.39	0.36	1.47%	10.25%	4.10%	2.19%	0.53%	1.65%	92.39%	51.85%	75.00%
People & Innovation	96.97	89.91	7.06	7.28%	11.80%		2.67%	0.61%	2.06%	94.01%	12.90%	100.00%
Quality	42.39	34.48	7.91	18.66%	23.20%		1.50%	1.50%		94.95%	14.29%	95.83%
Total	**233.38**	**207.57**	**25.81**	**11.06%**	**17.49%**	**0.96%**	**1.96%**	**0.87%**	**1.09%**	**94.32%**	**16.20%**	**86.96%**

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	*1 July 2025*
Item Number	*12.1*

Group Board 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*
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 LCHG strategic aims & objectives	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings	*X*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	*X*
2b: Empower our people to continuously improve and innovate	*X*
2c: Nurture compassionate and diverse leadership	*X*
2d: Recognising our people through thanks and celebration	*X*
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*X*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	*X*
3c: Enhance our digital, research & innovation capability	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	*X*

Executive Summary

The following report includes information pertaining to risks scoring 15 – 25 which are in relation to the highest risks across the Group.

Following a review of Group Strategic Objectives in line with the BAF all risks have been realigned to the updated objectives and relevant Committees. As this is the first report to Board following the implementation of the new strategic objectives, risk movement against each objective from the previous report is not highlighted but will commence again from September's reporting.

As of 16th June 2025, there are 745 (121 LCHS and ULTH 624) risks recorded on the Group risk registers. This is a reduction of 13 since the April 2025 report.

LCHS

There is 1 Very High risk (20 - 25) reported to the Quality Committee. This relates to:

- 403 - Children SLT Therapy Treatment Delays

There are no Very High risks (20-25) reported to the Finance, People, or Integration Committees this month.

ULTH

The are 9 Very High risks (20-25) reported to the Quality Committee this month, , 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
- 5200 - Backlog of Paediatric Cardiology clinics
- 5450 - Risk of Gastro service not being viable due to current fragility of Consultant workforce

Since the last reporting period the following risk has been presented at Risk Register Confirm and Challenge where it was agreed to be closed:

- 5143 - Removal of lift in H Block PHB affecting service delivery to patient records. Risk presented at Risk Register Confirm and Challenge meeting on 4th June 2025. The lift is now working correctly, the panel approved the risk closure (previous score 5 x 4 = 20).

There are 4 Very High risks (20-25) reported to the People Committee this month:

- 4844 – Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service
- 4996 - Consultant workforce capacity (Haematology)
- 4997 – Service configuration (Haematology)

- 5093 – Procurement service staffing levels - **presented and validated at RRCC meeting on 4th June 2025 for increase in score to 5 x 4 = 20 (previous score 4 x 4 = 16).**

Since the last reporting period the following risk has been presented at Risk Register Confirm and Challenge meeting on the 4th June 2025 where it was agreed to be closed:

- 4948 - Pharmacy workload demands - Risk closed and combined within existing risk profile 4844 due to similarity with actions to reduce the risk.

There are 5 Very High risks (20-25) reported to the Finance Committee this month. 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 - **Proposal to close risk – to be validated at the July RRC&C meeting.**
- 4657 - Compliance with Subject Access Requests
- 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
- 5447 - Cancellation of elective lists due to lack of theatre staff.

There are currently no Very High risks (20-25) reported to the Integration Committee.

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 LCHG Register Confirm and Challenge Group continues to meet monthly, 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 745 (LCHS 121 and ULTH 624) active and approved risks reported to lead committees in June 2025, this is a decrease of 13 from the April 2025 report.

2.2 LCHS

There is 1 risk with a current rating of Very High risk (20-25) and 14 rated High risks (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)
5 (4%)	**31** (25%)	**70** (60%)	**14** (10%)	**1** (1%)

2.3 ULTH

There are 18 risks with a current rating of Very High risk (20-25) and 62 rated High risk (15-16) reported to lead committees this month. **Table 2** below shows the number of active risks by current risk rating and proportion of the overall Trust risk profile:

Very low (1-3)	**Low** (4-6)	**Moderate** (8-12)	**High** (15-16)	**Very high** (20-25)
53 (-1) (8%)	**158 (+4)** (26%)	**333 (-6)** (53%)	**62 (-2)** (10%)	**18 (-1)** (3%)

Strategic objective 1a: Improve patient safety, patient experience and deliver clinically effective care

2.4 **LCHS**

There is 1 Very High risk, and 4 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	The service are planning to engage with partners regarding suggested new ways of working. A meeting has taken place with public health during May. The business case is not being progressed but the service is completing a sustainability framework with the planning department. Consideration is being given to how the service can match activity against financial envelope. No change to score	20/05/25

2.5 **ULTH**

There are 9 Very High risks, remaining stable and 38 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
4731	Reliance on paper medical records	Very high risk (20-25)	Corporate	The ULTH Electronic Patient Record (EPR) programme has now reached the final stages of contract and funding. The contract with our new supplier, Nervecentre, is due to be agreed and finalised in the next few weeks and ministerial approval for the programme has also been received. Once the contract has been finalised the Digital Services Team will submit the full business case and contract to the Cabinet Office who will then agree the funding.	29/05/2025
4828	Manual Prescribing Risk - ICU, Outpatients, Paediatrics & Maternity	Very high risk (20-25)	Clinical Support Services	Badgernet roll out in progress, however prescribing part of system not yet in use. Maternity are interested in EMIS ePMA but due to capacity with current digital workload the focus is on the roll out of Badger net.	21/05/2025
4879	Recovery of planned care cancer pathways	Very high risk (20-25)	Clinical Support Services	Awaiting budget profile from Finance to confirm whether 'at risk' posts agreed by former COO / CEO, and within 24/25 financial run rate, have funding for 25/26.	22/05/2025
4947	Inability to meet NICE medicines reconciliation targets	Very high risk (20-25)	Clinical Support Services	Workforce review in progress. All business cases on hold.	21/05/2025

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
5016	Patient Flow Through Emergency Departments.	Very high risk (20-25)	Medicine	During March, we achieved a four hour A&E performance of 78.2%, in spite of seeing an 8% increase in attendances year-on-year. (This means that patients attending the ED should be admitted, transferred or discharged within four hours. The national ask is currently 78%, but will move back to the 95% target which was the normal pre-COVID). This means we are one of the most improved trusts in the East Midlands, and crucially means that our patients are waiting less time to be seen and treated by us. Risk to be monitored and if levels maintain this level, risk to be reduced.	16/06/2025
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	This issue remains ongoing. The Group Chief Nurse has requested that a paper is written for presentation to Quality Governance Committee setting out the current position and proposals for development of the epilepsy service. Risk proposed to be amalgamated with risk ID 5101 following deep dive feedback from Quality Committee. All risk details to be transferred onto risk 5101. This risk will be presented at RRC&C in July for closure.	13/06/2025
5101	Delivery of paediatric epilepsy pathways-Acute Paediatrics & Community	Very high risk (20-25)	Family Health	This issue remains ongoing. The Group Chief Nurse has requested that a paper is written for presentation to Quality Governance Committee setting out the current position and proposals for development of the epilepsy service. Following deep dive feedback from Quality Committee the risk reduction has been updated to include all actions from risk 5100. This risk will now include both Acute and Community Paediatrics and risk 5100 will be presented at Risk Confirm & Challenge in July for closure.	13/06/2025
5200	Backlog of Paediatric Cardiology clinics	Very high risk (20-25)	Family Health	Discussed at specialty governance meeting. Financial approval received to arrange two extra 'Super Saturday' clinics with support from the network to review some additional patients prior to the new consultant starting at the end of June.	05/06/2025
5450	Risk of Gastro service not being viable due to current fragility of Consultant workforce	Very high risk (20-25)	Medicine	Risk remains unchanged for now pending further recruitment as still dependent on agency - If current round of recruitment successful pending further partial retirement approved by ROAG then to explore if risk to be downgraded.	04/06/2025

Strategic objective 1b: Reduce waiting times for our patients

2.6 **LCHS**

There are no Very High risks, and 2 High risks recorded in relation to this objective.

2.7 **ULTH**

There is 1 Very High risk, and 1 High risk recorded in relation to this objective. A summary of the Very High risk is provided below:

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
5447	Cancellation of elective lists due to lack of theatre staff	Very high risk (20-25)	Surgery	The reduction of theatre floor plan is progressing and is expected to be completed in the next few of months. Following this, the current nursing establishment will be sufficient, and this risk can be closed.	04/06/2025

Strategic objective 1c: Improve clinical outcomes Improve productivity and deliver financial sustainability

2.8 **LCHS**

There are no Very High risks, and 1 High risk recorded in relation to this objective.

2.9 **ULTH**

There are 4 Very High risks and 2 High risks, 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
4657	Compliance with Subject Access Requests	Very high risk (20-25)	Corporate	Additional band 2 temporary resource has been recruited. The process for staff SARs is being rewritten due to changes in how data is accessed linked to the national tenant. DATIX legacy backlog has significantly reduced and is currently estimated to be complete by end of summer.	10/06/2025
4664	Exceeding the agency cap due to the cost of reliance upon temporary clinical staff	Very high risk (20-25)	Corporate	The Trust's financial plan for 2025/26 includes a total agency plan of £12.7m and at the end of April 2025 the Trust has spent £1.7m more than planned. Both Lincolnshire ICS and our regulator will require the Trust to take actions to address this.	19/05/2025
4665	Delivery of CIP plan	Very high risk (20-25)	Corporate	The CIP target for 2024-25 has been achieved/ delivered in line with the forecast. Delivery of £40.5m against the target of £40.1m, resulting in a surplus of £0.4m. This risk is proposed for closure and a new risk raised for the CIP target for 2025-26. **This will be presented for closure with new CIP risk at July RRC&C meeting.**	19/05/2025

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
5020	Reliance on agency / locum medical staff in Urgent & Emergency Care	Very high risk (20-25)	Medicine	Approval provided for job planning for tier 2 rota. Job planning cycle will be the next step. Robust recruitment plan international recruitment Medical Workforce Management Project.	28/05/2025

Strategic objective 1d: Provide modern, clean and fit for purpose care settings

2.10 **LCHS**

There are no Very High risks, and 4 High risks recorded in relation to this objective.

2.11 **ULTH**

There are no Very High risks and 11 High risks, recorded in relation to this objective.

Strategic objective 2a. Enable our people to fulfil their potential through training, development and education

2.12 **LCHS**

There are no Very High risks, and 1 High risk recorded in relation to this objective.

2.13 **ULTH**

There is 1 Very High risk and 5 High risks, 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 added to register and latest review:
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)	-Recruitment of further substantive consultants - April 2025 -Cancer Services paper written awaiting CRIG invitation - February 2025	**Date added to the Trust Register:** **22/08/2022** **Date of latest review:** **16/05/2025**

Strategic objective 2b. Empower our people to continuously improve and innovate

2.14 **LCHS**

There are no Very High risks, and 1 High risk recorded in relation to this objective.

2.15 **ULTH**

There are 3 Very High risks and no High risks, 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	As a result of insufficient staffing establishment there is an inability to provide a safe and effective 7 day pharmacy dispensing service at ULTH. Current funding allows for the dispensaries to open Monday to Friday 9-5 and weekends mornings only. The dispensary workloads exceed the staffing capacity. As a result of this under staffing there is a risk that patients may require critical medication and/or specialist pharmacy advice over the weekend when pharmacy is closed, there is a risk that pharmacy staff working long hours without a break could make errors, pharmacy staff could become unwell due to working conditions, patients could be discharged from hospital without vital medication and pharmacy advice. All of these risks have multiple implications such as harm to patients from omitted medicines, delayed discharge from hospital effecting the efficiency of the hospital, readmission to hospital, long term effects on pharmacy staff health and wellbeing and the pharmacy department's ability to retain staff.	Very high risk (20)	A Business Case for a full 7 day dispensary service to be progressed through the CRIG process.	**Date added to the Trust Register:** **19/01/2022** **Date of latest review:** **21/05/2025**
4997	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.	Very high risk (20)	Cancer Services paper written awaiting CRIG invitation. Recruitment of further substantive consultants.	**Date added to the Trust Register:** **22/08/2022** **Date of latest review:** **16/05/2025**

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date added to register and latest review:
5093	As a result of vacancies and long term absence within the invoicing team, purchasing and pharmacy stores team there is a risk that any further absence or leavers will mean the remaining staff don't have the capacity to do the work of all 3 sites which would impact staff wellbeing and all drug ordering across all pharmacy sites (including bulk IV fluids, medical gases, chemotherapy). Inability to complete invoices will negatively impact the Trust finance target to pay invoices within 30 days, with potential of financial penalties, and could result in suppliers putting holds on our accounts rendering us unable to order medicines, this will therefore mean that we would be unable to complete biosimilar switches and meet CIP targets (£1.4m). Payment beyond 30 days presents a risk of companies levying late payment fees and interest on outstanding amounts.		Vacancy fulfilment - QIAs completed; Jobs advertised - July 2025 Staff trained and competent to fulfil roles - October 2025 Staff skill mix review to ensure that staff managing workload - October 2025 **Presented and validated at RRCC on 4th June 2025 for increase in score to 5 x 4 = 20 (previous score 4 x 4 = 16).**	**Date added to the Trust Register:** **16/02/2023** **Date of latest review:** **04/06/2025**

Updates from the previous report:

- 4948 - Pharmacy workload demands (Very High Risk 20) – Risk closed and combined within existing risk profile 4844 due to similarity with actions to reduce the risk.

- 5439 - Pharmacy weekend workload (dispensing and checking of medication) exceeds staffing capacity on all sites (High Risk 15) - Risk closed and combined within existing risk profile 4844 due to similarity with actions to reduce the risk.

Strategic objective 2c - Nurture compassionate and diverse leadership

2.16 There are no Very High risks, and no High risks recorded in relation to this objective across the Group.

Strategic objective 2d - Recognising our people through thanks and celebration

2.17 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.18 **ULTH**
There are no Very High risks and 1 High risk recorded in relation to this objective.

Strategic objective 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services

2.19 **LCHS**
There are no Very High risks (20 – 25) and no High risks recorded in relation to this objective.

2.20 **ULTH**
There are no Very High risks (20 - 25), and 1 High risk (15 -16) recorded in relation to this objective.

Strategic objective: 3b Move from prescription to prevention, through a population health management & health inequalities approach

2.21 **LCHS**
There are no Very High risks (20 - 25) and 1 High risk (15 - 16) recorded in relation to this objective.

2.22 **ULTH**
There are no Very High risks (20 - 25), and no High risks (15 - 16) recorded in relation to this objective.

Strategic objective: 3c Enhance our digital, research & innovation capability

2.23 **LCHS**
There are no Very High risks (20 - 25) and no High risks (15 - 16) recorded in relation to this objective.

2.24 **ULTH**
There are no Very High risks (20 - 25) and 3 High risks (15 - 16) recorded in relation to this objective.

Strategic objective: 3d Drive forward our improvement and efficiency agenda including sustainability and Green Plan

2.25 There are no Very High risks (20 - 25) and no High risks (15 - 16) recorded in relation to this objective across the Group.

3.0 Conclusions

3.1 As of 16th June 2025, there are 745 (121 LCHS and ULTH 624) risks recorded on the Group risk registers.

3.2 **LCHS**
There is 1 Very High risk (20 - 25) reported to the Quality Committee this reporting period:

- 403 - Children SLT Therapy Treatment

There are no Very High risks (20-25) reported to the Finance, People, or 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
- 5200 - Backlog of Paediatric Cardiology clinics
- 5450 - Risk of Gastro service not being viable due to current fragility of Consultant workforce

There are 4 Very High risks (20 - 25) reported to the People Committee this reporting period:

- 4844 – Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service
- 4996 - Consultant workforce capacity (Haematology)
- 4997 – Service configuration (Haematology)
- 5093 – Procurement service staffing levels

There are 5 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
- 4657 - Compliance with Subject Access Requests
- 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
- 5447 - Cancellation of elective lists due to lack of theatre staff

There are no Very High risks (20 - 25) reported to the Integration Committee this reporting period:

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 Very High and High risks - Group Board - June 2025

ID	Title	Division	Committee Responsible	Group Strategic Aim	Group Strategic Objective	There is a risk that:	Caused by:	Resulting in	Rating (initial)	Rating (current)	Updates by reviewers	Date of last review
403	Children SLT Therapy Treatment Delays	Children, Young People, and Specialist Services	Quality Committee (Lead assurance committee)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1a: Improve patient safety, patient experience and deliver clinically effective care	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	9	20	[17/06/2025 12:08:47 Ana Morgan] Risk reviewed at CYPSS Quality SMT 17/06/25: longest wait at 47 weeks. No change to score. [20/05/2025 10:45:13 Ana Morgan] Risk reviewed at CYPSS Quality SMT 15/05/25: the service will engage with partners regarding suggested new ways of working. Meeting with public health took place last week. No change to score. [17/04/2025 16:15:46 Ana Morgan] Reviewed at CYPSS Quality SMT 17/04/2025: one B6 vacancy was approved to go out to advert by the new vacancy controls. A meeting is booked for 24/04/25 to review current ways of working and to explore any alternatives. [20/03/2025 16:07:30 Ana Morgan] Reviewed at CYPSS Quality SMT 20/03/2025: the business case is not being progressed. The service are completing sustainability framework with the planning department. Consideration is being given to how the service can match its activity against the financial envelope. No change to score. [20/02/2025 15:36:26 Ana Morgan] Discussed at CYPSS Quality SMT 20/02/25: the longest wait is currently at 41 weeks, and it assumed that it will go over 52 weeks. No change to score. [20/01/2025 20:43:02 Ana Morgan] 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 15:14:57 Ana Morgan] 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 11:04:08 Ana Morgan] 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 16:19:00 Ana Morgan] 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:	17/06/2025
773	Community Adult SLT - demand and capacity	Children, Young People, and Specialist Services	Finance Committee (Lead assurance committee), Risk Register Confirm & Challenge (Accountable for)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1b: Reduce waiting times for our patients	LCHS will fail to meet the urgent speech and language needs of the adult population of Lincolnshire due to a significant mismatch between capacity and demand	Current staffing gaps due to vacancies and absence mean unable to meet the level of demand in a timely way. Newly qualified staff require training to be able to provide dysphagia, voice and communication assessments, which would reduce capacity of current staff to be able to meet most urgent caseload demands while delivering training. Limited non-registered staffing reduce ability further to deliver communication therapy following assessment.	Failure to receive timely specialist assessment and interventions regarding the safety of their swallow / Dysphagia: aspiration, infections, hospital admissions, possible death. Communication&voice needs impact: reduced quality of life (isolation,reduced participation in society & productivity, increased mental health problems, reduced autonomy & self-advocacy, loss of earnings, increased dependency & faster decline, greater care needs & safeguarding concerns). Longest wait for communication assessment likely to breach 18ww by 02/25. Staff: unable to offer effective, quality care to support countywide caseload, retention of staff / moral	16	16	[04/06/2025 14:59:24 Ana Morgan] Risk score increase agreed at RRCC 04/06/25. [20/05/2025 11:56:39 Ana Morgan] Risk reviewed at CYPSS Quality SMT 15/05/25: The service is experiencing further sickness, vacancy, and maternity leave, while the demand continues to be high. Within SLT community, there are 3.6 WTE vacancies across all bands, 1.2 WTE combined LTS and maternity, and 1.4 Leavers within the next 2 months. Within acute, there are 1.94 WTE vacancies across B7, B6, and B4 in ICU, and a combined 2WTE between maternity leave and LTS. Longest wait is 28 weeks (communication assessments); dysphagia waits not any longer than 12 weeks. Temporary actions taken include pausing community therapy and offering assessment only for higher priority pathways; pausing non-organic voice therapy and dysfluency referrals, to prioritise all dysphagia and higher priority communication referrals to minimise waiting for higher priority patients. Staffing allocated to non-organic voice and dysfluency pathways will be reallocated to support with communication assessments. Reduce provision of voice banking. Mutual aid being used from acute wards staffing to support with triage / screening for community caseload and bank shifts being used where available. Propose to increase score from L3 x S4 = 12 to L4 x S4 =16. [17/04/2025 16:19:47 Ana Morgan] Reviewed at CYPSS Quality SMT 17/04/2025: noted increased vacancies, which are being closely monitored for their impact. Longest wait is currently at 24 weeks. Plan on how to keep the longest waits below 30 weeks being developed. No change to score. [23/01/2025 09:28:44 Ana Morgan] New risk agreed at CYPSS Divisional Quality Scrutiny Group 23/01/25.	04/06/2025

714	Delivery of pressure ulcer care in the community	Collaborative Community Care	Quality Committee (Lead assurance committee)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1a: Improve patient safety, patient experience and deliver clinically effective care	Patients are not always receiving the correct level of care for pressure ulcers within community nursing settings	Variability in the delivery of care for pressure ulcers across community Lack of consistent senior clinical case review Variable clinical skill set of team members in delivering pressure ulcer care	Deterioration in pressure ulcers Increasing referrals for S42 safeguarding responses Poor patient and family/carer experience ICB/CQC oversight of pressure ulcer care	16	16	[06/05/2025 15:16:18 Zoe Wills] 06/05/2025 - Update going through to Patient Safety Group, still seeing same themes. Data is showing no decrease in PU's being reported for Existing patients. Further embedding of best practice needs to continue and measured. [05/11/2024 15:23:47 Zoe Wills] 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 15:18:37 Zoe Wills] 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 15:08:43 Zoe Wills] 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 17:25:33 Michael Brunton] 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 13:39:55 Zoe Wills] This has 2 workstreams ongoing. 1 for immediate actions in relation to current increase in S42's in specific teams. 2 is for overall improvement to PU care across all teams. Current weekly meetings being held and auditing of teams has started. A3 thinking has been completed with some areas which has supported development of quality improvement plans. This has been roll out now to all ICT Teams. Workshops mapping out pathways has been completed and themes that will improve care have been identified. These have been through the A3 thinking process and action plans for improvements are being drafted	07/05/2024
444	Failure to deliver financial plan 24/25 - Cost	Corporate	Finance Committee (Lead assurance committee), Risk Register Confirm & Challenge (Accountable for)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1c: Improve productivity and deliver financial sustainability	The Trust fails to deliver breakeven duty aspect of its financial plan by failing to contain costs within planned levels	Service pressures, continued pressure in the system and level of demand being experienced, and/or failure to manage performance effectively or unforeseen events; Inflationary 'cost of living pressures	Reputational damage including reduction in the SOF rating and/or lack of financial sustainability going forward, and a failure to meet statutory financial duties.	15	16	[29/05/2025 13:52:44 Ana Morgan] [22/05/2025 11:42:23 James Taylor] Risk closed as relates to FY 24/25. Will be replaced by FY 25/26 alternative. These will be reviewed at the Risk Register Confirm and Challenge meeting 25/06/2025 [22/05/2025 11:42:23 James Taylor] As above [25/11/2024 10:16:55 James Taylor] Costs continue to be tightly controlled. Greater grip and control implementation by association as part of LCHG group financial recovery plan. [17/10/2024 14:59:44 James Taylor] 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 14:20:49 Ana Morgan] 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 13:54:07 Dave Plumb] Monthly update. No change [20/05/2024 15:59:35 Dave Plumb] Decisions regarding cost pressures need to be made by ELT. [14/05/2024 15:33:43 Peter Chiutsi] Risk decrease from 12 in December 2023 to 6. Risk updated on 29/04/2024 with Mike Pockett." At the start of the year there is a lot of people involved in bringing a quality efficiency program to be delivered. There were risks that didn't happen and as the year has gone on a lot of changes have happened because of financial benefits so the risk reduced. 9 months worth of efficiency financial measure allowed a more informed view of were the organisation is going for the next few months. [27/04/2024 15:50:03 Ana Morgan] Retrospective decrease of score noted following FPPIC report 26/04/24. Narrative to follow on 29/04/24. [13/02/2024 09:45:55 Dave Plumb] Commentary to be added following FPPIC approval on 19/02/24	22/05/2025
695	Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care	Collaborative Community Care	People Committee (Lead assurance committee)	2. People: Better Opportunities – Develop, empower and retain great people	2b: Empower our people to continuously improve and innovate	Community nursing teams fail to provide high quality care due to reduced levels of District Nurse Qualified staff within the team structure	Lack of value placed upon the importance of the DNSPQ qualification within community nursing teams Failure to reimburse staff undertaking the role relevant to their responsibilities and thereby retaining them Failure to train sufficient number of DNSPQ qualified staff Lack of standard use of the Enhanced Practitioner role in community nursing teams and defined role Lack of qualified DN	Insufficient levels of qualified DNSPQ support for junior members of teams Lack of oversight for complex case management. Identified theme in case of patient harm Reduced safe management of caseload sizes in community nursing teams Lack of professional support and guidance for team development	16	16	[03/06/2025 15:14:21 Zoe Wills] 03/06/2025 - Review required to look at all teams and identify specific areas that are still not meeting the QNI standard requirements. [04/03/2025 15:19:06 Zoe Wills] 04/03/2025 - Risk still scoring 16. We are working towards supporting DNSPQ students. There is a risk that with the qualifications new students are gaining we will be unable to retain staff. [05/11/2024 15:25:19 Zoe Wills] 05/11/2024 - Increasing DNSPQ mentors and 6 people currently going through this process. [08/10/2024 15:19:26 Zoe Wills] 08/10/2024 - Update in 715 as these are linked. [10/09/2024 15:16:33 Zoe Wills] Still awaiting ELT conversation on proposed changes to CN structure. [23/08/2024 17:23:01 Michael Brunton] No change in the level of score currently. ELT conversation on business case for community nursing to be had [25/07/2024 13:34:06 Zoe Wills] 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 11:19:16 Ana Morgan] New risk agreed at Risk Register Confirm & Challenge Group 29/05/2024	03/06/2025

754	Moving and Handling	Corporate	People Committee (Lead assurance committee), Health and Safety Committee (Accountable for)		2a: Enable our people to fulfil their potential through training, development and education	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. Training delivery model is 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)	15	16	[10/04/2025 13:36:35 Russell Fordham] Training is going to be run through a group model and meetings between all trainers and providers are working together. [13/02/2025 12:45:14 Russell Fordham] 18/12/2024. RF Meetings between LCHS and ULHT manual hander ling teams have been conducted, Peer review and cross party working is being implemented to embed one process and support compliance and improvements needed. Good progress being made and site information and asset data has been collected. Once training scores have been reviewed we can look at reducing risk score. [05/11/2024 08:23:32 Ana Morgan] Discussed at Risk Register Confirm and Challenge 30/10/24: agreed as new risk scoring L4 x C4 = 16.	13/02/2025
783	TB Service Provision - Capacity & Demand	Community Partnerships	Integration Committee (Lead assurance committee)	3. Population: Better Health – Improve population health	3b: Move from prescription to prevention, through a population health management & health inequalities approach	The TB service are unable to meet the demand on its resources due to the increase in active and latent TB (LTBI) cases.	Lincolnshire has a 55% increase in active TB cases (2024) compared to 2023. The national increase for the same period is 13%. In addition there are 200 latent TB cases (151 cases working in the healthcare system) which are adding significant pressure and service disruption and an ARAP site with 16% of residents with LTBI. Service specification is outdated (2021) & funding attached to the contract does not reflect the significant increase in LTBI and % increase in active TB in Lincolnshire.	Waiting list times are not been met (6 week target) and the longest wait is 42 weeks 5 days). Impact on treatment / risk of inappropriate treatment (evidence of LTBI patients starting treatment before specialist monitoring commences leading to potential harm). The service is working at cost pressure having recruited band 6 and two band 3s on fixed-term contracts (FTC). Inability to meet NICE guidelines (contact screening, raising awareness in underserved populations).	20	16	[24/04/2025 17:25:45 Ana Morgan] Risk reviewed at CDRT Quality Scrutiny Group 23/04/25: a TB project manager was assigned to look at capacity and demand for the service. The first meeting between the DDL and the Project manager regarding how to take the service forward into a project is booked for 24/04/25. [26/03/2025 15:54:41 Julie Humphreys] 26 March 2025 - RRCC agreed risk rating of 16 but required change of risk to service disruption / capacity	23/04/2025
715	There is a risk that the Community nursing lacks capacity and skill set to meet community demand	Collaborative Community Care	Quality Committee (Lead assurance committee)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1a: Improve patient safety, patient experience and deliver clinically effective care	The community nursing service is unable to meet the demand of patients within Lincolnshire	Increased demand for service of 8% Care unit allocation above the maximum of 15 care units daily Case load levels above 150 max levels Reduced numbers of DNSPQ qualified staff	Variance in care delivery Ineffective case load management Poor patient experience Reduced complex caseload efficiency Task based service provision with a lack of holistic care planning	16	16	[03/06/2025 15:30:00 Zoe Wills] 03/06/2025 - Holding vacancies for apprenticeships has meant high unavailability in all teams. This has caused reduced capacity. Work ongoing to move VBYV into teams helping support unavailability. [04/03/2025 15:47:25 Zoe Wills] 04/03/2025 - We are currently seeing high unavailability in Sleaford, Skegness and Four Counties. Maternity and sickness rates have gone up impacting on this. Community Nursing Teams are unable to back fill people going of on maternity. [05/11/2024 15:21:59 Zoe Wills] 05/11/2024 - No change currently [08/10/2024 15:09:13 Zoe Wills] 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 15:45:12 Zoe Wills] No change [23/08/2024 17:26:39 Michael Brunton] No change in score as capacity continues to not meet demand for service [25/07/2024 13:42:10 Zoe Wills] 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 11:20:22 Ana Morgan] New risk agreed at Risk Register Confirm & Challenge Group 29/05/2024	03/06/2025

651	Contracted Pharmacy Service - Co-op	Medical	Finance Committee (Lead assurance committee); Risk Register Confirm & Challenge (Accountable for); Contract Management Partnership Board (Accountable for)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1b: Reduce waiting times for our patients	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.	12	15	[02/06/2025 15:38:13 Ana Morgan] For discussion at Medicines Safety Group and Risk Register Confirm and Challenge Group June 2025. [20/05/2025 12:14:35 Ana Morgan] Discussed with MSO CO 20/05/2025: contract now signed, but Co-op not delivering to agreed KPIs, and therefore it is proposed that this risk should be closed and a new one opened that reflects the new issues. [26/02/2025 16:13:25 Ana Morgan] Discussed at risk summit with DDMD SB and QPIL AM 26/02/25: a case is being developed for bringing the Clinical Pharmacy service in House. Increased challenges due to senior leadership team changes and staff leaving within Co-op, including the Lead Clinical Pharmacist for Community Hospitals and the dedicated HIV pharmacist. Currently working with Co-op around succession planning. No change to score. [15/11/2024 12:23:11 Ana Morgan] 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 08:29:44 Ana Morgan] 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 09:18:33 Ana Morgan] 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 17:33:06 Ana Morgan] 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	20/05/2025
649	Fire Safety Core Risk	Corporate	Finance Committee (Lead assurance committee); Health and Safety Committee (Accountable for); Fire Safety Group (Accountable for)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1d: Provide modern, clean and fit for purpose care settings	There is a risk of harm to building occupants (including patients)caused by fire. There is a risk that the Trust cannot demonstrate statutory compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO).	Inadequate fire protection systems, maintenance, training and procedures	Loss of facilities, services and injuries to patients and staff.	15	15	[14/04/2025 09:16:44 Russell Fordham] No change to the score or risks in this period and monthly and quarterly fire operational meetings are being attended by NHSPS to try to resolve the actions identified in the safety noticed severed on them. [17/02/2025 09:58:03 Russell Fordham] No change to score within this time frame. NHSPS have had several other Fire infringements notified to them as a organisation for concerns at Louth. ULHT Fire team and risk assessors are currently working to support on several concerns and attendance to Monthly Fire Safety Meetings are being undertaken. [11/10/2024 15:37:34 Dan Dring] 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 09:37:49 Dan Dring] 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 11:42:30 Dan Dring] 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 12:30:50 Dan Dring] Risk continues to be monitored. No change to score. [05/06/2024 11:54:42 Dan Dring] 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 11:01:17 Dan Dring] No change to score and it continues to be monitored and reviewed. [25/04/2024 10:56:22 Dan Dring] Fire officer working across the LCHS estate	17/02/2025
719	Impact of DHU Contract Changes on CAS Model	Integrated Urgent & Emergency Care	Quality Committee (Lead assurance committee)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1a: Improve patient safety, patient experience and deliver clinically effective care	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.	6	15	[10/06/2025 14:40:17 Ana Morgan] Risk reviewed at IUEC Quality Scrutiny Group pre-meet 10/06/25: the CAS calls being referred to by this risk are due to come back to LCHS WC 09/06/25. Risk to be reviewed July 2025 to assess their impact on CAS. [17/04/2025 14:37:56 Ana Morgan] Risk Reviewed at IUEC Quality Quality Scrutiny Group pre-meet 08/04/25: actual contract changes have not been implemented yet. No change to score. [17/03/2025 17:00:54 Ana Morgan] Risk reviewed at IUEC Quality Scrutiny Group pre-meet 11/03/25: noted decrease in acute presentations being sent to the non-collocated UTCs instead of ED. Recent presentations centred around patients not being sent to their nearest UTC. To keep open for another month and review Apr'25 with a view to decrease the score if improvement continued. No change to score. [29/11/2024 11:33:28 Ana Morgan] 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 15:41:24 Ana Morgan] 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	10/06/2025

390	John Coupland Hospital Theatres ventilation	Corporate	Finance Committee (Lead assurance committee), Health and Safety Committee (Accountable for), Risk Register Confirm & Challenge (Accountable for)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1d: Provide modern, clean and fit for purpose care settings	Patient safety/ infection control / loss of service and disrupted service to patients	Theatre one - The plant in JCH theatre 1 is running inconsistently resulting in temperatures being close to or over the limit of 22c and humidity at times being close to or breaching the limit of 60.	Creating a patient safety risk if not effectively monitored, theatre lists have had to be cancelled for patient safety at short notice, a risk to service delivery and LCHS reputation.	10	15	[05/06/2025 11:07:25 Ana Morgan] Work has been completed early 2025. To consider closing the risk once the documentation and commissioning certificates are confirmed to have been received. [14/04/2025 09:37:27 Russell Fordham] No change to this risk in month. [01/04/2025 13:56:14 Ana Morgan] Risk discussed at Risk Register Confirm and Challenge 26/03/2025, where the score was proposed for decrease to 8 from 15. Change not agreed. [03/03/2025 15:01:43 Russell Fordham] Please see update with regards to improvements works completed by NHSPS and have reduced the risk score to 8 from 15. 03/03/2025 [17/02/2025 10:22:47 Russell Fordham] Replacement scheme has been undertaken on the AHU and commissioning results are being reviewed for HTM compliance. A couple of on going concerns are present and once NHSPS shares this information, a review of this risk can be conducted. [11/10/2024 15:39:02 Dan Dring] 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 11:35:58 Dan Dring] 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 11:51:43 Dan Dring] 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 16:41:49 Dan Dring] Project kick off meeting is set for July to start the work at JCH. No change to risk score currently. [06/06/2024 11:44:41 Dan Dring] NHSPS Update: the AHUs have been awarded to the contractor and the Programme is expect days have been signed. Content	05/06/2025
391	John Coupland Hospital Water Safety	Corporate	Finance Committee (Lead assurance committee), Health and Safety Committee (Accountable for), Risk Register Confirm & Challenge (Accountable for)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1d: Provide modern, clean and fit for purpose care settings	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective;	Risk of harm from Legionella and other waterborne pathogens	20	15	[05/06/2025 11:20:01 Ana Morgan] For consideration of closure at RRCC June 2025: reframed risk around overarching Water Safety assurance (731, score of 12). [01/04/2025 13:58:03 Ana Morgan] Risk reviewed at Risk Register Confirm and Challenge meeting 26/03/2025, where it had been proposed for decrease from L3 x C4 = 12 to L2 x C5 = 10. The score change was not agreed. [13/02/2025 12:34:27 the reporter] PPM and L8 data being reviewed for concerns and reports provided by contractors and review meeting between AS & RF held monthly to support. No change in score as concerns and NHSPS performance is still poor. Some of LCHC buildings now on L8 guard also and monitoring will continue. [11/10/2024 15:32:47 Dan Dring] 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 11:49:57 Dan Dring] 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 11:46:03 Dan Dring] 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 11:36:14 Dan Dring] 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 10:45:10 Dan Dring] NHSPS Update. All identified dead legs have been removed and a chemical flush has been booked	05/06/2025
792	Reduction of Phlebotomy appointments breaching the ICB service spec	Collaborative Community Care – Community Hospitals	Quality Committee (Lead assurance committee), Risk Register Confirm & Challenge (Accountable for)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1a: Improve patient safety, patient experience and deliver clinically effective care	Due to staff shortages our phlebotomy availability has decreased causing an impact to the local community for routine blood appointments, currently there is a 16 day wait to the public. This is now a safety concern as it is impacting on patients health for diagnostic treatment or intervention. Patients are now waiting longer, risk of late diagnoses , treatment delays.	Due to staff and clinic establishments not being rectified within our budget i have been unable to recruit more staff that have left which has left us in the position of short staff unable to support are local community	resulting in reduced phlebotomy appointments leading to late blood tests for the public that could cause delay in treatment. Added increased work load and stress pressure on the staff, which could lead to stress and staff absence. Also poor reputation to the service and media coverage or poor service to our local community	15	15	[06/06/2025 10:10:25 Ana Morgan] New risk agreed at RRCC 04/06/25.	04/06/2025

393	Skegness Hospital Water Safety	Corporate	Finance Committee (Lead assurance committee), Health and Safety Committee (Accountable for), Risk Register Confirm & Challenge (Accountable for)	1. Patients: Better Care – Timely, affordable, high quality care in the right place	1d: Provide modern, clean and fit for purpose care settings	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective	Risk of harm from Legionella and other waterborne pathogens	20	15	[05/06/2025 11:18:32 Ana Morgan] For consideration of closure at RRCC June 2025: reframed risk around overarching Water Safety assurance (731, score of 12). [10/04/2025 13:24:38 the reporter] NHSPS have still not provided the data and information needed to review this concern, so the potential reduction can be not be presented to the group for consideration. [01/04/2025 14:02:40 Ana Morgan] Risk reviewed at Risk Register Confirm and Challenge meeting 26/03/2025, where it was proposed for decrease from L3 x C5 = 15 to L2 x C5 = 10. The change was not agreed. [03/03/2025 15:44:01 Russell Fordham] Score can be reduced to show the improvements made by NHSPS on managing the water systems on site. Two locations with adverse sample still and being monitored for usage and extra flushing conducted to mitigate low usage in the area that has been reported. Reduced to 10. [13/02/2025 11:50:45 Russell Fordham] Scores to stay the same as several resamples are needed to sign off as clear and no data has been presented to the compliance team for reassurance. [11/10/2024 15:31:15 Dan Dring] 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 11:46:37 Dan Dring] Awaiting results from NHSPS. No change to score and risk continues to be monitored. [22/07/2024 11:15:23 Dan Dring] 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 11:47:11 Dan Dring] NHSPS Update: Room SG 26/27 (open space)continues to return high counts even after thermal disinfections. Adjoining room close. Decision taken to replace pipework due to possible biofilm build up	05/06/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	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: Improve patient safety, patient experience and deliver clinically effective care	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.	-All new referrals are triaged by Leicester but scanning is then requested locally. -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	06/06/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	-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	[05/06/2025 16:02:17 Nicola Cornish] Discussed at specialty governance meeting. Financial approval received to arrange two extra 'Super Saturday' clinics with support from the network to review some additional patients prior to the new consultant starting at the end of June. [30/04/2025 14:41:45 Nicola Cornish] Discussed at RRC&C meeting on 30/04. The only local paediatric cardiologist has left the Trust so there is no one who can see these patients currently. Recruitment for a replacement consultant is ongoing, with an anticipated start in June. There is also no scanning capacity at Boston, and limited scanning capacity at Lincoln delivered by a visiting specialist from Leicester twice a month. Working is ongoing to review the backlog patients from a risk stratification perspective and to undertake harm reviews where required - 2 cases of harm have been identified for further review so far. Increase in score to 20 was agreed by panel. [04/04/2025 12:10:29 Nicola Cornish] The only paediatric cardiologist has left ULTH so there is now no one to review these patients. The most urgent patients are being sent to Leicester to be seen however the waiting list for all other patients will inevitably increase. Recruitment is underway for a new cardiologist however they will not be in post until June and the very earliest. As the likelihood of patient harm has increased, this will need to be presented to Confirm & Challenge meeting in April to approve an increase in score to 5x4=20 (Very High). [20/02/2025 14:15:16 Nicola Cornish] Leicester have triaged all patients on the waiting list and identified a priority for each patient. However no additional clinic sessions have been offered to ULHT so only there is only capacity within existing clinic slots to offer appointments to the most urgent patients. The existing Cardiologist is leaving in mid-March so it is likely that the risk will increase following this until	8	30/06/2024	30/06/2025	06/07/2025
1b: Reduce waiting times for our patients	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 in place. Daily review of staffing/lists and prioritisation of patients within available capacity. Use of agency staff where required to avoid cancellations where possible.	Incident reporting Review of cancellations	15/05/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Business case to be submitted for increase in nursing establishment. Project group at Lincoln to introduce activity manager to try to support planning and management of deficits.	[04/06/2025 14:03:55 Nicola Cornish] Discussed at RRC&C meeting on 4th June. Reduction of theatre floor plan is progressing and it is expected that this will be completed in the next couple of months. Following this, the current nursing establishment will be sufficient and this risk can be closed. [14/05/2025 13:09:52 Nicola Cornish] Floor plans to reduce to 9 theatres are now being finalised by the division. Once this reduction has been completed, it is expected that the existing staffing establishment will be able to meet the demand and the likelihood of list cancellations will reduce. [29/04/2025 11:00:58 Nicola Cornish] Risk reviewed, no further update. [13/03/2025 15:42:21 Nicola Cornish] Staffing template reviewed and amended to support 9 theatres at Lincoln - roster templates will reflect this change from July 2025. Waiting for confirmation of theatre floor plans from BU. Review of Pilgrim theatres to start in April. [21/02/2025 12:57:19 Nicola Cornish] Risk reviewed, no change. [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	8	30/06/2025		15/06/2025
1c: Improve productivity and deliver financial sustainability	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, could lead to complaints to the Trust and Information Commissioner's Office (ICO). This has resulted in regulatory action and could possibly have 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.	ULHT policy in place. Monitoring through IGG and at exec level. Temporary additional resource has been agreed to be put in place to support admin parts of role. 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. Went live 1/12/25 and fully rolled out.	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.	10/06/2025	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.	[10/06/2025 10:31:13 Fiona Hobday] Additional band 2 temp resource has been recruited- going through onboarding currently. The process for staff SARs is having to be rewritten due to changes re how data is accessed linked to national tenant. DATIX legacy backlog has significantly reduced- currently estimate to be complete by end of summer. [28/04/2025 14:20:06 Fiona Hobday] Additional temp band 2 resource has been agreed by CEO and Dir to support clearing backlog of old requests (DATIX)- working through HR processes which has slowed progress. Agreed some service support from LCHS IG colleagues- awaiting system access to be setup. Volume of incoming requests remains very high and there is little resilience in the team when there is any form of absence. [10/03/2025 10:02:35 Fiona Hobday] Weekly compliance monitoring being carried out- reporting to SIRO/ Dir of Corp Affairs. Compliance for newer requests is doing well with resource available but won't meet national targets. Central IG resource continues to be reallocated to support team. Ongoing discussion with LCHS as to any possible support they can provide. Number of current cases of lost personnel files for staff SARs- adds to risk of legal action/ complaints/ etc... HR advise to add to corporate risk register. No short term fix. [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.	6	31/12/2025	01/09/2025	11/07/2025

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2a: Enable our people to fulfil their potential through training, development and education	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	16/05/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Recruitment of further substantive consultants - Sarah Chester-Buckley April 2026 Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026	[16/05/2025 10:38:24 Gemma Staples] Risk reviewed and remains the same. [16/04/2025 10:06:19 Gemma Staples] Vacancy control now in force within the Trust, CRIG not excepting Business Cases which are not funded by charitable funds therefore unable to proceed at present. [18/03/2025 11:35:42 Gemma Staples] Business case submitted due to financial situation no further update. [20/02/2025 11:01:13 Gemma Staples] ELT requested ICB Business Case review by the 25th February 2025. CBU writing paper to cover all points requested. [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.	8	30/09/2023	01/04/2025	16/06/2025
1c: Improve productivity and deliver financial sustainability	4665	14	Finances	Antunes Goncalves, Paul	Sargeant, Paula	Clinical Effectiveness Group	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 increased as the Improvement Steering Group meets as a	27/05/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	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.	[27/05/2025 16:22:42 Rachael Turner] REQUEST TO CLOSE - The CIP target for 2024-25 has been achieved/ delivered in line with the forecast. Delivery of £40.5m has been saved against the target of £40.1m, resulting in a surplus of £0.4m. This risk is proposed to be closed and a new risk raised for the CIP target for 2025-26. This risk will be presented for closure with new CIP risk at June RRC&C. [17/04/2025 16:12:59 Rachael Turner] The CIP target for 2024-25 has been achieved in line with the forecast. Delivery of £40.5m has been saved against the target of £40.1m, resulting in a surplus of £0.4m. This risk is proposed to be closed and a new risk raised for the CIP target for 2025-26. [19/03/2025 09:05:08 Rachael Turner] Risk reviewed, no change this month from previous. [19/02/2025 11:25:07 Rachael Turner] The current CIP forecast is £40.1m which represents full achievement of the plan for 2024-25. This has been identified through non recurrent mitigations forecast to deliver in the last 2 months of the year. [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.	4	31/03/2023	31/03/2024	27/06/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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	As a result of insufficient staffing to meet the level of demand, there is a risk that we will may be unable to deliver epilepsy pathways within both Community & Acute Paediatrics that meet national standards. This may result in patient harm, regulatory action and reputational damage.	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;	20/05/2025	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 5. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	[13/06/2025 11:24:14 Gemma Staples] Risk reviewed following deep dive feedback from Quality Committee the risk reduction has been updated to include all actions from risk 5100. This risk will now include both Acute and Community Paediatrics and risk 5100 will be presented at Risk Confirm & Challenge in July for closure. [20/05/2025 14:02:04 Nicola Cornish] This issue remains ongoing. The Group Chief Nurse has requested that a paper is written for presentation to Quality Governance Committee setting out the current position and proposals for development of the epilepsy service. [18/02/2025 13:19:19 Nicola Cornish] No progress, still awaiting decision about business case. [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	8	14/03/2024	16/02/2024	20/06/2025

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1c: Improve productivity and deliver financial sustainability	4664	5	Finances	Antunes Goncalves, Paul	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)	19/05/2025	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	[19/05/2025 09:38:14 Rachael Turner] The Trust's financial plan for 2025/26 includes a total agency plan of £12.7m and at the end of April 2025 the Trust has spent £1.7m or £0.4m more than planned. Both Lincolnshire ICS and our regulator will expect/require the Trust to take actions at the scale to address this. [17/04/2025 16:45:21 Rachael Turner] In 2024/25, the Trust's financial plan required the Trust to make a similar level of reduction to agency expenditure as made in 2023/24, but the focus in 2024/25 has been to reduce expenditure in relation to medical and dental (M&D) staffing, whereas in 2023/24 it was on reducing expenditure in relation to registered nursing and midwifery. The 2024/25 financial plan included a total agency plan of c£15m and the expenditure profile in the plan required agency expenditure to reduce quarter by quarter. Prior to finalisation of the Trust's financial accounts for 2024/25, agency expenditure of c£23m is c£8m higher than planned, but c£10m lower than expenditure of c£33m in 2023/24. The adverse agency pay position is part of a larger adverse movement to plan in the overall pay position, which is a major driver of the Trust's overall adverse movement to plan. The agency pay position, and our wider pay position have been of considerable concern in 2024/25 to both Lincolnshire ICS and our regulator; both will expect/require the Trust to take actions at the scale in 2025/26 to address this	8	31/03/2023	31/03/2024	19/06/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	4947	27	Physical or psychological harm	Sakthivel, Mr Kulandaivel	Saddick, Ahtisham	Clinical Effectiveness Group	17/06/2022	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of insufficient staffing establishment there is an inability to provide a safe and effective 7 day pharmacy clinical service at ULTH. Current funding allows for the clinical cover Monday to Friday 9-5. The clinical pharmacy workload exceeds the current pharmacy capacity. As a result of this under staffing the Trust is failing to meet NICE NG5 Medicines Reconciliation targets and there is no pharmacy capacity to review eDDs or provide specialist pharmacy advice. All of these risks have multiple implications such as harm to patients from omitted medicines, delayed discharge from hospital effecting the efficiency of the hospital, readmission to hospital, cost pressures from use of FP10s, long term effects on pharmacy staff health and wellbeing and the pharmacy department's ability to retain staff.	Prioritising the current clinical pharmacy service to direct admission areas. The dispensaries are open weekend mornings for urgent requests On call pharmacist service is available for urgent advice.	Medicines reconciliation audits Monitoring FP10 spend Monitoring on call access Reported medication incidents (including HPF) PALS Staffing levels / budget benchmarked against other similar trusts. Staff Survey results Staff exit interviews	21/05/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Business case for 7 day ED cover was submitted to CRIG 29th Nov 2024 and a one page summary was submitted 25th Feb 2025 as requested by CRIG, currently awaiting further instruction Ahtisham Saddick July 2025. Further business case development to be decided.	[21/05/2025 11:41:56 Lisa Hansford] Workforce review in progress. All business cases on hold. [22/04/2025 11:02:39 Lisa Hansford] Case was submitted to CRIG 29th Nov 2024 and a one page summary was submitted 25th Feb 2025 as requested by CRIG, currently awaiting further instruction [20/03/2025 10:57:17 Lisa Hansford] Updated the risk description, controls and actions. [10/03/2025 09:53:16 Lisa Hansford] Risk review meeting arranged for 20.3.25 to update all risks relating to staffing. Risk remains the same at this time [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.	8	30/06/2023	30/04/2025	23/06/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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	21/05/2025	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	[16/06/2025 09:13:30 Rachael Turner] This risk will be included as part of the actions in risk 5680-Risk of paper based records and standalone digital systems, currently waiting to set up meeting with Digital to go through all risks relating to this topic area as 5680 will be an overarching risk. [21/05/2025 12:01:21 Lisa Hansford] Badgernet roll out in progress, however prescribing part of system not yet in use. Maternity are interested in EMIS ePMA but due to capacity with current digital workload the focus is on the roll out of Badger net. [22/04/2025 13:27:31 Lisa Hansford] Badger net roll out in progress. Maternity are interested in EMIS ePMA but due to capacity with current digital workload the focus is on the roll out of Badger net. [21/03/2025 13:06:14 Lisa Hansford] Badger net roll out is still imminent, until this is completed the issues with out patients/ICU and Paeds will not considered therefor this risk will remain the same [24/02/2025 11:56:00 Lisa Hansford] Roll out of Badgernet for maternity is imminent. Outpatients/ Paediatrics and ICU are still under review for suitable electronic prescribing and administration systems. [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	4	31/12/2023	30/06/2025	23/06/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	5016	22	Physical or psychological harm	Hamer, Fiona	Lentz, Blanche	Workforce Strategy Group	02/09/2022	25	Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's Introduction of "Pit stop" model. The development of a CDU in October 2024 will enable some flow from the emergency department to home for patients requiring treatment to discharge. This will be monitored through UEC improvement work to ensure area is fit for purpose. If CDU is utilised to enable ambulances to offload before 2 hours this will effect the flow through CDU.	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	16/06/2025	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.	[16/06/2025 09:08:37 Rachael Turner] Risk reviewed.The risk is not ready for reduction as we still come into many DTA pts on a morning, flow is still fairly slow and the speciality pathways are not 24/7 – we have some mitigations currently needs to stay at risk score of 20. [28/05/2025 11:44:10 Rachael Turner] Risk reviewed, no current change to risk scoring at this time. [07/05/2025 12:54:09 Rachael Turner] Risk reviewed, no change to current flow. [03/04/2025 14:07:00 Rachael Turner] During March, we achieved a four hour A&E performance of 78.2%, in spite of seeing an 8% increase in attendances year-on-year. (This means that patients attending the ED should be admitted, transferred or discharged within four hours. The national ask is currently 78%, but will move back to the 95% target which was the normal pre-COVID). This means we are one of the most improved trusts in the East Midlands, and crucially means that our patients are waiting less time to be seen and treated by us. Risk to be monitored and if levels maintain this level, risk to be reduced. [04/03/2025 15:04:42 Rachael Turner] We are improving our 4 hour standard to enable patients to move through pathway quicker. We are completing AAR's on all 12 hour breaches to enable any learning opportunities. We are changing some pathways, we are going to have a 4 week trial for streaming at Lincoln, this starts on the 24th March and also a 4 week trial at Pilgrim, this will utilise chair space in SDEC,	10	02/09/2023	31/03/2024	16/07/2025
2b: Empower our people to continuously improve and innovate	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 vacancies and long term absence within the invoicing team, purchasing and pharmacy stores team there is a risk that any further absence or leavers will mean the remaining staff don't have the capacity to do the work of all 3 sites which would impact staff wellbeing and all drug ordering across all pharmacy sites (including bulk IV fluids, medical gases, chemotherapy). Inability to complete invoices will negatively impact the Trust finance target to pay invoices within 30 days, with potential of financial penalties, and could result in suppliers putting holds on our accounts rendering us unable to order medicines, this will therefore mean that we would be unable to complete biosimilar switches and meet CIP targets (£1.4m). Recruitment has been further delayed due to VCP to improve the current financial status. Payment beyond 30 days presents a risk of companies levying late payment fees and interest on outstanding amounts.	Band 7 covering the Band 3 gap when needed	Staff Survey Staff Feedback Staff sickness Finance performance on invoice payment Workload CIP tracking Biosimilar switching targets	04/06/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Vacancy fulfillment - QIAs completed; Jobs advertised - Andrew Baines - July 2025 Staff trained and competent to fulfil roles - Andrew Baines - October 2025 Staff skill mix review to ensure that staff managing workload Andrew Baines - October 2025	[04/06/2025 16:12:48 Gemma Staples] Risk increase approved at RRC&C 4/06/2025 from a 4x4 to a 5x4. Helen asked that the risk incorporate's some narrative around what the financial implications for the penalties for the 30 day invoicing are and the impact on the CIP be included on the risk. [25/04/2025 10:39:09 Lisa Hansford] Risk wording updated to reflect current situation [26/03/2025 09:21:33 Lisa Hansford] B2 sickness ongoing and we anticipate 0.6 WTE B2 invoice clerk leaving in July to commence pre-registration pharmacist training. 0.6xB3 purchase clerk leaving in April (bringing vacancy up to 1.6 WTE), 1.0 WTE B2 storekeeper vacancy at Lincoln and 1.0xB2 storekeeper leaving Pilgrim in April. Recruitment underway to cover the existing B2 and B3 vacancy at Lincoln but subject to a delayed start date currently (aim to appeal this) Vacancy request submitted at risk in anticipation of significant invoicing gap by August. Vacancy request to be submitted for B2 storekeeper at Pilgrim. [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.	4	16/02/2024	16/02/2024	04/07/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5100	487	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	As a result of insufficient staffing to meet the level of demand, there is a risk that we will may be unable to deliver epilepsy pathways within Acute Paediatrics that meet national standards. This may result in patient harm, regulatory action and reputational damage.	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;	13/06/2025	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.	[13/06/2025 11:24:32 Rachael Turner] Risk reviewed, risk proposed to be amalgamated with risk ID 5101 following deep dive feedback from Quality Committee. All risk details to be transferred onto risk 5101. This risk will be presented at RRC&C in July for closure. [20/05/2025 14:03:52 Nicola Cornish] This issue remains ongoing. The Group Chief Nurse has requested that a paper is written for presentation to Quality Governance Committee setting out the current position and proposals for development of the epilepsy service. [10/04/2025 09:14:55 Nicola Cornish] Still awaiting update on business case outcome. [18/02/2025 13:20:41 Nicola Cornish] No progress, still awaiting decision about business case. [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 busiinness 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	8	14/03/2024		20/06/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	4879	28	Physical or psychological harm	Carter, Mr Damian	Lynch, Diane		28/03/2022	20	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	As a result of National long waits post COVID there may be significant delays within the cancer pathway and as a consequence patients may experience extended waits for diagnosis and surgery which would lead to a failure in meeting national standards and potentially reducing the likelihood of a positive clinical outcome for many patients.	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group Intensive support meetings in association with the ICB - 2/52 Cancer Delivery and recovery - 2/52 Cancer Board - Monthly	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait Diagnostic standard less than 6 weeks	22/05/2025	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	[22/05/2025 11:42:57 Gemma Staples] Awaiting budget profile from Finance to confirm whether 'at risk' posts agreed by former COO / CEO, and within 24/25 financial run rate, have funding for 25/26. [28/04/2025 08:53:33 Gemma Staples] Updated QIA submitted for Executive / ICB. Awaiting feedback. [27/03/2025 12:16:24 Gemma Staples] The Cancer right-sizing Business Case for Haematology and Oncology was prioritised by CSS Care Group and submitted in line with the Trust's programme for 25/26, aligned to the health System process. Next step for review via Executive colleagues, through a CSS submission by 28 Feb 2025 with a refreshed risk assessment and QIA aligned to regulatory risk and patient safety. At the request of the Execs, QIAs have been refreshed for all investment business case, including this one. [26/02/2025 15:24:47 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 Executive colleagues, through a CSS submission by 28 Feb 2025 with a refreshed risk assessment and QIA aligned to regulatory risk and patient safety. [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.	8	31/03/2023	31/03/2023	23/06/2025
1c: Improve productivity and deliver financial sustainability	5020	6	Finances	Hamer, Fiona	Lentz, Blanche	WORK	02/09/2022	20	Medicine	Urgent and Emergency Care CBU		Trust-wide	If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	28/05/2025	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[28/05/2025 11:35:37 Rachael Turner] Approval provided for job planning for tier 2 rota. Job planning cycle will be the next step. [07/05/2025 12:51:56 Rachael Turner] Risk reviewed and remains at current level, Tier2 rota is being worked on. [03/04/2025 14:08:46 Rachael Turner] Escalation to execs being considered with a view to implement required output via the job planning process. [04/03/2025 15:09:11 Rachael Turner] Conversations around tier 2 have failed so this has been escalated to executive level. [04/03/2025 15:05:36 Rachael Turner] Risk reviewed, conversations are currently taking place around tier 2 rotas. [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	10	02/09/2023		28/06/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	4731	33	Physical or psychological harm	Landon, Caroline	Landon, Caroline	Experience Group, 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.	29/05/2025	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.	[29/05/2025 09:16:48 Rachael Turner] Risk remains on current level-no change. [19/05/2025 09:45:29 Rachael Turner] Risk reviewed, no change from last months update. Risk remains at current level. [08/04/2025 10:30:22 Rachael Turner] The ULTH Electronic Patient Record (EPR) programme has now reached the final stages of contract and funding. The contract with our new supplier, Nervecentre, is due to be agreed and finalised in the next few weeks and ministerial approval for the programme has also been received. Once the contract has been finalised the Digital Services Team will submit the full business case and contract to the Cabinet Office who will then agree the funding. [06/03/2025 09:58:09 Rachael Turner] Risk reviewed, no change until EPR in place [17/02/2025 11:24:13 Rachael Turner] Risk reviewed, no change from January, risk remains at same level until EPR in place. [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.	4	30/06/2018	31/03/2025	29/06/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	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)	16/06/2025	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.	[16/06/2025 09:12:31 Rachael Turner] Work hasn't started for moving Gastro service into community. There has been slight improvement but Division would like to wait until August review time to look at possibly reducing score. [04/06/2025 11:52:28 Charles Smith] Risk remains unchanged for now pending further recruitment as still dependent on agency - If current round of recruitment successful pending further partial retirement approved by ROAG then to explore if risk to be downgraded. [29/04/2025 14:47:41 Rachael Turner] We have recruited a substantive consultant. Rotas: bleed gaps covered at Lincoln. We have had consultants returned from sickness. [01/04/2025 14:38:14 Rachael Turner] Risk remains in current position but with further update to be provided around current recruitment. [05/03/2025 09:18:37 Rachael Turner] Risk reviewed, risk remains in current position at the same risk score. [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.	8	05/06/2025		16/09/2025
2b: Empower our people to continuously improve and innovate	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)	Trust-wide	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	16/05/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026 Recruitment of further substantive consultants - Sarah Chester-Buckley - April 2026	[16/05/2025 10:39:50 Gemma Staples] Risk reviewed and remains the same. [16/04/2025 10:05:53 Gemma Staples] Vacancy control now in force within the Trust, CRIG not excepting Business Cases which are not funded by charitable funds therefore unable to proceed at present. [18/03/2025 11:35:18 Gemma Staples] Business case submitted due to financial situation no further update. [20/02/2025 11:00:52 Gemma Staples] ELT requested ICB Business Case review by the 25th February 2025. CBU writing paper to cover all points requested. [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.	8	01/04/2023	01/04/2023	16/06/2025
2b: Empower our people to continuously improve and innovate	4844	38	Service disruption	Lynch, Diane	Lynch, Diane	Medicines Quality Group	19/01/2022	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of insufficient staffing establishment there is an inability to provide a safe and effective 7 day pharmacy dispensing service at ULTH. Current funding allows for the dispensaries to open Monday to Friday 9-5 and weekends mornings only. The dispensary workloads exceed the staffing capacity. As a result of this under staffing there is a risk that patients may require critical medication and/or specialist pharmacy advice over the weekend when pharmacy is closed, there is a risk that pharmacy staff working long hours without a break could make errors, pharmacy staff could become unwell due to working conditions, patients could be discharged from hospital without vital medication and pharmacy advice. All of these risks have multiple implications such as harm to patients from omitted medicines, delayed discharge from hospital effecting the efficiency of the hospital, readmission to hospital, long term effects on pharmacy staff health and wellbeing and the pharmacy departments ability to retain staff.	Provision of an emergency supply only service on weekends between 9am and 12:30 On call pharmacy service outside of pharmacy working hours Quarterly comms to staff to remind them that that weekend service is for urgent items only and what the cut off time is and that we cannot do MDS.	Staffing levels / budget benchmarked against other similar trusts. Reported medication incidents occurring out of hours. Monitor sickness rates following weekend working Staff Survey results Staff exit interviews	21/05/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	A Business Case for a full 7 day dispensary service to be progressed through the CRIG process – AS July 2025	[21/05/2025 11:40:04 Lisa Hansford] Workforce review in progress and all business cases are on hold. [22/04/2025 11:01:30 Lisa Hansford] Case was submitted to CRIG 29th Nov 2024 and a one page summary was submitted 25th Feb 2025 as requested by CRIG, currently awaiting further instruction [20/03/2025 11:11:25 Lisa Hansford] Case was submitted to CRIG 29th Nov 2024 and a one page summary was submitted 25th Feb 2025 as requested by CRIG, currently awaiting further instruction. [04/03/2025 10:43:34 Lisa Hansford] Pharmacy are currently providing a limited 7 day pharmacy service which is being funded by winter pressures money. This relies on staff ding overtime and is therefore not sustainable long term. [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	4	29/10/2021	21/06/2023	23/06/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	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	02/06/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business Case written and awaiting CRIG invitation - Sarah Chester-Buckley - April 2026 Development of SPC SOP & business continuity plan - Jill Edwards - September 2025	[02/06/2025 16:27:49 Gemma Staples] Education delivered to Palliative champions, Internationally educated nurses and now supporting HCSW band 2-3 training. SPC team working towards being recognised as fragile service. Awaiting new framework from Division. SOP in draft format and being circulated. Progress slow due to fragility of service and time for staff to focus on development. Proposed withdrawal of Macmillan in-reach role has been noted as a risk. This risk will be monitored closely. [25/02/2025 09:58:09 Gemma Staples] Business case progressing to next steps and with Business Manager Fragile service documentation being completed – Target March 2025 SPC updating SOP and options paper to explore how best to use the resources we have available. – target April 2025 SPC Team reviewing data to look at how we use our data more effectively to showcase areas of good practice and impact of gaps in service. – target April 2025 Palliative champions forum March 2025 to support education across organisations. [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	4	30/12/2024		02/09/2025
2a: Enable our people to fulfil their potential through training, development and education	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 5 Substantive consultants in place at LCH and 4 at PHB. We have a vacancy of 1 for Grantham. It is recommended by GIRFT that we have 15 substantive consultants and at this time we continue to have 9 plus 3 locum/agency. As such we not have the recommended workforce 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)	27/05/2025	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.	[27/05/2025 14:50:21 Rachael Turner] Risk reviewed, risk description updated to reflect current position. [04/03/2025 16:00:39 Rachael Turner] Consultant staffing is now only 1 short of establishment, but a rightsizing paper submitted in November was for an additional 7 Consultants above current establishment. [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	4	30/12/2022	03/06/2024	27/08/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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.	03/04/2025	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.	[03/04/2025 14:10:48 Rachael Turner] Escalation to the execs in relation to tier 2 implementation awaiting next steps to proceed towards job planning. [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	03/07/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	5267	485	Physical or psychological harm	Mooney, Mrs Katy	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 278 as of the 7th April, the oldest scan being 5th December.	1.Paper for outsourcing option submitted to exec team for consideration for sign off (more economical than paying substantive consultants extra contractual rates) to clear backlog. 2. Locally agreed KPI's to outline number of scans to be reported within allocated PAs. 3.Undertaking additional reporting sessions - this will help significantly with the reporting backlog but not solve causal factors. At cost. 4. We now have a Radiographer that can report Cardiac MRI's independently which is approx 8 a week. 5. Additional imaging consultant recruited (starts September 2025)-joint funding from CDC/radiology 6.Backlog monitored weekly and escalated through Divisional Governance structure.	Size of reporting backlog (number/time required) Average time for reporting of scans from date of imaging Locally agreed KPI's to outline number of scans to be reported within allocated PAs-This is being monitored.	09/04/2025	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. 3. planned job planning changes to give us more capacity, this will take place October 2025 (additional device consultant starting in October 25 will enable one of our part time imaging consultants to reduce ward commitments and provide more reporting capacity) 4. There is a possibility of mutual aid from Sherwood Forest, ongoing negotiations are taking place. 6. Submitted paper to the Exec Team for £35,000 for an external company to clear 200 scans from the backlog.	[09/04/2025 10:54:58 Rachael Turner] Cardiac MRI backlog was recorded at 278 as of the 7th April, the oldest scan being 5th December. Risk controls and reduction plan updated to reflect current position. [03/03/2025 11:08:24 Rachael Turner] As of today there 217 CMO scans awaiting reporting, the oldest of this is the 21st November 2024. The demand currently outstrips the capacity by far. The mitigation in place there are planned job planning changes to give us more capacity, this will take place October 2025. We now have a Radiographer that can report Cardiac MRI's independently which is approx 8 a week. Additionally we have a consultant who has been under-reporting that is now reporting 8 a week. We also are in early negotiations with a consultant from Nottingham to support with our backlog. There is a possibility of mutual aid from Sherwood Forest, but this is in the early negotiations. We have submitted a paper to the Divisional Managing Director for £35,000 for an external company to clear 200 scans from the backlog. [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	3	01/07/2024		09/07/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	4855	207	Physical or psychological harm	Halliion, Simon	Chantry, Chris		10/02/2022	16	Family Health	Women's Health and Breast CBU	Breast Services		As a result of insufficient staffing and clinic capacity within the Breast service, Pathology and Oncology, there is a risk of delays in diagnosis of breast cancer and increased waits for treatment of confirmed cancers, which may lead to patient harm. There is also a risk of staff fatigue through the provision of additional clinics to reduce delays and a 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.	15/05/2025	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.	[15/05/2025 14:57:15 Nicola Cornish] Still heavily reliant on agency radiology staff, pathway development still requires further input from pathology and oncology. Additional clinic requirement for symptomatic patients has decreased due to progress made but screening still has a fluctuating level of demand due to variations in recall rate. [14/04/2025 13:35:54 Nicola Cornish] Staff still undertaking additional clinics to meet demand for diagnosis. business case to increase staffing has been completed to stabilise breast workforce, await outcome. [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	4	31/12/2021	29/12/2023	15/08/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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 due to a steady increase in demand, in particular for Cardiac Echo scans and other diagnostics this could result in a risk of delays to patient care/harm, service restrictions, delays in discharge and site escalation pressures. Although inpatients always take priority the current workforce model is not enough to manage DMO1 and RTT performance in line with the national access targets (6 weeks diagnostics DMO1 and 18 Week referral to treatment). 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 is a priority for the Division and the waits are reducing.	additional clinics/lists where deemed cost effective. additional staffing where feasible to increase capacity Job planning exercises are completed and work has started with efficiency team on mapping job plans/time tables to our demand and capacity work. Consistent choice and access staff allocated to Cardiology bookings which has made a significant impact/improvement, although choice and access continue to have significant recruitment and retention issues which is impacting on CBU staff who have to pick up this work on top of their day to day tasks. Weekly PTL meeting with CBU admin and secretarial and management staff where every patient 28 weeks and over are discussed with a plan to be put in place. Advice & Guidance currently performing well.	Weekly monitoring of DMO1,RTT and PBWL Datix incidents being recorded when appropriate. Weekly meetings with planned care managers	13/06/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Weekly waiting list meeting-ongoing -Weekly RTT meeting-ongoing For both of these we make plans for all patients that are 28 weeks and over. This will be ongoing. -The weekly RTT meeting has changed focus and each medical secretary reviews their own consultants patients to give more ownership to the pathways. Although there are still delays we are now appointing at 28 weeks. -Ongoing negotiations with ICB for additional ECHO capacity at community diagnostic centres.	[13/06/2025 10:44:49 Rachael Turner] Risk reviewed with risk description, controls and risk reduction plan updated to reflect current position. April performance was 64.1% against national recovery standard of 65% by end of March 2026. DMO1 is at 72.8% for May but this is dependant on ICB funding additional activity in community diagnostic centres. Due to slight improvement in performance in recent months and current mitigations to recover risk score proposed for reduction. Risk proposed to reduce to 3x4: 12 Moderate Risk. [09/04/2025 11:02:52 Rachael Turner] We have maintained our 18 week RTT position at over 60% since January, our submitted position showed cardiology at 60.29% with 12 patients over 52. Risk controls updated to reflect current position. [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	8			13/09/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	5520	753	Physical or psychological harm	Landon, Caroline	Hunter, Sarah	Emergency Planning Group	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.	07/05/2025	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?	[07/05/2025 13:05:44 Rachael Turner] Risk remains the same with no current update. We have attempted to lobby the transfer of category allocated to a 1 but this was denied by EMAS. [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		07/08/2025
3c. Enhance our digital, research and innovation capability	4641	18	Service disruption	Fradgley, Daren	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	25/03/2025	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.	[03/04/2025 11:30:21 Rachael Turner] Work is continuing to commission the two new locations at Lincoln and on the building of the new data centre at Pilgrim Hospital. Work is also planned this coming 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, new fibre has between the new data centre has been run and fibre work has started at Lincoln to run new fibre out to end cabinets around the site, work will follow on other sites, as the new locations come on line. [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	4	31/03/2023	31/03/2023	25/06/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5651	871	Physical or psychological harm	Chester-Buckley, Sarah	Rigby, Lauren		07/05/2025	16	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	As a result of East Midlands Cancer Alliance Centre for Psycho Social Health having temporary funding for the level 4 Psychological Oncology support service until the 31st August 2025 they currently don't have any substantive funding beyond this date. This means this service will cease as well as the delivery of level 2 psychological support to our specialist teams which would lead to an increase in Psychological distress and harm that potentially could lead to physical harm to the cancer patients of Lincolnshire so therefore having a knock on effect to patients and ULTH staff as this will increase the expectation on specialist staff who are currently only trained to level 2 psychological support and lead to moral injury and burn out due to circumstances outside of their scope of practice and no services to refer onto.	Urgent meetings are taking place between EMCA, ICB and the Mental Health Trust in Nottinghamshire. We have Macmillan psychologists who can provide level 4 support to Bostonian and Waddington – funded until February 2026. (The Levels are the complexity of psychological support Level 4 requires specialist input from a psychologist we can only train staff up til level 2 (CNS). The Mac ones are an inreach they only have capacity for the two inpatient areas due to resource etc)	Datix Complaints Cancer Performance targets	07/05/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ICB having conversations regionally - Lauren Rigby - August 2025	[06/06/2025 10:16:59 Gemma Staples] Risk approved as a 4x4 at RRC&C on the 04/06 with the request that the risk description includes that this risk has a knock on effect to our patients and staff. Risk updated and approved by Helen Shelton. [07/05/2025 13:28:09 Gemma Staples] Risk approved at CSS Cabinet on 15/04/2025. Update: East Midlands Cancer Alliance (EMCA) Psychological Services provides our temporarily funded support, which finishes in August, although no Comms received, as yet. It is a big risk for Cancer patients in Lincolnshire, as they will not have access to this specific support. Psychological distress will therefore increase for this cohort of patients due to inability to refer them, if this service stops. Currently in discussion as we currently have Macmillan Psychologists but they cover the wards one day a week as their remit does not cover Outpatients, which is approximately 238 including supervision support to staff increasing this to thousands. Without this support and Level 2 training which they currently provide free of charge, this will have a knock-on effect. Will raise, as a risk at the Cancer Board but our organisation needs sight of this because of the huge impact it will have on our patients. Scored as 16: severity agreed as 4 but likelihood to be reconsidered. SLe highlighted that the talks had not gone well so likelihood is higher. Comms will go out by the end of this week so will not take any more patients from end of August onwards. CS stated that, as the team sits under EMCA, should they be employed under LPFT or is there a different approach we could take? SLe clarified that EMCA cannot fund these and need to go to their individual ICBs to see if they can. AC agrees it needs raising with ICB and our Executives to be sighted on this as it will sit with our staff / resources which will lead to moral injury and burnout with it being outside their remit. As this service is not going to be available, this is quite likely. Document approved so needs presenting at the Risk Confirm & Challenge meeting and Executives will then have sight of this. Risk to be presented on 28th May meeting.	4	07/05/2026		07/08/2025

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1d: Provide modern, clean and fit for purpose care settings	4725	466	Reputation	Taylor, Ruth	Taylor, Ruth	Health and Safety Group	13/01/2022	20	Clinical Support Services	Therapies and Rehabilitation CBU	Rehabilitation	Lincoln County Hospital	As a result of the poor Estates requiring essential repairs and maintenance requirements at Lincoln County Hospital Therapy & Rehabilitation Medicine Department there is a risk that staff, patient and visitors may experience harm as result of inadequate temperature control and ventilation, poor quality flooring, poor quality furnishings, inadequate toilet facilities and poor infrastructure. There is a security risk to the building due to failing infrastructure..	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) Frequent escalations to Estates Team for repairs Increased use of flexible working policy Site visits by senior Exec Team members Frequent escalations through Governance processes	IPC flo scores Datix incidents Staff surveys Complaints / PALS	30/04/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Work with Estates to identify better facilities – Ruth Taylor – December 2025	[30/04/2025 15:17:58 Gemma Staples] Feedback from staff survey, recent appraisals and staff morale feedback has highlighted the this risk remains a significant factor in staff satisfaction in roles. RT to escalate to DL via PRM escalations. [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	4	31/03/2022	31/03/2023	30/07/2025
1d: Provide modern, clean and fit for purpose care settings	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. * Refurbishment of Lincoln site includes increased security and zoning of areas within mortuary. * Titan units are no longer in use now that new refrigeration equipment is in use yielding increased capacity. * Additional security processes are being scoped following the Police led walk-through of Mortuary facilities.	ULHT Improvement action plan HTA Governance Group	20/05/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	DI to escalate to ULTH security team the HTA governance group approval of the recommendations made following the Police Led review. Ciro Rinaldi – February 2024 Refurbishment completion at Lincoln – Andy Clay – March 2025	[20/05/2025 13:36:08 Gemma Staples] Request for the risk to be reduced from a 4x4 to a 1x4 - To go to CSS Cabinet in May then RRCoC for agreement - the rationale for lowering this high rated risk was in respect of the refurbishment programme of works. Whilst still underway at Lincoln (to update / improve the PM room) the refurbishment works have yielded increased and more reliable refrigerated storage (including freezer capacity) which includes bariatric storage capabilities. The refurbishment programme has therefore transformed and updated the Trust's premises, mitigating almost entirely the HTA concerns from their inspection in 2022. The Trust are assured of this following the return visit in November 2024 which was whilst the refurbishment was underway still, no concerns were expressed. [20/05/2025 09:51:48 Gemma Staples] Titan units no longer in use. Boston Titan has been removed. Lincoln Titan to be removed during June 2025. Refurbishment largely complete. HTA original concerns about fabric of the estate have been mitigated. Suggest reduction in risk rating. [21/02/2025 11:30:56 Gemma Staples] 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. [19/02/2025 14:46:24 Gemma Staples] The Mortuary refurbishment work at Lincoln is still ongoing, whilst the Refrigeration is near completion we are still using the temporary store at this time so the risk still stands. [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	4	31/03/2024	01/01/2025	20/08/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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	07/05/2025	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	[07/05/2025 13:03:30 Rachael Turner] Still not up and running on TIA pathway, general wait times are coming down possible due to new TIA coordinator in place. Date yet to be confirmed for TIA pathway go live. [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		07/08/2025

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2a: Enable our people to fulfil their potential through training, development and education	5469	697	Service disruption	Rinaldi, Dr Ciro	Chablani, Manish		21/06/2024	16	Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of Pharmacy struggling to budget and recruit into the role whilst there are budgetary provisions on the medical education side there is a risk that without adequate educators we would fail to deliver the curriculum across the entire clinical years for years 3,4 & 5 which would lead failure of our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	We are currently liasing with the Pharmacy department around the appointment of a part time prescribing skills lead. This would be a 50/50 appointment shared with the pharmacy team	Meeting reviews.	19/05/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[19/05/2025 12:04:21 Rachael Turner] Risk reviewed, no current change, risk remains at current level. [18/02/2025 15:12:47 Rachael Turner] Currently working with LCHS to have a shared Prescribing Skills Lead. The JD are ready and awaiting for LCHS to advertise from their side. Although funding may be an issue owing to the freeze on new appointments prior to May. [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		19/08/2025
1c: Improve productivity and deliver financial sustainability	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.	28/04/2025	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.	[28/04/2025 14:09:57 Fiona Hobday] Is a growing area of importance due to EPR, EDMS, personnel file issues etc... Lack of an SME is a challenge. Work ongoing to look at structure and resource for a future role as part of portfolio restructures under Group. Awaiting transfer of funding from Digital projects. Decision to procure an EDMS that can't (and won't ever) include corporate records mgmt is a missed opportunity for the Trust. [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.	4	28/06/2024	31/12/2025	31/07/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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	16/04/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a fragile service review - Awaiting Trust new process for Fragile Service Review - Sarah Chester-Buckley - April 2026	[16/04/2025 10:05:30 Gemma Staples] Vacancy control now in force within the Trust, CRIG not excepting Business Cases which are not funded by charitable funds therefore unable to proceed at present. [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):	4	31/03/2023	31/03/2023	16/07/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	5488	738	Physical or psychological harm	Rivett, Kate	Flatman, Deborah	Children & Young Persons Oversight Group	12/07/2024	16	Family Health	Children and Young Persons CBU	Children's Community Services	Community	As a result of inadequate staffing Levels, there is a lack of capacity to safely manage the Children's Community Nursing Caseload. This creates a risk of 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	06/06/2025	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	[06/06/2025 10:08:48 Nicola Cornish] Discussed at specialty governance meeting on 27th May. Recruitment is complete and the new staff are now completing their induction and training. It is anticipated that the CCN service will revert to a 3 team model at the end of July. As such, it is felt that the risk score should be reduced from 4x4=16 High to 4x3=12 Moderate, with a view to closing the risk once the 3 team model is reintroduced and functioning effectively. To be listed for presentation to RRC&C to approve the decrease in score. [20/05/2025 14:35:44 Nicola Cornish] Recruitment is continuing and newly appointed staff are completing their induction periods. [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	06/09/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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)	Trust-wide	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: Improve patient safety, patient experience and deliver clinically effective care	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.	10/04/2025	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.	[10/04/2025 09:48:32 Lisa Hansford] Escalated to SPMM for progress update. [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, Boston. However, the practice seems to replicate at	4	30/09/2022	31/03/2023	10/07/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	5617	854	Physical or psychological harm	Upjohn, Emma	Rayner, Gemma	Workforce Strategy Group	24/03/2025	20	Family Health	Women's Health and Breast CBU	Obstetrics	Lincoln County Hospital	As a result of insufficiencies within the current maternity services triage system, there is a risk that not all pregnant individuals will be able to access safe and timely care, which could lead to harm to the mother and baby. A recent MNSI Escalation of Concern notification highlighted 'insufficient triage processes in place to support safe care for mothers' and 'evidence of the Trust gate keeping access to acute care'. The trust is in the process of looking to adopt the BSOTS model for triage which is the nationally recognised standard for an individualised, 24 hour service. Despite an agreed temporary uplift in staff of 2.52 wte B6 for LCH and 2.73 wte for PHB, there is still insufficient midwifery and medical staff to fully implement BSOTS. In addition to patient harm, there is also a financial risk to delivery of CNST year 7 due to business case for 12.1wte uplift in line with BR+ establishment review is still undecided. If 12.1wte uplift is not approved the trust will not be compliant with CNST yr 7 and risk loosing the CNST rebate monies.	• Lead midwife for triage appointed September 2024 to lead the implementation of BSOTS, action plan has already been developed to support this. Initially fixed term for 12 months due to complete in September 2025, within the Business case this has been asked to extend to a substantive position. • Uplift of staff on both sites for a designated triage midwife to provide a 24 hours service. 2.75 WTE for PHB and 2.25 WTE for LCH. • Maternity specific triage training is being delivered to core triage midwives and HCSW in line with BSOTS methodology to help improve the safety for women and babies. This training will then be rolled out to all maternity staff during the role out of the BSOTS pathway. • Communications issued to all staff outlining a clear directive to all maternity staff emphasising that women should not be discouraged from attending triage based on criteria such as membrane rupture or the number of prior telephone calls. We are moving to Badgernet maternity IT system late Spring 2025 which has a BSOTS specific triage to be followed improving compliance. • A business case has been submitted to consider a staffing uplift in line with 2024 Birthrate Plus (BR+) establishment review data which equates to 12.1 WTE midwives.	MNSI reporting Audit Currently women are seen in a timely manner by a midwife but the medical review is often delayed due to not having dedicated 24 hour medical cover for triage.	30/04/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Conducting a full audit of triage cases from the past three months to identify trends and assess the impact of our interventions. Implementing a patient feedback system to evaluate the effectiveness of the changes and enhance the overall maternity experience. Continuing our collaboration with MNSI, ensuring that insights from the final investigation report are integrated into our maternity care strategy. Progress with the triage action plan is monitored through the Maternity and Neonatal Safety Improvement Plan (MatNeoSIP) and reported through to the Maternity and Neonatal Oversight Group (MNOG) with upward reporting to the Group Quality Committee.	[30/04/2025 14:25:13 Nicola Cornish] There is a continued risk due to current establishment vacancy. Additional shifts are being picked up by substantive staff to fill current templates, further recruitment is ongoing to appoint into the uplift vacancy. Expected recruitment by September 2025. [30/04/2025 12:51:59 Nicola Cornish] Discussed at RRC&C meeting on 30/04. Gemma Rayner explained that we are currently not following national recommendations and this has recently been highlighted by MNSI as part of an intrapartum stillbirth investigation. Uplift of 12.1WTE midwifery staff across both sites would be needed to effectively implement BSOTS system and a business case has been submitted for this. However there will also need to an increase in medical staffing to support implementation - need to reflect that in this risk and also add in CNST implications. Risk scoring approved subject to these amendments in wording.	4	30/06/2025		30/07/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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).	Rotas are set and monitored by a Consultant who formulates the rota and identifies gaps which cannot be covered in advance. Staff are being offered paid in TOIL for any additional sessions undertaken in order to minimise additional budgetary impact. Escalation to Divisional Triumvirate to request agency cover when gaps cannot be filled by existing staff. 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.	Monitoring of gaps in rotas Agency spend reporting Datix incidents recorded	04/06/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruitment to vacant posts.	[04/06/2025 13:55:04 Nicola Cornish] Discussed at RRC&C meeting on 4th June. This risk has been ongoing for some time and it is recognised that there is now a need to look at alternative staffing options to mitigate the risk. As such recruitment is now underway for CESR (Certificate of Eligibility for Specialist Registration) trainees. [15/05/2025 10:38:01 Nicola Cornish] Recruitment is ongoing, with interviews scheduled for July. [21/02/2025 13:00:38 Nicola Cornish] Risk reviewed, no change. [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.	4	31/10/2022		04/09/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5495	725	Physical or psychological harm	Upjohn, Emma	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	12/06/2025	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.	[12/06/2025 14:24:09 Gemma Staples] Quality Committee asked if the risk can be reviewed as they believed the work had been done. Emma Upjohn confirmed that the risk remains the same on the LCH site. The works are being planned, but not commenced yet. [01/05/2025 15:26:56 Nicola Cornish] Charitable funds are working with team at Lincoln to redesign room 4, although complete sound-proofing is unlikely to be possible. [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		12/09/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5515	737	Service disruption	Upjohn, Emma	Agarwal, Vandana		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	01/05/2025	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.	[01/05/2025 15:28:26 Nicola Cornish] Now have dedicated theatre lists at Lincoln for T/W/T/F starting in June. Capacity remains an issue on Boston site but conversations are ongoing with Surgery. [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 EICS rate. [25/09/2024 13:24:51 Nicola Cornish] New risk agreed by Libby Grooby. To be added to agenda for October RRC&C meeting for approval.	2	30/09/2025		01/08/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	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)	17/04/2025	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	[17/04/2025 10:21:23 Rachael Turner] To mitigate this risk we continue to seek advise with colleagues in Nottingham. This risk continues to be monitored [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	17/07/2025
1d: Provide modern, clean and fit for purpose care settings	5334	533	Physical or psychological harm	Upjohn, Emma	Gould, Georgina		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.	01/05/2025	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.	[01/05/2025 15:25:19 Nicola Cornish] Risk reviewed, no change. [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		01/08/2025
3c. Enhance our digital, research and innovation capability	5245	19	Service disruption	Fradgley, Daren	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.	25/04/2025	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.	[10/06/2025 11:59:10 Rachael Turner] Development of the overall Digital Services BIA and BCP has progressed with both documents now under review by the Digital Services senior leadership. Rubrik continues to be progressed along with assignment of system tiers against all servers. [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.	10	30/08/2024		25/07/2025

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1d: Provide modern, clean and fit for purpose care settings	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.	13/06/2025	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.	[13/06/2025 10:58:55 Rachael Turner] No current change, risk score remains. [12/03/2025 14:02:25 Rachael Turner] Both labs have had the switch over completed, the new technology lets the Cath Lab acquire. We need to understand how long we can acquire for, how long to charge etc. We now have machine capable of screening but if we do not have the data to support the acquisition this could still lead to a risk if a patient was being treated. As there is 1 generator there is the question of whether there is one single place of failure. We need this to be confirmed with Estates. An email has been sent to Estates for confirmation, update to be provided once we hear back. [26/02/2025 13:25:10 Rachael Turner] Risk discussed as part of RRC&C Deep Dive, risk to be reviewed for reduction in score due to work around of fixing electrical supply which has reduced the likelihood of risk. This risk will be reviewed and brought back for a reduction in score [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.	1	31/12/2023		13/09/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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.	Reported incidents Staff feedback on training and support available in staff surveys. Inspection feedback	21/05/2025	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 packages. ESR team have developed the draft programmes, and these are being amended as feedback and comments are received. Plan is to then trial and take to APPG for approval before going live - Lisa Hansford July 2025	[21/05/2025 10:58:02 Lisa Hansford] ESR packages now in draft and will be going out for feedback in the next few weeks. The next step will be to get approval from APPG. [10/04/2025 10:07:11 Lisa Hansford] MM package is close to completion and will be added to ESR once the draft has been circulated to clinical leads. CD package will be next to be created. [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		21/08/2025
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	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 the 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 5900 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 1x new consultant starting 01/09/25 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	13/06/2025	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. Action 4-Multiple papers drafted for GLT updating on situation. Most recent has requested permission for insourcing.	[13/06/2025 14:13:57 Rachael Turner] Neurology has the largest PBWL and is a small service. There are currently 9000 on the services PBWL, 5900 of which are overdue with no plan to mitigate and no capacity to clinically audit. At present no route to improve operational RTT performance or meet Trust objectives. At this time service will likely see 65 week breaches in circa Q3. On this basis and lack of substantial sustainable plan it is recommended that this risk be increased in score to 5x4:20 Very High Risk. This will be presented at RRC&C in July for validation. [04/03/2025 15:59:18 Rachael Turner] Risk reviewed, no change to current risk score [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		13/09/2025

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1d: Provide modern, clean and fit for purpose care settings	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/Entonox Oxide levels in Pilgrim and Lincoln (Theatre and Maternity Units), it was identified that in a number of locations, staff were exposed to higher levels of nitrous oxide where levels exceed the Workplace Exposure Limit (WEL) OF 100 ppm (8hr time weighted average (TWA)).	Following notification the following actions were undertaken: Pilgrim Hospital – Labour Ward: Estates staff checked the supply ventilation from the Air Handling Unit (AHU) to the Supply Grilles within the labour rooms. At the time of inspection, the Estates staff identified the dampers restricting airflow were not adjusted correctly. This was addressed and airflow checks were undertaken. Typical air change rates were around 6 air changes per hour (ACH) – current guidance is a minimum of 10 ACH, however the ventilation systems are circa. 1960 and the guidance is not retrospective. Following the actions undertaken, resampling commenced 15th March (15 sample tubes), 13 were within WEL limits, but 2 sample results were recorded at 255 and 407 ppm (8 h TWA) in Rooms 2/2a and Room 3, respectively and exceeded WEL limits. Estates are reviewing the current system to look at increasing air changes by upgrading the supply fans / changing pulleys / upgrading filter media or a combination of factors. Further works to increase ventilation has been completed and whilst not HTM03 compliant by design - supply ventilation has been increased to reduce the risk of WEL exceedance. Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had failed and was deemed beyond economical repair and a decision had been made not to replace (no one is aware of why this was made or by whom). Estates plan to reinstate the ventilation, where feasible, which will likely include partial refurbishment and deep clean of existing systems. N.B the use of sampling tubes to monitor Nitrous oxide levels can be highly time and place dependent, the person with the sampling equipment and their activities, can indicate exposure levels that are as a result of human error, not as a failing of the environment. As such G210 analysers specifically designed for highly accurate measurement and verification of the quality of piped N2O and O2 gases, are being sourced.	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	17/03/2025	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 involved	[17/03/2025 12:54:09 Rachael Turner] There is a trail in place for monitoring equipment but there are current issues around acquiring data from the software. Pipes for nitrous is being removed. We have purchased a small LEV system which will support air changes in the room, if successful this will be rolled out across all maternity wards. [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.	10	28/03/2024		17/06/2025
1d: Provide modern, clean and fit for purpose care settings	5234	510	Service disruption	Lynch, Diane	Biddulph, Victoria	Clinical Effectiveness Group, Outpatient Improvement Group	25/08/2023	15	Clinical Support Services	Diagnostics CBU	Neurophysiology	Pilgrim Hospital, Boston	As result of the Emergency Department new build project, Pilgrim (PHB) H block was demolished and therefore clinical space was taken from Neurophysiology. No EEG or EMG service is 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 therefore there is a delay in treatment which would lead to patient harm and additional stress caused to patients having to travel to another location.	Adhoc bookings of space available within Outpatients at PHB. Booked where and when possible. Inpatient being transferred to Lincoln (although this is taking staff off wards in Pilgrim)	Waiting times Travel times Patient Feedback Datix Incident	29/05/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Working with Estates to get costings for a permanent room – Victoria Biddulph – June 2025	[29/05/2025 16:51:00 Gemma Staples] Estates have presented specification options to the Head of Service. Once requirements agreed then estates to gather quotes for works required. [25/02/2025 11:19:15 Gemma Staples] Neurophysiology had a meeting on 15/01/2025 with Capital Projects Team, awaiting further update. [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.	4	26/08/2024		29/08/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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	21/05/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to ensure future sustainability once recovered.	[04/06/2025 14:07:03 Nicola Cornish] 21/05/25 - Leanne Chamberlain - no new update, continue to work through action as previous [14/02/2025 13:13:59 Nicola Cornish] Discussed at governance meeting on 14th Feb. Currently 4097 on the PBWL, with numbers remaining relatively unchanged. Recruitment is ongoing. [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	4	31/07/2021	30/06/2022	21/08/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	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: Improve patient safety, patient experience and deliver clinically effective care	5614	825	Service disruption	Fulloway, Mr Ian	Woods, Mr Michael		04/03/2025	16	Clinical Support Services	Diagnostics CBU	Audiology	Trust-wide	As a result of Increasing demand on referrals to the service, the Paediatric Audiology Service not meeting the Paediatrics Quality Standards and the consequence of the requirement to attain UKAS IQIPS accreditation, due to insufficient staffing, capacity and lack of soundproofing rooms (the room at Boston has recently been condemned after IQUIPS benchmarking visit which has reduced capacity further) there is a risk of 1) an increase in waiting times which is a causing a delay in patients being seen and a delay in treatment which could lead to long term patient harm and risk of litigation and 2) the risk of the Trust not attaining accreditation which could lead to Audiology losing the contract for Paediatric Services in Lincolnshire.	Audiology team are undertaking work to bring the service up to this standard by updating or developing new policies, operating procedures and work instructions to meet the new Paediatric Quality Standard requirements. This is causing capacity pressures as staff are having to be taken out of clinical time due to the work involved in revising the required documents. Team is working to review IQUIPS standards and match requirements to policies and procedures currently in place within the department and to develop the new working practices and quality monitoring processes required. Work will then be undertaken to produce an action plan to put into place any policies, procedures or processes that are not currently embedded in service. Once action plan is complete and revised systems suitably embedded then an application will be placed to UKAS for initial assessment for department's compliance with IQUIPS standards. Clinics are pausing during testing while noise levels abate. Clinic dates have been amended to quieter clinic days. Insert earphones used for greater attenuation of external sounds. Paediatric room layout reviewed to reduce reverberation. Soundfield testing has been stopped at Pilgrim site for paediatric under 5's and defined complex patient group. With other children groups if ear specific information not obtained then patient transferred for testing at Lincoln site in soundproof facilities. Development of business case to provide Gold standard soundproof facilities at Pilgrim site to reduce the need for cross site referral. The service is Investigating an option for temporary Booth's to be leased until proposed building works can be completed.	Standards met Waiting times report Action plan review and UKAS initial assessment report. (This is relating to IQUIPS) Environmental sound levels measured between patients and at times of testing. Recent training identified reverberation risks which cannot be measured Facility will not meet stage C calibration standard for freefield testing hence test stopped. Monitor numbers of patients being transferred and action plan for impact as data is recorded.	26/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Audiologists to take time out of clinical work to review, revise and complete the required documentation. Locum Audiologist in place to reduce backlogs of clinics - Michael Woods - December 2028 Development of Case of Need / Business Case to increase staffing and improve facilities to Gold Standard at all sites - Michael Woods - April / May 2025 Action planning from the UKAS Benchmarking visit is underway - Michael Woods - April 25 Review of waiting list currently underway - Michael Woods + Victoria Biddulph - March 25 Reviewing with Procurement options around temporary booth hire as an interim resolve for the CoN for refurbishment - Michael Woods + Clare Wright - February 25	[26/03/2025 13:38:10 Gemma Staples] Risk approved as a Service Disruption risk scoring a 4x4(16) at RRCoC meeting on 26/03/2025 and agreed for this to supersede 5236 / 5287 / 5317 / 5318 & 5235. [04/03/2025 17:28:57 Gemma Staples] Risk is to be presented at March RRCoC for approval and will supersede 5236 / 5287 / 5317 / 5318 & 5235.	4	31/03/2026		26/06/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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.	04/06/2025	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	[05/06/2025 14:45:39 Nicola Cornish] Discussed at specialty governance meeting on 4th June. New substantive nurse started last week and has a 3-6 development plan to learn how to insert PICCs so increased capacity will not be available until after she has been signed off for this and an additional HCA is in place to support her. Need to relook at the business case and how this can be progressed. [24/03/2025 12:39:14 Nicola Cornish] Discussed at specialty governance meeting on 12th March. JJ advised that they have received funding for a further PICC nurse, permanent post. Interviews tomorrow for this. [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	1	01/06/2023		04/09/2025
1d: Provide modern, clean and fit for purpose care settings	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). Fire safety mandatory training	13/03/2025	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	[17/04/2025 09:29:19 Rachael Turner] Works continue on compartmentation within capital projects on the basis of risk. surveys being undertaken for the potential new fire alarm installation at Pilgrim within capital spend. [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	10	31/03/2022 31/03/2025		13/06/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	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: Improve patient safety, patient experience and deliver clinically effective care	4789	32	Service disruption	Landon, Caroline	Venugopal, Mr Vinod	Clinical Effectiveness Group	16/01/2022	20	Medicine	Cardiovascular CBU	Cardiology		As a result of ongoing pressures to clinical staffing shortages this has led to a 40% reduction in the DMO1 performance. Clinical staffing shortages have been impacted by maternity leave and lack of agency staff being available for eight months. The Trust is currently unable to fund seven day echo despite this being an NHS England requirement. The Recruitment and Retention package has not been renewed which impacts ability to recruit staff. We have been unable to staff complex Echo Lists as cardiology staff are excluded from recent band 3 uplift. Length of stay for patients is increasing due to lack of cover. In addition we have recruited four new admin posts, however it will take around 3 months until fully trained which leads to delays in processing internal and external requests. Skegness CDC opened in November, however this can only be covered by admin 5 days a week which limits capacity.	Weekly review and monitoring of OP activity /utilisation data Monthly data provided throughout CBU to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell All referrals are triaged to ensure appropriate	DMO1 activity - monthly review Backlog consistently increasing. Booking Team are now part of the Cardiovascular Division.	09/04/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Continued recruitment process, which included current recruitment and retention package. Due to be completed April 2025 -Lincoln CDC is online and is staffed for seven day working -Business Case is currently in process, this was submitted in November in the Investment Planning Round-this will now go through Trust Process. -Review of Band 2/3 uplift job description currently with HR-cardiac physiology assistant currently unwilling to support Specialist Echos due to skill required being above band 2 pay band. Currently backfilling with trained nurses at additional cost	[09/04/2025 10:30:32 Rachael Turner] Risk updated to being a service disruption risk. Currently performance is 58.24%. A paper has gone to the exec team via HR requesting the continuation of a recruitment and retention premium for Cardiac Physiology staff. This is due to a nationwide shortage in this field. NHSE have only funded 3000 scans to be done in the community diagnostic centres which will mean the ULTH acute service will have to pick up the shortfall (3200 approx).This will result in an increase length of stay for inpatients and outpatient waiting list will increase causing further strain on the service and its staff. Due to this current position risk to be requested for increase in score to 4x4:16. This will be presented in May. [26/02/2025 13:20:40 Rachael Turner] Risk presented at RRC&C as part of the Deep Dive 26/02/2025, risk to be reviewed looking at in as a service disruption risk and score reviewed to reflect. It can then be returned to RRC&C for re-scoring. [24/02/2025 11:56:57 Rachael Turner] Risk reviewed, risk description and risk reduction plan updated to reflect risks current position. [09/01/2025 12:12:12 Rachael Turner] There has been staffing challenges so performance has dropped-currently 68% as of December. There is a significant inpatient backlog. Due to the significant drop in performance risk to be presented at February Risk Confirm and Challenge meeting for an increase in score to 4x4:16 High Risk. [08/10/2024 08:54:23 Rachael Turner] Risk reviewed, risk score to remain at current position. [31/07/2024 13:15:20 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated for reduction in score 3x4:12 Moderate risk. [21/06/2024 13:40:15 Rachael Turner] Current position: 93% of patients are being seen within 6 weeks of their request. Risk can now be reduced in score, this will be presented at RRC&C in July. [24/04/2024 14:25:46 Nicola Cornish] Discussed at RRC&C on 24/04/24 - in last 18 months, reduced waiting list from 8,000 patients to 1800 patients so backlog is now	4		01/02/2024	09/07/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	4646	66	Physical or psychological harm	Landon, Caroline	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 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours 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	12/06/2025	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.	[12/06/2025 10:19:08 Rachael Turner] ED still not following process which is going outside of safety measures, which causes a negative effect on the NIV audit. This remains to be at both Lincoln and Pilgrim but more so at Pilgrim, Patient safety incidents continue to be reported around appropriate usage, equipment, exclusion/inclusion criteria for treatment, ongoing monitoring and usage of an already robust NIV pathway to Respiratory teams. A study day was put on for ED staff, however not been able to move forward as for national standards they need to be exposed to starting off NIV and have a competency. ED are currently looking into how they can put in place this competency. In the meantime the teams need to follow the current policy which is not happening. Due to this this risk needs to remain at current High Risk score of 16. [29/04/2025 14:38:43 Rachael Turner] Escalation has been made, we agreed that NIV & ED meetings need to be set again due to lack of engagement.The policy remains until education is delivered. Three more attempts will be made for these meetings if this fails this will be escalated again to PRM. [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.	4		31/12/2024	12/09/2025
2a: Enable our people to fulfil their potential through training, development and education	5467	695	Service disruption	Babu, Suresh	Chablani, Manish	Corporate	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	04/06/2025	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	[04/06/2025 13:49:40 Rachael Turner] Risk reviewed at RRC&C currently awaiting for confirmation until reduction, this will be monitored and be brought back for reduction [28/05/2025 16:53:27 Rachael Turner] Risk proposed to be reduced to 3x4:12 Moderate Risk, the locum consultant did not leave, however still a risk as may leave. Risk to be presented as part of Deep Dive at RRC&C for reduction in score. [19/05/2025 12:00:19 Rachael Turner] Risk to be presented as part of the Deep dive for RRC&C in May for reduction. [18/02/2025 15:17:11 Rachael Turner] A different locum consultant in place who is the specialty lead and is delivering the teaching. Contract is reviewed on an annual basis. Risk to be presented in March RRC&C meeting for reduction in score [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	04/09/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	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: Improve patient safety, patient experience and deliver clinically effective care	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.	03/03/2025	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 with recommendations/ actions has been attached to this sick	[04/03/2025 10:56:23 Rachael Turner] Work remains ongoing. Ventilation Safety Group is now set up and regular audits and actions are produced and monitored to support and find solutions for ventilation issues. [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		03/06/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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	07/05/2025	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	[07/05/2025 13:07:54 Rachael Turner] We are currently undertaking a project called Clear which is looking at the whole stroke pathway (acute & community) with an aim for patients getting appropriate access-as and when needed. This is due to close in September. [03/03/2025 13:05:35 Rachael Turner] Risk discussed as part of the Cardiovascular Deep Dive at Risk Confirm and Challenge, risk remains at current position and was agreed is at an accurate risk score. [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.	6	31/03/2025	28/02/2023	07/08/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5598	853	Physical or psychological harm	Landon, Caroline	Hunter, Sarah		19/02/2025	20	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	As a result of the consolidation of stroke services and acute service demands there has been occasions when patients requiring admission to the hyperacute stroke unit [HASU] have not had access due to capacity issues. The HASU is often full and patients are stepped down when stable enough to enable new admissions. There have been occasions when no patient is suitable to step down therefore acute patients have been admitted to the ward area resulting in non-hyperacute monitoring due to differing staff levels and skill-mix/competences. This has been identified as a risk to patients as deterioration may be missed resulting in death or further disability.	•When HASU overspill happens, acute patients are cohorted in a bay area within the stroke unit, additional staffing is requested for increased patient acuity and monitoring requirements, staff with the most appropriate skills will be allocated to the additional acute cohorted patients. •Medical staffing will be reviewed to attempt to support the new admissions, staffing levels allowing, CBU will be notified. •Consultant on-call and/or ACP to ensure patients most at risk of deterioration/needing HASU treatments are allocated to HASU, and less acute/at risk patients will be allocated to the 2nd Bay for cohorted acute admissions unable to be cared for in HASU. •If additional nursing staff cannot be allocated this will reduce the ability to mitigate risk.	Patient incidents Datix Staff reports/concerns voiced	30/04/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Improve capacity Increase HASU capacity – ASR plans to increase 5 HASU beds to 7 – plan to be completed 2026 Action 2. Risk reduction Ward co-ordinator/ward manager to liaise with site manager and CBU [lead nurse] to help support with additional staffing in line with acute patient acuity. Increase staffing levels to ensure appropriate monitoring/treatments for acute patients admitted to the ward but not into HASU, attempting to assign those individuals with the most appropriate skills. Ensure middle grade doctor support if staffing capacity allows. Extra staffing to be sort for upcoming shifts/up-lift nursing numbers whilst 2nd acute bay open – ward manager/ward co-ordinator to contact staff members Action 3. Risk reduction On-call Consultant and/or Stroke ACP to risk stratify patients liaising with ward co-ordinator/ward manager to ensure those most at risk of deterioration are moved into or stay in HASU and other acute patients cohorted in ward bay area with additional monitoring and enhanced staffing levels.	[30/04/2025 13:15:22 Rachael Turner] Risk presented at RRC&C 30th April 2025. Due to current actions in place with ACPs, consultants skill mix this will take the score 4x4:16 High Risk.	8	31/03/2026		30/07/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	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: Improve patient safety, patient experience and deliver clinically effective care	5564	783	Physical or psychological harm	Landon, Caroline	Anderton, Kerry		19/12/2024	16	Corporate	Operations		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	27/05/2025	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.	[27/05/2025 09:44:34 Rachael Turner] The service improvement team are currently collating the data from our audit of jobs which should have been done in the daytime and will then draw themes and work on a plan to work with the wards to try to improve this We are also currently in talks regarding our staffing at Lincoln at nights which is run by Suresh Babu and attended by myself and Andy (Boston Lead ACP) along with representatives from medicine and surgery. The initial plan is for medicine to find us an extra Dr, but also the hope is that we also gain an extra ACP at night. Jamie Hodgkins has left corporate and our new boss is the deputy COO Lee Ann Taylor. She has put together a working group to look at a full review of the service, including the work we do and our staffing levels. This working group consists of Lee Ann, Andy, myself, Aarti Varma and a representative from PMO. Our first meeting is next week, date and time to be confirmed. [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		27/08/2025
1c: Improve productivity and deliver financial sustainability	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
3c. Enhance our digital, research and innovation capability	5648	870	Physical or psychological harm	Fradgley, Daren	Humber, Michael		25/04/2025	20	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	The Trust is currently carrying a significant number of risks associated with the reliance on paper-based health records (covered by Datix risk ID 4731) and legacy stand-alone digital systems. There is currently an inability to deliver the required level of patient safety that is enabled by technology and innovation, via more robust and consistent clinician decision making and access to the right information in the right place at the right time. Without an integrated Electronic Patient Record (EPR) and Electronic Document Management System (EDMS) the Trust risks not achieving the key benefits outlined in the EPR Full Business Case (FBC). There is clear evidence in the FBC that an EPR can deliver significant benefits to an organisation which may be unrealistic to deliver with (paper-based systems and) stand-alone digital health systems. These include: •Providing accurate, up-to-date, and complete information about patients at the point of care • Enabling quick access to patient records for more coordinated, efficient care • Securely sharing electronic information with patients and other clinicians •Providing integrated evidence-based Clinical Decision Support (CDS), which allows clinicians to access relevant and focused medical knowledge, at the point of care •Helping providers more effectively diagnose patients, reduce medical errors, and provide safer care •Improving patient and provider interaction and communication, as well as health care convenience •Enabling safer, more reliable prescribing via drug interaction and allergy alerts • Helping promote legible, complete documentation and accurate, streamlined coding and billing.	There are many mitigations and manual workarounds in place to enable the organisation to work more efficiently with paper based health records and stand-alone digital health systems, such as digital tracking of paper based case notes and back office data integration between stand-alone digital health systems. However none of these workarounds mitigate fully against the adherent risk of relying on paper-based health records and stand-alone digital health systems.	The risk will be measured by bidirectional reference to this risk from Datix incidents, subordinate Datix risks and programme and operational digital clinical safety hazard logs.	04/06/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The implementation of an integrated EPR and EDMS systems, predominantly funded by the national Frontline Digitisation Programme.	[04/06/2025 14:15:51 Rachael Turner] Risk presented at RRC&C, validated at 4x4:16. All mitigations need to be included in controls. There are currently a number of active risks on the register in different service areas relating to stand alone digital systems and paper based records. A deep dive meeting will be organised to go through these risks and add as actions to this risk to make it an overarching risk for the Group.	8	25/04/2026		04/09/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5519	739	Physical or psychological harm	Fradgley, Daren	Evans, Thomas		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	27/05/2025	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	[10/06/2025 12:19:29 Rachael Turner] Reviewed, meeting with Deputy Group Gov lead 23/05/2025 - for further review and return to risk confirm and challenge given new information and further identified issues with legacy systems. [26/02/2025 14:10:50 Rachael Turner] Risk presented at RRC&C 26/02/25, risk to be reviewed looking at it from a regulatory compliance perspective and a new risk to be developed looking at patient harm. These risks will be brought back in March. [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		27/08/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	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: Improve patient safety, patient experience and deliver clinically effective care	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	There is significant a risk of unauthorised entry into the Trust's mortuary departments. 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 Access Control: Swipecard access to main mortuary departments (governed by SOPs). Alarm system: All 3 sites main mortuaries have intruder alarm that is connected to the Switchboard.	Incident reporting	20/05/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	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) - Robert Hughes - December 2025	[20/05/2025 13:34:56 Gemma Staples] Request for the risk to be reduced from a 4x4 to a 3x4 - To go to CSS Cabinet in May then RRCoC for agreement - the rationale for lowering this high rated risk was in respect of the refurbishment programme of works. Whilst still underway at Lincoln (to update / improve the PM room) the refurbishment works have yielded increased and more reliable refrigerated storage (including freezer capacity) which includes bariatric storage capabilities. The refurbishment programme has therefore transformed and updated the Trust's premises, mitigating almost entirely the HTA concerns from their inspection in 2022. The Trust are assured of this following the return visit in November 2024 which was whilst the refurbishment was underway still, no concerns were expressed. [20/05/2025 09:56:58 Gemma Staples] Update needed on actions in response to Police led walk-around. Meeting held with Estates team in May to get updates. [19/02/2025 14:50:31 Gemma Staples] This is being monitored by the HTA Governance group. Recommendations have been received from Lincs Police and we are seeking engagement. Further review will also be required on completion of the Lincoln refurbishment, which has been raised by the HTA to ensure that the CCTV and access is reviewed to ensure suitability for the new environment. [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	6	02/08/2024	31/12/2025	20/08/2025
2d: Recognising our people through thanks and celebration	4780	74	Service disruption	Mooney, Mrs Katy	Hunter, Sarah	Patient Safety Group	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	11/04/2025	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.	[11/04/2025 14:14:39 Rachael Turner] Stroke are now back to one full substantive Consultant which puts further pressure on the service. Stroke continue to advertise. [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	8	31/03/2022	01/07/2024	11/07/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5003	342	Physical or psychological harm	Farquharson, Colin	Edwards, Mrs Jill	Patient Safety Group	23/08/2022	16	Clinical Support Services	Cancer Services CBU	Specialist Palliative Care	Trust-wide	As a result of the lack of staffing resource for Specialist palliative care, the Trust is not able to meet the Commissioning Guidance requirements for Specialist palliative care service. Resulting in lack of skilled professionals to provide specialist palliative care, negative impact on staff wellbeing with poor staff retention and recruitment with a potential for serious and life-threatening patient harm. Staffing deficit results in increase for Senior lead to work operationally decreasing the ability to influence, improve and innovate across the Group and partners.	National Policy/Guidance - NICE Cancer service guideline [CSG4] Improving supportive and palliative care for adults with cancer - Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026 - RCN Guidance on safe nurse staffing levels in the UK - NHS Health and Wellbeing Strategic Overview. Creating a health and wellbeing culture - Commissioning guidance for specialist palliative care 2012 ULH Policy Health and wellbeing policies 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 increasing team support to improve wellbeing Senior leadership visibility increased Internal and external ask for multi disciplinary support to the SPC team. Education training needs analysis for team completed Workforce plan to identify gaps in alignment with national policy and guidance completed Service improvement gap analysis completed Prioritised 1:1 meetings with individuals and protected time for essential education. Daily check in/out with team. Clear escalation route developed for concerns/risks	Gap analysis for staff education Daily escalation reports with staffing levels and patient caseload numbers Number of referrals to service Number of referrals to assessment outside KPI target Figures for nurse recruitment/retention SPC absence rates Staff feedback on NACEL reports Staff vacancy rates and appraisal rates 1:1 supervision feedback on staff wellbeing	03/04/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business Case written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026	[30/04/2025 14:18:11 Gemma Staples] Agreed at RRCoC meeting on 30/04/2025 to increase scoring from 3x4 to a 4x4 and to include additional narrative. [03/04/2025 13:32:48 Gemma Staples] To go to RRC&C for a request to increase the scoring from 3x4(12) to a 4x4(16) due to the additional vacancy of retirement and long term sickness absence. [03/04/2025 09:51:39 Gemma Staples] Business case completed and awaiting next steps. Framework being completed to have service officially recognised as a fragile service – need to go on to new framework document launched 1st April 2025. Additional 7.5hr CNS vacancy due to retirement from 1st April 2025. Long term absence (20hrs CNS) from 31st March 2025 of at least 6 weeks. This means the SPC CNS cover is reduced by 27.5hrs over the next 3 months. Deputy Lead Nurse working clinically to provide cover to mitigate risks where possible but there are additional gaps in provision where we are unable to provide a 5/7 face to face service on Lincoln and Boston sites. [20/01/2025 13:05:37 Gemma Staples] Business case ready for submission to CRIG. Deputy Lead Nurse has continued to cover gaps in the SPC team to ensure delivery of service across LCH/PHB. Request from current staff to reduce contracted hours to support draw down of pension and health/wellbeing will further impact service provision from April 2025. Review meeting with finance planned. Team time out session 22/01 to discuss meeting demand with current resource and priorities. 1 WTE post for Palliative Consultant closed for applications – 2 applicants to shortlist [27/09/2024 16:35:57 Gemma Staples] Check out staff well being call implemented. Yearly team absence is 7.97% which is above average for the Trust target. Changes to senior leadership rota planning implemented to increase visibility during service operational hours. The team have stated that they feel well supported and connected which is a positive.	8	30/12/2024		03/07/2025

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2a: Enable our people to fulfil their potential through training, development and education	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	19/05/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[19/05/2025 12:07:47 Rachael Turner] Risk remains at current position, no change to current score. [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	19/08/2025
1d: Provide modern, clean and fit for purpose care settings	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.	17/03/2025	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. Year end capital money for SDA to carry out full site surveys to identify the current state of infrastructure-this will include high level budget costs.	[18/03/2025 09:19:55 Rachael Turner] Confirmation of estimated time for survey to be carried out is 15 weeks [17/03/2025 12:44:08 Rachael Turner] Year end capital money for SDA to carry out full site surveys to identify the current state of infrastructure-this will include high level budget costs. The order is the process of being placed, confirmation of estimated time for when this will be carried out to be provided. Risk score to remain at current level. [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 243m^3/243,000L, This is potable quality water & will supply the hospital for approx. 20 hours. [21/10/2022 09:06:00 Walter Thompson] Scheme for replacement of critical water	5	31/03/2026	31/03/2026	17/06/2025
1b: Reduce waiting times for our patients	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
1a: Improve patient safety, patient experience and deliver clinically effective care	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	28/05/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Continue to monitor and assess medication shortages and alternatives – Andrew Baines - Ongoing	[28/05/2025 11:50:54 Lisa Hansford] National supply shortages out of pharmacy control. The situation is monitored closely by the team and where medications shortages arise there is a risk assessment process in place. [28/02/2025 09:15:28 Lisa Hansford] National supply shortages out of pharmacy control. The situation is monitored closely by the team and where medications shortages arise there is a risk assessment process in place. [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.	6	01/12/2021	31/05/2023	28/08/2025

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1d: Provide modern, clean and fit for purpose care settings	4701	85	Reputation	Upjohn, Emma	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.	01/05/2025	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.	[01/05/2025 15:23:40 Nicola Cornish] No change. IPC raised concerns about estate on both sites, ongoing conversations with IPC group and E&F for immediate actions to be taken. [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	6	31/03/2025	31/03/2025	01/08/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5433	646	Physical or psychological harm	Upjohn, Emma	Marshall, Lisa		08/05/2024	8	Family Health	Women's Health and Breast CBU	Gynaecology		As a result of insufficient EPAU scan capacity to meet the demand, there is a risk that patients may not be offered an appointment in a timely manner. National and local recommendation is that patients should be seen within 24 hours but patients are currently waiting up to 2 weeks. This increased waiting time may cause psychological harm during a very emotional and worrying time for a patient but can also result in physical harm as not all treatment options may not be open to the patient by the time they are seen.	24 hour emergency service via GAU Patient information around signs and symptoms to be aware of and who to contact for advice and help. Offer scan capacity at either site. Review of referral criteria along with Lead EPAU Consultant. Weekend scanning where possible if agreed within Division as overspend to support to reduce demand. EPAU nurse currently undertaking sonography course to support improved scanning availability and efficiency within the service.	Complaint data PALS enquiries Patient and staff feedback	30/04/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Requirement for nurse-led sonography is being considered within the Gynaecology TNA currently being undertaken. Need a 7 day service at each site but plan is to increase capacity by one day at first. Explore utilisation of CDCs to support scan delivery - this will also assist with the separate risk of patients who are potentially losing their baby from having to access care in Maternity areas where there are heavily pregnant women and babies.	[30/04/2025 14:59:50 Nicola Cornish] Discussed at RRC&C meeting on 30/04. RCOG recommend patients are seen by EPAU within 24 hours of referral however our current wait time can be up to two weeks. This delay can cause permanent physical harm as well as psychological harm eg if an ectopic pregnancy is detected early, fallopian tube saving medication can be used but late diagnosis results in tube removal. Reviewing EPAU criteria to minimise when scans are essential to protect scanning capacity and perhaps have over 16 weeks patients seen within antenatal services. EPAU nurse is undertaking sonography training but this is not a quick solution. Radiology to review their risk relating to sonography. CDCs may be an option for EPAU scans but this would require appropriately qualified radiology staff to deal with early pregnancy. Panel agreed increase in score, subject to the risk description being updated to accurately reflect the cause/risk/impact. [15/04/2025 12:16:01 Nicola Cornish] Position has worsened as the service is no longer able to offer additional clinics at weekends due to financial position. Matron reviewing referral criteria to see if anything can be done differently to protect emergency scan slot availability eg changing the timing of follow up reassurance scans. There has been a marked increase in negative feedback received from patients regarding delays in appointments and the psychological harm which this is causing. Propose to increase likelihood score to Extremely Likely which would make the overall rating High - list for RRC&C to approve. [25/10/2024 13:52:50 Nicola Cornish] Remains the same, sonography training is is progress but an increase in establishment is required. [21/08/2024 10:17:42 Nicola Cornish] Trialling an additional clinic on one Saturday per month at Lincoln to increase capacity.	4	31/05/2025		30/07/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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.	30/04/2025	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	[30/04/2025 15:21:17 Gemma Staples] Move to delivery of plans to better manage capacity and demand for outpatient and inpatient services commencing June 25. Outcome of this work to be completed by September 25. [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.	9	30/09/2023	18/12/2023	30/07/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	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	11/04/2025	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	[11/04/2025 14:16:37 Rachael Turner] Risk reviewed, business case has been updated to include recommended staffing level of neuro psychology for acute and community services. Business case is due to go to CRIG this month. [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		11/07/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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.	20/03/2025	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	[02/06/2025 08:36:22 Gemma Staples] Risk removed from the RRC&C agenda due on the 4th June as Sangeeta would like some further work completing on this before considering a reduction in the scoring. [25/03/2025 11:05:03 Gemma Staples] Risk level reviewed and request for the risk to be reduced to moderate score 3x3(9) from 5x3(15). This will be presented at April RRC&C meeting for approval in reduction of scoring. [20/03/2025 10:15:41 Lisa Hansford] Audit schedule currently under review to make this more manageable and will be utilising the newly qualified pharmacy technicians to get the audits completed. Risk level reviewed and reduced to moderate score 9 [10/03/2025 09:52:41 Lisa Hansford] Risk review meeting arranged for 20.3.25 to update all risks relating to staffing. Risk remains the same at this time [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		20/06/2025
2a: Enable our people to fulfil their potential through training, development and education	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	As a result of insufficient nurse staffing levels and skill mix within the current establishment in Lincoln ICU, there is a risk that patients may not receive the specialist care they require in a timely manner, which may result in patient harm or increased length of stay.	Recruitment to vacant posts now complete. Concerns escalated within CBU/Division as required.	Staffing vacancy rate within ICU nursing Incident reporting	04/06/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Programme of clinical education and development to support staff to gain the required level of specialist knowledge and skill.	[04/06/2025 13:48:40 Nicola Cornish] Discussed at RRC&C meeting on 4th June. Decrease in score has not been formally approved at Surgery Cabinet as the meeting was stood down on Monday. As such the C&C panel agreed the change in principle subject to approval by cabinet. Wendy Rojas will confirm once this approval has been given. [14/05/2025 13:16:29 Nicola Cornish] The ICU nursing team in now fully established, and there have been improvement in the level of skill amongst the team, with a robust training plan in place to address the remaining gaps. As such it is proposed that the likelihood should be reduced to 3 (Reasonably Likely) which would reduce the risk score to Medium. To be raised for approval during deep dive discussion at Risk Register Confirm & Challenge meeting in May. [21/02/2025 12:59:05 Nicola Cornish] Risk reviewed, no change. [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.	6	30/06/2021	30/09/2022	04/09/2025

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1d: Provide modern, clean and fit for purpose care settings	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	As a result of estates plant and pipes that are prone to blockage and overflow being located above the pharmacy at Pilgrim Hospital Boston, there is a risk that if there were to be a flood this could lead to extensive damage to medicines; computer equipment and aseptic facilities that disrupts service continuity and has serious financial implications.	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 Contingency plan in place - medicines and equipment are moved to a temporary location in the event of overflow into Pharmacy.	Reported incidents of service disruption	21/03/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Estates to identify potential solutions to the blockage / overflow issues – Estates – March 2026	[21/03/2025 12:49:47 Lisa Hansford] This risk remains the same until such a time when work can take place to move the problematic pipes. [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 (KCI) – 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	6	30/09/2021	31/03/2022	20/06/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5480	683	Service disruption	Spendlove, Mrs Clare	Bursey, Sarah		05/07/2024	12	Medicine	Cardiovascular CBU	Endocrinology/Diabetes	Trust-wide	As a result of a depleting workforce in diabetes this is leading to withdrawal of ward work which is impacting on the quality of care that patients are receiving. Currently pan Trust Trust there should be eleven DSN nurses WTE and there is currently only two in post. Out of these two in post one is due to retire. There is currently three members of staff on maternity leave. Care is having to be withdrawn from ICU, DSN reviews and referrals. For Navenby Ward they are having to rely on junior medic workforce. Active in reach for ED is now limited due to lack of resources. This leads to the potential of missing patients. Staff education has stopped, if its not on ESR or online but no face to face is not currently possible due to work pressures.There is an impact of outpatient referrals, unless it is life threatening these are delayed till further notice which would lead to an increase in waiting lists. Unless patients are pregnant PUMP cannot be offered, there is currently a significant backlog. This risk may lead to possible patient harm, longer waiting times, delayed discharge,service disruption, reputational risk to Trust and pressure and wellbeing to staff.	-2x secondments approved and 1x secondment to be advertised -Working with Patient Safety Team looking at DKA within the ward and education. -Working with cost efficiency manager for department but yet to hear feedback.	staffing levels and service provision Datix incidents-list of Datix with insulin provided by Medical Safety Lead. Themes remain the same.	13/06/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	-Action 1-Buiness plan currently in process, yet to hear feedback. -business plan attached to documents. -Action 2-Service review which is currently ongoing Action 3- Assurance required for current secondment position for the future. Action 4-Working with Efficiency Manager for department but yet to hear back. Action 5-Ongoing work with the community team to have a cohesive service.	[13/06/2025 10:55:21 Rachael Turner] Risk reviewed, some members of staff have returned from maternity. Currently risk remains at current risk score. [19/03/2025 12:08:09 Rachael Turner] Confirmation received that 90% do not have access. Risk increased to 5x3:15 High Risk. [26/02/2025 13:04:37 Rachael Turner] Risk presented at RRC&C 26/02/25, need confirm whether 90% or more do not have access to diabetic nurse, if this is the case risk will be increased to 5x3. [05/02/2025 09:34:13 Rachael Turner] Risk reviewed. Risk description, controls and risk reduction plan updated to reflect current position. Due to ongoing depleted workforce risk to be presented at Risk Confirm and Challenge in February for an increase in score to 5x3:15 High Risk. [28/01/2025 09:44:14 Rachael Turner] Due to current position of depleted workforce risk to be reviewed for increase in risk score. Meeting booked for 31/01/25 to review risk, following this risk to be agreed at CBU governance to then be presented at Risk Confirm and Challenge in February to validate increase in score. [09/01/2025 12:44:47 Rachael Turner] Risk currently remains unchanged. No change to risk score. [09/10/2024 12:14:17 Rachael Turner] This risk remains ongoing. This has been escalated to the Quad in relation for maternity cover.	2	05/07/2025		13/09/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	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	As a result of consolidating the acute stroke services at one site without appropriate stroke therapy staffing & bed base, many stroke inpatients reside outside the stroke unit as outliers and do not receiving the adequate level of therapy input in line with guidelines and patient-centred care, the effect is increased risk of mortality and long term disability, as well as low staff morale and poor staff retention. There is a risk of an increase of delays to patient care, causing harm and reduced functional outcomes/recovery for stroke patients. Current mitigations mean patients on the Stroke Unit may also receive less therapy input in an attempt to deliver some input to outliers.	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. Cohort some outlier	SSNAP data Datix Complaints Staff retention & post vacancy	12/05/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1) Recruit stroke therapists [PT/OT/SALT/Dietician] consistent with current service demands in line with guidelines - Ruth Taylor - December 2025 2) A Consultant AHP post to provide leadership and stroke pathway oversight needed across the group [this has been in development since 2024 but yet to be recruited to.] - Ruth Taylor - December 2025 3) Expand Stroke bed base with funded therapy posts in line with Stroke Guidelines to reduce risk, reduce length of stay and deliver the 'centre of excellence' the population of Lincolnshire were promised - Ruth Taylor - December 2025 4) Refurbishment and workforce development – business case to be submitted - Rebecca Johnson - March 2026	[12/05/2025 13:29:49 Gemma Staples] I believe the Consultant AHP job has been out to advert and shortlisted, interviewing still to take place. [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	3	13/05/2024		12/08/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Manager	Handler	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: Improve patient safety, patient experience and deliver clinically effective care	5146	277	Physical or psychological harm	Upjohn, Emma	Marshall, Lisa	Estates Strategy Group, Health and Safety Group	13/04/2023	9	Family Health	Women's Health and Breast CBU	Gynaecology		As a result of insufficient scanning capacity, the termination of pregnancy service is currently unable to meet RCOG standards resulting in reduced patient experience and potential psychological harm. This is also a reputational risk to the trust due to non-compliance with standards.	Matron working with the ICB to look at improvements, Undertaking patient feedback requests and questionnaires to ascertain patient's voice to improve service. Home termination of pregnancy implemented, next steps to look at implementing tele medicine service which will potentially reduce the need for scanning of all patients, however reliant on patients knowing LMP and having a regular cycle.	Monitoring number of patients unable to receive service at the trust and have to be referred elsewhere.	30/04/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Full implementation of at home termination of pregnancy service including audit of services to understand if patients under 9 weeks can safely have a termination of pregnancy without a scan. Meeting with commissioners to ensure understanding of patient experience and how to improve service moving forward.	[30/04/2025 14:49:17 Nicola Cornish] Discussed at RRC&C meeting on 30/04. The referral to assessment wait is currently 3 weeks, against a standard of 5 days, with a further wait for subsequent treatment. As terminations within ULHT only done up to 12 weeks, this delay is significant as it decreases the options open to patients - prior to 10 weeks, TOP can be done in the patients own home but after this has to be done in hospital and may require surgical intervention. Working with ICB as they are currently having to commission additional service outside of ULH. The additional scan clinics that were previously being run on a weekend have now stopped due to cost pressure. Panel agreed increase in score, subject to the risk description being updated to reflect that scanning capacity is the cause of this risk. [15/04/2025 12:06:34 Nicola Cornish] Current wait at Boston is 4 weeks and at Lincoln is 2 weeks. Weekend additional lists are no longer possible due to the financial position but alternative ways of working eg telemedicine are being considered. There has been a marked increase in negative feedback received from patients regarding delays in appointments and the psychological harm with is causing. Propose to increase likelihood score to Extremely Likely which would make the overall rating High - list for RRC&C to approve. [25/10/2024 13:59:31 Nicola Cornish] This is ongoing. The RCOG standard is for patients to be seen within 7 days but currently patients are waiting 2-3 weeks for their first appointment. A deep dive is being done into the TOP service as it has become apparent that we aren't currently capturing activity correctly. [21/08/2024 10:26:08 Nicola Cornish] Additional weekend clinic capacity is being used for TOP scans where needed. [10/05/2024 13:38:09 Nicola Cornish] Risk reviewed, no change. Still constrained by sonography capacity, with an extra clinic being required at each site. [26/01/2024 15:14:51 Nicola Cornish] Still not meeting standards, extra clinics have	3	29/02/2024		30/07/2025
1d: Provide modern, clean and fit for purpose care settings	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	13/04/2025	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 2025 Wider organisational piece of work - Karen Bailey - December 2025	[13/04/2025 18:09:12 Gemma Staples] Still waiting estates to give us a quote or if the work is possible [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	14/07/2025

NHS
Lincolnshire Community and Hospitals NHS Group

Risk Report Appetite Statement 2025/2026

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*1 July 2025*
Item Number	*12.1.1*

Risk Appetite Statement

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*
Recommendations/ Decision Required	The Group Board is asked to: • Review the contents of the report. • Agree the updated risk appetite descriptions/levels against each of the strategic objectives. • Approve the content of the risk appetite statement for 2025/2026 in Appendix 1 with agreement to append to the Risk Management Policy.

How the report supports the delivery of the LCHG strategic aims & objectives	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings	*X*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	*X*
2b: Empower our people to continuously improve and innovate	*X*
2c: Nurture compassionate and diverse leadership	*X*
2d: Recognising our people through thanks and celebration	*X*
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*X*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	*X*
3c: Enhance our digital, research & innovation capability	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	*X*

Executive Summary

The setting of Risk Appetite is a key tool in communicating the Group Board's assessment of the nature and extent of the principal risks that the Group is exposed to and is willing to take to achieve its strategic objectives.

The Group has developed its risk appetite in an iterative manner with collaboration of key stakeholders including the Board, Committees, specialist risk functions and external risk support which will enable future iterations of the risk appetite easier to embed over time.

As part of the Board Development programme being undertaken by NHS Providers, the risk appetite against the revised LCHG strategic objectives for 2025/26 have been agreed in principle following a workshop held in March 2025. Following a number of meetings with both the Executive and the Non-Executive leads for each of the sub-committees of the Group Board, supported by a risk deep dive for those the committees that requested them, the following report outlines to updated risk appetite statements aligned to the strategic objectives.

1.0 Introduction

1.1 Risk appetite is the amount and type of risk that an organisation is willing to take to meet their strategic objectives. The Group Board determines its level of risk appetite each year which is then applied to the Board Assurance Framework and is utilised during decision making discussions as part of the Group's approach to managing risk.

1.2 A Group Board risk appetite development session was held in March 2025 to discuss and consider the Group's appetite for risk.

1.3 By defining a risk appetite statement, the Group Board is able to set the optimal position of its strategy and the upper tolerances for risk reporting and escalation as required. A risk appetite also informs all those responsible for managing risk at LCHG of the context to use when assessing how a risk should be evaluated. The risk appetite statement will form an appendix to the Risk Management Policy once approved.

1.4 The Risk Appetite will be reviewed annually moving forward by the Group Board.

2.0 Changes across the Group

2.1 From April 2024 United Lincolnshire Teaching Hospitals NHS Trust (ULTH) came together as a Group with Lincolnshire Community Health Services NHS

Trust (LCHS), this enabled us to review and align risk management across the Group with the development of a Group Risk Management Policy.

2.2 As this was the first year of working as a Group, a risk appetite was not developed to allow the two organisations to come together, review systems and processes and work towards an agreed set of Group strategic objectives which came to fruition in April 2025.

3.0 Risk Appetite Levels and Descriptions

3.1 Risk appetite can apply to a wide variety of risks and opportunities and within some appetite domains, the Group Board risk appetite sits across several appetite levels (e.g. Finance, Regulatory, Safety) and individual risks or opportunities should be reviewed individually.

3.2 Executive and Non-Executive Directors have oversight of the Group Board and its sub-committees. The Executive and Non-Executive Directors provide direction and challenge on risks, ensuring any deviation from the Group's appetite for risk is appropriate and/or highlighted where applicable.

3.3 The risk appetite is used when reviewing the Risk Registers to ensure that the Group is managing, accepting, and holding risks in line with the Group Board's risk appetite. The risk appetite is used to inform risk management training and guidance (e.g. the types of risk the Group is prepared to accept and those which may need greater levels of control and assurance).

3.4 The Risk Appetite statement for 2025/26 can be found in **Appendix 1**. It is proposed that the following risk appetite levels and descriptions are utilised across the Group for this financial year:

Hungry	•This would mean we are willing to take risks such as being innovative or using new technologies
Open	•Open is when we are willing to consider all potential options and recognises that there will be risk exposure
Cautious	•Preference of cautious is to always be safe but we accept there may be some risk exposure
Minimal	•Minimal is when we will accept the safest options only
Averse	•We will avoid all risk exposure and cease activity

4.0 Applying Risk Appetite

4.1 It is now essential that the Group considers the approach to embed risk appetite to ensure that it is used as part of the day-today planning and management across all the Corporate Directorates and Care Groups. As both LCHS and ULTH come together across the Group it is intended that the approach and the use of risk appetite will mature over time.

4.2 A robust risk management training package has now been developed which will be rolled out during this financial year and it is anticipated that this will strengthen the current provision for risk management across the Group and support the ability to embed risk appetite.

4.3 The refreshed LCHG Board Assurance Framework (BAF) guides the agenda setting for the Board and its Committees and in turn, is used as a framework for the committees to report assurance and / or escalate gaps in assurance in respect of the delivery of the Group's strategic aims and objectives.

5.0 Conclusion and Recommendations

5.1 The Group Board is asked to:

- Review the contents of the report.
- Agree the updated risk appetite descriptions/levels against each of the strategic objectives.
- Approve the content of the risk appetite statement for 2025/2026 in Appendix 1 with agreement to append to the Risk Management Policy.

Appendix 1

Risk Appetite Statement 2025/26

Introduction:

LCHG recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, LCHG will not accept risks that materially impact on patient safety. However, LCHG has an appetite to take considered risks in terms of their impact on the Group and its reputation. LCHG has the utmost appetite for innovation that will challenge current working practices where positive improvements can be anticipated, acknowledging the limits within regulation. The Group has adapted definitions for Risk Appetite and Risk Tolerance for the 'Orange Book – Risk Appetite guidance note August 2021.

Definitions:

'Risk appetite' is the level of risk within which LCHG aims to operate, informed by the Group's strategic objectives while ensuring we provide safe and effective patient outcomes.

'Risk Tolerance' is the level of risk within which LCHG is willing to operate, given current constraints.

Risk Appetite and Tolerance Levels:

Table 1 shows the risk appetite levels agreed by the Group Board, with the associated upper risk tolerance levels.

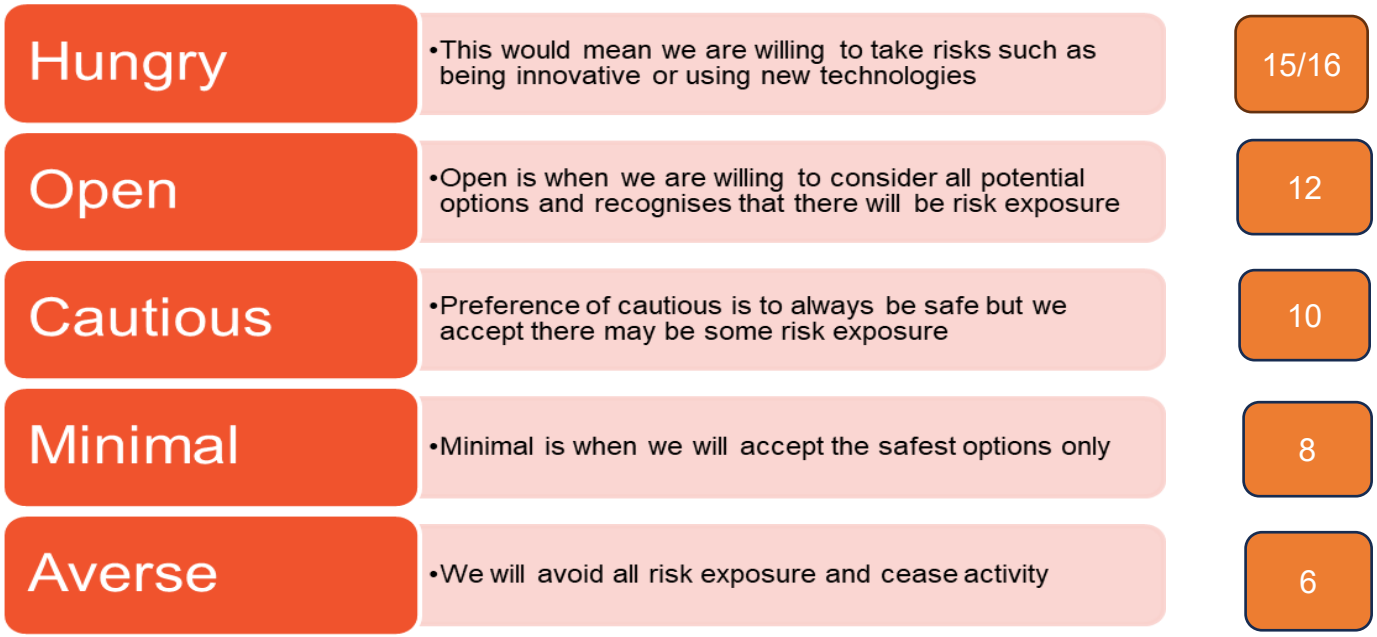

Table 2 details each strategic objective, along with associated risk appetite level and risk appetite statement. The upper tolerance level shown represents the maximum risk tolerance for each objective and provides guidance for risk owners to use in managing their risks.

Strategic Objective	Risk Appetite Level	Risk Statement	Upper Tolerance Level
1a (i) Patient Safety	**Cautious**	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny.	**10**
1a (ii) Patient Experience	**Open**	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients	**12**

		resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny.	
1a (iii) Clinically Effective Care	**Open**	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny.	**12**
1b	**Open / Cautious**	If we do not improve the efficiency and effectiveness of our services then we will not improve **access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes, and increased risk of clinical harm.	**10-12**
1c	**Open**	If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not return to **financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients	**12**
1d	**Open**	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny.	**12**
2a	**Open**	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable, less efficient services and the inability to attract and retain staff.	**12**
2b	**Hungry**	If we do not **empower our people to continuously improve and innovate**, they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience.	**15-16**
2c	**Open**	If we do not nurture **compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement.	**12**
2d	**Hungry**	If we do not continue to **recognise people through thanks and celebration**, then we will be unable to attract staff of the required calibre and experience resulting in services becoming unsustainable / fragile.	**15-16**

3a	**Open**	If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience.	**12**
3b	**Hungry**	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners, then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes.	**15-16**
3c	**Hungry**	If we do not enhance our **digital, research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale.	**15-16**
3d	**Open**	If we do not drive forward our Green Plan, we will be unable to effectively transform key clinical pathways and reduce our **carbon footprint** resulting in services becoming unsustainable.	**12**

Risk Appetite Management:

Below Appetite - Risks which have a residual risk score below an agreed risk tolerance are deemed to be being actively managed. If the risk remains within tolerance for six months, the risk should be subject to review and if satisfied that the scoring reflects the control environment and assurances remain positive then the risk should be considered for closure, via the normal governance processes, giving a clear rationale in the closing comment box.

Exceeding Appetite - Where a risk exceeds the Group's agreed risk tolerance, an action plan should be developed that mitigates the residual risk down to the agreed tolerance level. Until the residual risk score meets the agreed risk tolerance it requires ongoing monitoring and reporting. Where a risk exceeds its risk tolerance and has done so for more than six months a deep dive review of the risk and its control environment should be undertaken to ensure that all appropriate mitigation actions have been put in place. Deep dives should be undertaken every six months until such times as the risk reduces to the agreed risk tolerance. All risks that exceed risk tolerance should be reported and discussed with line management with onward reporting to the relevant Committee's of the Group Board as per the Risk Management Policy.

NHS
Lincolnshire Community and Hospitals NHS Group

Group Board Assurance Framework (BAF)

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*1 July 2025*
Item Number	*12.2*

Group Board Assurance Framework (BAF)

Accountable Director	*Jayne Warner, Group Director of Corporate Affairs*
Presented by	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations/ Decision Required	*The Group Board is asked to:* • *note progress with the development of the new group BAF;* • *note plans to further refine the group BAF over the coming months with continued input from lead executives and review and challenge from the relevant board committees;* • *agree the need for any additional action or assurance at this stage*

How the report supports the delivery of the LCHG strategic aims & objectives	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings	*X*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	*X*
2b: Empower our people to continuously improve and innovate	*X*
2c: Nurture compassionate and diverse leadership	*X*
2d: Recognising our people through thanks and celebration	*X*
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*X*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	*X*
3c: Enhance our digital, research & innovation capability	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	*X*

Executive Summary

Background & Introduction

An effective BAF should guide the agenda setting for a board and its committees and, in turn, should be used as the framework for the board committees to report assurance and / or escalate gaps in assurance to the board in respect of delivery of the group's strategic aims & objectives.

In order to reflect the move to group and to provide a more high-level and concise view of the risks to the achievement of the group's strategic aims & objectives and, in turn, the controls, sources of assurance and any gaps, the LCHG Board had agreed in January 2025 to the introduction of a revised BAF format.

Work to further refine the new style BAF – including the addition of clear timescales and leads for agreed actions – and embed its use within the board and committee cycle will continue over the coming months. Each of the board committees, in turn, will continue to review, challenge and seek assurance in respect of the areas of the BAF for which they have oversight with escalation, as required, to the Group Board.

Work is also underway as a priority to align the underpinning risks on the ULTH and LCHS risk registers to the relevant strategic risks within the BAF.

Summary of the Report

This report provides the second iteration of the BAF in the agreed new format.

BAF entries have been populated with reference to the previous LCHG BAF and with input from relevant executive directors. Some entries continue to be more developed than others recognising the early stage of the process, and all entries have been reviewed by the relevant board committees throughout May and June with the exception of the Audit Committee. The BAF will be received by the Audit Committee during July 2025.

Group Board Action Required

The Group Board is asked to:

- note progress with the development of the new group BAF;
- note plans to further refine the BAF over the coming months (including the addition of clear timescales and leads for all agreed actions) with continued input from lead executives and review and challenge from the relevant board committees;
- agree the need for any additional actions or assurances at this stage.

LincoInshire Community & Hospitals NHS Group (LCHG)

Group Board Assurance Framework (BAF)

As at June 2025

The LCHG BAF

Background & Introduction

An effective BAF should guide the agenda setting for a board and its committees and, in turn, should be used as the framework for the committees to report assurance and / or escalate gaps in assurance to the board in respect of delivery of the group's strategic aims & objectives.

In order to reflect the move to group and to provide a more high-level and concise view of the risks to the achievement of the group's strategic aims & objectives, the LCHG Group Board has agreed to the introduction of a revised BAF format. This report provides the first iteration. Work to further refine the new style BAF and embed its use within the board and committee cycle will continue over the coming months. Each of the board committees, in turn, will continue to review, challenge and seek assurance in respect of the areas of the BAF for which they have oversight.

Scoring the BAF

Risk Scores

The scoring methodology for BAF risks reflect the group's existing risk scoring matrix (as shown in Table 1 below) calculating the impact / severity of the identified risk should it occur by the likelihood of the risk occurring.

Table 1:

	Impact / Severity score & descriptor (with examples)				
Risk type	**1 Minimal**	**2 Noticeable**	**3 Moderate**	**4 Severe**	**5 Extreme**
Physical or psychological harm	Low level of temporary harm (no clinical attention required) affecting individual patients, staff or visitors	Relatively low level of harm (requiring first aid or psychological support) affecting multiple patients, staff or visitors	Significant, temporary harm (requiring clinical treatment but expected to make a full recovery) affecting one or more patients, staff or visitors	Significant long-term or permanent harm affecting individual patients, staff or visitors	Significant long-term or permanent harm affecting multiple patients, staff or visitors
Reputation	Small number of individual concerns raised	Small number of individual complaints raised	Multiple complaints received; negative local media / social media attention	Direct intervention from a regulator; serious complaint from one or more partner organisation; sustained negative national media / social media attention	Fundamental loss of confidence amongst the public, partner organisations and regulators
Service disruption	Manageable, temporary disruption to peripheral aspects of service provision affecting one or more service	Manageable, prolonged disruption to essential aspects of service provision reducing the efficiency & effectiveness of one or more service	Temporary, unplanned service closure affecting one or more service or significant disruption to efficiency & effectiveness across multiple services	Extended, unplanned service closure affecting one or more service; prolonged disruption to services across multiple services	Indefinite, unplanned general hospital or site closure
Regulatory compliance	Technical non-compliance with reasonable justification; no regulator attention	Recommendations for improvement for one or more service	Improvement / warning notice for one or more service; recommendation for independent review; legal action for regulatory / contract breach	Special measures; prohibition notice for one or more service; prosecution	Suspension of CQC registration; Parliamentary intervention
Finances	Some adverse financial impact (unplanned cost / reduced income / loss) but not sufficient to affect the ability of the service / department to operate within its annual budget	Noticeable adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more services / departments to operate within their annual budget	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more business units to operate within their annual budget	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of the organisation to achieve its annual financial control total	Significant aggregated financial impact (unplanned cost / reduced income / loss) affecting the long-term financial sustainability of the organisation

Likelihood score & descriptor (with examples)				
1 Extremely Unlikely	2 Quite Unlikely	3 Reasonably Likely	4 Quite Likely	5 Extremely Likely
Unlikely to happen except in rare circumstances Less than 10% chance	Unlikely to happen except in specific circumstances Between 10-30% chance	Likely to happen in a significant number of circumstances Between 31-70% chance	Likely to happen in the majority of circumstances Between 71-90% chance	Almost certain to happen Greater than 90% chance

Risk Scoring Matrix						
Impact / Severity	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	2	3	4	5
		Likelihood				

Risk Rating	Very Low (1 – 3)	Low (4 – 6)	Moderate (8 – 12)	High (15 – 16)	Very High (20 – 25)

Risk Appetite

How much risk is the Trust prepared to accept for each level of appetite?

Table 2 below provides the group's risk appetite statement and tolerance levels.

Hungry	• This would mean we are willing to take risks such as being innovative or using new technologies	15/16
Open	• Open is when we are willing to consider all potential options and recognises that there will be risk exposure	12
Cautious	• Preference of cautious is to always be safe but we accept there may be some risk exposure	10
Minimal	• Minimal is when we will accept the safest options only	8
Averse	• We will avoid all risk exposure and cease activity	6

Assurance Rating

For each strategic risk, the BAF identifies a number of controls (the actions that are already being taken to manage the risk) and outlines the sources of assurance against these (how it can be determined that the controls are working) and any gaps. For each strategic risk an overall assurance rating is provided using the assurance level definitions set out in Table 3 below. This is intended to assist the LCHG Group Board to assess the level of confidence it can have that appropriate controls are in place and that they are working effectively, that any material gaps in control have been identified and that clear actions, leads and timescales have been agreed to address them.

Table 3:

Assurance Rating Key	
Strength	**Description**
Red	**Effective controls are not in place or are insufficient to manage the risk and / or appropriate assurances are not available to the board**
Amber	**Effective controls are mostly in place and actions have been agreed to implement the remaining controls and / or assurances are uncertain or possibly insufficient**
Green	**Effective controls are definitely in place and the board is satisfied that appropriate assurances are in place**

Action Plan Progress: RAG Rating

Progress with delivery of actions to address gaps in controls and / or assurances will be rated in accordance with the matrix shown in Table 4 below.

Table 4:

Action Plan Progress RAG Rating	
Blue	**Completed & embedded and added to controls or assurances**
Green	**Completed & ongoing and / or not yet fully embedded**
Amber	**In progress & on track**
Red	**Not yet completed / significantly behind agreed timescales**

Group BAF Overview: Strategic Risks

Strategic Aim	Strategic Objective	Strategic Risk
Patients: Better Care – Timely, affordable, high quality care in the right place	1a: Improve patient safety, patient experience and deliver clinically effective care	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny
	1b: Reduce waiting times for our patients	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm
	1c: Improve productivity and deliver financial sustainability	If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients
	1d: Provide modern, clean and fit for purpose care settings	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny
People: Better Opportunities – Develop, empower and retain great people	2a: Enable our people to fulfil their potential through training, development and education	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable, less efficient services and the inability to attract and retain staff
	2b: Empower our people to continuously improve and innovate	If we do not **empower our people to continuously improve and innovate** they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience
	2c: Nurture compassionate and diverse leadership	If we do not **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement
	2d: Recognising our people through thanks and celebration	If we do not continue to **recognise our people through thanks and celebration** then we will be unable to attract and retain staff of the required caliber and experience resulting in services becoming unsustainable / fragile
Population: Better Health – Improve population health	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience
	3b: Move from prescription to prevention, through a population health management & health inequalities approach	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes
	3c: Enhance our digital, research and innovation capability	If we do not **enhance our digital, research and innovation** capability then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale
	3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable

Group BAF: Position Overview as at 24 June 2025

Strategic Aim	Strategic Objective	Strategic Risk	Executive Lead(s)	Board Committee Oversight	Current Risk Score (as at June 2025)	Target Risk Score (March 2026)	Assurance Rating (as at June 2025)	Target Assurance Rating (March 2026)
Patients: Better Care – Timely affordable, high quality care in the right place	1a (i): **Improve patient safety**, patient experience and deliver clinically effective care	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny	Group Chief Nursing Officer / Group Chief Medical Officer	Quality Committee	**8 (Moderate)**	**3 (Very Low)**	**Amber**	**Green**
	1a (ii): **Improve** patient safety, **patient experience** and deliver clinically effective care				**9 (Moderate)**	**4 (Low)**	**Amber**	**Green**
	1a (iii): Improve patient safety, patient experience and **deliver clinically effective care**				**8 (Moderate)**	**3 (Very Low)**	**Amber**	**Green**
	1b (i): Reduce waiting times for our patients **(Unplanned Care)**	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm	Group Chief Operating Officer / Group Chief Integration Officer	Finance & Performance Committee	**15 (High)**	**10 (Moderate)**	**Amber**	**Green**
	1b (ii): Reduce waiting times for our patients **(Planned Care)**				**15 (High)**	**10 (Moderate)**	**Amber**	**Green**
	1c: Improve productivity and deliver financial sustainability	If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients	Group Chief Financial Officer	Finance & Performance Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	1d: Provide modern, clean and fit for purpose care settings	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny	Group Director of Estates & Facilities	Finance & Performance Committee	**20 (Very High)**	**16 (High)**	**Red**	**Amber**

People: Better Opportunities – Develop, empower and retain great people	2a: Enable our people to fulfil their potential through training, development and education	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable harm, less efficient services and the inability to attract and retain staff	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Amber**	**Green**
	2b: Empower our people to continuously improve and innovate	If we do not **empower our people to continuously improve and innovate** they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Amber**	**Green**
	2c: Nurture compassionate and diverse leadership	If we do no **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Amber**	**Green**
	2d: Recognising our people through thanks and celebration	If we do not continue to **recognise our people through thanks and celebration** then we will be unable to attract and retain staff of the required caliber and experience resulting in services becoming unsustainable / fragile	Group Chief People Officer	People Committee	**6 (Low)**	**3 (Very Low)**	**Amber**	**Green**
Population: Better Health – Improve population health	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	3b: Move from prescription to prevention, through a population health management & health inequalities approach	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving**	Group Chief Integration Officer	Integration Committee	**9 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**

		population health resulting in less equitable access to services and poorer clinical outcomes						
	3c. Enhance our digital, research and innovation capability	If we do not **enhance our digital, research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (i): **Improve patient safety**, patient experience and deliver clinically effective care
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

8 (Moderate)

⇔

Last Review Date:	March 2025
Lead Executive:	Group Chief Nurse / Group Chief Medical Officer
Committee Oversight:	Quality Committee
Risk Appetite:	Minimal

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	2	8 (Moderate)	Amber
Target	Mar-26	3	1	3 (Very Low)	Green

Assurance Rating & Movement since last review:

Amber

⇔

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Quality & safety priorities and KPIs agreed
2	Safety culture approach established, Patient Safety Partners appointed and human factors guidance & training in place.
3	Quality governance teams & structures, policies and processes (including robust processes to identify risks and issues) in place and refined to reflect the move to group
4	PSIRF & learning from incidents processes well embedded
5	Strong focus on maternity & neonatal safety reported through MNOG
6	Improvement plans in place to address identified risks e.g. management & use of medical devices, medicines safety, wound care management, effective practice & harm free care
7	Ward / service accreditation process in place
8	IPC team and governance framework in place across the group
9	Safeguarding team and governance framework in place across the group

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Quality & safety priorities and KPIs being refreshed
2	Safety culture not yet fully embedded across all areas of the group
3	Inconsistency of some policies, procedures & guidelines across the group
4	'Just Culture principles not yet fully embedded across all areas of the group
5	Children & Young People Oversight Group to revert to reporting to Quality Committee for continued oversight of improvements within paediatric services
6	• Medicines safety across the group remains a risk although oversight is improving • There has been an increase in category 3 & 4 pressure ulcers in community services
7	Ward / service accreditation programme not fully embedded in community
8	NHSE and other external reviews of the group's IPC arrangements have identified gaps
9	Low uptake of mandatory safeguarding training by operational teams

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of quality & safety agenda and key risks by the Quality Committee and reporting sub-groups (e.g. Patient Safety Group, Maternity & Neonatal Oversight Group, Safeguarding & Vulnerabilities Group), with escalation to the Group Board as required
2	Reporting on quality & safety KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	QIAs reviewed by care groups and executives with Quality Committee oversight
4	Learning from incidents reported to the Patient Safety Group and disseminated across the group
5	Incident themes & trends monitored through the Patient Safety Group
6	Delivery of quality & safety KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
7	Local level and Group Board Maternity & Neonatal Safety Champions in place with reporting to the Group Board
8	Internal & external audit, external reviews and visits provide independent assurance of the robustness of the group's quality governance arrangements
9	Internal audit review of ULTH's management of medical devices undertaken during 2024 / 25 has provided 'reasonable assurance'. Medical Devices Group in place reporting to Patient Safety Group

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	QIAs not universally used across the group
4	The occurrence of repeated or same type incidents suggested processes for learning lessons are not yet fully embedded across the group
5	None identified
6	None identified
7	None identified
8	None identified
9	Medical Devices Group to be renamed to be representative of the LCH group

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Engagement Plan for further embedding the safety culture to be agreed	Group Chief Clinical Governance Officer	Deputy Chief Clinical Governance Officer	30 September 2025	Not yet started
2	Just Culture action plan covering engagement, training and new processes in place and ongoing	Group Chief Clinical Governance Officer / Group Chief People Officer	Deputy Directors – People and Clinical Governance	Ongoing	Underway
3	Aligned policy agreed on the development of policies, procedures & guidelines. Improvement trajectories to be agreed for bringing all out of date documents into compliance	Group Director of Corporate Affairs	Deputy Trust Secretary	TBC	TBC
4	Weekly pressure ulcer assurance meetings being held with the community nursing teams with safeguarding support. Improvement Trajectory agreed (10% reduction by the end of December 2025)	Group Chief Nurse	Deputy Chief Nurse	31 December 2025	Underway
5	Full review of pharmacy and medicines management to be undertaken across the group / system (key priority for incoming Chief Pharmacist)	Group Chief Medical Officer	Chief Pharmacist	30 September 2025	~~Not yet started~~Underway
6	Ward / service accreditation programme to be fully established in community	Group Chief Nurse	Deputy Chief Nurse	31 March 2026	Underway
7	Response to findings from NHSE inspection and other reviews of the group's infection control arrangements to be developed and implemented.	Group Chief Nurse	Deputy Chief Nurse	31 March 2026	Underway

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Underway
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Underway – some slippage in finalising and approval of the PMAF and IPR but aligned PRMs in place
3	Group level Medical Devices Group to be renamed to be representative of the LCH group	Group Chief Medical Officer	Deputy Medical Director	30 June 2025	Underway
4	Review of learning lessons mechanisms to be undertaken and a plan developed for a programme of learning lessons mechanisms across the group	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	31 December 2025 (plan)	Not yet started
5	Group QIA process to be embedded across the group underpinned by a training plan	Group Clinical Governance Officer	Head of PMO	30 September 2025	Underway

Related risks on Risk Register – ULTH

Trust	Datix ID	Score	Summary Risk Description
ULTH	4844	20	Pharmacy 7-day service
ULTH	4879	20	Recovery of planned care cancer pathways
ULTH	4947	20	Inability to meet NICE medicines reconciliation
ULTH	4997	20	Service configuration: Haematology
ULTH	5016	20	Patient flow through ED
ULTH	5100	20	Acute paediatric epilepsy pathway
ULTH	5101	20	Community paediatric epilepsy pathway
ULTH	5143	20	Removal of H block lift
ULTH	5200	20	Paediatric cardiology backlog
ULTH	5450	20	Gastroenterology consultant workforce

Related risks on Risk Register – LCHS

Trust	Datix ID	Score	Summary Risk description
LCHS	403	20	Children's SLT treatment delays

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (ii): **Improve** patient safety, **patient experience** and deliver clinically effective care
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

9 (Moderate)

⇔

Last Review Date:	March 2025
Lead Executive:	Group Chief Nurse / Group Chief Medical Officer
Committee Oversight:	Quality Committee
Risk Appetite:	Minimal

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	3	3	9 (Moderate)	Amber
Target	Mar-26	2	2	4 (Low)	Green

Assurance Rating & Movement since last review:

Amber

⇔

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Quality & safety and patient experience priorities and KPIs agreed
2	Patient Experience & Involvement Team in place
3	Established complaints & PALS teams
4	Group Complaints & PALS Policy agreed
5	Improvement Plans developed in response to national patient experience surveys
6	PLACE reviews completed and improvement plans developed

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Quality & safety and patient experience priorities and KPIs being refreshed
2	• Group approach to Patient Panels agreed and being implemented • There are currently workforce gaps in the Patient Experience Team
3	None identified
4	None identified
5	Lack of staff engagement has the potential to lead to a lack of timely implementation of improvement plans
6	PLACE improvement plan not yet delivered

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of patient experience and key risks by the Quality Committee and its reporting sub-group: the Patient Experience & Involvement Group, with escalation to the Group Board as required
2	Reporting on quality & safety and patient experience KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	Patient Stores are heard at the Group Board
4	Patient Experience data is gathered and improvements tracked through the Patient Experience & Involvement Group
5	Delivery of patient experience KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
6	Internal & external audit, patient surveys, PLACE reviews etc. provide independent assurance on the quality of the patient experience

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	None identified
4	Triangulation of patient experience data with other sources of information e.g. complaints, PALS etc. requires strengthening
5	None identified
6	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Agree patient experience metrics / KPIs that reflect the group priorities with oversight through the Patient Experience & Involvement Group to periodically assess that agreed actions are achieving the intended benefits and priorities	Group Chief Nurse	Head of Patient Experience	30 September 2025	Underway
2	Group approach to Patient Panels to be implemented from April 2025	Group Chief Nurse	Head of Patient Experience	1 April 2025	In Place
3	Ensure action plans from national patient experience surveys are SMART and translated to local action and establish a robust process / protocols for disseminating data to frontline teams	Group Chief Nurse	Head of Patient Experience	31 December 2025	Underway
4	Define and enforce timeframes for implementation of improvements identified during PLACE assessments	Group Chief Nurse	Head of Patient Experience	31 March 2026	Underway

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Underway – on track
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Underway – some slippage in finalising and approval of the PMAF and IPR but aligned PRMs in place

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (iii): Improve patient safety, patient experience and **deliver clinically effective care**
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

8 (Moderate)

Last Review Date:	March 2025
Lead Executive:	Group Chief Nurse / Group Chief Medical Officer
Committee Oversight:	Quality Committee
Risk Appetite:	Minimal

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	2	8 (Moderate)	Amber
Target	Mar-26	3	1	3 (Very Low)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

	Identified Controls *(What are we already doing to manage the risk?)*
1	Quality & safety and clinical effectiveness priorities and KPIs agreed
2	Established clinical audit team in place and clinical audit plan agreed
3	NICE Policy and process in place
4	Medical Examiner in post and learning from deaths process well established
5	Mortality review process in place and well established

	Gaps in Controls *(What are the gaps in control that are required to manage the risk)*
1	Quality & safety and clinical effectiveness KPIs being refreshed
2	Some specialty clinical audit / governance groups require strengthening
3	None identified
4	None identified
5	None identified

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of clinical effectiveness and key risks by the Quality Committee and its reporting sub-group: the Clinical Effectiveness Group, with escalation to the Group Board as required
2	Reporting on quality & safety and clinical effectiveness KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	Learning from deaths reported to the Clinical Effectiveness Group and disseminated across the group
4	There is oversight of delivery of the clinical audit programme through the Clinical Effectiveness Group with reporting to the Quality Committee as required
5	There is oversight of compliance with NICE guidance through the Clinical Effectiveness Group with escalation to the Quality Committee as required
6	Delivery of clinical effectiveness KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
7	Internal & external audit, external reviews and visits provide independent assurance

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	None identified
4	'Outlier' status has been received for some of the National audit projects
5	None identified
6	None identified
7	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	TBC				
2					
3					
4					

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Underway – on track
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Underway – some slippage in finalising and approval of the PMAF and IPR but aligned PRMs in place

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description
ULTH	4828	20	Manual prescribing risk
ULTH	4731	20	Reliance on paper medical records

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1b (i): Reduce waiting times for our patients **(Unplanned Care)**
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm

Current Risk Score & Movement since last review:

15 (High)

Last Review Date:	March 2025
Lead Executive:	Group Chief Operating Officer / Group Chief Integration Officer
Committee Oversight:	Finance & Performance Committee
Risk Appetite:	Open / Cautious

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	5	3	15 (High)	Amber
Target	Mar-26	5	2	10 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	High	High	High									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Daily internal capacity meetings in place to improve discharge and flow and troubleshoot operational issues at the front door
2	Daily ICB UEC calls occur to escalate issues across the system and provide support to unblock pressure areas with the aim of reducing bed blocking and delayed discharges
3	Group Discharge Board in place with a focus on discharge & flow, SAFER principles and criterial-led discharge
4	Unplanned Care Group established to drive delivery of agreed performance & improvements
5	System Unplanned Care Partnership Board in place to have oversight of system issues and challenges and to drive delivery of agreed improvements
6	OPEL escalation triggers and actions in place
7	Winter Plan (2025) in development ~~place~~
8	45 minute a~~A~~mbulance handover protocol agreed and enacted and delivered consistently

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	ED streaming allocation not aligned to presentation
2	Discharge across P0/1/2/3 requires improvement
3	Redesigned EPIC/NIC roles need support and embedding
4	Assessment chair ~~area~~ capacity not substantially funded
5	SDEC on both sites not large enough
6	Debate ~~Confusion~~ regarding 'send' to assessment areas remains ongoing ~~still exists~~
7	Not all specialty teams attend ED within 30 minutes of request in line with IP standards
8	None identified

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	OPEL triggers regularly used and activated
2	ED activity, flow and LoS regularly reviewed by site teams and issues escalated through the daily capacity meetings
3	Improvement trajectories in respect of ED performance and expectations agreed for all specialties
4	Suite of metrics in place to measure improvements and focus Care Group leadership teams on discharge target
5	ED performance monitored through the Unplanned Care Group and System Unplanned Care Partnership Board
6	Delivery of ED performance and improvements reviewed through the Care Group PRMs
7	Reporting on ED performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board as required
8	Sustained improvements seen across the UEC pathway: standard currently being delivered

Gaps in Assurance	
1	None identified
2	
3	
4	
5	
6	
7	
8	

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Work is ongoing internally to increase SDEC / assessment centres ~~utilisation~~utilisation and ensure appropriate use of SDEC pathways in support of ED	Group Chief Operating Officer	Group Deputy Chief Operating Officer	30 September 2025	Underway
2	Work is ongoing to address 'send' and IPR	Group Chief Operating Officer	Group Deputy Medical Director	Ongoing	Ongoing
3	Discharge task force being refreshed	Group Chief Operating Officer	Group Deputy Chief Nurse	30 April 2025	Complete
4	Escalation Policy & Full Capacity Protocol to be reviewed and aligned	Group Chief Operating Officer	Group Deputy Chief Operating Officer	31 July 2025	Underway

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	None identified				

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1b (ii): Reduce waiting times for our patients **(Planned Care)**
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm

Current Risk Score & Movement since last review:

15 (High)

Last Review Date:	March 2025
Lead Executive:	Group Chief Operating Officer / Group Chief Integration Officer
Committee Oversight:	Finance & Performance Committee
Risk Appetite:	Open / Cautious

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	5	3	15 (High)	Amber
Target	Mar-26	5	2	10 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	High	High	High									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Clinic template project initiated
2	Weekly PTL / activity meetings in place
3	Weekly 6/4/2 meetings held to support theatre utilization
4	Booking ~~Centre~~ 'protocol' being developed
5	Planned Care Group established to driver delivery of agreed planned care performance & improvements
6	Forecast performance in place and used to monitor delivery
7	List brokering commenced
8	

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Lack of standardised and centralised scheduling and booking
2	Inconsistent approach to validation / validation not comprehensive. Internal validation team recruited. National validation initiative commenced
3	Opportunities exist to maximise theatre productivity & utilisation - theatre timetable not refreshed
4	Gaps in job planned and delivered activity for admitted and non-admitted
5	Workforce gaps
6	Time to first appointment delivery is high risk for 2025 / 26
7	Delivery of cancer 62 day performance remains a risk
8	There is no shadow booking process in place

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	RTT and cancer improvement trajectories agreed for all specialties
2	Theatre dashboard in place and monitored through the Planned Care Group
3	RTT & cancer performance monitored through the Planned Care Group
4	Delivery of RTT and cancer performance and improvements reviewed through the Care Group PRMs
5	Reporting on RTT and cancer performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board, as required
6	Improved performance: sustained backlog reduction
7	Internal audit review of RTT pathways within ULTH during 2025 / 26 provided 'reasonable assurance)

Gaps in Assurance	
1	IPR is not comprehensive
2	Reports to committee and ELT require improvement
3	
4	
5	
6	
7	

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Maximise theatres & out-patient improvements (scheduling / booking / cancellations). EY commissioned to support elective productivity improvements. PWC commissioned to support scheduling / booking efficiencies ~~including introduction of Booking Centre~~	Group Chief Operating Officer	Deputy Group Chief Operating Officer	31 October 2025	Underway

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Diagnostic reporting tools in development	Group Chief Operating Officer	Deputy Group Chief Operating Officer	30 September 2025	Underway
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Underway – some slippage in finalising and approval of the PMAF and IPR but aligned PRMs in place

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description
ULTH	5447	20	Cancellation of elective lists due to theatre staffing

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1c: Improve productivity and deliver financial sustainability
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not manage costs effectively, optimise productivity and deliver our efficiency / cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unsustainable services for patients

Current Risk Score & Movement since last review:

12 (Moderate)

Last Review Date:	March 2025
Lead Executive:	Group Chief Financial Officer
Committee Oversight:	Finance & Performance Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	3	12 (Moderate)	Amber
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

	Identified Controls *(What are we already doing to manage the risk?)*
1	Finance teams & structures, policies & processes in place including Standing Financial Instructions and Scheme of Delegation
2	Financial planning & budget setting processes across the group harmonised and single budget holder manual developed and implemented
3	Single operational & financial plan, planned deficit and CIP / efficiency target for the group agreed
4	Processes in place for holding Care Groups / Corporate Directors to account for budgetary control & adherence, the delivery of financial plans & activity and efficiency / cost improvements
5	Productivity, Improvement & Transformation Group in place, reporting to the Group Leadership Team, to oversee delivery of the group's financial plan (including specific deep dive sessions as required)
6	Capital, Revenue & Investment Group in place, reporting to the Group Leadership Team, to oversee the development and delivery of the group's capital, revenue and investment plan (also introduced post-investment evaluation process)
7	Pay controls in place (VCP) to support delivery of the financial and workforce plan
8	Non-pay discretionary spend controls in place to reduce spend whilst transformational plans are developed (and reviewed/amendments proposed to Audit Committee in June)

	Gaps in Controls *(What are the gaps in control that are required to manage the risk)*
1	Current financial policies are up to date but some have yet to be aligned across the group
2	Financial literacy of the organization not fully developed
3	Finance Strategy for the group to be agreed
4	Forward assurance on efficiency delivery and activity position being developed
5	The delivery of workforce / headcount reduction, adherence to workforce controls (e.g. bank and agency spend) and activity levels are key risks.
6	Business Case development, review and approval process not yet fully harmonised
7	
8	

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of finance and key risks by the Finance & Performance Committee and reporting sub-groups with escalation to the Group Board as required
2	Reporting on finance KPIs to the Finance & Performance Committee and Group Board through the Integrated Performance Report (IPR)
3	Internal & external audit arrangements in place
4	Internal audit review of performance management and data quality within ULTH during 2024 / 25 provided 'reasonable assurance'
5	Assessment of 'grip and control' undertaken by external parties including through ICB and regulator challenge

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	Internal audit arrangements have been aligned across the group but work remains ongoing to develop a single report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability
4	Internal audit review of overseas and contracts within ULTH provided 'limited assurance'
5	

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Harmonise the remaining financial policies across the group	Group Chief Financial Officer	Deputy Director of Finance – Financial Services	31 December 2025	Underway – on track
2	Review, harmonise and strengthen the financial training offer and culture	Group Chief Financial Officer	Deputy Director of Finance - Strategy	30 June 2025	Underway – on track. First Finance roadshow training event held in February 2025. Budget holder refresher training held in February & March 2025 Ongoing training offer available within ESR.
3	Agree the Group Finance Strategy	Group Chief Financial Officer	Deputy Director of Finance - Strategy	~~30 June 2025~~ 31 October 2025	Underway – ~~on track~~Timescale delayed to allow increased engagement with care groups and Committees
4	Approve & implement the Group Performance Management & Accountability Framework (PMAF)	Group Chief Integration Officer	Deputy Director of Finance – Financial Management	30 June 2025	Underway – PMAF drafted FPAM content reviewed with DMD lead, proposed finance meeting being reviewed and triangulation of other metrics concluded

5	Deliver the financial plan and maximise CIP opportunities with a focus on key high impact areas Continue to explore and work up income generation opportunities	Group Chief Financial Officer	Care Groups / Corporate Directorates	31 March 2026	Underway
6	Complete the work to harmonise the business case development, review and approval process	Group Chief Financial Officer	Deputy Director of Finance – Financial Services	31 July 2025	Underway – ToR being finalized on investment process

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		**Executive Lead**	**Operational Lead**	**Due Date**	**Progress**
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Underway – clarity on reporting of efficiency (PITOF and PRMs) and activity (Planned and Unplanned Steering Groups), further work ongoing on other finance indicators~~on track~~
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Underway – some slippage in finalising and approval of the PMAF and IPR but aligned PRMs in place
3	Complete the work to develop a single internal audit report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability	Group Chief Financial Officer	Head of Internal Audit	31 August 2025	Underway – on track

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**
ULTH	4664	20	Exceeding the agency cap – temporary staff
ULTH	4665	20	Failure to meet 24 / 25 CIP
ULTH	4657	20	Compliance with subject access requests
ULTH	5020	20	Reliance on agency / locum UEC medical staff

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1d: Provide modern, clean and fit for purpose care settings
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

20 (Very High)

Last Review Date:	March 2025
Lead Executive:	Group Chief Estates & Facilities Officer
Committee Oversight:	Finance & Performance Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	5	4	20 (Very High)	Red
Target	Mar-26	5	3	15 (High)	Amber

Assurance Rating & Movement since last review:

Red

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Very High	Very High	Very High									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Red	Red	Red									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Estates & Facilities Management (EFM) leadership & professional structures in place (including Authorising Engineers (AEs), Authorised Persons (APs) and Competent Persons (CPs). The Director of Estates & Facilities is the 'Designated Person' for EFM for the group and this is now a board role
2	EFM governance structure and safety groups in place reflecting Health Technical Memorandums (HTMs), Health & Safety legislation and other statutory requirements
3	Estates Strategy, Green Plans and EFM Transformation & Improvement Plans in place
4	EFM policies, processes, work plans and risk assessments in place covering HTMs, Health & Safety legislation and other statutory requirements
5	Six-facet survey completed for ULTH in 2024: good level of understanding of the estates statutory compliance and critical infrastructure risks with clear ELT, Finance & Performance Committee and Group Board 'line of sight'
6	Decisions on EFM investment from the group's capital allocation are risk-based and prioritised based on the results from the six-facet survey and affordability
7	Alternative sources of capital continue to be explored wherever possible

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	There is currently a lack of EFM capacity due to the limited EFM resource within LCHS ~~(and termination of the shared service agreement with LPFT and support from NHSPS)~~ and some senior leadership and professional roles currently remain unfilled including AEs for LCHS. Work remains ongoing to bring together the Fire Safety, Health & Safety and Emergency Planning & Business Continuity Teams
2	A review of the EFM governance structure is underway to ensure alignment with the wider group governance arrangements. Safety groups are being expanded to cover the LCHS estate
3	Estates Strategy and Green Plans not yet aligned for group, reports to Integration Committee
4	Fire and health & safety policies have been aligned but work remains ongoing to align the remaining EFM policies & procedures
5	There are still some unknown / unquantified risks in respect of the LCHS premises – work underway to assess
6	The backlog maintenance programme for ULTH of £123~~180~~m remains a significant risk. The lack of space and the need to decompress the acute site also remains a key area of focus
7	Inability to address critical infrastructure risks with limited capital

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Increased levels of compliance with EFM statutory compliance requirements as demonstrated through internal audits, external condition surveys, AE audits etc.
2	External / independent review processes in place including AE annual audits and quarterly reviews across all HTMs (ULTH) with monitoring of improvement actions through the EFM Cabinet and reporting to the Finance & Performance Committee in the monthly EFM report
3	Premises Assurance Model (PAM) utilised annually to evaluate the effectiveness of premises performance against a set of common domains / SAQs with assurance and / or key risks reported to the Finance & Performance Committee and the Group Board. Comparison of the 2023/23 & 2023/24 PAM evaluation submissions for ULTH show a year on year on year improvement in compliance across most domains
4	Benchmarking of EFM performance is undertaken against local & national indicators and reported through the governance structure
5	Patient Led Assessment of the Care Environment (PLACE) assessments are undertaken with good levels of compliance in the areas assessed: privacy & dignity, cleanliness, food and general building maintenance and reporting to the Patient Experience & Involvement Group and Quality Committee
6	Oversight of EFM statutory compliance and key risks by the Finance & Performance Committee and relevant sub-groups (e.g. Health & Safety Committee, Infection Prevention & Control Committee, Water Safety Group) with escalation to the Group Board as required
7	Internal audit review of EFM areas provides independent assurance and / or escalation of risks. Internal audit review of the business continuity and emergency planning arrangements within ULTH during 2024 / 2025 provided 'reasonable assurance'

Gaps in Assurance	
1	EFM compliance dashboards not yet fully aligned
2	LCHS: AE audit programme for relevant HTMs not yet in place for LCHS premises ULTH: None identified~~Further AE audit on fire planned at ULTH to ascertain the level of improvement since the previous audit and the delivery of the improvement actions by the Fire Safety Team~~
3	• Comparison of the 2022/23 & 2023/24 PAM evaluation submissions for LCHS show a deterioration in compliance across the majority of domains although with good levels of compliance in the patient experience domain. The requirement for risk assessed, costed action plans for SAQs rated 'inadequate' or requiring 'moderate or minor improvements' was rated 'Inadequate' across all domains • Areas for focus from the PAM evaluation for both trusts, albeit to differing degrees, include policies, procedures & availability of documentation, risk assessment, maintenance, training & development and resilience, emergency & business continuity • The PAM evaluation process is not yet fully aligned across the group • There is no clear process for monitoring PAM improvement actions through the year
4	Reliability of LCHS Estates Returns Information Collection (ERIC) scores to be evaluated
5	Shortfalls in housekeeping staffing levels, due to difficulties in recruiting, have the potential to impact on PLACE scores
6	There is a need for further clarity on the elements of the EFM agenda to be reported to the Finance and Performance Committee and the Integration Committee
7	Internal audit review of planned and preventative estates maintenance within ULTH during 2024 /25 provided 'limited assurance'

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Appoint to directorate critical / professional roles as a priority and in line with vacancy controls process	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	Ongoing	Underway
2	Recruit to the AE roles for LCHS during Q1 2025/26	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	30 June 2025	Underway
3	Transfer preventative and reactive maintenance for LCHS from NHSPS to the ULTH EFM team from 1 April 2025	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	1 April 2025	Complete
4	Undertake a planned preventative maintenance (PPM) and asset register review across the group – to include the findings and response to the 2024 / 25 internal audit	Group Chief Estates & Facilities Officer	Group Chief Estates & Facilities Officer	1 April 2026	Brief & scope work currently being developed (Estimated cost: c£150k)
5	Complete the work to bring together the Fire Safety, Health & Safety and Emergency Planning & Business Continuity Teams	Group Chief Estates &	Group Chief Estates &	30 April 2025	Complete

		Facilities Officer	Facilities Officer		
6	Complete the review of EFM governance structure and associated assurance processes	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	30 September 2025	Underway
7	Once the EFM risks in respect of LCHS are clear following the AE audits, service mapping exercise, PAM, review of leases and licences etc, complete the work to align the Estates Strategy & Green Plans. Transformation & Improvement Plans for 2025/26 already in development – consider 3d	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	2 September 2025	Underway
8	Complete the work to align the EFM policies & procedures across the group	Group Chief Estates & Facilities Officer	Deputy Directors of Estates and Facilities	31 December 2025	Underway
9	Undertake an estates rationlisation review with a focus on decompressing the acute site and agile working – consider 3d	Group Chief Estates & Facilities Officer	Group Chief Estates & Facilities Officer	30 June 2025	External support to undertake the review being sourced at an estimated cost of £22.5k. Work to be progressed during 2025/26
10	Align and update the group business continuity plans to reflect the group infrastructure risks and challenges	Group Chief Estates & Facilities Officer	EPRR Lead	31 December 2025	Underway
11	Continue to explore alternative sources of capital funding	Group Chief Estates & Facilities Officer	Group Chief Estates & Facilities Officer	Ongoing	Ongoing

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		**Executive Lead**	**Operational Lead**	**Due Date**	**Progress**
1	Align the EFM compliance dashboards across the group as part of the review and strengthening of the EFM governance arrangements	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	30 September 2025	Underway
2	Undertake full AE audit for all LCHS properties and regular annual programme of audits and quarterly reviews to be put in place thereafter	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities / AEs	30 September 2025	Underway
~~3~~	~~Undertake follow-up AE fire audit at ULTH~~	~~Group Chief Estates & Facilities Officer~~	~~TBC~~	~~TBC~~	~~TBC~~
4	Align the process for the completion and submission of the PAM and strengthen the process for the delivery and oversight of agreed improvement actions	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	31 July 2025	Underway
5	As part of the review of the board committee terms of reference and work plans, ensure there is greater clarity on the elements of the EFM agenda for which the Finance & Performance Committee has oversight and which come under the remit of the Integration Committee	Group Chief Estates & Facilities	Group Director of Corporate Affairs	6 May 2025	Complete: Board Committee Work Plans &

		Officer			'Assurance Map' provide clarity

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2a: Enable our people to fulfil their potential through training, development and education
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable harm, less efficient services and the inability to attract and retain staff

Current Risk Score & Movement since last review:

Moderate (9)

Last Review Date:	March 2025
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	3	3	Moderate (9)	Amber
Target	Mar-26	3	2	Low (6)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Education, Learning & Organisational Development Team working with Care Groups to improve statutory and mandatory training compliance to 90% by 31 March 2026, with a focus on areas where compliance is <50%
2	Education, Learning & Organisational Development Team working with Care Groups to ensure that staff have the correct training and support available to fulfil their roles as leaders through upskilling, strengthening and awareness of responsibilities through active engagement with leadership and development training
3	Further opportunities being developed for improving productivity and integration through a 'grow our own' approach and use of apprenticeship levy being maximised
4	Education Oversight Group in place
5	Processes in place for holding Care Groups/Corporate Directors to account for the delivery of people KPIs and improvements to support ownership at local level
6	Lincolnshire (system) People Plan in place. Continued focus on ensuring that the People Promise themes are embedded across the group in line with the wider Lincolnshire System People Plan objectives

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Divisional/Clinical Care Group Leadership Teams awareness of areas of non-compliance to support local improvement interventions
2	Divisional/Clinical Care Group uptake of leadership and development training
3	Limited oversight of apprenticeship levy use at Clinical Care Group level
4	There is no Education Oversight Group KPI dashboard in place and assurance that Education Oversight Group agenda is in line with assurance required within People Committee, and that KPI Dashboard is in place to monitor progress against key deliverables
5	FPAM monthly reports are not aligned to the refreshed PRM packs. Divisional Leadership Teams not able to / unclear on how to access the standard reports to support oversight
6	None identified

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of the people agenda and key risks by the People Committee and reporting sub-groups with escalation to the group board as required
2	Reporting on People KPIs to the People Committee and Group Board through the Integrated Performance Report (IPR). Mandatory training compliance continues to improve
3	Reporting on medical and non-medical education and medical revalidation to the People Committee
4	Reporting on safer staffing (including training and knowledge gaps) to the People Committee
5	Monthly FPAM and PRM meetings take place which review KPIs against targets, and this is reported at overall Trust level at People Committee within the scorecard
6	Internal audit review of the people agenda provides independent assurance and / or escalation of risks. Internal audit review of mandatory training within ULTH undertaken during 2024 / 25 provided 'reasonable assurance'
7	National and regional benchmarking data considered through the People Committee and reporting sub-groups
8	External oversight and assurance in respect of people performance is undertaken through the Lincolnshire People Board/Workforce Committee

Gaps in Assurance	
1	Sub-Groups ensuring that agenda items and upward reports are in line with People Committee annual plan
2	IPR metrics currently being confirmed – have been reviewed within People Directorate and shared, with alignment across LCHS and ULTH in line with Workforce Plans for 2025/26.
3	None identified
4	None identified
5	Alignment to PRM Packs required to ensure consistency of data and reporting by exception
6	Limited oversight of group-wide audit schedule where there is an impact on people. Audit of LCHS areas unclear
7	Oversight of benchmarking data needs to be considered and consistent across all sub-groups – currently in place in line with agenda items and discussion points within Workforce Strategy Group
8	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	People Systems Team are undertaking a review of ESR hierarchy structures to ensure reporting lines are validated / accurate to support leaders to access statutory / mandatory training and appraisal compliance, and support accurate recording of appraisals. Additionally, monitoring of workforce metrics / compliance rates through monthly performance meetings such as FPAM and PRM	Group Chief People Officer	Head of Workforce Planning & Reporting / People Systems Manager	30 June 2025	~~Completed – continues to be fully embedded~~ ~~Underway – on track~~
2	Monitoring uptake of leadership and development training through monthly performance meetings such as FPAM, with a focus on further supporting the areas with the least uptake to release staff to be able to attend and the identification of trends and any correlation between HR / ER cases, sickness and turnover	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track
3	Development of Education Oversight Group KPI Dashboard which reports monthly into the Education Oversight Group and upwardly into People Committee to ensure that there is oversight of apprenticeship levy use across the Group and our position against the public sector target	Group Chief People Officer	Education & Learning Managers	May 2025	~~Completed – continues to be fully embedded~~ ~~Underway – on track~~
4	Standardised upward report from Education Oversight Group into People Committee in place, and the current development of Education Oversight Group KPI Dashboard is ongoing	Group Chief People Officer	Education & Learning Managers	31 May 2025	~~Completed – continues to be fully embedded~~ ~~Underway – on track~~
5	Review of FPAM Packs within the acute Trust (People Section) underway to bring in line with PRM format and report by exception. This will include updated training for Divisional Head of HR and Leadership Teams on how to access core People KPI Reports to maintain regular oversight	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	~~Completed – continues to be fully embedded~~ ~~Underway – on track~~
6	People Promise work streams embedded within the Reward, Recognition & Engagement Manager role within the Education,	Group Chief	Education &	31 March 2026	Underway – on

	Learning & Organisational Development Team to maintain oversight of People Promise themes	People Officer	Learning Manager		track

	Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*	Executive Lead	Operational Lead	Due Date	Progress
1	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee workplan and ensuring that each sub-group is aware of its reporting objectives in year.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	Underway – on track
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025/26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief People Officer	Group Deputy Director of People / Head of Workforce Planning & Reporting	30 June 2025	Completed – continues to be fully embedded ~~Underway – on track~~
3	Regular report into Workforce Strategy Group and upward report into People Committee – to be reviewed and refreshed in line with 2025/26 objectives (as required)	Group Chief Medical Officer / Group Chief People Officer	Business Manager to the Group Chief Medical Officer / Head of Workforce Planning & Reporting	30 September 2025	Underway – on track~~Not yet started~~
4	Regular report into Workforce Strategy Group and upward report into People Committee – to be reviewed and refreshed in line with 2025/26 objectives (as required)	Group Chief Nurse / Group Chief People Officer	Assistant Director of Nursing / Head of Workforce Planning & Reporting	30 September 2025	Underway – on track~~Not yet started~~
5	Review of standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms	Group Chief People Officer	Group Deputy Director of People / Head of Workforce Planning & Reporting	30 September 2025	Underway – on track~~Not yet started~~
6	Audit schedule to be requested and shared with key plan in place to manage audit cycles which impact People (close working between Corporate Governance and People Directorate required to deliver)	Group Chief People Officer	Head of Workforce Planning & Reporting	31 May 2025	Completed – continues to be fully embedded ~~Not yet started~~
7	All sub-groups to incorporate benchmarking (using as a minimum Model Hospital data) as regular agenda items in 2025/26	Group Chief People Officer	Group Deputy Director of People	30 June 2025	Completed – continues to be fully embedded ~~Not yet started~~
8	Develop and embed standard reporting mechanisms into Lincolnshire People Board / Workforce Committee	Group Chief People Officer	Deputy Group Chief People Officer	30 September 2025	Underway – on track~~Not yet started~~

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description
ULTH	4996	20	Consultant workforce capacity: Haematology

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2b: Empower our people to continuously improve and innovate
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **empower our people to continuously improve and innovate** they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience

Current Risk Score & Movement since last review:

Moderate (9)

Last Review Date:	March 2025
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	3	3	Moderate (9)	Amber
Target	Mar-26	3	2	Low (6)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Education, learning and development programmes and KPIs in place
2	Engagement 'Tube Map' – 'Better Together' Programme in place and ongoing including OD support
3	Improved job planning compliance rate to 95% with supporting evidence in place, and a move towards a prospective cycle.
4	Improved Medical & Dental middle tier vacancy rate with a focus on stabilisation and succession planning through fully embedding a revised 'Plan for Every Post' process
5	Quality Improvement (QI) strategy/Quality Management System (QMS) being developed as a key enabler to support innovation/delivery of the group improvement/transformation agenda
6	Creating a culture of research and innovation recognised as a group priority

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Delivery of action plans and improvements at operational level needs to be incorporated into the Performance Management & Accountability and PRM process
2	Staff awareness at all levels of group strategy, values and approach to innovation and continuous improvement remains ongoing
3	2023 / 24 and 2024 / 25 job plans are still being finalised although significant improvements have been made
4	Division/Clinical Care Groups not yet fully owning the 'Plan for Every Post' process
5	Capacity of staff to engage with improvement agenda to be determined
6	Culture of research and innovation not yet embedded

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Upward Reporting: Pulse Survey and NHS Staff Survey results are reported to the Executive Leadership Team, People Committee and Group Board and action plans are monitored through the People Committee with escalation to the Group Board as required.
2	
3	Oversight of the people agenda and key risks by the People Committee and reporting sub-groups with escalation to the group board as required. Reporting on people KPIs to the People Committee and Group Board through the Integrated Performance Report (IPR)
4	
5	Oversight of research & innovation has transferred to the Integration Committee

Gaps in Assurance	
1	Monitoring of action plan progress not fully embedded within sub-groups and relevant upward reporting, with priority focus being on the Divisional Clinical Care Groups monitored via PRM/FPAMs so that leaders are accountable and undertaking their actions
2	
3	Sub-Groups ensuring that agenda items and upward reports are in line with People Committee annual plan. IPR metrics currently being refreshed
4	
5	Regular reporting to be established

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review the way in which Staff Survey action plans are monitored and reported through standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms	Group Chief People Officer	Education & Learning Manager / Head of Workforce Planning & Reporting	30 September 2025	Underway – on track~~Not yet started~~
2	Staff awareness at all levels of group strategy, values, behaviours and approach to innovation and continuous improvement remains ongoing and will form part of a rolling programme of regular communications and engagement in 2025 / 26	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track
3 4	IPR metrics have been reviewed within People Directorate and shared, with alignment across LCHS and ULTH in line with Workforce Plans for 2025/26. People Committee Scorecard to be refreshed to ensure inclusion of current job planning and Medical & Dental middle tier rates for assurance purposes.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	31 May 2025	Completed – continues to be fully embedded~~Underway – on track~~

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee workplan and ensuring that each sub-group is aware of its reporting objectives in year.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 Jun2 2025	Completed – continues to be fully embedded~~Underway – on track~~
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025/26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	Completed – continues to be fully embedded~~Underway – on track~~
3 4	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce	30 June 2025	Completed – continues to be fully embedded~~Underway – on~~

			Planning & Reporting		track
5	Reporting requirements to be agreed as part of the refresh of the board committee terms of reference and work plans	Group Director of Corporate Affairs	Deputy Trust Secretary	30 June 2025	Underway – on track

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**
ULTH	4948	20	Pharmacy workload demands

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2c: Nurture compassionate and diverse leadership
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then out staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement

Current Risk Score & Movement since last review:

Moderate (9)

Last Review Date:	March 2025
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	3	3	Moderate (9)	Amber
Target	Mar-26	3	2	Low (6)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	**Apr-25**	**May-25**	**June-25**	**Jul-25**	**Aug-25**	**Sept-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
	Moderate	Moderate	Moderate									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Group values agreed by the Group Board – Compassionate, Collaborative & Innovative
2	HR policies and T&Cs are being harmonised across the group supported by staff side
3	Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) submissions are completed and signed off by the Group Board
4	Results from Pulse surveys and NHS staff survey are systematically reviewed and action plans developed in response to findings
5	Culture and Leadership Programmes are in place across the group: Equality, Diversity & Inclusion (EDI), Civility & Respect, Compassionate Leadership and Just Culture
6	There are clear processes for raising concerns with Freedom to Speak Up Guardians in place across the group
7	Staff networks are in place with executive sponsorship
8	A comprehensive staff well-being offer is in place including a board level well-being guardian, a health and well-being operational lead and champions with further developments planned

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Behaviours that underpin each value – 'Our Values in Action' – being developed through staff engagement exercises
2	The review of HR policies and T&Cs will take time to complete due to capacity issues
3	HR reporting and analysis (e.g.: Employee Relations) needs to be strengthened to support WRES / WDES work streams
4	Delivery of pulse surveys and NHS staff survey action plans at operational level needs to be incorporated into the Performance Management & Accountability and PRM process
5	None identified
6	None identified
7	None identified
8	There is currently insufficient funding for the development of the menopause service

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Feedback on the adherence to the group values and expected standards of behaviours is gathered through a variety of sources including engagement roadshows, surveys, exit interviews, staff networks, and union engagement
2	There is monitoring of progress with the review and alignment of HR policies and T&Cs through engagement with staff side colleagues and through JCNC/JNF
3	WRES and WDES results and actions plans are monitored through the People Committee with escalation to the Group Board as required
4	Pulse Survey and NHS Staff Survey results are reported to the Executive Leadership Team, People Committee and Group Board and action plans are monitored through the People Committee with escalation to the Group Board as required. NHS Staff Survey results are currently above average in the 'People Promise' areas. Pulse Surveys are above benchmark
5	People KPIs / metrics are reported through the IPR to the People Committee
6	There is routine reporting on employee relations activity and themes to the People Committee and Group Board
7	There is routine reporting on FTSU concerns to the People Committee and Group Board
8	Staff networks meet regularly and there is reporting from the network chairs to the People Committee
9	Staff well-being offer is monitored through discussion with staff side and through the People Committee
10	Internal audit review of the people agenda provides independent assurance and / or escalation of risks. Internal audit review of equality, diversity and inclusion undertaken within ULTH during 2024 / 2025 provided 'reasonable assurance'

Gaps in Assurance	
1	Triangulation of data sources and feedback with other relevant sources of information and where this is reported needs to be reviewed and strengthened
2	There is currently no shared platform for oversight of when when policies are due for review
3	None identified
4	Monitoring of action plan progress is not fully embedded within sub-groups and relevant upward reporting
5	IPR metrics are currently being refreshed to reflect the group strategic aims & objectives and workforce plans for 2025 / 26
6	Ability to support triangulation of HR/ER data with other key performance metrics to support wider oversight and ability to identify trends and develop action plans
7	
8	None identified
9	None identified
10	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Education, Learning & Organisational Development Team are actively developing ways of communicating across LCHG, including the 'Better Together Forum' relating specifically to values, and this will include how we embed as part of our business as usual cycles.	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track
2	LCHG Policy Group has commenced and is working collaboratively to review policies at pace. Policies have been prioritised to focus on contractual policies as the priority	Group Chief People Officer	Group Deputy Chief People Officer	31 March 2026	Underway – on track
3	People Directorate Teams are working collaboratively to develop improved reporting mechanisms to support the inclusion of relevant WRES / WDES data to enhance ability to support annual reporting and identify trends with a view to creating improved inclusion data in standard reporting	Claire Low	Group Deputy Chief People Officer	31 March 2026	Underway – on track
4	People Directorate Teams (Education, Learning & OD and People, Planning & Transformation) are working together to identify improved reporting within FPAMs / PRMS	Claire Low	Education & Learning / OD & People & Transformation Teams	30 September 2025	Underway – on track
5	Review of menopause service and review of funding options to be undertaken	Claire Low	Education & Learning Manager	31 March 2026	Not yet started

	Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*	Executive Lead	Operational Lead	Due Date	Progress
1	Develop a KPI dashboard to enable triangulation and highlighting of cultural trends and issues with reporting into the Culture and Leadership sub-group on a monthly basis with onward upward reporting to People Committee	Group Chief People Officer	Education & Learning Managers	30 June 2025	~~Completed – continues to be fully embedded~~ ~~Underway – on track~~
2	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the Policy report and due dates and create a dashboard which provides oversight	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 September 2025	Underway – on track
3	Review the way in which Staff Survey action plans are monitored and reported through standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms.	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track
4	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee workplan and ensuring that each sub-group is aware of its reporting objectives in year	Group Chief People Officer / Group Director of Corporate Affairs	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	~~Completed – continues to be fully embedded~~ ~~Underway – on track~~

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2d: Recognising our people through thanks and celebration
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not continue to **recognise our people through thanks and celebration** then we will be unable to attract and retain staff of the required caliber and experience resulting in services becoming unsustainable / fragile

Current Risk Score & Movement since last review:

Low (6)

Last Review Date:	March 2025
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	3	2	Low (6)	Amber
Target	Mar-26	3	1	Very Low (3)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Low	Low	Low									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Reward and Recognition arrangements harmonised across the group including the development of a group Reward and Recognition Policy
2	Reward, Recognition and Engagement Manager in post to support ongoing workstreams from 'People Promise' themes
3	ELT visibility and recognition of staff and teams through established communication and engagement channels
4	Annual staff awards ceremony held to recognise the contribution of individuals and teams
5	Robust review processes in place including appraisal, 1:1 meetings and feedback

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Policy approved but needs embedding
2	Role is in place within ULTH workforce but needs expanding to work across the group with an ability to utilise insights from this role to support wider reporting and identification of trends and development of action plans
3	None identified
4	None identified
5	Concept of group appraisals and appraisal lite process to be considered as part of review and alignment of HR policies

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Reporting through relevant sub-groups and People Committee on compliance rates for key workforce performance indicators (e.g. Turnover, Vacancies, Sickness, HR Cases, Appraisals)
2	Pulse Survey and NHS Staff Survey results are reported to the Executive Leadership Team, People Committee and Group Board and action plans are monitored through the People Committee with escalation to the Group Board as required. NHS Staff Survey results are currently above average in the 'People Promise' areas. Pulse Surveys are above benchmark
3	Pastoral care award received for recruitment and on-boarding of international nurses
4	Internal audit of people agenda provides independent assurance

Gaps in Assurance	
1	Regular reporting in place for key performance indicators via People Committee Scorecard and Workforce Strategy Group, but there is limited triangulation of wider data sources such as datix, complaints and Freedom to Speak Up Concerns which would highlight cultural trends / issues
2	Monitoring of action plan progress not fully embedded within sub-groups and relevant upward reporting
3	None identified
4	None identified in respect of reward and recognition

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Embed Group reward & Recognition Policy	Group Chief People Officer	Group Deputy Chief People Officer	31 March 2026	~~Completed – continues to be fully embedded Ongoing~~
2	Review how the Reward, Recognition and Engagement Manager role aligns to wider LCHG workstreams and how the role can bring insights to wider workstreams, including reporting into FPAM and other key assurance meetings	Group Chief People Officer	Group Deputy Chief People Officer	31 March 2026	Not yet started
3	Launch refreshed appraisal cycle as part of further harmonisation across the group	Group Chief People Officer	Education & Learning Managers	30 June 2025	~~Completed – continues to be fully embedded Underway – on track~~

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Develop a KPI dashboard to enable triangulation and highlighting of cultural trends and issues with reporting into the Culture and Leadership sub-group on a monthly basis with onward upward reporting to People Committee	Group Chief People Officer	Group Head of Workforce Planning & Reporting	31 March 2026	Not yet started
2	Review the way in which Staff Survey action plans are monitored and reported through standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms.	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **transform key clinical pathways,** rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience

Current Risk Score & Movement since last review:

12 (Moderate)

Last Review Date:	March 2025
Lead Executive:	Group Chief Integration Office
Committee Oversight:	Integration Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	3	12 (Moderate)	Amber
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Left Shift Transformation Plan with oversight of delivery by the Alliance Steering Group
2	Transformation of planned and unplanned pathways to be managed through a sub-group of the Alliance Steering Group
3	Governance structures and QIA processes in support of the transformation programme in place
4	Integrated Neighbourhood Working programme to be managed through the a sub-group of the Alliance Steering Group~~Programme / project interdependencies to be managed through the Productivity, Improvement & Transformation Forum (PITOF)~~
5	Partnership Strategy in place to support transformation
6	Dedicated work stream to support collaboration at scale in place with key sub-work streams
7	Health Inequalities Working Group established to identify and address health inequalities, focusing on the use of the Health Inequalities Maturity Matrix to drive improvement
8	Estates strategy being developed, Space Group set up to support rationalization and specific service transformation request

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Alliance Steering Group currently being set up with first meeting planned for May 2025
2	Alliance Steering Group sub-groups on planned / unplanned care group transformation, left shift re-design programmer and integrated neighborhood teams not yet commenced
3	Governance and reporting being refined in support of transformation programme
4	Sub-groups being established with partners, supported by workshops on each workstream and the Alliance in development~~PITOF currently being set up with first meeting planned for May 2025~~
5	Partnership Strategy needs to be refreshed in line with the Group Strategy and Alliance Model
6	Spectrum of integration options to be formalised for all partners based on Partnership Strategy
7	
8	No aligned Estates Strategy across the Group

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of transformation work streams by the Integration Committee with escalation to the Group Board as required
2	External assurance will be provided through the Alliance Steering Group updates to Lincolnshire Leaders Group and partner provider boards
3	PITOF upward reports including reporting on delivery of key KPIs and milestones to the Integration Committee
4	IPR to support demonstration of a positive shift in key metrics such as improved LOS, improved staff and patient satisfaction, improved access to services
5	
6	
7	
8	

Gaps in Assurance	
1	Integration Committee in place but work plan and reporting sub-groups not yet fully established
2	
3	
4	Work streams, KPIs and timelines still being worked up
5	
6	
7	
8	

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Alliance Steering Group first meeting with external partners to be arranged for July ~~May~~ 2025 with terms of reference and subgroups to be agreed with members	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	~~31 May~~ July 2025	Underway
2	Alliance Steering Group sub-groups to be established and work streams being set up with a clear 12 month delivery plan developed with Alliance partners including through workshops	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	~~31 May~~July 2025	Underway
3	First PITOF meeting diarised for 12 May 2025 and to take place monthly	Group Chief Integration Officer	Director of Improvement and Integration	~~12 May 2025~~Ongoing	Complete
3	Partnership Strategy to be refreshed with sign off by the Integration Committee	Group Chief Integration Officer	Associate Director of Partnership	30 June 2025	Underway
4	Work with EFM to contribute to developing the Estates Strategy	Group Chief Integration Officer	Chief Estates Officer	31 ~~August 2025~~March 2026	Underway

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Integration Committee work plan and reporting sub-groups to be established	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	31 May 2025	Underway
2	Left shift specialties being identified, relevant population health management data collated to produce evidence packs to commence service redesign with relevant partners from acute, community and wider system	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	31 May 2025	~~First meeting held with population health mgmt. team and wider system~~Underway
3	Strategy, improvement and redesign team working on pulling together programme plans for all the work streams to report through a central reporting mechanisms	Group Chief Integration Officer	Director of Improvement and Integration	31 May 2025	Underway
4	Integration brochure to provide options for collaborative working being developed.	Group Chief Integration Officer	Director of Improvement and Integration	31 May 2025	Underway

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3b: Move from prescription to prevention, through a population health management & health inequalities approach
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes

Current Risk Score & Movement since last review:

9 (Moderate)

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Last Review Date:	March 2025
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	3	12 (Moderate)	Amber
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

⇔

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Group Strategy developed. Tackling health inequalities identified as a key organisation / system priority within the group strategy and operational and financial plan
2	The delivery of the Alliance Programme (overseen by the Alliance Steering Group) will support the work required to reduce health inequalities
3	Health Inequalities Working Group in place to oversee delivery of the plan to improve group health inequalities maturity matrix scores
4	Tackling health inequalities is a key area of focus within the board development programme
5	Consistent use of the linked data set to design, deliver and review services supported by the skills and capability to use tools and frameworks embedded as BAU within the new LCHG Transformation Framework
6	Workshops with specialties being scheduled to identify areas of focus for transformation supported by programme managers and business partners.
7	

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	None identified
2	None identified ~~Alliance Steering Group not yet in place~~
3	Health inequalities action plan in development
4	None identified
5	Data packs in development for key left shift transformation priorities and a progrmme to address skills / knowledge gaps. Respiratory pack shared with the Integration Committee last month as an example
6	Data packs and a workshop format being developed.
7	

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Health Inequalities Working Group upward report into the new Alliance Steering Group and Integration Committee and Group Board
2	Development of a LCHG Co-production Strategy to support the health inequalities and personalisation agenda and reduce health inequalities
3	PHM and HI are golden threads through the LCHG Strategy and delivery will be monitored through upward reporting to the Integration Committee and Group Board
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Gaps in Assurance	
1	Health inequalities action plan in development ~~/ Alliance Steering Group being established with the first meeting planned for May 2025~~
2	Co-production Strategy in development ~~-~~ working with ICB Health Inequalities and Personalisation Teams
3	Strategy to be launched across the group from April 2025
4	
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Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Monthly Alliance Steering Group with external partners will start meeting in July (an initial ASG meeting to brief internal members on the ToR and work programme took place on 02/06/25)~~Alliance Steering Group date to be confirmed for May 2025~~	Group Chief Integration Officer	Director of Integration and Improvement / Deputy Chief Integration Officer	July 2025~~31 May 2025~~	Underway
2	Health Inequalities action plan in development and will be shared with Alliance Steering Group and Integration Committee in ~~May~~June 2025	Group Chief Integration Officer	Associate Director of Partnership	~~31 May~~June 2025	Underway
3	Population Health data packs/intelligence being produced for all of the first tranche of left shift specialties, supported via ICB team and LCHG Data Analysts. PHM approach embedded in BAU Transformation Framework. Confirming any resource issue internally to support the data workstream.	Group Chief Integration Officer	Director of Integration and Improvement / Deputy Chief Integration Officer	~~31 May~~July 2025	Underway - date being arranged for first workshop~~meeting~~

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Alliance Steering Group meeting with external partners to be held in July ~~May~~ 2025 – narrative reports being provided directly to Integration Committee in the interim ~~Health inequalities action plan to be developed and approved~~	Group Chief Integration Officer	Associate Director of Partnership	31 May 2025	Underway
2	Health Inequalities Action Plan completed ~~in development from the four work stream leads~~ and will be provided to the Alliance Steering group/Integration Committee in May 2025	Group Chief Integration Officer	Associate Director of Partnership	~~31 May~~June 2025	Underway
3	Communications cascade to be developed (as one of the four Health Inequalities work streams) to increase awareness of the role of the Exec Lead for Health Inequalities and Personalization	Group Chief Integration Officer	Associate Director of Partnership/Associate Director of	~~31 May~~June 2025	~~Planned~~Underway

			Communications and		
4	New LCHG Strategy ~~to be signed off by Board in May 2025 and~~being deployed via Roadshow and in communications cascade	Group Chief Integration Officer	Director of Integration and Improvement	30 June 2025	Underway

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3c: Enhance our digital, research and innovation capability
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **enhance our digital, research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale

Current Risk Score & Movement since last review:

12 (Moderate)

Last Review Date:	March 2025
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	3	12 (Moderate)	Amber
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

	Identified Controls *(What are we already doing to manage the risk?)*
1	Digital Strategy for the group developed with a focus on digital transformation, integration & new ways of working
2	Digital systems across the group mapped and plan developed to align. 'Enabling Technology Programme in place to deliver improved technical infrastructure
3	Transition of LCHS and GPIT Digital services from AGEM to LCHG to enable and integrated digital approach. ~~Single Microsoft 365 teams platform in place~~
4	EPR and EDMS programmes under way, both strategic enablers, ~~Director of Digital in post and digital team to be aligned with a single identity~~
5	Disaster Recovery Plans in place. Cyber security & malware processes in place and tested
6	Digital Oversight Group in place to driver delivery of digital agenda
7	Key group focus on research and innovation including Artificial Intelligence (AI)
8	Process has begun for LCHS to become a teaching trust alongside ULTH

	Gaps in Controls *(What are the gaps in control that are required to manage the risk)*
1	There is a need to enhance digital capability & skills through training
2	Insufficient capital / revenue to replace ageing technology
3	Alignment and change to operating model of LCHG Digital services to scale to the combined requirement, including transition. ~~Processes require embedding~~
4	Capacity within the digital team to deliver the digital transformation
5	Effectiveness of operational business continuity plans ~~None identified~~
6	None identified
7	LCHG Research & Innovation Strategy not yet developed
8	Application in development. Resource allocated to support application

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of digital strategy, digital transformation and key risks by the Integration Committee
2	Digital Maturity Assessment completed
3	Digital Innovations Group established to assess and accelerate safe use of AI technologies
4	Oversight of AGEM IT service transition to LCHG via upward reporting to Integration Committee to manage risk, including agreement of structures.
5	Digital led business continuity exercise to identify improvement and learning, with departments providing assurance to Emergency Planning Group.
6	
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Gaps in Assurance	
1	None identified~~TBC~~
2	None identified
3	None identified
4	Business as usual service assurance to be aligned to support service development and alignment to standards. Responsibility to move from AGEM to LCHG.
5	Output of exercise upwardly reported and actions owned.
6	
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Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Implementation Partner to be procured to provide capacity for EPR and other in scope initiatives as part of EMAP DDC collaborative.~~Technical / Implementation Partner to be procured to provide capacity as and when required~~	Group Chief Integration Officer~~TBC~~	Group Director of Digital Services~~TBC~~	TBC to alignment with EMAP~~TBC~~	Scoping in progress June 2025~~TBC~~
2	LCHG Research & Innovation Strategy to be developed	Chief Medical Officer	Head of Research & Innovation	TBC	First meeting with stakeholders to be held early June 2025
3	Recruitment into key project team positions, including the commencement of the EPR Programme Director position – joining 30th June 2025	Group Chief Integration Officer	Group Director of Digital Services	30 June 2025 – Programme Director	Underway and ongoing
~~3~~4	Meeting to be arranged with DHSC to confirm the position on the LCHS teaching status application and timescales	Group Chief Integration Officer	Associate Director of Partnerships	1 April 2026	~~Scoping due to commence April 2025~~Underway
5	Digital led cyber/business continuity exercise with reporting to Emergency Planning Group to support improvement and recommendations for action outside of the digital service	Group Chief Integration Officer	Group Director of Digital Services	30 June 2025	Underway and ongoing
6	Review of Digital Capital funding sources taking place to ensure opportunities are maximized to invest in improving technology and opportunity through the strategic programmes EPR and EDMS is maximised. Report to be presented to Digital Oversight Group August 2025.	Group Chief Integration Officer	Group Director of Digital Services	30 August 2025	Underway and ongoing

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	ULTH and LCHS Technical Digital Service Assurance reporting to transition to LCHG from AGEM as part of transition, this will support a more detailed understanding and allow further actions to be identified to align standards.~~TBC~~	Group Chief Integration Officer	Group Director of Digital Services	30 October 2025	Part of Digital Service transition

2	Report and recommendations from Exercise Subaqua to Digital Oversight Group (Digital Response) in August and to Emergency Planning Group (Operational Resilience)	Group Chief Integration Officer	Group Director of Digital Services	30 June 2025 (Report)	Underway and ongoing
3					
4					

Related risks On Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable

Current Risk Score & Movement since last review:

12 (Moderate)

Last Review Date:	March 2025
Lead Executive:	Group Chief Integration Officer / Group Chief Estates and Facilities Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	3	12 (Moderate)	Amber
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate									

Assurance Rating	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Amber	Amber	Amber									

Identified Controls *(What are we already doing to manage the risk?)*	
1	Productivity & Transformation Framework developed – outline programme for 2025 / 26 agreed
2	Common PMO approach developed to monitor and drive oversight of our CIP
3	Productivity, Improvement & Transformation Group being set up reporting to GLT
4	ULTH and LCHS Sustainability & Green Plans reviewed – phase 1 actions complete: improvement workshops complete and areas of opportunity and risk identified
5	Network of Green Champions formed
6	Green Group meetings scheduled
7	Sustainability agenda embedded in new Group Strategy
8	The Director of Estates & Facilities is the SRO for the sustainability agenda

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Care group transformation and improvement programmes not yet fully worked up – support being provided from strategy, improvement and re-design teams
2	PMO not yet embedded and programmes still being developed
3	~~Green Plan areas of oversight to be agreed by GLT~~
4	Green Plan areas of oversight to be agreed by GLT ~~Refreshed Sustainability & Green Plan being drafted for board approval~~
5	None identified
6	None identified
7	Refreshed Sustainability & Green Plan being drafted for board approval
8	None identified

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of productivity, improvement & transformation by the Integration Committee
2	Sustainability report to the Alliance Steering Group for oversight and assurance. Upward reporting to the Integration Committee and Group Board
3	Green Plan for LCHS and ULTH
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Gaps in Assurance	
1	Clarity is needed on oversight responsibilities of Integration Committee v Finance & Performance Committee
2	~~Sustainability sub-group (Green Group) not yet established~~ None identified
3	Green Plan not yet approved by the Board
4	
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Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Care Group transformation programme being finalized as part of planning submission / CIP / annual plans and will be complete by the end of April 2025	Group Chief Integration Officer	Director of Improvement and Integration	30 April 2025	Underway
2	PMO being embedded and establishing all programmes onto Aspyre – working with finance to ensure full capture of all programmes	Group Chief Integration Officer	Director of Improvement and Integration	30 April 2025	Underway
3	New Green Plan in development with key work stream leafs, for socialization via ELT, GLT and approval by Group Board	Group Director of Estates & Facilities	Group Head of Sustainability	31 July 2025	Underway

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Sustainability sub-group (Green Group) terms of reference agreed by Integration Committee in April 2025 – first meeting to be scheduled for May 2025	Group Director of Estates & Facilities	Group Head of Sustainability	31 May 2025	~~Underway~~Complete

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

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*
Date of Meeting	*1 July 2025*
Item Number	*12.3*

Group Audit Committee Upward Report of the meeting held on 16th June 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 and the recommendation made to Extraordinary Private Board*

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 2025/26 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG).

The meeting held in June dealt only with business relating to the sign off of the annual report and annual accounts

Internal Audit

The Committee received the Internal Audit Annual Report 2024/25 for both organisations. The organisations were both issued with Reasonable Assurance and the Head of Internal Audit Opinions did not highlight any areas of material concerns. The Committee noted the pressure that had been experienced with the completion of the audit plans for the year and that a small number of audit reports were still to be issued.

External Audit

The Committee received the Audit Completion Report and Auditors Annual Report for both organisations. The Committee were advised that the audit work was still ongoing as was usual but was substantially completed. The queries which were outstanding were being resolved between the team and the Auditors. The

Committee were advised that there were no significant control deficiencies for either Trust. There were however a number of recommendations which were presented with management comments for action.

The Committee were advised of one adjusted misstatement in the final version of the LCHS report which was above the reporting threshold but below materiality.

The Committee were advised of one unadjusted misstatement in the ULTH report which was above the reporting threshold of £300,000 which related to a differing opinion on how the refund for the Brockenhurst Case had been accounted for.

The Audit Team highlighted comments in relation to tailoring how the financial statements were presented but that overall the process had gone well.

The Committee thanked all of the teams which had been involved in the work.

The Committee raised an issue in relation to the wording of the Auditors report in relation to the financial challenge faced in ULTH moving forward and the reference to the fact that some ongoing issues may have not been addressed, but then went on to state that the Trust should continue taking the actions which were already in chain. The Audit Team agreed to take this away and consider the wording, noting that they were bound by the use of some language for some areas in the report due to the Trust reporting a deficit position.

Annual Report and Annual Accounts 2024/25

The Committee received the annual report and annual accounts for both organisations, noting as described in the discussion about the external audit process that there were still some final amendments being made ahead of reporting to Board. The Committee offered wording amendments in relation to the reports.

The Committee recommended that the annual report and annual accounts were presented to the Board ahead of final submission for approval.

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 (def. from May)					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 Report to the Board	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 Progress Briefing	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 (def. from May)			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		