Bundle LCHG Board Meeting in Public Session 2 September 2025

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

10.1 Assurance and Risk Report from the Integration Committee
Chair, Integration Committee
> Item 10.1 Integration Committee Upward Report July 2025
> Item 10.1 Integration Committee Upward Report August 2025v1

10.2 NHS 10 Year Health Plan Gap Analysis
Group Chief Integration Officer
> Item 10.2 10 Year Plan Cover Sheet -TB
> Item 10.2 Appendix 1 10 Year Plan Overview and Timeline-IC
> Item 10.2 Appendix 2- LCHG strategy- 10 year plan- gaps-v1

10.3 Green Plans - LCHS/ULTH
Deputy Director of Estates and Facilities
> Item 10.3 IC Report August 2025 final
> Item 10.3 LCHS Green Plan 040825
> Item 10.3 Green Plan ULTH 040825

11 Integrated Performance Reports - ULTH/LCHS
Group Chief Integration Officer
> Item 11 Front Sheet Trust Board - IPR
> Item 11 Appenidx One ULTHIPR Trust Board August 2025
> Item 11 LCHS IPR Report - Front sheet - July
> Item 11 Appendix A LCHC Integrated Performance Report - July

12 Risk and Assurance

12.1 Group Risk Management Report
Group Chief Clinical Governance Officer
> Item 12.1 Group Board - LCHG Risk Report September 2025
> Item 12.1 Appendix A LCHS Very High Risk Report
> Item 12.1 Appendix B ULTH Very High and High Risks August 2025

12.2 Board Assurance Framework
Group Director of Corporate Affairs
> Item 12.2 BAF Group Board Front Sheet 2 September 2025
> Item 12.2 Appendix LCHG Group BAF as at 27.08.25

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

12.4 Group Corporate Governance Manual (Standing Orders and Standing Financial Instructions)
Group Director of Corporate Affairs
> Item 12.4 Corporate Governance Manual Front Sheet 1 July 2025
> Item 12.4 Corporate Governance Manual 080825 - ULTH
> Item 12.4 Corporate Governance Manual 080825 - LCHS

12.5 Board Forward Planner
Group Director of Corporate Affairs
Information item
> Item 12.5 Board Annual Planner

13 Any Other Notified Items of Urgent Business

14 The next meeting will be held on Tuesday 4th November 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.

NHS

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

Minutes of the Joint Public Board Meeting

Held on 1 July 2025

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Group Chair
Mr Jim Connolly, Non-Executive Director
Ms Dani Cecchini, Non-Executive Director
Mr Neil Herbert, Non-Executive Director
Mrs Vicki Wells, 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
Mr Paul Antunes Goncalves, Group Chief Finance Officer

Non-Voting Members:
Mrs Kathryn Helley, Group Chief Clinical Governance Officer
Mr Mike Parkhill, Group Estates and Facilities Officer
Ms Caroline Landon, Group Chief Operating Officer
Mrs Jayne Warner, Group Director of Corporate Affairs
Miss Claire Low, Group Chief People Officer
Mrs Sarah Buik, Associate Non-Executive Director
Ms Caroline Landon, Group Chief Operating Officer

In attendance:
Mrs Karen Willey, Deputy Trust Board Secretary, ULTH
Mrs Rachel Lane, Board Administration, LCHS (minutes)
Jason Green, Matron (ULHT) – Item 2.1
Alan Greef, Theatre Service Manager (ULHT) – Item 2.1
Vikki Smith, Operational Services Manager (ULHT) – Item 7
Dr Shaza Obaid, Consultant Rheumatology (ULHT) – Item 7.1
Lara Marshall, Rheumatology Service Co-ordinator (ULHT) – Item 7.1

Apologies:

Professor Duncan French, Non-Executive
Director
Mrs Rebecca Brown, Deputy Chair/Non-
Executive Director
Mr Ian Orrell, Associate Non-Executive Director

318/25	**Item 1 Introduction** The Group Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream.
319/25	**Item 2 Public Questions** **Q1 Received from Vi King** Please can I ask why people are not being offered Grantham hospital for planned orthopaedic surgery, especially when Grantham is a place of excellence for this. Also, please can I ask why people who have booked into A.E at pilgrim hospital are having to wait in the fracture clinic area. Is there not a waiting area in the new A/E?
320/25	The Group Chief Operating Officer advised that almost all elective orthopaedic surgery took place at Grantham, however not all patients required the same level of care or had the same presentations and may require a higher level of post operative care which could not be offered at Grantham and was therefore offered at alternative sites. The facilities at Grantham enabled more patients to be treated and were in the process of being expanded.
321/25	In relation to the Pilgrim Hospital Accident and Emergency Department, the waiting room remained under construction, and this was expected to be completed by the end of September. Currently the Outpatient waiting area had been separated and was being shared with the Emergency Department. The Group Chief Operating Officer advised that the Fracture Clinic waiting room should not be being used for Accident and Emergency patients. It was noted that, from September 2025 there would be a much-improved area for patients to wait in for treatment. **Q2 Received from Stephen Moseley**
322/25	Why has the United Lincolnshire Hospitals Trust decided to limit face-to-face consultations for over 6,000 patients, while simultaneously leaving critical facilities like the £4 million blood unit empty or underutilized? What accountability exists for the financial and clinical consequences of this decision?
323/25	The Group Chief Operating Officer advised that offering NHS patients virtual appointments was a national ambition and something many patients welcomed. There were a significant amount of Outpatient appointments which could be delivered effectively via telephone or video consultation that offered many benefits to patients. Several routine follow up appointments did not require a face to face consultation and delivering those appointments remotely meant patients may not need to take time off work and would not have to worry about the challenges of travelling to and parking at the hospitals.

324/25	In respect of the question relating to the blood unit, the Group Chief Operating Officer advised that she and her colleagues were unaware which unit was being referred to and should further clarity be provided, it would be possible to provide a response to the question.
325/25	**Item 2.1 Ward Accreditation** The Group Chair was pleased to be able to commence the Board meeting with the celebration of achievement of the provision of high quality, safe care through the awarding of ward accreditation.
326/25	Jason Green, Matron and Alan Greef, Theatre Services Manager from Louth County Hospital Theatres were welcomed to the meeting to celebrate their achievements.
327/25	The Group Chief Nurse introduced the team who had successfully achieved the Bronze award as part of the quality accreditation programme. Board members were reminded of the core requirements the departments were required to achieve against a range of quality indicators, in addition to presenting a portfolio of evidence to the Quality Accreditation Panel.
328/25	The Theatre Service Manager shared examples of good working in respect of delivering safer and more patient centred care where the potential for a safety risk had been identified regarding incorrect medication administration. The Theatre Service Manager described a process introducing sterile syringe labelling at the point of administration and was pleased to confirm that there had been no reported incidents. There had also been an increase to patient flow from 12 to 20 and the team had received national recognition being described as a credit to the organisation. One challenge the team had faced was in relation to late sterilisation deliveries and following work there had been fewer cancelled operations and improved delivery timescales.
329/25	In relation to people, the Theatre Services Manager also described the way in which the team had strengthened the role of Health Care Support Workers (HCSWs) leading to smoother patient pathways. Patients had previously complained of being unable to contact the Ward by telephone and as a result there was now a dedicated person covering phone lines and from a staff wellbeing perspective a new environment had been created, changing cultures, and staff members were feeling more valued and supported.
330/25	The Group Chair thanked the Theatre Services Manager for sharing examples of how positive changes had been made and commented that the patient focus had been embedded into these new ways of working. The Group Chair was pleased to hear of the cultures changes that had also been made.
331/25	The Group Chief Medical Officer advised of having been in attendance when the team had presented their evidence to achieve the Bronze Ward Accreditation and commented that it had been good to see the work which had been undertaken in respect of empowering HCSWs, the sterile syringe labelling and ensuring a presence on the telephones. The wellbeing initiatives were also a good improvement and

	helped from a cultural perspective and there was recognition that this exemplar practice could be rolled out to other areas of the organisation.
332/25	The Group Chief Executive welcomed the Matron and Theatre Services Manager to the meeting and thanked them for the excellent presentation where their enthusiasm had shone through. It was pleasing to hear of the outcomes of the actions taken by the team, which had included no near misses, the eradication of complaints and many compliments from Louth patients and the Group Chief Executive acknowledged the collective efforts of the team to improve patient experiences.
333/25	The Group Chief Executive offered that this was one example of why the organisation needed to maintain services on the Louth site and suggested sharing these examples widely across the County.
334/25	Mrs Buik commented that the holistic nature of what had been implemented stood out within the presentation and appreciated the level of analysis that would have taken place. What came through in the narrative was how targeting specific areas in a strategically approached manner had allowed for measured and structured improvements to be embedded within the department.
335/25	The Group Chair thanked the Matron and Theatre Services Manager for attending the meeting and for their continued leadership adding that the service was a credit to the organisation and commented that the team should be proud of their achievements.
336/25	**Item 3 Apologies for Absence** Apologies for absence were received from Professor Duncan French, Non-executive Director (ULTH), Mr Ian Orrell, Associate Non-executive Director and Mrs Rebecca Brown, Deputy Group Chair/Non-executive Director.
337/25	**Item 4 Declarations of Interest** There were no additional Declarations of Interest made.
338/25	**Item 5 Minutes of the meetings held on 6 May 2025** The minutes of the meeting held on Tuesday 6 May 2025 were approved as an accurate record.
339/25	**Item 5.1 Matters Arising from the previous meeting/log** There was one outstanding action, relating to minute number 204/25 regarding cyber and where oversight of this should sit within Board Committees. The Group Director of Corporate Affairs informed those present that the Information Governance elements and cyber were referenced within the Audit Committee Handbooks and there had been agreed delegation of this to the Finance and Performance Committee. Clarity would be provided on this via both Committee's Terms of Reference.

	The Board: • **Agreed to close the action**
340/25	**Item 6 Group Chief Executive's Report to the Board** The Group Chief Executive presented the report to the Board and advised that teams were exceptionally busy and continued to work hard to offer excellent services and care across urgent and emergency care pathways, planned care and cancer pathways and were being supported by community teams and partners across the system.
341/25	The Model Integrated Care Board (ICB) Blueprint had been published in May 2025 and ICB colleagues were working through the requirements and a formal way forward was awaited.
342/25	The Group Chief Executive advised of several political changes following the recent elections and explained that the System Chief Executives had recently written to the newly appointed Mayor of Greater Lincolnshire, Dame Andrea Jenkyns welcoming her to the County, and extended an offer to work alongside the Chief Executives across healthcare. The Group Chief Executive informed Board members of recent attendance at a meeting of the newly established Lincolnshire County Council Health Overview Scrutiny Committee where collective services for Lincolnshire residents had been discussed.
343/25	The urgent and emergency care plan had recently been published which set out plans and requests for the winter period, which were being worked through. The Group Chief Executive offered that the Group had strong and robust arrangements with partners which would be further built on in responding to the plan.
344/25	A letter had been received from the Secretary of State for Health and the Chief Executive of NHS England, which set out requirements to meet reductions in agency spend, which the Group did well across non-medical workforce and there were plans to reduce medical workforce and the use of temporary staff.
345/25	The Group Chief Executive informed Board members that Clair Raybould had been appointed as Interim Chief Executive of the ICB, following the recent retirement of John Turner, who would be missed across the system.
346/25	NHS England had published the 2025/26 Oversight Framework at the end of June 2025 with assessment criteria for ICBs and NHS Trusts which was aimed at allocating ICBs and providers a segmentation rating of one to four and an additional segment rating of five for the most challenged areas. The Group Chief Executive explained that due to the level of ICB change, NHS England would not be issuing comparative ratings for ICBs in 2025/26 however there would be comparable ratings for providers. At the time of offering the report to the Board it was not known what segmentation the Lincolnshire ICB or acute/community trusts would be scored as. NHS England would also report against a full suite of metrics and the Group Chief Executive anticipated the formal segmentation ratings in mid-July.

347/25	Phase one of the Pilgrim Emergency Department work had been completed and was opened in May. The Group Chief Executive offered that was a great facility and the phase two work had now commenced and once complete would be triple the department in size.
348/25	Pilgrim Hospital, Boston had recently been awarded £23m in funding through the Public Sector Decarbonisation Scheme. This investment would 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 would contribute significantly to the hospital's sustainability goals and long-term operational efficiency.
349/25	The Group Chief Executive advised that the organisation had also received the approvals required for the Electronic Patient Record (EPR) Business Case, which would now be moving into the planning phase. This would align digitalisation of current patient records.
350/25	In January 2024 ULTH had been 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.
351/25	On 14th May 2025, the Group Chief Executive had attended the Education and Skills Garden Party at Buckingham Palace, alongside the Group Chair, Group Chief People Officer and the Talent Academy Strategic Lead and members of the Lincolnshire Talent Academy team. The invitation was in recognition of the academy's outstanding contribution in the field of education and skills development. A member of staff from the Armed Forces Staff Network had also attended the Royal Garden Party who had been recognised for driving work for armed forces veterans and adult cadets who were supported across the organisation.
352/25	The Group Chief Executive also informed Board members that a series of Group Leadership Team (GLT) Roadshows had been held across the Group during May and June and the team had met many colleagues and had discussed the new Group values, heard of colleagues triumphs and challenges that were being experienced in some areas. Several concerns had been unlocked as a result of discussions and themes were being gathered which would inform the next steps of engagement work across the Group.
353/25	The Group continued 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 supported patients in their recovery before they transitioned to the next stage of their care journey.
354/25	As part of Volunteers Week in June, the Group proudly celebrated and recognised the invaluable contributions of the dedicated volunteers. The Group currently had 329

	volunteers who generously contributed 46,069 hours of their time over the last financial year to support the work of the Group.
355/25	The Group Chief Executive also offered that the University of Lincoln had recently received confirmation that following the GMC submission, Lincoln Medical School was able to progress the recruitment of students for two new medical courses. The school could now proceed with a Gateway Year course from September 2025 and the new five-year independent medical programme from September 2026.
356/25	The Group Chief People Officer commented that as a member of GLT the opportunity of meeting clinical and non-clinical teams across the County had been welcomed with the work to pull together themes from all visits and from discussions with staff members would be led by the People Directorate. The visits had also provided an opportunity to launch the Group Values and the Group Chief People Officer informed those present of the launch of a bespoke training package, the Lincolnshire Community and Hospitals Group (LCHG) Way, a module-based programme for staff members, who would be able to attend the modules which were applicable to them.
357/25	The Group Chair and Group Chief Executive had met many staff members over recent weeks at Staff Awards events and the Group Chair had been surprised at how little knowledge and awareness amongst colleagues there had been about the Group Board and what the intentions were in terms of future direction of travel for the residents of Lincolnshire. The Group Chair would be pleased to hear how that detail would be taken forward in due course.
358/25	The Group Chair also took the opportunity to endorse the comment made by the Group Chief Executive on the retirement of the former Chief executive of the Lincolnshire ICB, John Turner, and to thank him for his contributions to the Lincolnshire system and for being an advocate of LCHS and ULTH. The appointment of the Interim Chief Executive was noted as a good replacement, and the Group Chair looked forward to working with her in the coming months. The Board: • **Received the report and noted the significant assurance provided**
359/25	**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.
360/25	The Group Chief Executive advised that the Plan was delivering and there had been the inclusion of some additional actions relating to estates workstreams which would continue to develop in the coming months. Attnetion was drawn to some small issues which were being attended to which would be the subject of focus over the coming weeks.
361/25	The Group Chair thanked the Group Chief Executive for the clarity provided on the escalations. The Group Chair also commented that some of the timescales had expired and required updating.

	The Board:
	• **Received the report**
362/25	**Item 7 Patient/Staff Story**
	The Group Chair welcomed the Operational Services Manager to the meeting who was in attendance for this item. The Group Chief Nurse offered thanks to Tanita for bravely sharing her story and for working with the organisation to build something positive from such a tragic loss.
363/25	A recording was shared with the Board outlining the story of the death of nine day old Amelia Rose at Lincoln County Hospital. Tanita shared her experiences when sadly saying goodbye to her daughter, Amelia Rose, in a busy resuscitation department and described how she had worked with the hospital to develop a relatives room within the Emergency Department (ED), which had provided a much improved environment for bereaved families to digest difficult news, spend some time and say goodbye to loved ones. Tanita's ideas and feedback had resulted in two new purpose built family rooms in the ED's at both Pilgrim Hospital, Boston and Lincoln County Hospital, which had been supported by the ULTH Charity and were well equipped with seating, lighting and facilities to ensure families felt comfortable in difficult circumstances.
364/25	Mrs Wells commented that despite this harrowing story it was pleasing to hear how proactive the organisation had been in seeking feedback from patients about their experiences, however wondered how proactive the organisation was for people who did not have the strength to speak up. The Group Chief Nurse offered that work was being undertaken recognising communities that were hard to reach. The newly appointed Patient Experience Lead would be creating patient engagement groups which would enrich work that was already taking place in terms of next level feedback.
365/25	The Group Chief Executive thanked Tanita for sharing this emotional story and for having the courage to advocate for other people's experiences and added that through such distress and trauma, a legacy had been left for Amelia Rose.
366/25	The Group Chief Medical Officer agreed that this had been an emotional story and did not underestimate the impact this would have had on Tanita and her partner. He offered that it took bravery and courage in the face of devastating circumstances to offer feedback to help others, which he was grateful for in order that the organisation could learn and improve. Visits to the new areas within the EDs had been made and it was noted that these were calming and welcoming and were a great legacy for Amelia Rose.
367/25	The Operational Services Manager informed Board members that to have Tanita's feedback was invaluable and commendable given the tragic circumstances.
368/25	The Group Chair thanked the Operational Services Manager for attending the meeting and for sharing this story which showcased learning for the organisation. The Group Chair also took the opportunity to thank Tanita and her family; she offered

	that the bereavement room was a fabulous legacy for Amelia Rose and acknowledged the investment of charitable funds. The Board: • **Received the Patient/Staff Story**	
369/25	**Item 7.1 Celebrating Group Success** The Group Chair welcomed members of the Rheumatology team from ULTH to the meeting who provided an inspiring presentation which detailed the establishment of a biotic therapies homecare service for those patients that require high-cost biologic drugs.	
370/25	The service offered support for patients in their own homes, working with homecare providers to ensure patients received the treatment needed, managing the medication received by each patient to ensure that it worked for them, as well as tracking and monitoring them in their own home. In addition, the team offered personalised support to patients, and kept the service running, including funding, manging changes to treatment, offering advice and shaping departmental guidelines.	
371/25	The Group Chair thanked the Rheumatology Consultant and the Rheumatology Service Co-ordinator for the presentation and expressed a view that this was a good example of providing holistic care for patients, recognising the financial constraint climate.	
372/25	The Group Chief Executive thanked colleagues for attending the meeting and for sharing the detail of this innovative service and reflected on the uniqueness of this service, which was not offered in the same way by other organisations. The view was expressed that this service was one example of a way in which out of hospital care could be provided and could move to a hybrid offering moving forward and anticipated discussions taking place on the potential for this shortly.	
373/25	The Group Chief Medical Officer commented that this was a good proof of concept for what was coming next for many specialities and was also a good example of left shift being able to deliver in the ways in which were demonstrated throughout the presentation. There were clear perimeters for delivering the service and doing the right things for patients. The Group Chief Medical Officer added that there were lessons that could be learned for other specialities which could be utilised elsewhere.	
374/25	The Rheumatology Consultant thanked Board members for the comments regarding the service and for their encouragement, adding that she was extremely proud of this holistic service for patients.	
375/25	The Group Chair offered that this service fitted with what the Group was trying to achieve and new models of care moving forward and added that this was an excellent celebration of success. The Board: • **Received the presentation**	

	Item 8 Strategic Aim 1 Patients
376/25	**Item 8.1 Assurance and Risk Report Quality Committee**
	The Chair of the Quality Committee, Mr Connolly, presented the Committee reports following the meetings held during May and June 2025 and the reports were taken as read with no formal escalations made to the Board from either meeting.
377/25	The Committee was seeing ongoing themes in relation to treatment delays, communication, deteriorating patients and pressure ulcers which would all be the subject of ongoing watchfulness.
378/25	Patient safety mortality indicators were within expected ranges, and a cluster of MRSA cases had been reported within maternity services, where appropriate actions had been taken with ongoing mitigations in respect of some challenges in infection prevention and control practices. Action plans had been developed to ensure improvements were made.
379/25	The Committee received a laparoscopic audit highlighting ULTH as an outlier at Pilgrim Hospital, Boston. The Committee was reassured that case note audits were being undertaken and a further report would be submitted to the Quality Committee at the appropriate time.
380/25	Antibiotic use in ULTH also remained an outlier and work had been identified on culture, ownership and associated challenges. The Committee supported the initial improvement plan and requested an overall antibiotic reduction plan review in six months. The Committee also heard of some fragility within paediatric services, however significant improvement had been seen in Looked After Children initial health assessments and were now reporting a position of 85% - 87% completion within 20 days which was noted as a great improvement.
381/25	Several patient and staff stories on end-of-life care had been received by the Committee, demonstrating excellent work, however ongoing challenges remained, and the Committee sought improvements for patients and relatives.
382/25	With regards to maternity and neonatal services, the Clinical Negligence Scheme for Trusts (CNST) maternity standards confirmed that ULTH was now fully compliant with year six and was moving into year seven. Mr Connolly informed the Board that for standard one, the quarter four report had been received, reviews had been completed, and standards had been met.
383/25	Standard three, the IV antibiotic quality improvement project was ongoing. Standard four related to neonatal clinical staff and there were clear improvements in place. Standard five was noted with a deficit of 12.1 whole time equivalent posts and mitigation plans were in place. The Committee noted progress towards full compliance in respect of standard six. Standard seven identified funding risks on infrastructures and all mitigations required with regards to training were received by the Committee in respect of standard eight. Standard nine in respect of floor to Board, Non-executive Director Maternity Safety Champion meeting and perinatal leadership meetings were being held bi-monthly. Standard ten demonstrated there were two qualifying cases and no early notifications, 100% compliance on duty of

	candour had been achieved, including accessible formats. Mr Connolly advised that all relevant papers were available within the iBabs Reading Room for Board members.
384/25	Mr Connolly informed Board members that the Board Assurance Framework (BAF) remained amber rated across all strategic domains. The 2024/25 Quality Accounts had also been reviewed by the Committee and were recommended to Board for approval.
385/25	The Group Chief Nurse advised that work was ongoing with the Medical Directors Office to review Infection Prevention and Control processes and antibiotic champions, which would strengthen action plans. The Group Chief Medical Officer also offered that in terms of antibiotic stewardship a team approach was being taken to addressing this. Pathlinks contributed to this in terms of the algorithm which lends ULTH to be an outlier in treating some conditions and discussions were taking place regarding potential changes to the pathway. A deep dive would also be provided to the Committee in respect of End-of-Life strategies which would provide further assurance.
386/25	The Group Chair commented that it would be helpful for the Board to understand the gap analysis in respect of maternity services. The Group Chief Medical Officer responded stating that a stocktake would be undertaken.
387/25	With regards to the laparoscopic audit the Group Chief Medical Officer also advised that as part of a national audit, ULTH predominantly reported on emergencies in acute cases, and the Pilgrim Hospital site had been flagged as an outlier. This often related to data integrity issues and therefore a case note audit was being undertaken and the actions would be reported to the Clinical Effectiveness Group.
388/25	The Group Chair asked about the paediatric cardiology audit and noted some harm which had been caused as a result of delays. The Group Chief Medical Officer advised that work was underway to clear a backlog through triage, to ensure that the service moving forward was more sustainable. As a consequence of this there could be harm relating to the delay and two cases had been identified where patients had been treated elsewhere with deteriorating symptoms. The Group Chief Medical Officer reassured the Board that there was a robust process in place and harm would normally be identified via Datix; this would continue to be monitored. Monthly meetings were continuing to take place with NHS England and the Group Chief Medical Officer was chairing a task and finish group to enact the actions required in respect of the backlog and potentially establishing additional services.
389/25	The Group Chair acknowledged the improvements in Looked After Children compliance and took the opportunity to thank the Director of Midwifery for the excellent suite of maternity papers which clearly set out the risks, actions and timeframes. The Board: • **Received the assurance reports, noting there were no escalations** • **Noted the CNST Standards**

390/25	**Item 8.2 2024/25 Quality Accounts** The Board received the Quality Accounts for 2024/25 for both ULTH and LCHS. The documents outlined the work that had been completed during the last financial year, with a focus on improving the quality of care that was provided to patients. The Quality Accounts included comments from partner organisations, which acknowledged the work that had taken place in some areas and identified other areas of focus into next year.
391/25	The Group Chief Clinical Governance Officer took the opportunity to formally thank the Head of Clinical Effectiveness and Complaints for the work undertaken on both documents within the required timescales. The Board: • **Received the 2024/25 2024/25 Quality Accounts**
392/25	**Item 8.3 Urgent and Emergency Care Plan 2025/26** The Group Chief Integration Officer presented the 2025/26 Urgent and Emergency Care Plan which had recently been released. The document set out a roadmap for rapid and sustained improvements within urgent and emergency care, focussing on the core constitutional standards in respect of services at the front door with the addition of 12 hour wait changes to national reporting and the new additional 45-minute handover mandatory standard.
393/25	The Group Chief Integration Officer explained that across Lincolnshire plans were being developed as a healthcare system, which would include several high priority actions in respect of immunisation rates of the population and outbreak management. There would also be benchmarking against key measures with two areas of care metrics, already scrutinised by the Finance and Performance Committee, for 12 hour waits and 45-minute handovers.
394/25	The winter plan would be submitted to the next Board meeting for approval and there would also be countrywide Emergency Preparedness, Resilience and Response (EPRR) test of those before the end of September 2025. The Board: • **Received the 2025/26 Urgent and Emergency Care Plan**
395/25	**Item 8.4 Assurance and Risk Report Finance and Performance Committee** Ms Cecchini provided the assurances received by the Finance and Performance Committee, at the meetings held during May and June 2025 and the reports were taken as read.
396/25	In respect of operational performance following a successful year, Ms Cecchini advised the Board of a small deterioration within urgent and emergency care, planned care had zero waits for 104-weeks and zero 78-week waits with 14 65-week

	waiters, due to patient choice in the main. Improvements were being seen within diagnostic services and long-term support was being sought.
397/25	The cancer 28-day standard had not been achieved for the first time for a long period and stood at 72% and there had been a further deterioration in 31- and 62-day activity to 75%; the standards would be reviewed going forward.
398/25	A review of community metric wait times had taken place and a more focussed discussion would take place at the next meeting.
399/25	At the June meeting the Committee received an upward report from the Productivity, Improvement & Transformation Oversight Forum (PITOF), which members found helpful and had also been submitted to the Integration Committee and offered assurance against of the transformational changes required to achieve more sustainable improvement in operational performance and cost improvement programmes (CIP).
400/25	From a finance perspective, whilst the organisations were on plan in terms of CIP significant changes were expected in months four and seven and whilst the approved plan identified all CIPs, further validation had identified a gap which teams were working on to mitigate and was a significant undertaking. The Committee had noted that one area agreed in May was a post evaluation programme for investments which was welcomed, and the first report was expected at the July Committee meeting.
401/25	The Committee had received the corporate cost reduction plans which had been submitted to NHSE and deemed as compliant. There were some exceptions which were awaiting a response from NHSE.
402/25	With regards to estates, Ms Cecchini advised the Board that this area remained red rated largely due to the community estate managed by NHS Property Services due to unacceptable levels of assurance being able to be gained in respect of Authorised Engineers (AE's) reports for statutory compliance. AE's had been appointed and the Committee were awaiting an outcome of reviews to ascertain if there were positive improvements on the ratings.
403/25	The Estates team had responded to an internal audit report regarding planned preventative maintenance which had returned limited assurance, and a commissioned external review had been requested to undertake a deep dive.
404/25	An onward referral to the People Committee was recommended with regards to health and safety and mandatory training metrics as mandatory fire training was not compliant with KPIs. A cyber dashboard was also received along with an update from the Information Governance Group which demonstrated positive improvement would be made in subject access requests backlogs by August 2025. Subject access request issues relating to record keeping, particularly in relation to staff records was noted which was limiting the ability to respond efficiently and effectively.
405/25	The Committee also received the Emergency Planning Annual Reports for LCHS and ULTH which were recommended to the Board.

406/25	The Board approved the publication of the EPRR policy noting that this had been reviewed on their behalf by the Finance and performance Committee.
407/25 408/25	The Group Chief Finance Officer offered that the learning from the 2024/25 post investment had concluded, and lessons would be learned for this programme of works for 2025/26. The Group Chief Finance Officer also offered that the corporate cost return had been submitted in line with national timescales and actions would be monitored through budget management or the efficiency programme.
409/25	The Group Chief Operating Officer provided assurance that the FDS position of 72.5% related to a myriad of issues and the position had improved to 76.2% in June. The Group Chief Estates and Facilities Officer informed Board members that the AE's had now been appointed and were working through reports. The first water safety report had been received, and the rest would follow over the coming weeks and there would be more knowledge of the risks being carried soon.
410/25 411/25	The Group Chief Clinical Governance Officer informed those present that she was Chairing the PITOF meetings, and the meeting brought together all productivity and improvement activity taking place along with the CIP programme detail which enabled colleagues to review data in more detail. The meetings were being found to be of benefit in respect of providing oversight on the CIP programmes across the Group. The Group Chief Estates and Facilities presented the EPPR reports for ULTH and LCHS which had been considered and approved on behalf of the Board at the Committee meeting.
412/25	For LCHS, the Group Chief Estates and Facilities Officer explained that improvements had been seen over the last year and was 84% compliant, with 49 of 58 core standards fully compliant and there was a high level of compliance for tactical and operational commanders. LCHS had taken part in internal and regional exercises and a vast amount of work had been completed to meet the core standards. In terms of areas of risk, Business Continuity Plans (BCPs) remained a concern and documentation was limited around external suppliers. Some training needs also required re-emphasising and addressing. The Group Chair acknowledged the improvement made with the LCHS ratings over the last year.
413/25	The Group Chief Estates and Facilities Officer advised Board members that ULTH was 90% complaint and good improvements had been made with the organisation now fully compliant on 58 of 62 core standards and had participated in major incident exercises and several internal incidents which teams had responded to well. Some risks remained in respect of counter measure plans, lockdown procedures for both ULTH and LCHS which would require a staged approach and 24/7 loggist coverage was also an area which was being further explored. There had been continued focus on BCPs. There were five partially compliant standards which would receive continued oversight from the Emergency Planning Group.
414/25	The Group Chief Operating Officer took the opportunity to commend the Emergency Planning Teams across the Group who had dealt with some internal incidents

	throughout the year and for their ownership of the SBAR cascade and standdown procedures which had been significant.
	
	The Board:
	    • **Received the assurance report**
	    • **Received the 2024/25 EPRR Annual Reports for LCHS and ULTH**

415/25	**Item 8.5 Finance Briefing** The Group Chief Finance Officer offered a summary of performance as at month two advising that for 2025/26 the ULTH year to date financial position was a £7.1m deficit, which was in line with plan, and the LCHS year to date financial position was a £1m deficit, £0.1m favourable to plan.
416/25	The ULTH Cost Improvement Programme (CIP) year to date had delivered savings of £5.3m which was in line with plan and LCHS had delivered £0.7m in savings, which was £0.2m favourable to plan.
417/25	As part of the CIP work, the Group Chief Finance Officer explained that several service transformation projects were underway and as well as work to ensure that workforce spend was controlled, there would also be a focus on limiting spend on temporary workforce and vacancy control.
418/25	The Group Chief Nurse described a risk-based approach to not utilising the temporary workforce and a process whereby other wellbeing measures had been implemented to reduce sickness and controls, good roster compliance would also be key to this. There would be an end to the usage of overtime which would see an impact in reducing workforce figures. The Group Chief Nurse also advised Board members that 80 whole time equivalent Health Care Support Workers (HCSWs) had been appointed following a period of recruitment which would offset trajectories from August 2025. The Group Chief Nurse explained that the same oversight process would be applied to administrative bank.
419/25	The Group Chief Medical Officer offered that earlier job planning processes had been undertaken this year which would help to define decisions and identify gaps in establishment vacancies, and a review would be undertaken through temporary staffing solutions to tighten controls. Retrospective approvals also required further grip and control to reduce the spend, which would be enacted imminently.
420/25	The Group Chief People Officer offered that work was underway with the Digital Team for live reporting to be available in respect of the reporting of temporary staffing. The vacancy control process had also been reviewed and the focus was on the temporary staffing elements to ensure patient safety was not compromised. Weekly reporting would be implemented to provide more thorough oversight of use and spend. The Board: • **Received the report**

	Item 9 Strategic Aim 2 People
421/25	**Item 9.1 Assurance and Risk Report People Committee** Mrs Wells provided the assurances received by the People Committee, at the meetings held during May and June 2025 and the reports were taken as read.
422/25	At the June meeting the Education Oversight Group provided a positive position on statutory and mandatory training with LCHS at 91.44% and ULTH 92.57%. Fire safety training was being reviewed, and an update would be provided at the next meeting.
423/25	Discussions would be held with the University of Lincoln regarding changes to apprenticeship levies and an update would be provided at a future meeting. Discussion also took place on temporary workforce and bank/agency use as previously described. In terms of medical education there was positive feedback from NHS England on trainees, however education space for some medical education continued to be a challenge in some areas across the Group which the Space Group was reviewing. The results of a GMC survey were expected in August 2025.
424/25	The Committee recognised the significant number of volunteer hours being undertaken across the Group and several celebration events for the volunteer workforce had been held over recent weeks.
425/25	An update from the Workforce Strategy Group was provided and vacancy rates were above expected levels in some areas. A deep dive had been provided on speech and language therapy, and staffing had been raised as a risk. There had also been a reduction in sickness rates across the Group, and the Committee was optimistic that rates would have further reduced at the next meeting. There had been a positive update in respect of appraisal rates and good outcomes were being seen.
426/25	A workforce hub had been created to support change programmes to ensure staff members were fully supported. The Committee also commended the work undertaken on the Mutually Agreed Resignation Scheme (MARS) so far, in respect of pace and delivery.
427/25	Rest space remained an issue and had been referred to the Group Chief People Officer and an Equality Diversity and Inclusion Report had been received with the Committee noting work in progress to explore reductions in scores and an update would be provided at the next meeting. The Culture and Leadership Group upward report acknowledged the volume of change programmes and Group Leadership Team (GLT) Roadshow feedback. The Committee was also advised of five employee exclusions across the group.
428/25	All areas of the Board Assurance Framework remained amber rated.
429/25	At the May meeting, the Committee had been advised of work in the emergency department on culture and behaviours and the Organisational Development team had been providing support to leaders and a further update would be provided in six months, where it was anticipated that improvements would be seen.

430/25	The Group Chief People Officer advised that the vacancy position remained higher than expected within the vacancy control period and the current process had been extended for a further three months. The Board: • **Received the assurance reports**
	Item 10 Strategic Aim 3 Population
431/25	**Item 10.1 Assurance and Risk Report from the Integration Committee** Mr Connolly provided the assurances received by the Committee at the meetings held in May and June 2025 noting there were no upward escalations to the Board. The Board Assurance Framework had been reviewed in detail with updated narrative, and no changes were noted in assurance ratings.
432/25	From an estates perspective updates were received regarding capital which was on track and the Committee had received improvement plans relating to space utilisation which remained between 50% - 54%. An update on the development of integration neighbourhood teams was also provided and had been well received. Population health data was starting to develop further, and the Committee would maintain oversight and assurance of this moving forward.
433/25	The Electronic Patient Record (EPR) procurement work had been completed, and it was anticipated that scanning would commence in January 2026.
434/25	Draft Green Plans were received for both LCHS and ULTH which required further refinements and would be presented to the Board at the September 2025 meeting.
435/25	The Committee approved the approach to a discharge dashboard which had underpinning methodologies and would support a move to reduce average length of stay for patients.
436/25	In respect of Digital, BadgerNet had gone live, and the Digital Strategy was presented to the Board for approval.
437/25	The Group Chief Integration Officer offered that the Committee had received two deep dives relating to the discharge work and the new system would be implemented on three Wards on each of the two acute sites during July. The ICB Target Operating Model work had been paused as a result of the ICB Model Blueprint and work would be recommencing shortly.
438/25	The Group Chief Integration Officer explained that ULTH was trying to complete the introduction of the Electronic Document Management System work in 18 months.
439/25	The Group Chief Estates and Facilities Officer advised that in terms of space, 54% related to open space bookable via NHS Property Services, this was not overall space utilisation.

440/25	The Group Chair commented that the Digital Strategy was professionally written and presented. The Board: • **Received the assurance reports** • **Approved the Digital Strategy**
441/25	**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 and several areas had been discussed throughout the meeting.
442/25	The Group Chief Integration Officer explained that the new Integrated Performance Reports would be seen by Committees during the next cycle of meetings which would cascade through to Board reports.
443/25	In relation to the Summary Hospital-level Mortality Indicators (SHMI), the Group Chief Medical Officer provided some clarification in relation to the methodology. It was explained that the detail within the report appeared to demonstrate an upward trend, however this was a dynamic measure where the upper limit of normal described that this was normal or above expected numbers and over a period of time the trend had increased to the upper limit of normal, following a number of expected deaths. The current level for the SHMI was 109.34% and this would need to be scoring 115% for this to flag as above normal.
444/25	The Group Chief Medical Officer advised those present that the organisation was remaining well within the normal range and assured the Board that this was not an area of concern, however this would continue to be monitored. The Board: • **Received the Integrated Performance Reports noting the moderate assurance**
	Item 12 Risk and Assurance
445/25	**Item 12.1 Group Risk Management Report** The Group Chief Clinical Governance Officer presented the risk report to the Board noting that the number of very high risks had remained static for LCHS. There had been one very high risk reported to the Quality Committee and one risk increase relating to procurement staffing. The pharmacy workload had been closed as a result of merging this with another risk.
446/25	The Finance and Performance Committee had been presented with five very high risks and the Integration Committee held no very high risks.
447/25	The Group Chief Clinical Governance Officer advised that work was underway to realign the risks to the new strategic objectives and further movement would be seen within the next Committee reporting cycle.

	The Board: • **Accepted the risks as presented noting the significant assurance**
448/25	**Item 12.1.1 Risk Appetite Statement 2025/26** Following a recent Board Development Session, the Group Chief Clinical Governance Officer informed those present that the Non-Executive Director Chairs of Committees and Executive Leads had met to review the Risk Appetite Statement for 20252/26 which was now presented for approval by the Board.
449/25	The Group Chief Clinical Governance Officer took the opportunity to formally offer thanks to the Deputy Group Clinical Governance Officer for developing this document. The Board: • **Received the report and agreed the updated risk appetite description/levels against each strategic objective** • **Approved the 2025/26 Risk Appetite Statement and agreed to append this to the Risk Management Policy**
450/25	**Item 12.2 Board Assurance Framework** The Group Director of Corporate Affairs presented the 2025/26 Board Assurance Framework and explained that significant work had been undertaken on this. Colleagues acknowledged some elements remained under development and work was ongoing with Executive Directors.
451/25	The Board acknowledged that this had been considered by Committees during May and June 2025 and there had been no changes to the assurance ratings against the strategic objectives since it was last received. The Board Assurance Framework continued to be aligned to risk reporting and the risk appetite statement.
452/25	The Group Chair requested that Audit Committee gave this independent oversight at the next meeting and should report back to the Board to provide an added layer of assurance. **Action: Audit Committee Chair, 25 July 2025** The Board: • **Accepted the 2025/26 Board Assurance Framework**
453/25	**Item 12.3 Assurance Report from the Audit Committee** Mr Herbert provided the key highlights from the Audit Committee meeting held in June 2025 which had dealt only with business related to the sign-off of the annual report and 2024/25 annual accounts for both ULTH and LCHS, and the report was taken as read.
454/25	The Committee had 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 concern. 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.
455/25	The Committee received the Audit Completion Report and Auditors Annual Report for both organisations. The Committee was advised that the audit work was still ongoing as was usual however was substantially completed. The queries which were outstanding were being resolved between the team and the Auditors.
456/25	The Committee had been advised of one adjusted misstatement in the final version of the LCHS report which was above the reporting threshold but below materiality.
457/25	The Committee was advised of one unadjusted misstatement in the ULTH report, which was above the reporting threshold of £300,000, related to a differing opinion on how the refund for the Brockenhurst Case had been accounted for.
458/25	In respect of the value for money review, there had been some weakness highlighted for ULTH in terms of financial sustainability which was required to be referred to the Secretary of State for Health.
459/25	The 2024/25 Annual Accounts and Annual Reports for both LCHS and ULTH had been received and subject to financial amendments both reports were recommended to the Board for approval and had subsequently been approved at a Board meeting on 23rd June 2025.
460/25	With regards to the external auditors value for money assessment, the Group Chief Finance Officer explained that feedback had been received that more progression had been seen in the 2025/26 financial plan and it was anticipated that a review would be undertaken once a breakeven plan had been delivered. The Board: • **Received the Assurance Report**
461/25	**Item 13 Board Forward Planner** The Group Director of Corporate Affairs presented the Forward Planner for Board for information. The Board: • **Received the Board and Board Development Forward Planner**
462/25	**Item 14 Any Other Notified Items of Urgent Business** No further items were discussed.
463/25	The next scheduled meeting will be held on Tuesday 2nd September 2025 via MS Teams live stream.

Voting Members	6 May 2025	1 July 2025											
ULHT/LCHS													
Elaine Baylis	X	X											
Rebecca Brown	X	A											
Neil Herbert	X	X											
Dani Cecchini	X	X											
Jim Connolly	A	X											
Karen Dunderdale	X	X											
Daren Fradgley	X	X											
Nerea Odongo	X	X											
Colin Farquharson	X	X											
Paul Antunes Goncalves	X	X											
LCHS													
Gail Shadlock	X												

Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
1 July 2025	451/25	Board Assurance Framework	Audit Committee to give the Board Assurance Framework independent oversight to provide an added layer of assurance.	Audit Committee Chair	2 Sept 2025	Audit committee considered the Board Assurance Framework in detail at it's meeting on 25 July. Assurance was received from Committee Chairs that the framework was fit for purpose and was being fully utilised in Committees. Audit Committee would continue to maintain it's oversight as the framework continued to develop

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	*2nd September 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 July and August 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.

b) Resident Doctors participated in national industrial action coordinated by the British Medical Association from 25 to 30 July 2025. The action was in response to ongoing disputes over pay restoration and working conditions. During the industrial action the Group implemented its established business continuity protocols to mitigate any disruption and we continue to monitor the national situation in preparation for any potential future action. I would like to pay tribute to our colleagues and partners for the robust planning and ensuring our patients remained safe.

c) The Department of Health and Social Care published the 10 Year Health Plan for England during July 2025, marking a pivotal moment for the NHS. The plan titled 'Fit for the Future' responds to Lords Darzi's review of the NHS. The plan sets out a transformational vision for the NHS aiming to ensure long term sustainability. The health plan focuses on three fundamental shifts - from hospital to community, from analogue to digital and from sickness to prevention. The Lincolnshire system is engaging with the plan's priorities, particularly around digital transformation, workforce empowerment and financial sustainability, as part of the strategic planning and operational delivery.

Eight working groups have been established to support the delivery of the 10 Year Health Plan. Following an expression of interest I have been invited to be part of the Oversight, Foundation Trust Licensing and Integrated Health Organisations working group and other CEOs in Lincolnshire have also joined other working groups.

d) On 16 July 2025 the Department of Health and Social Care published the findings of independent review into the roles of Physician Associates (PA) and Anaesthesia Associates (AA) led by Professor Gillian Leng. The review provides a comprehensive assessment of the safety, effectiveness, and integration of these roles within multidisciplinary teams across the NHS. The review was an opportunity to reset and clarify the scope and supervision of these roles, with immediate changes including revised job titles and deployment guidance. As a Group, we are committed to supporting the implementation of these recommendations, ensuring that our workforce is aligned with national expectations and continues to deliver safe, high-quality care.

e) During July Dr Penny Dash's, Chair of NHSE, independent review of patient safety across the health and care landscape was published. This review highlights the need for a more coherent and strategic approach to patient safety across health and care. It identifies fragmented oversight, underused data and digital tools, and weak integration of patient and staff voice. The report sets out nine key recommendations to streamline governance, strengthen accountability, and embed quality improvement, placing greater emphasis on leadership, digital innovation, and meaningful engagement.

f) Following the consolidation of Integrated Care Boards it has now been formally agreed that Lincolnshire ICB will become part of a cluster arrangement with Derby and Derbyshire ICB and Nottingham and Nottinghamshire ICB. Work is ongoing to develop the structures for this cluster along with confirmation regarding the Chair and Accountable Officer designated appointments.

g) The Quarter 1 Lincolnshire System Review Meeting took place on 16 July 2025 with the regional NHSE team. This was a positive meeting and there continues to be confidence in the system.

h) NHS England published the 2025/26 Winter Plan in July which sets out the system wide strategy to strengthen resilience and improve performance across urgent and emergency care services. The Lincolnshire system is developing robust winter plans to address the key priorities of the plan and ensure alignment with national performance targets. Regional stress testing of the plan will be conducted in September with final plans and Board Assurance statements submitted to NHS England by October.

Group overview

a) At month 4, ULTH reports a YTD financial position of £10.6m deficit, in line with plan

b) LCHS's YTD financial position is £1.7m deficit, £0.1m favourable to plan.

c) The ULTH CIP YTD has delivered savings of £13.7m, 0.7m favourable to plan. LCHS CIP YTD has delivered £1.4m, which is £0.1m favourable to plan.

d) During June 2025 annual appraisals for the Executive Leadership Team (ELT) were completed in line with the Board member appraisal guidance. In addition, all ELT members continue to meet the criteria set out in Fit and Proper Persons Requirement , with no issues identified through the appraisal or ongoing assurance process. This reflects the Group commitment to strong governance, accountability and leadership standards.

e) Following the signing of the contract with Nervecentre in June, the Initiation Stage of the Electronic Patient Record (EPR) Programme commenced on 14 July. This short phase is designed, via a series of workshops involving staff, to produce a high-level plan for the programme, which will be the blueprint for the detailed Implementation Stage, in which each of the modules will be designed and built. The excellent level of attendance at the workshops has demonstrated staff commitment and excitement that the EPR Programme has moved from planning into an active stage.

f) The Group has undertaken a public engagement exercise, for a period of 6 weeks, about the future location of orthopaedic clinics in Lincoln. The Orthopaedic Clinic (11) is currently located next to the Same Day Emergency Care (SDEC) at Lincoln County Hospital, which is an area identified for development to improve the urgent and emergency care pathways. To enable these developments to take place and increase the footprint of SDEC, ULTH is exploring the option to relocate the existing orthopaedic clinic to free up additional space. The Trust is proposing to relocate the orthopaedic clinic to Lincoln Community Diagnostic Centre and staff, patient and public views are being sought on this change.

g) Construction is currently underway on a new £26.5 million Endoscopy Unit at Lincoln County Hospital, designed to meet the growing healthcare needs of residents across Lincolnshire. This state-of-the-art facility will offer modern, accessible spaces for patients while significantly enhancing the working environment for staff. Once complete, the unit will expand the Group's diagnostic capacity, enabling faster, more comfortable diagnostic services and improving overall patient care.

h) Following submission of the annual review by the Endoscopy Service at ULTH, the Trust has received confirmation that all required Joint Advisory

Group (JAG) accreditation standards have been met and the accreditation has been renewed for a further year. This significant achievement is a testament to the consistent high standards of care, professionalism and dedication demonstration by every member of the team. Achieving and maintaining JAG accreditation reflects a deep commitment to quality, safety, and continuous improvement in patient care.

i) As part of the annual reporting process for the National Neonatal Audit Programme (NNAP), the Neonatal Service at Lincoln County Hospital has been formally recognised as outstanding in Retinopathy of Prematurity (ROP) screening. The service achieved a compliance rate of 97.5%, significantly exceeding the national average of 80%. This outstanding result reflects the team's unwavering commitment to clinical excellence, early intervention, and the highest standards of neonatal care.

j) On 18 July 2025 I attended the official launch of Age UK Lincolnshire. The event marked a significant milestone with the beginning of a new chapter for the organisation, which has evolved from its previous form to better reflect its expanded reach and renewed commitment to supporting older people across the region.

k) On 1 August 2025 the Group hosted a visit to Lincoln County Hospital by NHS England Chief Executive, Sir Jim Mackey. This provided an opportunity for us to talk through how we are planning to take forward the NHS 10 Year Health Plan. The visit included a tour of the urgent and emergency care pathways which provided an opportunity for the teams to showcase the amazing work they do to support the residents of Lincolnshire. There was also an opportunity with partners to demonstrate our joined up working and sense of community.

Group Model Workstream Progress Briefing

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2nd September 2025*
Item Number	*6.1*

Group Model Workstream Progress Briefing

Accountable Director	*Karen Dunderdale, Group Chief Executive*
Presented by	*Karen Dunderdale, Group Chief Executive*
Author(s)	*Wendy Booth, Interim Governance Advisor*
Recommendations/ Decision Required	*The Board is asked to:-* - *review progress with the delivery of the group development programme plan; and* - *note the issues highlighted requiring further action*

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

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

There has been continued good progress on delivery of the agreed programme milestones. In the main, slippage on agreed timescales for some actions remains as previously reported although within the report as at August 2025, slippage is being reported in respect of some actions due to delays in GLT and / or board approval of relevant matters. In all instances, revised timescales for seeking the necessary approvals have been included within the plan.

Issues for escalation and further action:

- work to align the IPR and finalise the group KPIs remains outstanding – a revised timescale of 31 August 2025 to complete this work is indicated;

- the newly revised upward report & report templates, report writing guidance and any planned training need to be launched as a priority;

- the number of out of date policies (primarily within ULTH) is a risk for the group. The need for an improvement plan and trajectory to improve compliance in this area has recently been agreed by ELT.

Group Board Action Required

The Group Board is asked to:

- review progress on delivery of the group development programme plan; and

- note the issues highlighted requiring further action

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)**	**Complete:** 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 communicated and 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)**	**Complete:** As above. PRMs are now in their sixth cycle and are scored as per the Performance Management & Accountability Framework **(but see also work stream 2)**	🟩
Align the group support services and associated policies, processes and arrangements	1 April 2025 **(implementation)** 30 June 2025 **(embedded)**	Underway but not yet complete – 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 & Ongoing	Comms cascade underway through GLT roadshows	🟧

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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)**	Group Performance Management & Accountability Framework approved and aligned PRMs in place (now in sixth cycle). The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet complete. **Proposed revised timescale of 31 August 2025**	■
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)**	**Complete & ongoing:** Structure agreed. 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)**	**Complete:** Committees are now meeting jointly although arrangements continue to be embedded 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 have also been updated as part of the strengthening of the board & board committee templates Review of groups reporting into board committees is also complete. (The review of sub-groups reporting into those groups is a separate piece of work as part of BAU)	🟩
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)**	Revised suite of upward report and report templates and report writing guidance developed and agreed. Date of launch to be confirmed	🟥

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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)**	**Complete:** Review of executive governance / meeting structures undertaken – final iteration submitted to and approved by ELT on Thursday, 6 June 2025. Structures to be socialised through GLT and embedded	🟩
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	**Complete:** Final Terms of Reference agreed	🟩

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Board Reporting Framework (BAF) & Risk Registers			
Phase 1: Complete the work to align the two trust BAFs including a review and alignment of 'assurance ratings' and ensure that each strategic risk is cross-referenced with related risks on the corporate risk registers. **[Note:** Whilst the aligned BAF will reflect risks to the delivery of the strategic objectives which have been agreed for the group and the controls, assurance, gaps and actions may be the same for each organisation, where there are risks which are specific to either ULHT or LCHS, the controls, assurances, gaps and actions to be explicitly referenced for each separate organisation] Phase 2: Consider and agree the 'design' of the aligned BAF for 2025/26 onwards i.e. should the format of the aligned BAF look and feel different for the group? Agree the board committee oversight for each strategic aim & objective Phase 3: Implement the new style BAF	31 October 2024 **(underway)** 21 January 2025 **(Group Board workshop)** 1 April 2025 **(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 the 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 will start to be included from June 2025 onwards	(green)
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	(green)
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	(green)
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	(green)

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	Policy & Policy Approvals: 31 March 2025 **(policy in place) - complete** 31 June 2025 **(embedded) – not yet complete** Compliance 30 September 2025 **(agreement of improvement plan & trajectories)** 31 March 2026 **(improved performance)**	A combined document control policy and process is in place although is not yet fully embedded. The move to a single Intranet will enable policies to be in retained in one place A historical backlog of out of date policies & guidelines (primarily at ULTH) remains – this represents a risk to the group. Improvement plan and trajectories to be agreed for bringing out of date policies back into compliance and performance improved	■ RED
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	■ AMBER
Review and update relevant policies, documentation and templates to reflect the move to group and the group brand	As above	As above	■ AMBER

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. GLT and Group Board approval originally scheduled for July 2025 but delayed due to GLT cancellations and holiday periods. **Proposed revised timescale of 2 September 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	🟩

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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	**Complete:** LCHS staff now have access to ULTH intranet which became the group intranet from 6 August 2025	🟩
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	Comms & engagement support in place and ongoing	🟩
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) 31 March 2026 (remaining)	Priority policies have been harmonised and formally ratified. The Managing Attendance Policy remains outstanding and is scheduled for further discussions throughout August, with ratification anticipated by the end of September. While some policies have required more detailed dialogue to reach agreement, this has helped ensure that outcomes are well-considered and aligned with organisational needs. Once the final contractual policy is agreed, we expect to see an increase in the pace of policy harmonisation. Work will remain ongoing to harmonise all relevant remaining policies	🟧
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 has been scheduled 12 month ELT Development Programme in place and being supported by Acqua The OD team are developing the 'LCHG Way' and a key part of this is the LCHG leadership development programme. Both the LCHG Way and the group leadership development programme will be launched in Quarter 3 at the 'Better Together' Forum in October 2025	🟧
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	**Complete & ongoing:** The LCHG staff health & well-being offer continues to be developed and harmonised across the group. The menopause service was extended across the group in July 2025 and is now available to both ULTH and LCHS staff	🟩

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	**Complete:** Strategy considered by the Integration Committee in June 2025 and 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)**	**In progress & on track:** part of expanded AGEM service transition to LCHG • Phase 1 due to handover to LCHG July 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)**	**In progress & 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)**	In progress 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, however, mitigations are being put in place and work is progressing well • TUPE / due diligence process agreed. Measures Letter has been sent to NHSE. Group Deputy Director of People supporting process • Review of plan underway • 1 month slippage envisaged due to TUPE agreement. **Proposed revised timescale of 1 November 2025**	
• 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)	**In progress & on track:** 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)**	**Complete & ongoing:** Structure agreed. 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)**	In progress & on track: • 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: • All but 6 of 101 servers have been migrated. The teams continue to make slow progress due to significant technical issues and third-party dependency. However, Stalis, Bighand and Netcall are either scheduled or about to enter UAT testing. Datix continues to prove challenging. 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*	RED
• 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	AMBER
• 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 New Space Manager in place, however, issues remain with under utilisation. New process for booking open space being implemented. Future GLT sessions planned on space and space management	RED
• continue the programme of ward refurbishments, as funding is available	Ongoing	No funding currently available – programme to be reviewed in new financial year	AMBER
• undertake a review of all leases and licences across the group	30 June 2025	**Complete & ongoing:** All LCHS leases now obtained. New MOTO being negotiated with NHSPS which will move a number over to being in place and compliant. In respect of ULTH, there are a number of minor occupancies to work through and formalise. New Property Manager being recruited and will lead on this area of work	GREEN
• 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	GREEN
• 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	GREEN

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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 monitoring delivery of the agreed improvement actions	30 September 2025	Commenced – on track. Latest NHSE guidance and assessment tool received. Submission due 30 September 2025	
• undertake a review of Approved Persons (APs) for the relevant HTMs and as a key element of the EFM governance & assurance processes	30 September 2025	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	

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

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	**Complete:** reporting 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	**Complete & ongoing:** work underway to support reviews / updates of enabling plans including corporate nursing, health & safety, finance, quality & governance, estates and R&I	
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	

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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 note yet started	🟨
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)	**Complete:** Alliance Model and programme confirmed and approved via Integration Committee. Communications plan in development for internal awareness. New Terms of Reference to include a review of external members to be received by the Integration Committee in August 2025	🟩
Develop a Partnership Strategy for the group	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 September 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. Board approval originally scheduled for July 2025. **Proposed revised timescale – 1 September 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	**Complete:** Strategy agreed	🟩
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:** Consultation closed 29 July 2025. Review of counter proposals and final structure to be confirmed	🟨

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	1 July 2025 **(strategy drafted)** 31 October 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	**Complete:** Capital, Revenue & Investment Group (CRIG) 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	**Complete & ongoing:** 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	**Completed** – First finance roadshow training event held in February 2025. Budget holder refresher training held in February & March 2025. Ongoing training offer available within ESR	

Appendix A: Group Development Programme: Work Streams & SROs

Work Stream 1:
Group Operating Model & Leadership

SRO: Group Chief Executive (supported by Group Chief Integration Officer)

Work Stream 2:
Accountability, Information & Reporting

SRO: Group Chief Executive (supported by Group Chief Integration Officer)

Work Stream 3:
Aligned Governance & Decision-Making

SRO: Group Director of Corporate Affairs / Group Chief Clinical Governance Officer

Work Stream 4:
Comms & Engagement

SRO: Group Chief Executive / Group Director of Corporate Affairs

Work Stream 5:
HR & Workforce

SRO: Group Chief People Officer

Work Stream 6:
Organisational Development

SRO: Group Chief People Officer

Work Stream 7:
Digital

SRO: Group Chief Integration Officer

Work Stream 8:
Estates & Facilities

SRO: Group Director of Estates & Facilities

Work Stream 9:
Strategy & Planning

SRO: Group Chief Integration Officer

Work Stream 10:
Finance

SRO: Group Chief Finance Officer

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'
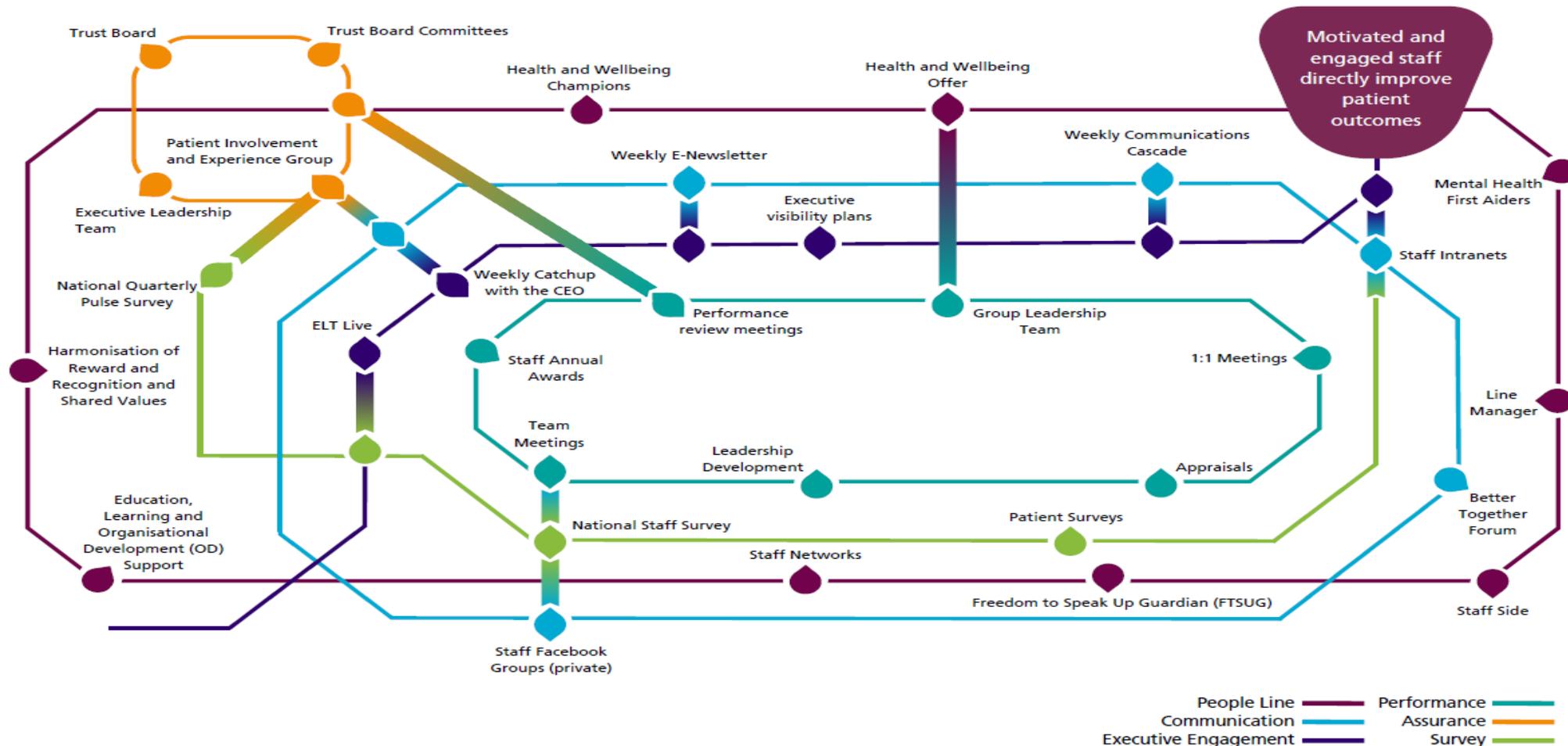
Appendix C: Staff Engagement 'Tube Map'

BETTER TOGETHER

Lincolnshire Community and Hospitals NHS Group

SURVEY
- National Quarterly Pulse Survey
- National Staff Survey

ASSURANCE
- Trust Board
- Executive Leadership Team
- Stakeholder Engagement Involvement Group
- People Executive Group
- Finance, Performance, People and Innovation Committee

PEOPLE
- Staff Networks
- Freedom to Speak Up Guardian
- Staff Side
- Leader
- Health and Wellbeing Offer
- Health and Wellbeing Champions
- Mental Health First Aiders
- People Interventions
- Harmonisation (shared values)

PERFORMANCE
- Team meetings
- Staff annual awards
- Leadership development
- Appraisals
- PMRs and managers reviews
- Heads of service and deputy directors group
- 1:1 meetings
- LDP alumnus

EXECUTIVE ENGAGEMENT
- CEO weekly email
- JCNC
- ELT Live

COMMUNICATION
- Better Together
- Staff Facebook groups
- Town Halls
- Back to Floor visits or shadowing
- Communication Cascade
- Staff Intranet
- Induction and mandatory training

Motivated and engaged staff directly improve patients' outcomes

NHS

Lincolnshire Community and Hospitals NHS Group

Quality Committee Upward Report

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2 September 2025*
Item Number	*8.1*

Quality Committee Upward Report of the meeting held on 15 July 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:

- Clinical Effectiveness Group Upward Report
- Clinical Audit Annual Report – LCHS/ULTH (**appendix 1a/1b**)
- Patient Safety Group Upward Report including ULTH Director of Infection Prevention and Control Annual Report 2024-25 (**appendix 2**)
- High Profile Cases
- Children and Young People Oversight Group Upward Report
- Focussed Discussions – Safer Discharge
- Patient Experience and Involvement Group Upward Report
- Patient Experience Annual Report – LCHS/ULTH (**appendix 3**)

- Safeguarding and Vulnerabilities Oversight Group Upward Report
- Safeguarding Annual Report – LCHS/ULTH (**appendix 4a/4b**)
- Complaints Annual Report – LCHS/ULTH (**appendix 5a/5b**)

The Committee recognised the Get It Right First Time (GIRFT) process and the need for further action to be undertaken by the Clinical Effectiveness Group (CEG) to progress.

The National Early Inflammatory Arthritis Audit (NEIAA) had identified ULTH as an outlier with the Committee noting the mitigations in place. The backlog of open local audits was noted within Surgery and a number of limited and moderate assurance levels were reported through the group.

The Committee requested, through CEG, an update on the emergency laparotomy audit, noting the case note review position to date.

The Patient Safety Incident Investigation summary report was received, with the Committee noting the ongoing development of this and the need to identify the 'so what' question through the report.

There was recognition of the 1 open overdue Central Alert System (CAS) alert, for which a deep dive would be undertaken, and it was noted that a wider understanding was required in order for this to be addressed appropriately.

The Children and Young People's Oversight Group upward report highlighted the areas of concern known to the Committee, with recognition of the ongoing work to address actions and consider service redesign. Transformation work associated with the services would be considered through the Integration Committee.

The Safer Discharge focused discussion identified the operational issues being face with an improvement plan in development though the Integration Committee work already being undertaken. The Committee would focus on the risks and mitigations associated with unsafe discharges with a request for an update to be offered back to the Committee in 6-months.

The Patient Experience and Involvement Group upward report highlighted the positive work being undertaken however there was recognition of the need to continue to develop the 'we did' element of the report to demonstrate how the Group responded to feedback received.

Concern was noted in respect of the funding associated with looked after children with the Committee noting the continuing challenges in respect of funding associated with the service. Escalation would be made to the System Quality Group.

The Committee received a series of annual reports as noted above and was satisfied with the positions presented for the 2024/25 year and therefore commended these to the Board, subject to the identification delivery dates for actions where not already provided.

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
- Quarterly Group CQC Progress Update
- Committee Performance Dashboard

The 2025/26 Board Assurance Framework was received with the Committee noting the updates offered in respect of the risks and confirmed that the assurance ratings would remain amber.

The Committee received and noted the risk register recognising the actions from the deep dive were taking place and reflected within the report with a ned to strengthen oversight of risks for all Committees.

The policy position was noted with the Committee noting the ongoing work to continue to progress the position.

The closure of the final outstanding CQC actions were awaited with recognition of the refinement of the evidence libraires being undertaken and aligned to the 10-year plan.

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	A	S	O	N	D	J	F	M	A	M	J	J
Jim Connolly Non-Executive Director (Chair)	A	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson Non-Executive Director												
Colin Farquharson Medical Director, ULHT	X	X	X	D	A	A	X	D	D	X	X	D
Rebecca Brown, Non-Executive Director (Maternity Safety Champion), ULHT/LCHS	X	X	X	A	X	X	X	X	X	X	A	X
Gail Shadlock, Non-Executive Director, LCHS	X	X	X									

Julie Frake-Harris, Chief Operating Officer, ULHT/LCHS		5										
Anne-Louise Schokker, Medical Director, LCHS												
Nerea Odongo, Group Chief Nurse	X	X	D	X	X	A	D	X	X	X	X	D
Caroline Landon, Group Chief Operating Officer	X	X	X	X	A	X	X	X	X	A	D	X
Daren Fradgley, Group Chief Integration Officer	X	X	X	D	A	X	X	D	X	A	X	X

X in attendance
A apologies given
D deputy attended

LCHS Clinical Audit Annual Report 2024-2025

Contents

1.   Executive Summary

The Clinical Audit Teams are aligning their processes to enable a standardised approach to the management of clinical audit within LCHS and ULTH. This will ensure that both teams understand the shared vision and objectives of the Group Model and how the roles contribute to the overall success of the clinical audit programme, which will include identifying duplication or differencing in existing processes and standardising workflows to improve efficiency and consistency.

LCHS have participated in 100% of all national audits that were applicable. Reports and action plans are presented within the Speciality and at Clinical Effectiveness Group (CEG). There is a comprehensive local audit programme with LCHS registering 228 audits.

2.   Introduction

The report provides an overview of the clinical audit programme for 2024-2025. LCHS continues to proactively manage the clinical audit programme, improving process and quality of audits, to enable the learning to be embedded into our services and practice.

3.   Forward Audit Plans 2025-2026

Each year, Care Groups / Specialties agree a programme of planned clinical audit activity for the forthcoming financial year. This process is co-ordinated by the Clinical Audit Facilitator (through consultation with clinical / nursing staff and Care Groups) and which is overseen by the Clinical Effectiveness Group (CEG).

Each year's plan reflects agreed priority audits, based on considerations such as anticipated Trust / Care Group quality objectives, national clinical audits, commissioning priorities, national guidance (NICE, Royal College) and local clinical priorities. Audits are categorised based on priority areas for clinical audit as outlined within the Healthcare Quality Improvement Partnerships (HQIP) 'Clinical Audit Programme Guidance'. The Forward Audit Plans have been forwarded to the Care Groups for approval through their Clinical Cabinet Meetings.

4. Clinical Audit Training

Throughout the year, the Clinical Audit Facilitators at ULTH continued to run a 'Beginner's Guide to Clinical Audit' sessions aimed at Foundation Doctors and staff with little or no previous experience of carrying out a clinical audit who would like a good grounding in the basic principles. Further sessions are planned for 2025-2026 and the team will focus on promoting these as a Group.

5. Clinical Audit awareness Week

The Clinical Audit Awareness Week is an annual event dedicated to highlighting the importance of clinical audit in improving patient care and outcomes. It provides a platform to celebrate best practices, shared learning, and engage staff in audit activities. In conjunction with ULTH, we organised a series of exciting activities including an audit competition to showcase innovative projects. There were also national presentations featuring expert speakers discussing key developments and insights into clinical audit. These activities aim to increase awareness, encourage participation, and demonstrate the value of audits in driving continuous improvement across our Trust.

6. Internal Audit

As part of 2024/2025 Audit and Assurance Plan, Internal Audit undertook a review of Clinical Audit within LCHS. The audit focused on the annual planning process, the delivery and completion of projects and monitoring and reporting arrangements. The final report was issued in December 2024 and the overall assurance opinion on the design and operation of controls was found to be of 'Reasonable Assurance'. Recommendations made included making changes to current policy / internal documentation, suggested changes to the systems and processes of recording evidence to improve assurance and standardisation of reporting. An action plan has been developed, and progress is being made on the recommendations.

7. National Clinical Audit

LCHS are participating in 100% of all relevant audits.

The Trust have participated in 7 national clinical audits which is 100% of national audits that they were eligible for.

Graph 1 - National audit participation compliance.
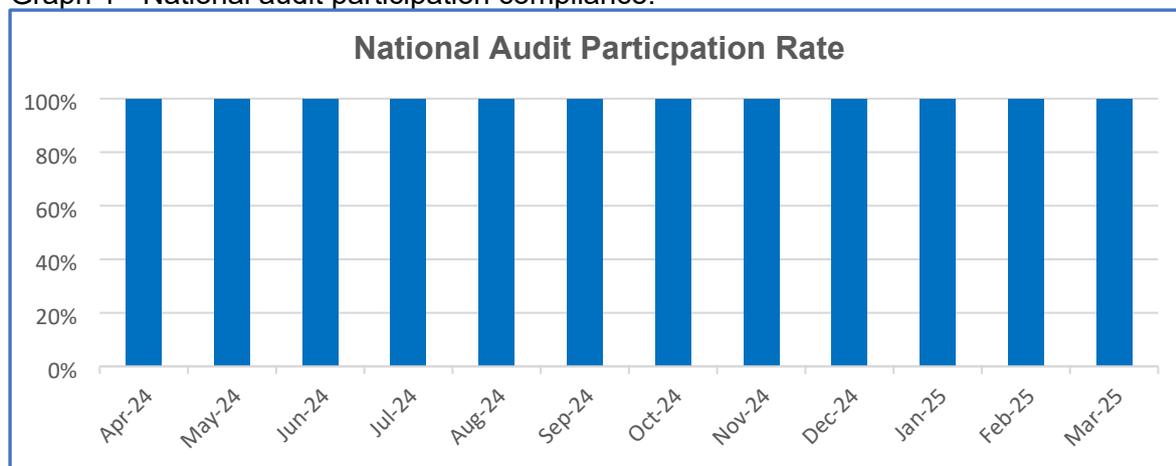
LCHS participate in seven national audits. In 2024-2025, there were three national audit reports published.

Table 1 – List of national audits published during 2024-2025

Date Published	Name of National Audit	Presented at Speciality Meeting	Presented at CEG
October 2024	National Inpatient Falls Audit		Data presented within ULTH data (LCHS report monthly)
October 2024	National Audit of Cardiac Rehabilitation (NACR)	Data will be presented at Quality Safety Group in May 25.	Date to be confirmed
November 2024	Sentinel Stroke National Audit Programme (SSNAP)	Report being presented at May Clinical Audit Group.	Date to be confirmed

8.   Local Audit Programme

LCHS have a comprehensive local audit programme, however, there have been a number of audits that had to be closed due to the audit not progressing. The development of a robust forward audit plans will help eliminate the need going forward to close audits due to them not being progressed by the auditor. The Clinical Audit Facilitators are actively pursuing open actions with the Audit Leads to enable

audits to be closed within the required timeframes, however, there are some audit actions that remain open, and a trajectory has been developed to aid closure.

Audits Registered / Open

LCHS have a rolling audit programme across all Divisions, therefore, every year the audits are rolled forward to the following year. There have been 228 audits registered since 2022.

Table 2 - Number of audits registered by Division

Division	2022-2023	2023-2024	2024-2025	Total
Integrated Urgent & Emergency Care	11	12	15	38
Community Hospitals	17	23	28	68
Community Nursing	0	1	9	10
Children & Young People Specialist Service	25	31	36	92
Trust wide	1	1	3	5
Corporate	3	4	8	15
LCHS	**57**	**72**	**99**	**228**

There are currently 91 audits being completed within the Divisions.

Table 3 - Number of open audits

Division	2024-2025
Integrated Urgent & Emergency Care	14
Community Hospitals	24
Community Nursing	7
Children & Young People Specialist Service	34
Trust wide / Corporate	12
LCHS	**91**

Outstanding Actions

There are 75 outstanding actions dating back to 2022.

Table 4 - Number of outstanding actions

Division	2022-2023	2023-2024	2024-2025	Total
Integrated Urgent & Emergency Care	0	0	0	**0**
Community Hospitals	2	8	0	**10**
Community Nursing	0	1	0	**1**
Children & Young People Specialist Service	0	2	62	**64**

Trust wide / Corporate	0	0	0	**0**
LCHS	**2**	**11**	**62**	**75**

9. Clinical Audit Group

The Trust have a monthly Clinical Audit Group where staff present the results of their audits to help share the learning across the Group.

10. Corporate Audits

Within LCHS corporate audits are aligned to their local audit programme.

11. Learning from Completed Audits

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. This approach eliminates the need to access multiple templates, simplifying and enhancing overall workflow.
North Lincolnshire Integrated Sexual Health (NLiSH) Clinical System Task Audit	During 2024, an incident occurred whereby a Doctor within the NLiSH service had stated in their clinical note that a patient 'Needs Doctor appointment at next availability', however no follow-up task had been set by the Doctor 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 NLiSH Team, recall tasks to be set up correctly within the Inform clinical system permitting a consistent approach to results management across NLiSH and a weekly task audit to be completed.
Heart Failure Record Keeping Audit	Areas of improvement included arranging 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.

12. Summary

Clinical audit processes are being streamlined and standardised. LCHS is compliant in participating in 100% of the national audits that are applicable and there is evidence that the results are shared within the Divisions and at CEG. There is a comprehensive local audit programme, and outstanding actions are being monitored

by the Clinical Audit Team. There is evidence of changes being made on the results of the national and local audit programme which will ultimately have improvements in the care we deliver to our patients.

ULTH Clinical Audit Annual Report 2024-2025

Contents

1. Executive Summary

The Clinical Audit Teams are aligning their processes to enable a standardised approach to the management of clinical audit within LCHS and ULTH. This will ensure that both teams understand the shared vision and objectives of the Group Model and how the roles contribute to the overall success of the clinical audit programme, which will include identifying duplication or differencing in existing processes and standardising workflows to improve efficiency and consistency.

ULTH have participated in 100% of all national audits that were applicable. Reports and action plans are presented within the Speciality and at Clinical Effectiveness Group (CEG). There have been four national potential outliers reported in 2024-2025, however, after data validation one national report was deemed not to be an outlier and the remaining three are being reviewed to confirm outlier status.

2. Introduction

The report provides an overview of the clinical audit programme for 2024-2025. ULTH continues to proactively manage the clinical audit programme, improving process and quality of audits, to enable the learning to be embedded into our services and practice.

3. Forward Audit Plans 2025-2026

Each year, Divisions / Specialties agree a programme of planned clinical audit activity for the forthcoming financial year. This process is co-ordinated by the Clinical Audit Facilitator (through consultation with clinical / nursing staff and Care Groups) and which is overseen by Clinical Effectiveness Group (CEG).

Each year's plan reflects agreed priority audits, based on considerations such as anticipated Trust / Care Group quality objectives, national clinical audits, commissioning priorities, national guidance (NICE, Royal College) and local clinical priorities. Audits are categorised based on priority areas for clinical audit as outlined within the Healthcare Quality Improvement Partnerships (HQIP) 'Clinical Audit Programme Guidance'. The Forward Audit Plans have been forwarded to the Care Groups for approval through their Clinical Cabinet Meetings.

4.   Clinical Audit Training

Throughout the year, the Clinical Audit Facilitators continued to run a 'Beginner's Guide to Clinical Audit' sessions aimed at Foundation Doctors and staff with little or no previous experience of carrying out a clinical audit who would like a good grounding in the basic principles. Further sessions are planned for 2025-2026 and the team will focus on promoting these as a Group. In addition to scheduled workshops, bespoke training sessions were provided by the Clinical Audit Facilitators for other staff groups within Divisions / Specialties.

5.   Clinical Audit awareness Week

The Clinical Audit Awareness Week is an annual event dedicated to highlighting the importance of clinical audit in improving patient care and outcomes. It provides a platform to celebrate best practices, shared learning, and engage staff in audit activities. As part of last year's awareness week, we organised a series of exciting activities including an audit competition to showcase innovative projects, interactive stalls where staff could learn more about the audit processes and how to get involved. There were also national presentations featuring expert speakers discussing key developments and insights into clinical audit. These activities aim to increase awareness, encourage participation, and demonstrate the value of audits in driving continuous improvement across our Trust.

6.   National Clinical Audit

The Group are participating in 100% of all relevant audits.

The Trust have participated in 58 national clinical audits which is 100% of national audits that they were eligible for.

Graph 1- National audit participation compliance.

National Audit Particpation Rate

There were 38 national audit reports published during 2024 - 2025. All national audit reports are presented initially at the Speciality Governance Meetings to agree the actions required. The report and action plan are then presented at the Clinical Effectiveness Group (CEG). There are several national audits awaiting presentation at CEG which are being monitored.

Table 1 - National Reports published / presented

Date Published	Name of National Audit	Presented at Speciality Governance	Presented at CEG
April 2024	National Lung Cancer Audit (NLCA)	May 2025	TBC
April 2024	SSNAP	May 2024	July 2024
April 2024	National Cardiac Audit Programme	June 2024	TBC
May 2024	ICNARC Case Mix Programme (CMP)	July 2024	November 2024
May 2024	National Ophthalmology Database – Cataract Audit	October 2024	February 2025
July 2024	Children & Young People Asthma	September 2024	February 2025
July 2024	National Comparative Audit Blood Transfusion Programme - 2024 Bedside Transfusion Audit	July 2024	August 2024
July 2024	Royal College Emergency Medicine – Care of the Older People year 2	August 2024	TBC
August 2024	National Respiratory Audit Programme	September 2024	October 2024
August 2024	Royal College Emergency Medicine – Adolescent Mental Health year 2	August 2024	TBC
September 2024	Falls and Fragility Fracture Audit Programme (FFFAP) – National Hip Fracture Database (NHFD)	October 2024	February 2025
September 2024	Non-Hodgkin's Lymphoma	November 2024	February 2025

September 2024	National Ovarian Cancer Audit (NOCA)	TBC	TBC
September 2024	National Pancreatic Cancer Audit (NPaCA)	TBC	TBC
September 2024	National Kidney Cancer Audit (NKCA)	TBC	TBC
September 2024	National Hip Fracture Database (NHFD)	October 2024	February 2025
October 2024	National Neonatal Audit Programmes	TBC	TBC
October 2024	Falls and Fragility Fracture Audit Programme (FFFAP) - National Audit of Inpatient Falls	TBC	TBC
October 2024	Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI)	December 2024	N/A
October 2024	National Emergency Laparotomy Audit (NELA)	October 2024 & January 2025	February 2025
October 2024	National Early Inflammatory Arthritis Audit (NEIAA)	February 2025	
October 2024	BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	TBC	TBC
November 2024	National Vascular Registry (NVR)	January 2025	April 2025
November 2024	National Paediatric Diabetes Audit	TBC	TBC
December 2024	National Audit of Dementia	Date to be confirmed	April 2025
December 2024	PROMS (Patient Reported Outcome Measures) in Surgery, Elective Hip and Knee Replacements 2022/23	February 2025	March 2025
January 2025	National Prostate Cancer Audit (NPCA) State of the Nation Report	February 2025	March 2025
January 2025	National Bowel Cancer Audit (NBOCA	TBC	Outlier notification discussed at CEG February 2025
January 2025	National Oesophago-Gastric Cancer Audit (NOGCA)	TBC	
February 2025	Patient Reported Outcome Measures (PROMs)	March 2025	March 2025

March 2025	National Cardiac Audit Program (NCAP) Annual Report	TBC	TBC
March 2025	National Paediatric Diabetes Audit	TBC	March 2025 – Alert notification presented

7.   National Audit Outlier Notifications

ULTH received four potential outlier notifications in 2024-2025, however, after data validation, the Trust are outliers on three.

National Dementia Audit Round 6 – Potential Outlier

Trust notified 20 March 2024, potential outlier for Delirium screening. A data validation exercise was completed by April 2024 and amendments were made to the data. The Trust notified 23 May 2024 it is no longer a potential outlier.

National Epilepsy 12 – Outlier Notification

The data relates to analysis for the year 2022-2023. The data period is prior to the recruitment of the Epilepsy Specialist Nurses (ESN's) and establishment of the service for newly diagnosed children and young people to be seen by an ESN. The ICB is currently finalising a business case to ensure the right establishment for the Children and Young people Epilepsy service.

National Bowel Cancer Audit (NBOCA) – Outlier Notification

The Trust was identified as an outlier on 18-month unclosed ileostomy after anterior resection at United Lincolnshire Hospitals NHS Trust. There is a review of the unclosed ileostomies, and the report will be presented at CEG in June 2025.

National Paediatric Diabetes Audit – Alert

Pilgrim Hospital status is alerting for Case mix adjusted mean HbA1c.
The national (England and Wales) HbA1c mean after adjustment for type 1 Diabetes is 63.5mmol/mol. At Pilgrim, the mean HbA1c for children and young people with Type 1 diabetes was 67.5mmol/mol. The adjusted mean was 66.8 mmol/mol.
A report will be presented at CEG in May 2025.

8.   Positive Outlier

National Neonatal Audit Programme (NNAP) 2023 – Positive Outlier
Pilgrim Hospital outstanding outlier status for retinopathy of prematurity screening 100%. The Clinical lead has been asked to present at the Network meeting on how this was achieved.

9.   Local Audit Programme

ULTH have a comprehensive local audit programme, however, there have been a number of audits that had to be closed due to the audit not progressing. The development of a robust forward audit plans will help eliminate the need going forward to close audits due to them not being progressed by the auditor. The Clinical Audit Facilitators are actively pursuing open actions with the Audit Leads to enable audits to be closed within the required timeframes, however, there are several actions that remain open, and trajectories have been requested to aid closure.

Audits Registered / Open

Since 2022, there have been 935 audits registered across ULTH of which 522 have been completed. There are 364 audits that have been registered that remain open.

Graph 2 - number of audits registered at ULTH versus number completed from 2022.
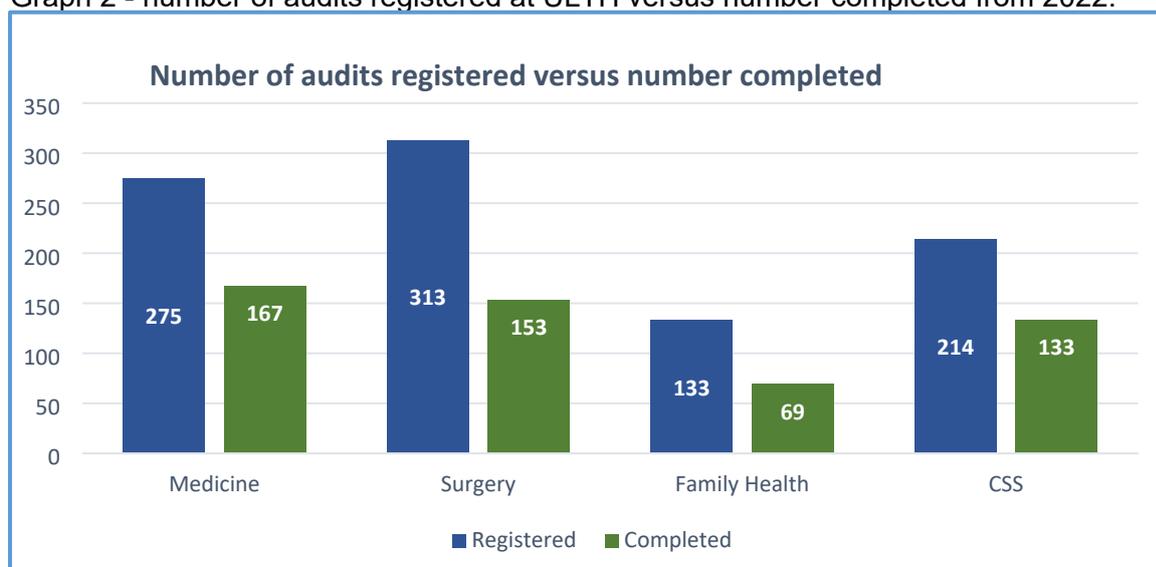
The tables below highlight the number of audits registered, completed and open audits for each Division from 2022.

Table 2 – Number of audits registered by Division for each year

Division	2022-2023	2023-2024	2024-2025	Total
Medicine	64	83	128	**275**
Surgery	102	114	97	**313**
Family Health	43	43	47	**133**
CSS	77	81	56	**214**
ULHT	**286**	**321**	**328**	**935**

Table 3 - Number of audits completed

Division	2022-2023	2023-2024	2024-2025	Total
Medicine	56	61	50	**167**
Surgery	64	65	24	**153**
Family Health	26	28	15	**69**
CSS	64	51	18	**133**
ULHT	**210**	**205**	**107**	**522**

*There have been 54 audits closed from 2022, due to the audit not being able to be progressed.

Table 4 - Number of open audits

Division	2022-2023	2023-2024	2024-2025	Total
Medicine	7	18	75	**100**
Surgery	36	46	72	**154**
Family Health	6	11	31	**48**
CSS	4	16	37	**57**
ULHT	**53**	**91**	**215**	**359**

Outstanding Actions

There are 106 actions outstanding from 2022 that have not been completed.

Table 5 – Number of outstanding actions

Division	2022-2023	2023-2024	2024-2025	Total
Medicine	4	5	17	**26**
Surgery	14	9	13	**36**
Family Health	3	3	4	**10**
CSS	8	16	10	**34**
ULHT	**29**	**33**	**44**	**106**

10. Clinical Audit Group

The Clinical Audit Group (CAG) was initially developed to review local audits and outstanding actions; however, this group has progressed to being a shared learning forum for staff to present their audit findings as learning identified could be

transferrable to other departments within the Trust. This is a monthly meeting for all Audit Leads to attend.

11. Corporate Audits

There were 4 corporate audits completed by the Clinical Audit Team and presented during 2024-2025.

NHS Resolution Consent Report 2024-25

The Trust must demonstrate that they have and adhere to a policy of taking informed and appropriate consent as an integral part of clinical care (Policy for Consent to Examination or Treatment). Over a six-week period the team reviewed almost 1000 patient consent forms across Lincoln, Pilgrim and Grantham hospital sites. As results became available during March, Speciality and site-specific reports were sent to the appropriate audit leads who were asked to review, discuss and share findings in their Audit/Specialty Governance Meetings and complete action plans.

Each Speciality will present their individual results at speciality governance and produce an action plan.

ED Long Wait Harms Review

The aim of the review was to:

- Assess if extended/prolonged ED waiting times (more than 12 hours) directly resulted in harm to patients.
- To quantify the scale and severity of harm due resulting from ED delays.

The report was presented at Patient Safety Group and Quality Committee and there was a request to complete a re-review with later data as data used was from October – December 2023 which was presented at Patient Safety Group in February 2025. The re-audit did not highlight any additional concerns.

eReferral Mailbox Audit

In response to a Serious Incident investigation, a Standardised Operating Procedure (SOP) was developed for eReferral Inboxes. The eReferral Inboxes is a system for ULTH staff to send routine patient referrals or requests for information electronically between specialties. The aim of the review was to review all eReferral Inboxes

against the eReferrals Standard Operating Procedure. The audit was shared with the Operational Team and further actions are being taken.

Paediatric Early Warning Scoring System

Following a Serious Incident where no observations were recorded prior to a paediatric patient's discharge. The incident identified that the patient should have had a review by the Paediatric Middle Grade Doctor and a period of monitoring prior to discharge. The aim of the audit was to assess:

- Babies aged 0-3 months attending ED are routinely seen by a Paediatric Middle Grade Doctor
- Observations are performed for babies 0-3 months prior to discharge from ED

A guideline was developed detailing the standards required for paediatric patients attending ED and UTC.

12. Learning from Completed Audits

Audit of timing and administration of medication for Parkinson's disease patients:	Comparing in-patient and usual place of abode experience identified 65% of patients audited did not have their usual individually prescribed times of Parkinson's medication documented on admission. The audit results concluded a large number of patients had missed doses of Parkinson's medication whilst an inpatient. As a result, time sensitive medication is now a compulsory part of staff induction. There is also work going on to update the hospital's self-medication policy which will be adopted for patients with Parkinson's disease.
Audit of antimicrobial management of Community Acquired Pneumonia.	The audit identified that patients did not always have appropriate antibiotics prescribed on admission. The CURB score was poorly documented. Following the audit a Confusion, Urea nitrogen, Respiratory rate, Blood pressure (CURB) score calculator was added to Microguide on the guidance pages for CAP prescribing. Training sessions and communications have also been rolled out to reiterate appropriate antimicrobial use.

Facing the future – RCPCH Standard Re-audit	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 (PAU) 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)	The audit identified that patients did not always have appropriate antibiotics prescribed on admission. The CURB score was poorly documented. Following the audit a CURB score calculator was added to Microguide on the guidance pages for CAP prescribing. Training sessions and communications have also been rolled out to reiterate appropriate antimicrobial use.

13. Summary

Clinical audit processes are being streamlined and standardised. ULTH is compliant in participating in 100% of the national audits that are applicable and there is evidence that the results are shared within the Divisions and at CEG. There is a comprehensive local audit programme, and outstanding actions are being monitored by the Clinical Audit Team. There is evidence of changes being made on the results of the national and local audit programme which will ultimately have improvements in the care we deliver to our patients.

Director of Infection Prevention and Control Annual Report 2024-2025

Caring and building a healthier future for all

Version Control

Version	1
Type	Annual Report
Directorate	Corporate
Author	Mrs Natalie Vaughan – Deputy Director Infection Prevention and Control
Contributors	Dr Reena Rambani - Consultant Microbiologist/Infection Prevention and Control Doctor

Mrs Sandra Smirthwaite – Clinical Lead Infection Prevention and Control

Mrs Joanne Bradshaw – IPC Matron

Mrs Balwinder Bolla - Consultant Antimicrobial Pharmacist

Mr Stuart Whitehead – Group Head of Estates

Mr Wayne McIntosh – Group Head of Facilities - Estates and Facilities Engagement Lead

Mrs Karen Bailey - Estates, Facilities and Decontamination Lead Nurse

Mrs Anita Pearson – Senior Occupational Health Advisor

Mr Nick Duckworth – Laboratory Manager NLaG

Mr Martin Bosworth - IPC Service Co-ordinator/Data Analyst |
| **Approving Person** | Mrs Nerea Odongo - Group Chief Nurse, Director Infection Prevention and Control |
| **Approval Date** | Infection Prevention Group: 11 June 2025 |

Contents

1.   Summary and Highlights

The Director of Infection Prevention and Control (DIPC) Annual Report details infection prevention and control (IPC) performance activities within United Lincolnshire Teaching Hospitals NHS Trust (ULTH) for the year 2024-2025

The report outlines a continued approach to preventing and reducing the risk of avoidable healthcare associated infection (HCAI), as well as the processes and interventions taken to mitigate risk. There is a strong commitment to lead on and support initiatives to prevent HCAI.

IPC practice is essential to ensure those who access the Trust's services receive safe care. Effective interventions require the hard work and diligence of all clinical and non-clinical staff, with a need for everyone to apply a consistent high level of practice.

The publication of this report is a requirement to demonstrate effective governance and public accountability. It highlights in addition the role, function and reporting arrangements of the DIPC and the IPC Team.

The Group model of the Lincolnshire NHS providers of physical health, Lincolnshire Community and Hospitals NHS Group (LCHG) has continued to develop with the IPC Team and associated colleagues dedicated to providing a high level of care to better meet patient needs.

There is enthusiasm and commitment to achieve a joint vision for the delivery of IPC initiatives and developments for the consistent and streamlined integration of clinical work and IPC processes, including incident and outbreak of infection management.

IPC key objectives have continued to provide a strategic and structured framework upon which to shape and develop IPC across the organisation.

The Infection Prevention Group (IPG) receives a Board Assurance Framework (BAF) for The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections, to achieve and sustain the required IPC key lines of enquiry. A gap analysis directs work to address an area of non-compliance by the application of remedial actions for the impact of poor environmental infrastructure as well as aspects of ventilation and water safety. Waste storage compliance is partially compliant along with in house decontamination processes.

Mandatory reporting of HCAI has identified an increase in cases of infections. Likely contributory factors relate to elderly medically vulnerable patients with underlying co-morbidities and very sick patients requiring treatment with sometimes several courses of appropriate antibiotic therapy.

 NHS England (NHSE) Midlands and the NHS Lincolnshire Integrated Care Board (ICB) visits put forward some improvements when compared to other visits but identified several areas requiring focus and development to ensure changes are completed and embedded within practice. These included IPC standards within the Emergency Department (ED), waste management, diligence with environmental and equipment cleanliness as well as intravenous and trolley and mattress practice. An action plan has been compiled in respect of control and mitigation actions.

Audit standards allude to some non-compliance with IPC fundamental practice in relation to practice, cleanliness and equipment concerns. Some evidence a lack of attention to detail whilst others put forward a lack of sustainability and embedding the required level of IPC practice.

The report furthermore offers an overview of activity and/or development of outbreaks of infection, policies and guidelines, programme of audits, antimicrobial stewardship (AMS), laboratory service, Occupational Health and IPC training.

The Estates and Facilities section identifies work relating to environmental cleanliness, water safety, ventilation and decontamination.

A forward plan details work and initiatives to be progressed through 2025-2026, in addition to updated IPC key objectives.

2. Infection Prevention and Control Arrangements and Team

The DIPC holds Board level responsibility for all matters relating to the safe delivery of IPC practice, supported by the Deputy DIPC who also provides operational leadership to the IPC Team.

During the year, there has been further development of the IPC Team to take forward the need for investment in strong, consistent clinical leadership to achieve a one team approach.

The LCHG Group model has continued to develop with the IPC Team and associated colleagues dedicated to providing a high level of care to better meet patient needs.

There is enthusiasm and commitment to have a joint vision for the delivery of IPC initiatives and developments for the consistent and streamlined integration of clinical work and IPC processes, including incident and outbreak of infection management.

Diagram 1: Infection Prevention and Control Team Structure

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                              ┌──────────┐        ┌─────────────────────────┐
                              │   DIPC   │        │ Consultant Microbiologist/IPC │
                              │          │        │         Doctor          │
                              └────┬─────┘        └─────────────────────────┘
          ┌─────────────┐         │
          │ Deputy DIPC ├─────────┘
          └──────┬──────┘
          ┌──────┴──────────┐
          │ Clinical Lead IPC │
          └──────┬──────────┘
          ┌──────┴──────────┐
          │ IPC Matron (interim) │
          └──────┬──────────┘
        ┌────────┴─────────┐
┌───────┴────────┐   ┌─────┴──────┐
│ IPC Clinical Nurse │   │ IPC Nurses │
│   Specialists    │   └─────┬──────┘
└────────────────┘         │
┌────────────────┐   ┌─────┴──────────┐   ┌──────────────┐
│ IPC Service Co-  │   │ Deputy IPC Service Co- ├───┤ IPC Assistant │
│ ordinator/Data Analysist │   │     ordinator     │   └──────────────┘
└────────────────┘   └────────────────┘
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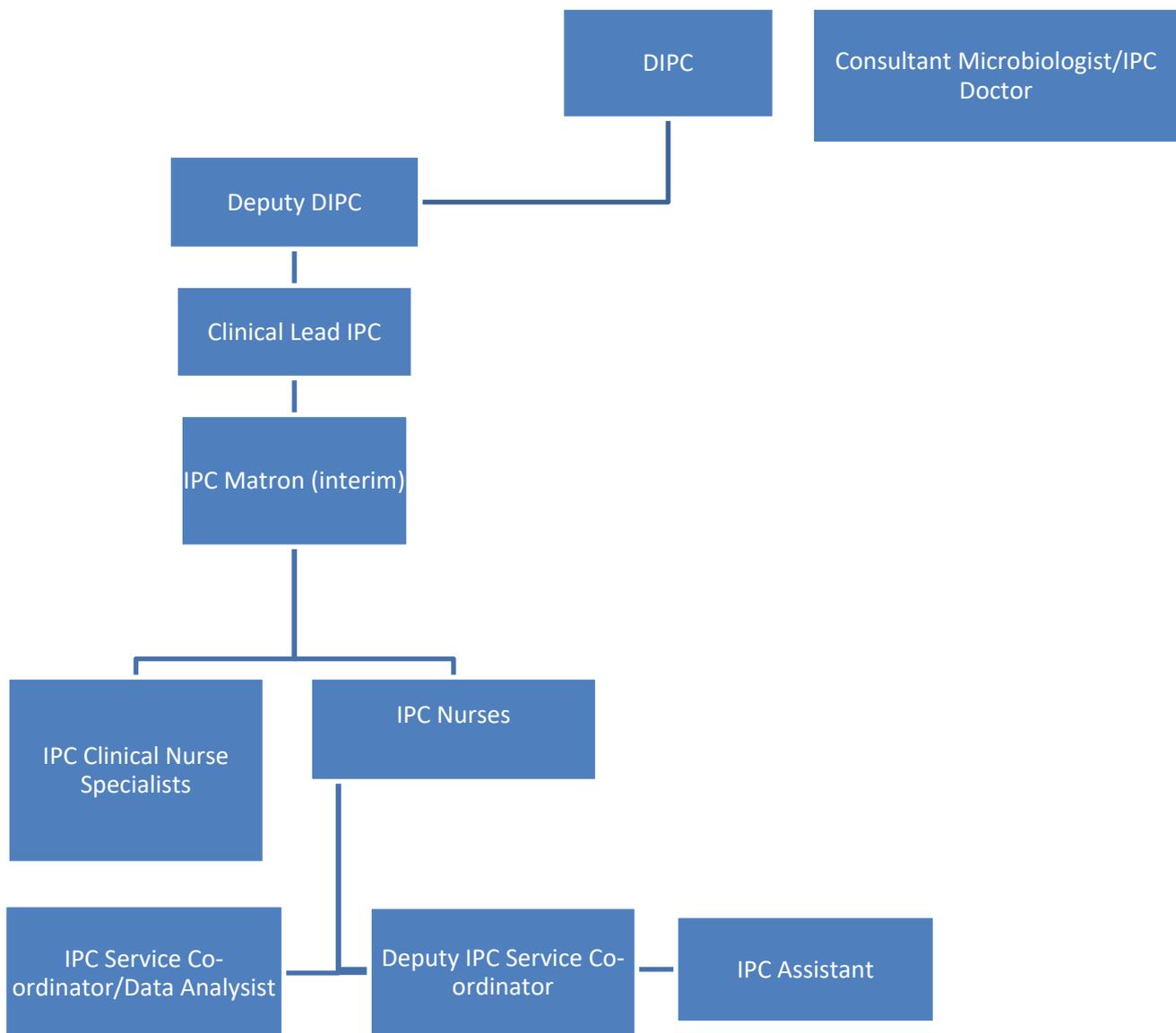
3. Infection Prevention and Control Governance, Assurance and Reporting Structure

The IPG meets monthly and provides strategic direction for the prevention and control of HCAI. The group performance manages and assures the organisation against IPC Key Objectives (Table 1) and ensures a risk-based and proportionate response to national and local directives and guidance. Upward reporting is to the Patient Safety Group (PSG), Quality Committee and the Trust Board.

Table 1: Infection Prevention and Control Key Objectives 2024-25

Number	Objective
1	Develop infection prevention and organisational and Care Group Governance arrangements across the Group
2	Continue to progress assessment and gap analysis of The Health and Social Care Act 2008. code of Practice on the prevention and control of infections and related guidance
3	Further development of surveillance of healthcare associated infections and performance
4	Investigate and manage the risks posed by novel infectious diseases to promote patient safety and prevent and reduce the risk of cross transmission
5	Investigate and manage the risks posed by the emergence of multi-drug-resistant organisms to promote patient safety and prevent and reduce the risk of cross transmission
6	Development of governance arrangements for appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
7	Implement and sustain standards of cleanliness in line with National Standards of Healthcare Cleanliness
8	Progress water safety, ventilation and decontamination requirements as sub-groups of the Infection Group to ensure patient safety requirements
9	Develop programmes of audit, education and the Infection Prevention Champion/Ambassador networks across the Group

AMS, water safety, ventilation and decontamination sub-groups report to the IPG with Divisions providing assurance and exception reporting in line with The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and related guidance.

The IPC Objectives and Programme of Work 2024-2025 provides a framework to devise, implement and evaluate initiatives and strategies to prevent and reduce the risks associated with HCAI. A programme spanning 2 years has given an opportunity to scope out a longer-term plan of work and vision, reflected in the content of the Forward Plan (Section 13).

The introduction of IPC Quality Improvement (QI) initiatives comprise of the following 4 projects:

- High consequence infectious diseases (HCID) to achieve compliance with regional and local directives to ensure the safe care of a patient requiring assessment for a suspected case
- Surgical site infection (SSI) to support the Surgery Division with the implementation of national initiatives to support a reduction in the risk of SSI. The adoption of standards and guidance along with a self-assessment will provide a foundation upon which to build a programme of SSI surveillance (subject to resource and capacity)
- The Gloves Off Campaign will further progress a national initiative to prevent and reduce the over and inappropriate use of non-sterile gloves across the organisation
- Device Related Infection Prevention Practice (DRIPP) to support best practice to prevent and reduce device-related infections, thereby improving outcomes for patients with an intravascular device/ urinary catheter.

Divisional IPC arrangements have continued to focus on tailoring IPC interventions to specific risk and patient population requirements. There has been the introduction of an IPC Business Partner model where nurse members of the IPC Team are assigned to a Division to offer a higher level of direction and support.

The model focus is to offer a clinical environment requiring enhanced IPC direction and support, provide guidance for the interpretation of IPC data and participate in some Divisional specific auditing (especially validation). There is furthermore support for their IPC work and investigations, e.g. NHSE visits and associated plans, Patient Safety Incident Response Framework (PSIRF) and IPG reports. There is an intention to work with triumvirates and attend an IPC Divisional meeting. Support will also be provided for IPC QI and other project initiatives as well as liaison with the Division's IPC Link Ambassadors (IPCLA).

To promote patient safety and prevent and reduce the risk of cross transmission, work has continued to progress on the investigation and management of novel and multi-drug-resistant organisms. The year highlighted challenges in respect of a Lincolnshire-system wide approach to HCID preparation work.

The report will summarise AMS activity and put forward several key challenges, realisations and opportunities that have steered work over the year. The organisation did not again meet the target to reduce broad spectrum antimicrobial usage. There have been resource and staffing challenges impacting upon service delivery. An understanding that current efforts are not enough to be effective have been recognised with a comprehensive overview of the key changes initiated.

IPC knowledge and expertise has supported the progression of further compliance with environmental cleanliness, water safety, ventilation and decontamination requirements and directives.

The strong Lincolnshire system-wide partnership work has created and sustained consistent and proportionate approaches to the investigation and management of relevant infections.

The integration of PSIRF into Trust governance and risk systems and processes has been achieved. From an IPC perspective this relates to the reporting and investigation of outbreaks of infection, some alert organisms and bacteraemia, HCID, breach of IPC policy and some infection-related deaths. This has led to the generation of lessons learnt for sharing and presented an opportunity for integration into educational initiatives.

3.1 Board Assurance Framework (BAF)

The IPG receives a BAF for The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and related guidance (Table 2).

Table 2: The Health and Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related Guidance Summary

No	Criterion Description: Registered Provider to Demonstrate:
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 others 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 infection 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 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 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

The BAF demonstrates the organisation responds in an evidence-based way to maintain the safety of patients, services users, and staff with areas of identified risk being subject to corrective intervention. It furthermore provides assurance to the Trust Board of the systematic review of organisational compliance, with a wide range of systems, processes, policies and procedures to prevent and reduce IPC risk.

Criterion 2 (the provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections) continues to be awarded partial compliance (Table 3). This is due to the impact of poor environmental infrastructure as well as aspects of ventilation and water safety. Waste storage compliance is also partially compliant along with in house decontamination processes.

Table 3: The Health and Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related Guidance: Board Assurance Framework Compliance Summary 2024-25

	Criterion	Theme
Compliant	Criterion 1	Governance
	Criterion 2	Environment
	Criterion 3	Antimicrobial stewardship
	Criterion 4	Information
Partial	Criterion 5	Management
	Criterion 6	Engagement
	Criterion 7	Isolation
	Criterion 8	Laboratory support
	Criterion 9	Policies
	Criterion 10	Workforce

4. Healthcare Associated Infection Performance

4.1 Mandatory Reporting

There is reporting of the following infections in line with the mandatory surveillance programme facilitated by the UK Health Security Agency (UKHSA):

- Meticillin-resistant *Staphylococcus aureus* (MRSA) blood stream infections (bacteraemia)
- *Clostridioides difficile* (*C. difficile*) infection
- Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia
- *Escherichia coli* bacteraemia *(E. coli)*
- *Klebsiella* species bacteraemia
- *Pseudomonas aeruginosa* bacteraemia.

To comply with data collection requirements, the above HCAI have been attributed to Hospital-Onset Health care Associated (HOHA) when the sample is taken on the 3rd day of admission (when day of admission is day 1) at an acute Trust. Community-Onset Healthcare Associated (COHA) defines a case not determined to be HOHA, but where a patient was discharged from the reporting organisation within 28 days prior to the current specimen date. The outcome of this reporting has seen an increase in infections compared to previous years' data.

4.2 Meticillin-Resistant *Staphylococcus aureus (S. aureus)* Bacteraemia (MRSA)

S. aureus is a bacterium commonly found on human skin and if enters the body can cause infection. In serious cases it can result in bacteraemia (blood stream infection), is resistant to many antibiotics, making it more difficult to treat.

Carrying MRSA on the skin is colonisation and it is important to screen some high- risk patient groups when they come into hospital to identify if they are carrying MRSA.

In 2024-2025, there were 3 hospital-acquired cases of MRSA bacteraemia associated with Pilgrim Hospital Boston (PHB) (Table 4), and this compares with 2 cases in 2023-24. There remains a zero tolerance to a case.

For each case, a PSIRF investigation has identified an area of concern as well as ensured actions to prevent recurrence and lessons learnt shared with the wider health care team.

The first 2 cases had contributory factors of a patient with multiple co-morbidities along with one already being colonised with MRSA. These factors increased the likelihood of the patient being at an increased risk of susceptibility to infection. Clinical practice non-compliance was attributed in all cases and for 2 alluded to a delay in commencing MRSA decolonisation treatment.

All cases indicated concern with the care and management of a peripheral device. Divisional actions plans to facilitate IPG assurance and monitoring are in place to track progress and identify gaps in practice necessitating further work.

Table 4: MRSA Bacteraemia by Site 2024-2025

Date → Site ↓	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Louth (CHL)	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln (LCH)	0	0	0	0	0	0	0	0	0	0	0	0
Pilgrim (PHB)	0	1	0	0	0	0	0	0	1	0	0	1
Grantham (GDH)	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total	0	1	1	1	1	1	1	1	2	2	2	3

4.3   Clostridioides *difficile (C. difficile)* Infection

C. difficile is a bacterium found in the gut of around 3% of healthy adults. It seldom causes a problem if kept under control by normal bacteria of the intestine but can cause an infection of the large intestine (colon). Certain antibiotics can disturb gut bacteria allowing *C. difficile* to multiply and produce toxins, which cause symptoms such as diarrhoea.

Table 5 describes 98 Trust attributable cases reported against a trajectory of not to exceed 95 cases. This compared with 98 Trust attributable cases reported in 2023-2024.

Nationally there has continued to be an increase in cases of this infection with the UK Health Security Agency (UKHSA) in September 2024 publishing a rate of 36.9 infections per 100,000 population compared to a September 2023 publishing a rate of 27.6 infections per 100,000 population (22.6% increase).

Table 5: Trust Attributable C. *difficile* Data 2024-2025

Date → Case Totals ↓	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Trajectory	7	8	8	8	8	8	8	8	8	8	8	8
Actual Acute Cases	6	8	9	8	12	5	6	11	8	11	7	7
+/- Trajectory	-1	0	+1	0	+4	-3	-1	+3	0	+3	-1	-1
Acute Actual Cumulative	6	14	23	31	43	48	54	65	73	84	91	98

The increase in cases especially in the Medicine Division have alluded to older patients with co-morbidities, requiring multiple antibiotic treatment, subsequently increasing the risk of acquiring *C. difficile*. There has also been an increase in the number of patients with a relapse of this infection.

There were investigations into 10 periods of increased incidence (PII) defined as two or more cases of *C. difficile* (occurring > 48 hours post admission, not relapses) in a 28-day period on a ward (5 at LCH, 5 at PHB). IPC interventions were patient isolation, deep cleaning, sending stool samples for ribotyping, weekly antimicrobial audits for a 3-week period as well as PSIRF investigation and holding PII meetings with clinical colleagues.

For 8 of the PIIs, the ribotyping indicated a cluster of unrelated cases, however for the remaining 2, one at LCH and another at PHB, the ribotyping indicated cross transmission. This resulted in the need for prompt and appropriate sampling and patient isolation (upon taking the stool sample), review of antimicrobial prescribing, ensuring the prompt commencement of treatment as well as the importance of maintaining high standards of environmental cleanliness.

To facilitate a detailed review, cases of Trust acquired *C. difficile* are subject to a thematic analysis investigation. Common themes requiring further work and development included recording a severity score, some suboptimal antimicrobial prescribing, i.e. long-term antimicrobials given without Microbiologist consultation, as well as in some instances their advice was not followed.

A patient was not always isolated when a stool sample was taken along with insufficient microbiological samples to diagnose an infection. Divisional action plans to facilitate IPG assurance and monitoring were compiled to track progress and identify gaps in practice necessitating further work.

4.4   Meticillin-Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

MSSA is a strain of these bacteria effectively treated with antibiotics. Infection can occur if there is an opportunity for the bacteria to enter the body and in serious cases can cause bacteraemia.

Table 6 details the 47 reported cases of Trust acquired MSSA bacteraemia, representing a 17.5% increase when compared to the 40 cases reported in the previous year. There is no trajectory for this infection. Contributory factors include patient acuity as well as skin/soft tissue and line infections. There has been an increased focus on the management of invasive devices.

Table 6: Trust Attributable MSSA Bacteraemia by Site 2024-2025

Date → Site ↓	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Louth (CHL)	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln (LCH)	2	4	3	2	3	4	1	3	0	1	4	1
Pilgrim (PHB)	0	1	0	1	1	2	2	3	3	1	3	0
Grantham (GDH)	0	0	0	0	1	0	1	0	0	0	0	0
Total	2	5	3	3	5	6	4	6	3	2	7	1
Cumulative Total	2	7	10	13	18	24	28	34	37	39	46	47

4.5   Gram Negative Bacteraemia

- ### *Escherichia coli (E. coli)* Bacteraemia

E. coli is a bacterium that normally resides in the intestines of healthy people and animals, aiding in the digestion of food. However, it can cause urinary, biliary or gastrointestinal tract related infection leading to bacteraemia.

Some *E. coli* are enzyme producers known as extended spectrum beta lactamase (ESBL) that increase the resistance to multiple antibiotics.

Attention to the insertion and care of urinary catheters, auditing, education and reporting of catheter associated urinary tract infection are the interventions directed to prevent and reduce a case of this infection.

For 2024-2025, 146 hospital and community cases against a trajectory of not to exceed 105 cases were reported. There were 106 cases in the previous year, representing an increase of 38%.

An investigation determined likely contributory factors as elderly medically vulnerable patients with an underlying condition which precipitated the infection rather than a HCAI.

- *Klebsiella* **species Bacteraemia**

Klebsiella species are part of the enterobacteriaceae family. They are commonly found in the environment and human intestinal tract and do not typically cause disease. These species can however cause HCAIs, including pneumonia, bacteraemia, wound or surgical site infections and meningitis. Additionally, they can exhibit resistance to a broad range of antibiotics.

For 2024-2025 there were 48 hospital and community cases against a trajectory of not to exceed 45 cases. The 47 cases reported in the previous year represented an increase of 2%.

An investigation of likely contributory factors also alluded to elderly medically vulnerable patients with underlying co-morbidities.

- *Pseudomonas aeruginosa* **Bacteraemia**

Pseudomonas is a type of bacteria frequently found in the environment, such as in soil and water. With many types, the one most often causing infection is an opportunistic pathogen called *Pseudomonas aeruginosa*. It can take advantage of a weakened immune system, produce tissue-damaging toxins and lead to bacteraemia, pneumonia, or infection in other parts of the body following surgery.

Through 2024-2025, there was a hospital and community trajectory of not to exceed 18 cases and in this period, there were 19 attributed cases. This compares to 18 cases reported in the previous year, representing an increase of 6%.

Likely contributory factors were extremely medically vulnerable patients with an increased susceptibility to infection, with no identification of a water-associated link.

4.6   *Stenotrophomonas maltophilia*

Stenotrophomonas maltophilia is a bacterium found in soil, water, plants and animals and can cause infection in humans, particularly in hospital environments. It is resistant to many antibiotics and therefore difficult to treat. As an opportunistic pathogen, it primarily affects an individual with a weakened immune system. Hospital settings as well as extended Intensive Care Unit (ITU) stays, mechanical ventilation, invasive devices such as a tracheostomy or central venous catheter and

the use of broad-spectrum antibiotics have all been demonstrated to increase the risk of this infection.

In November 2024, there was a PII in the ITU at PHB affecting 2 patients, with the bacteria being identified in sputum samples. Ribotyping did not identify cross transmission, and the environment received a deep clean. Improvements however were required to ensure items were not stored on hand wash basins, the appropriate wearing of gloves and ensuring bedside trolleys were not stored next to basins, thereby not creating a splash zone. A review of antimicrobial prescribing was also undertaken.

4.7   Carbapenemase Producing Enterobacterales (CPE)

The enterobacteriaceae family resides in the gut and aids in food digestion. This colonisation is harmless, not requiring treatment unless these bacteria enter areas like the bladder, bloodstream or wounds where they can cause infection. CPE bacteria are resistant to carbapenem antibiotics, making infections challenging to treat. Last year there was an increase in cases with a contributory factor being the necessary but increased use of antibiotics. There were 3 reported outbreaks of this infection at the LCH site (section 4.11).

4.8   Pulmonary Tuberculosis (TB)

Pulmonary tuberculosis (TB) is a contagious infectious disease caused by the bacterium Mycobacterium tuberculosis that primarily affects the lungs. It is spread through the air when an infected person coughs, sneezes, or talks, releasing respiratory droplets containing the bacteria.

Productive Group working promoted a rational and streamlined approach to a patient with TB attending at PHB and the management of community cases requiring acute hospital intervention. This included contact tracing, sending out warn and inform letters and an immunocompromised patient referral to the TB service for screening and follow up. There was staff Occupational Health follow up as appropriate.

4.9   Mpox/High Consequence Infectious Disease (HCID)

Mpox previously known as monkeypox is a rare infection most found in parts of central and east Africa. The risk of catching this disease in the UK continues to be low for most people.

Mpox symptoms can include a high temperature (fever), headache, muscle aches, backache, swollen glands, chills, exhaustion, and joint pain. A rash often appears 1 to 5 days after these initial symptoms and can be found on any part of the body.

The Lincolnshire system wide group led on the production of a process flowchart to enable the safe triage, diagnosis and treatment of a patient presenting with suspected case to an ED. Mpox is no longer categorised as a HCID.

Wider work in line with an addendum to the National IPC Manual initiated a collaborative initiative across the Group to ensure a patient being admitted with a suspected HCID follow a risk-based emergency care patient pathway. Action cards have been produced for the fast-track isolation and

assessment of patients. The required personal protective equipment (PPE) requirements are in place.

Challenges have related to a poor environmental infrastructure, specifically ventilation, the lack of single isolation room facilities, access to external training for the additional PPE requirements and the absence of an Infectious Diseases service and unit.

4.10   Vancomycin Resistant Enterococcus (VRE)

VRE are enterococci resistant to an antibiotic called vancomycin and often other antibiotics. It does not cause more serious infections when compared to other enterococci, however it is more difficult to treat.

During the year, a PII at PHB affecting 2 patients was investigated, with ribotyping determining the cases were not related to each other and good IPC practices overall observed.

4.11   Outbreaks of Infection

An outbreak of infection is defined as an episode of infection where there is spread of sufficient seriousness to demand immediate action and the year's outbreaks of infection are in Table 7.

Table 7: Outbreaks of Infection 2024-25

Organism	Number of Outbreaks	Number of Patients	Number of Staff
Influenza A	13	49	42
COVID	27	83	28
Norovirus	22	168	75
C. difficile	2	7	0
CPE	3	11	0
Total	**67**	**318**	**145**

- **Influenza A**

There was an increase in the number of cases of Influenza A (respiratory virus) across the East Midlands with 13 outbreaks declared. Full ward closure was not required as patient segregation in bays with the doors kept closed was successful to prevent and reduce transmission. Ward areas received a deep clean before being re-opened.

- **COVID**

A decrease and less severe cases of this respiratory infection reduced the risk of cross transmission. Through the year there were 27 outbreaks representing a significant decrease from the previous year when 45 were declared. Assurance was by thorough investigation of cases, patient isolation and the ability to contain within a bay to negate a full ward closure. IPC interventions and screening remained in line with national guidance.

- **Norovirus**

In 2024-25 there was a significant 340% increase in cases of this viral gastrointestinal infection compared to the previous year, reflecting a national picture and contributing to 22 outbreaks of this infection. There were outbreaks of norovirus at PHB in February 2025 affecting a total of 9 wards and 81 patients. IPC measures included the compartmental isolation of cases as much as possible and where necessary the closure of the wards to new admissions and a deep clean before re-opening. The deployment of hydrogen peroxide decontamination was of benefit.

The Trust was represented at the regional (NHSE) winter huddle forum to facilitate discussions relating to benchmarking, consistency and sharing of practice. Lincolnshire system-wide working facilitated appropriate discharge pathways. The organisation managed this extremely pressured period very well and received external acknowledgement.

- **CPE**

There were 3 outbreaks at the LCH site affecting a total of 11 patients. The outcome of investigations included a need to improve compliance with the wearing of PPE and to ensure equipment such as a dishwasher was in good working order. There was collaborative working with the Water Safety Group (WSG) and other colleagues. The experience of the Deputy DIPC enabled swift action to be taken to prevent patient harm and reduce transmission.

The instigation of enhanced cleaning was carried out along with assurance and monitoring via audit processes. A review of the integrity of equipment ensured replacement as required, as well as a review of cleaning methods such as hand wash basins to negate the risk of transference of micro-organisms. There was also refresher hand hygiene and cleaning training and enhanced swabbing of the relevant patients.

5.   Policies and Guidelines

Through 2024-2025, there has been the review, update and publication of policies to comply with the requirements set out in The Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and related guidance and the National IPC Manual. A policy matrix is in place to ensure documents are kept up to date and relevant.

Policies are subject to review at Trust IPG also attended by a patient representative. The Guidance at a Glance quick reference documents for key IPC practice have remained popular as a very good quick reference guide.

The Vascular Access Group has continued to give the IPG some level of assurance and monitoring of Care Group Peripheral Line Development Plans, but with recognition there is further work to undertake and a need to ensure the required practice is sustained and embedded.

The Mattress Working Group has also continued to also offer some assurance and monitoring of cleaning, replacement and storage of mattresses. Recent work has been widened to include all types of mattresses, including those on ED trolleys.

6.   Audit Programme

The IPC programme of audit has continued to monitor IPC practice standards across the organisation.

The Front-Line Ownership (FLO) audit has remained the standardised tool for all wards and departments by focussing on key areas of practice including hand hygiene, general and patients' immediate environment, patient isolation, dirty utility room / linen and waste disposal, ward kitchen, sharps safety, storage areas, clean utility and treatment room, patient equipment decontamination and clinical practice.

Divisions report progress, exceptions and actions each month to the IPG. This comprises a detailed overview of IPC practice in their clinical environments to reflect a need for responsibility, accountability and engagement to achieve the required standards. The IPC Team has continued to support a programme of validation audits, to promote collaborative working when results have highlighted discrepancies.

Analysis and triangulation of data has identified a number of Divisional data discrepancies when compared to results from the IPC Team FLO audits, such as non-compliance with IPC fundamental practice as well as cleanliness and equipment concerns. Some has evidenced a lack of attention to detail whilst some put forward a lack of sustainability and embedding of the required level of IPC practice. The findings furthermore replicate the outcomes of NHSE and ICB visits (Section 7).

To explore further, a thematic analysis of a clinical practice element has identified a need to achieve greater compliance with peripheral line practice, specifically for visual infusion phlebitis (VIP) scoring and insertion and removal of devices documentation. The latter is also a concern in respect of clinical indication for urinary catheters as well as ensuring the components of a care bundle are in place (Table 8).

Further work and interrogation are required, and the Venous Access Group meetings have recommenced to offer greater insight and leadership.

Table 8: ULHT Clinical Front Line Ownership Audit Results 2024-2025

	0	31	5	35	274	19	59	29

Effective hand hygiene is one of the most effective measures to prevent the spread of infection. The results in Table 9 describe overall high compliance with the requirements of the 5 moments of hand hygiene depicting when to conduct hand hygiene. Objective Structured Clinical Exam (OSCE) is the method used for assessment of the hand hygiene technique across the Divisions. Consistent high scores are also scrutinised via a validation process with some variation reported.

Table 9: Care Group Hand Hygiene Audit Scores (%) 2024-2025

Site	Division	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Average for 24/25	Divisional Average
Pilgrim	CSS	99.72%	99.37%	99.89%	99.84%	99.89%	99.83%	99.39%	99.69%	99.35%	99.42%	99.25%	99.14%	99.57%	
Lincoln	CSS	99.92%	99.86%	99.79%	99.93%	99.88%	99.96%	98.80%	96.96%	99.26%	99.75%	99.85%	99.93%	99.49%	
Grantham	CSS	100.00%	100.00%	99.33%	99.75%	100.00%	100.00%	99.39%	98.91%	99.82%	99.45%	98.80%	98.70%	99.51%	99.64%
Louth	CSS	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Pilgrim	Family Health	99.86%	99.50%	99.75%	99.50%	100.00%	99.75%	99.83%	99.83%	99.80%	100.00%	99.67%	100.00%	99.79%	
Lincoln	Family Health	100.00%	100.00%	97.80%	99.88%	99.78%	98.38%	99.14%	99.88%	100.00%	99.86%	100.00%	100.00%	99.56%	99.69%
Grantham	Family Health	100.00%	N/A	100.00%	100.00%	100.00%	100.00%	99.00%	99.00%	N/A	N/A	N/A	N/A	99.71%	
Louth	Family Health	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Pilgrim	Medicine	98.31%	98.31%	99.08%	99.38%	99.67%	98.62%	99.00%	98.54%	98.54%	99.00%	96.62%	96.22%	98.44%	
Lincoln	Medicine	97.62%	98.38%	98.38%	96.70%	97.53%	97.40%	99.75%	97.35%	97.89%	97.86%	98.37%	97.90%	97.93%	98.37%
Grantham	Medicine	99.00%	98.25%	99.25%	99.25%	98.25%	99.50%	98.50%	98.25%	99.00%	97.81%	99.00%	99.00%	98.76%	
Louth	Medicine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Pilgrim	Surgery	99.08%	99.00%	99.08%	97.83%	98.18%	98.00%	98.92%	97.92%	98.25%	97.55%	99.69%	99.25%	98.56%	
Lincoln	Surgery	99.00%	99.08%	99.36%	99.38%	99.75%	99.07%	99.92%	98.92%	98.25%	99.85%	98.92%	99.25%	99.23%	98.58%
Grantham	Surgery	98.50%	96.25%	98.50%	97.33%	97.33%	92.00%	96.00%	96.67%	100.00%	97.00%	92.00%	96.67%	96.52%	
Louth	Surgery	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	

(≤ 84% = red; 85-90% = amber; 91–100% = green)

6.1 Compliance Assessment Tool (CAT) Audits

The IPC Team will undertake a CAT audit following the identification of a clinically significant organism, including MRSA, *C. difficile*, and other multi drug-resistant organisms such as CPE, ESBL and VRE.

The tool continues to serve as a proactive measure to focus on patient isolation, commode cleanliness, clutter-free environment, the correct use of (PPE as well as appropriate and accurate documentation. The audits additionally provide support, focus and assurance to Divisional clinical teams to prevent and reduce the risk of HCAI within their clinical settings. Through 2024-25, 437 CAT audits were undertaken with a breakdown illustrated in Table 10.

Table 10: Compliance Assessment Tool Audits by Division Audits 2024-2025

Division	Number
Medicine	312
Surgery	91
Family Health	6
Clinical Support Services	28
Total	**437**

Table 11 describes improved practice in respect of labelling of clean equipment, completion of stool charts and the Saving Lives High Impact Intervention No 7: Care bundle to reduce the risk from *C. difficile*. Areas for improvement were in respect of completion of a relevant care pathway, patient isolation, i.e. delay in moving a patient to single room accommodation as well as some isolation room incorrect entrance signage.

Table 11: Compliance Assessment Tool Results by Non-Conformance 2024-2025
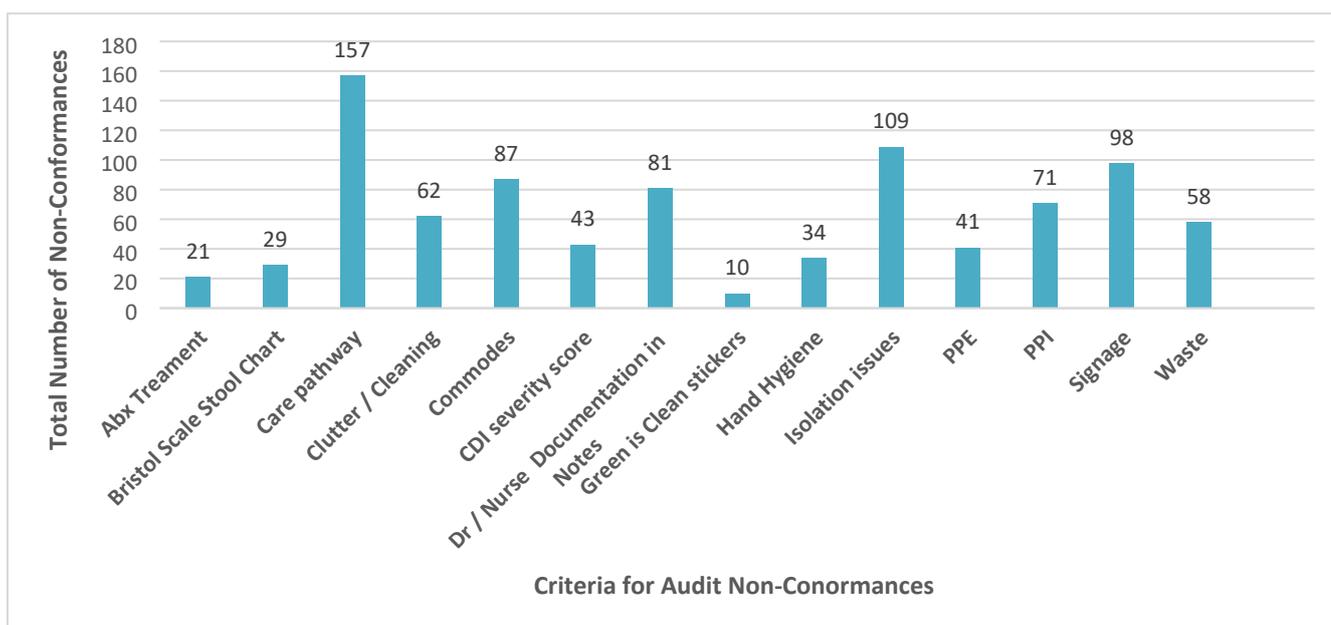
6.2   Sharps Container Audit

In May 2024, an external snapshot audit on the 4 sties was undertaken with 718 sharps containers observed. The vast majority were compliant demonstrating an improvement in practice, with only a small proportion requiring attention regarding the activation of the temporary closure mechanism. Non-compliance was identified for 21 containers at LCH, 21 at PHB, 8 GDH and 5 at CHL. These findings highlight a strong baseline of compliance, with ongoing efforts focused on further embedding best practices.

7.   External Inspections and Visits

In September 2024, The Assistant Director of Infection Prevention and Control, NHS England Midlands and the Lead Nurse, Health Protection for the NHS Lincolnshire ICB visited the LCH site. Their report concluded some improvements had been made when compared to previous visits but identified several areas requiring focus and development to ensure changes were completed and embedded within practice. These included IPC standards within the ED, management of mattresses, waste management, IV device practice as well as diligence with environmental and equipment cleanliness

An action plan has offered control and mitigation actions including the employment of a Waste Manager (January 2025) along with a new waste contractor. Environmental cleanliness has been subject to actions in respect of cleaning schedules. Enhanced attention to detail for clinical and non-clinical aspects of cleanliness has continued to be a focus of attention as well as the procurement of replacement equipment. There has been work in respect of the implementation of the IPC QI projects. A site wide static mattress audit did not identify a high percentage of failures, but work has continued to address issues with trolley mattresses and ensure storeroom practices meet the required standards.

The ICB Senior Health Protection Nurse has undertaken quarterly supportive visits, rotated between the sites to ensure a good overview of Trust premises. These visits have been extremely valuable, promoting working together as an integrated system and a "fresh eyes" approach. A summary of the findings demonstrated that environmental cleanliness has been overall very good, and patients are happy with the care they received.

Non-compliance with waste, peripheral line practice along with cleaning and replacement of equipment mirrored the NHSE visit findings. It was recognised more work is required to achieve appropriate glove usage and it is anticipated the Gloves Off campaign will provide this direction.

Visits have referred to poor environmental infrastructure and in some instances the impact of extensive building work.

8.   Antimicrobial Stewardship (AMS)

There have been several key challenges, realisations and new opportunities to steer AMS efforts over the course of the year, as well as setting the grounding for future work. Despite continued efforts, the organisation did not again meet the national target to reduce broad spectrum antimicrobial usage and remains one of the highest consumers of antimicrobials across the Midlands region. There appears to be more tendency to prescribe antimicrobials, and the most significant contributors to the trend are co-amoxiclav, and then clarithromycin (Graph 1).

Graph 1: East Midlands regional benchmarking of Total Antimicrobial Consumption 2024-25 Adjusted to Bed Activity (Source: Define database, accessed 17/04/25)
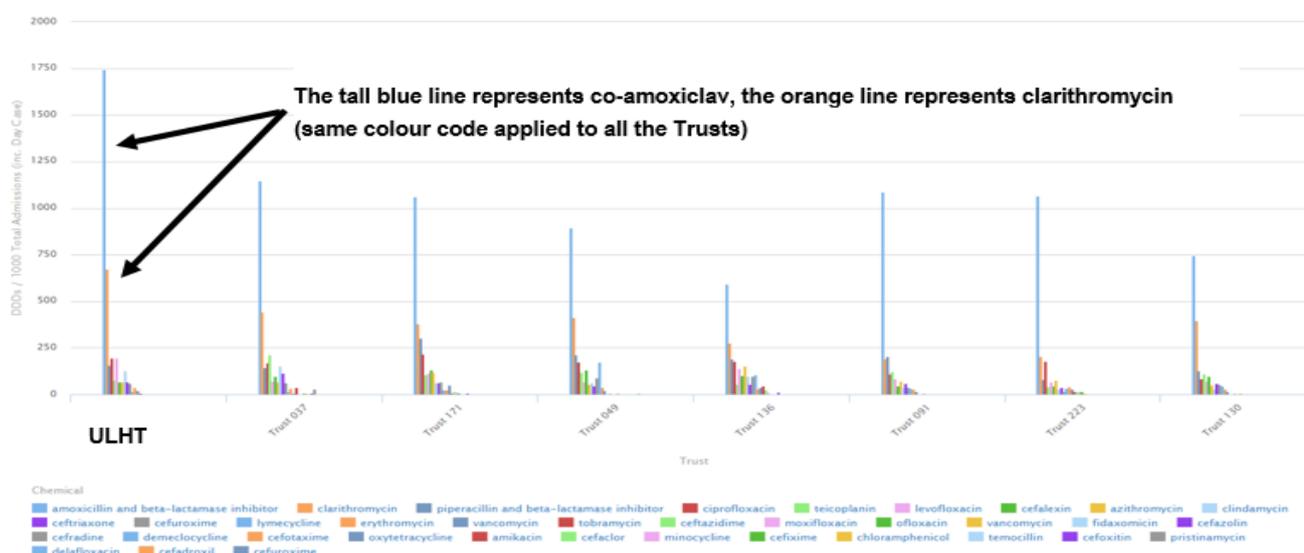
Challenges consuming much time and effort have included increased gaps in Microbiologist and Antimicrobial Team staffing, antimicrobial drug shortages, a new provider switchover for the antimicrobial app with system wide impact, along with setbacks for the Outpatient Parenteral Antibiotic Therapy (OPAT) service. The ability to undertake antimicrobial audits and QI projects has been impacted, affecting an ability to support PII audits and PSIRF investigation work.

The OPAT service has experienced another year of change with significant impact on the home care pathway but has offered an opportunity to explore and enhance other clinical pathways and navigate the governance processes required for the Group model. The re-instatement of the OPAT home care pathway for full-service capacity has now been actioned.

Relocation to the main hospital site has been invaluable to increase accessibility to wards to undertake patient assessments. For example, OPAT staff actively screening in-patient wards for IV antimicrobial prescriptions and initiating IV to oral switch reviews. This has supported good clinical decision making and therefore quality of care.

To explore further, the pan-organisation audit for the IV oral switch (IVOS) CQUIN suggested up to 25% of patients on IV antibiotics could have been switched (before the point of audit), offering clinical services a valuable review. The data enhances Care Group AMS surveillance and has furthermore presented an opportunity for educational insight. The timely switch from IV to oral antimicrobials also reduces the environmental impact of healthcare in terms of carbon footprint, and nursing time.

Primary antimicrobial guidelines and policy for antimicrobial prescribing updates are important to address resource constraints with a need to achieve better accessibility and awareness at the patient bedside. To achieve accountability, there must also be greater clinician awareness of antimicrobial prescribing competencies.

Increasing a patient engagement focus has been a key aim with successful development. Through the year, the antimicrobial awareness campaign has offered patient stories as a prominent theme.

Understanding that current efforts are not enough to effectively improve the performance in terms of the national targets (a strong indicator of AMS) has been pivotal to using the year to identify what needs to be done differently. Key changes that have been initiated are:

- Inclusion of antimicrobial resistance as a high-risk item on the Trust Risk Register to propel action to improve AMS

- DIPC oversight of the collaboration between Microbiology, Antimicrobial Pharmacy and the IPC Team to create a unified Infection Management Team, with revised clarity on roles and engagement with clinical teams and governance structures

- Revised approach to the development and implementation of antimicrobial guidelines to enable them to be more informative and accessible to users. Being ULTH specific has enabled material to be included, cross referenced, and structured in the guidelines to increase effectiveness and communication of resources

- Antimicrobial Pharmacy Team skill mix adjustment to promote the development and progression of the Care Group engagement strategy with regards to antimicrobial prescribing accountability and ownership. Successful development of existing staff to a Specialist Antimicrobial Technician post as well as data analyst roles to underpin future key change. Work has commenced on the development of an Antimicrobial Nurse post

- Close collaboration to improve stewardship via the Electronic Prescribing and Medicines Administration (ePMA) and rapid cascade of antimicrobial alerts and shortages has been invaluable. The functionality of the system is evolving well

- Laboratory progress in setting up in-county testing for some diagnostic tests and therapeutic drug monitoring, to enhance AMS efforts and patient safety.

The Antimicrobial Stewardship Strategy Group (ASSG) now encompasses the Group model, with a restructured approach to the agenda, surveillance, reporting and development of initiatives and resources. ASSG has support via Medicines Quality Group, Drug and Therapeutics Committee,

the IPG along with other relevant key forums. Lincolnshire ICB efforts have also progressed with revised enthusiasm.

Evolution is starting to have a local population AMS impact due to educational campaigns and work to enhance penicillin allergy de-labelling awareness, as well as identifying opportunities to improve this across Lincolnshire. To increase the scope of work there is a need for further resource.

Audits and QI projects have progressed including audits pertaining to antimicrobial IV to oral switch and the antibiotic Aciclovir to create a clinical support tool for viral meningitis. An identified issue with the ePMA system of antimicrobial indication was amended and led to prescribing insights in emergency areas. Antimicrobial prescribing standards audit have resulted in ratification and implementation of Teicoplanin specific prescription chart and ePMA process.

A QI project demonstrated awareness of Infection Management Teams and antimicrobial resources and a further supported an Antimicrobial App switchover to promote better functionality. PII process work promoted some meaningful outcomes and actions to review empirical antimicrobial treatments in the ITU setting to reduce ESBL, CPE and other alert organism selection pressure.

There has also been work in relation to penicillin allergy awareness to create cards and a patient leaflet. Enhanced education and training included the introduction of AMR mandatory e-learning introduced for all staff with clinical and non-clinical roles as well as the development and pilot of Junior Doctors induction packs in selected clinical areas.

The prognosis for AMS is looking hopeful for the coming year with support from key escalation routes, and intentions to optimise sustainable improvements in patient care. Clinical awareness of accountability with executive level oversight to drive this message, along with improvements, throughout the group and Lincolnshire are important influencing factors to secure successful achievement.

9.   Laboratory Service

Path Links has been able to directly transition to United Kingdom Accreditation Service (UKAS) ISO15189:2022 following inspection during spring 2024 and has just completed an annual surveillance visit ahead of the next accreditation visit in spring 2026.

As part of the ME2 (East Midlands 2) laboratory network of UKAS-accredited Microbiology laboratories, Path Links works collaboratively through an Operational Group of Microbiology Managers and Working Group of Microbiology Managers and Clinical Microbiology Leads. To enable service continuity, all ME2 Microbiology laboratories, whilst distinct entities, work together to support each other's services whenever possible to mitigate risk relating to service and/or supply disruptions.

The ME2 laboratories are in the early stages of a phased joint procurement of new analysers, assays and equipment due to be completed 2026-27. This will mean the majority will be standardised allowing for greater comparability of service provision and patient results. This is in addition to providing a potential opportunity to expand local testing and improve referred testing turnaround times by offering an enhanced regional based service.

In June 2024, there was the implementation of molecular testing for a range of viruses and bacteria in cerebral spinal fluid (CSF) by Polymerase Chain Reaction (PCR) from 7-10 days down to a day from receipt. This service is supporting AMS including prevention of antimicrobial resistance through rapid results allowing early intervention of management of patients due to a significantly more sensitive test. This moreover supports the standing down of an empirical treatment for suspected meningitis/encephalitis.

During July 2024, at the request of Microbiology the Path Links Blood Science Directorate implemented a serum Teicoplanin level assay. Results are now generated 7 days a week to enable greater use of this valuable antimicrobial in appropriate clinical cases, including patients accessing the OPAT service.

The Microbiology Clinical Lead (Consultant Microbiologist) and Path Links Microbiology Operational Manager have achieved a higher level of collaborative work with the ICB and LCHG colleagues. This has included key work streams pertaining to AMS, sepsis and IPC, allowing for an enhanced integrated and responsive Microbiology Directorate service. An opportunity has also been presented for more effective understanding of service requirements and to allow improved use of resources as well as future planning and developments.

The sepsis work stream has supported under a Blood Culture Optimisation Pathway improvement to achieve the key pre-analytical target of blood culture collection to receipt of less than 4 hours. This is via the procurement of analysers for the 3 acute sites, and to increase capacity to address problems at the PHB site and put in place the national recommendation of two sets of blood cultures per adult patient.

The Directorate is furthermore submitting a 6 monthly audit to the Midlands AMR group in respect of collection to receipt times, and the volume of blood in blood cultures (recommended 8-10ml per adult bottle). They have also assisted the Lead Antimicrobial Pharmacist in preparing the quarterly Midlands AMR highlights report.

From October 2024, the Microbiology Directorate Clinical Lead has been leading work to improve and develop all aspects of the laboratory service. This has included the recruitment of a Consultant Microbiologist to lead the PHB clinical microbiology service. Further substantive recruitment has been challenging but continues to be taken forward and in the meantime locum Consultants are working with the Team to ensure clinical cover. The Consultant Team is actively involved with ward rounds, multi-disciplinary teamwork and attend a variety of meetings to support system-wide colleagues.

10. Estates and Facilities

Estates and Facilities continue to progress effective work streams to further support and improve service delivery, along with the compliance assurance and planned preventative maintenance (PPM) activities to the IPG as per a reporting schedule.

The development of the LCHG has initiated wider scale groups for water safety and ventilation to achieve a governance strategy inclusive of partnership teams. This has been beneficial in the sharing of information leading to compliance improvements. There is recognition that effective governance is the way to manage actions from identified risks with concerns arising from Authorised Engineer (AE) audits being escalated for inclusion on the Trust Risk Register. This has been of value to provide organisational risk oversight.

Reporting mechanisms have clarity and consistency with concerns escalated where required, as well as providing assurance reports in a timely manner in accordance with governance reporting schedules.

10.1 Environmental Cleanliness

During 2024-25 housekeeping continued to play an important part in maintaining standards of environmental cleanliness across the organisation. From January 2025, ULTH was successful in their bid to provide the management of housekeeping services to CHL. Recruitment has continued to progress with an aim to achieve full establishment across all sites. The turnover of staff has remained a concern with plans in place to review recruitment and retention processes to endeavour to identify a way forward to address the issue.

The cleanliness star rating is embedded and an area scoring 3 stars or below is subject to an action plan along with additional cleans and further audits to ensure the required standards have been met. Tables 12-14 illustrate the overall very good average star ratings across the sites for all audits in the relevant functional risk (FR) category.

Table 12: Environmental Cleanliness Star Ratings Lincoln County Hospital (LCH) 2024-25

Date	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Category	Star Rating											
FR1 (98%)	4	4	4	4	4	5	5	4	5	5	4	4
FR2 (95%)	5	5	5	5	5	5	5	5	5	5	5	5
FR3 (90%)	5	5	5	5	5	5	5	5	5	5	5	5
FR4 (85%)	5	5	5	5	5	5	5	5	5	5	5	5
FR5 (80%)		5		5	5			5		5	4	5

Table 13: Environmental Cleanliness Star Ratings Pilgrim Hospital Boston (PHB) 2024-25

Date	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Category	Star Rating											
FR1 (98%)	5	4	5	5	5	5	4	4	5	5	4	5
FR2 (95%)	5	5	5	5	5	5	5	5	5	5	5	5
FR3 (90%)	5	1	5	5	5	5	5	5	5	5	5	5
FR4 (85%)	5	5	5	5	5	5	5	5	5	5	5	5
FR5 (80%)				5		5				5		5
FR6 (75%)	2	5			5	5	5				5	

Table 14: Environmental Cleanliness Star Ratings Grantham and District Hospital (GDH) 2024-25

Date	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Category	Star Rating											
FR1 (98%)	5	5	5	5	5	5	5	4	5	5	5	4
FR2 (95%)	5	5	5	5	5	5	5	5	5	5	5	5
FR3 (90%)		5		5		5	4	5		5	5	5
FR4 (85%)	5	5	5	5	5	5	5	5	5	5	5	5
FR5 (80%)			5	5		5		5			5	
FR6 (75%)				5	5							5

Deep Clean Teams have continued to play a significant part in supporting patient flow and infection cleans. Facilities have introduced an online booking system for bed space and bay cleans with a benefit of improved data collection, enabling a further review of housekeeping rotas. With guidance from the IPC Team, the deployment of hydrogen peroxide decontamination and a chemical drain cleaner have been successful.

To develop the delivery of ED cleaning services at the LCH and PHB sites, a 3-month trial of a dedicated supervisor was undertaken with improvements made in respect of standards and improved leadership of the housekeeping teams. Work to take forward a trial for a temporary housekeeper within these departments to support the cleaning of some clinical items has been

achieved. A Divisional plan and business case for this to be integrated more formally into the Healthcare Support Worker's role is being carried out.

The official Patient-Led Assessments of the Care Environment (PLACE) inspections at all sites allude to maintaining very high standards, with a score in 2024 of 99.4% (2023, 99.11%) measured against a national average of 98.31%.

10.2   Waste Management

A Waste Compliance Manager has been recruited to take the lead role for all aspects of waste management. As part of the Group model, they also have responsibility for overseeing all wards and departments for the provision of professional waste-related advice.

A new clinical waste contract commenced in December 2024 with strict contractor key performance indicators (KPI), such as meeting the expectation of the condition of a clinical waste (SULO) bin upon delivery to avoid rejection. Concerns have also been raised by NHSE and ICB colleagues whilst visiting the sites. Improvements are being seen with monitoring continuing to take place.

Contract review meetings where possible are now joint LCHG meetings with both organisations now overseen by the Facilities Management Team. A full programme of waste training for wards and department staff supported by the waste contractors under the direction of the Waste Compliance Manager is being planned. This will include a review of mandatory training requirements with regards to waste compliance with the support of the IPC Team.

10.3   Water Safety

The WSG meets quarterly and by exception depending on risk and development strategies. It comprises of technical, clinical and Health and Safety teams to ensure a management system is in place to control and mange water-related risks, implement robust maintenance strategies, oversee action and development progress as well as the provision of technical support to capital development schemes. Following each meeting, a report is produced for the IPG to provide assurance and escalate risks outside of the control of the WSG, or those that pose a significant risk to service impact, staff and patient safety.

Through the year, PPM at the 3 acute sites has remained stable with an average water hygiene completion of 88.2%. Table 12 illustrates this is slightly away from the 90% target but an improvement of 5% when compared to the previous year data.

Table 15: Water Safety Completed Planned Preventative Maintenance 2024 - 2025

Row Labels	Grantham			Lincoln			Pilgrim			Total PPMs Created	Total Completed	Total Completed %
	Created	Completed PPMs	Completed %	Created	PPMs	%	Created	PPMs	%			
Apr-24	39	34	87.2%	67	64	95.5%	25	25	100.0%	131	123	93.9%
May-24	39	34	87.2%	72	63	87.5%	24	16	66.7%	135	113	83.7%
Jun-24	36	36	100.0%	70	55	78.6%	26	21	80.8%	132	112	84.8%
Jul-24	39	38	97.4%	97	58	59.8%	29	22	75.9%	165	118	71.5%
Aug-24	36	36	100.0%	70	64	91.4%	23	21	91.3%	129	121	93.8%
Sep-24	41	40	97.6%	76	70	92.1%	37	25	67.6%	154	135	87.7%
Oct-24	41	41	100.0%	59	52	88.1%	23	23	100.0%	123	116	94.3%
Nov-24	36	34	94.4%	66	54	81.8%	24	18	75.0%	126	106	84.1%
Dec-24	41	37	90.2%	70	59	84.3%	25	22	88.0%	136	118	86.8%
Jan-25	38	35	92.1%	57	54	94.7%	26	25	96.2%	121	114	94.2%
Feb-25	36	34	94.4%	73	68	93.2%	25	20	80.0%	134	122	91.0%
Mar-25	39	37	94.9%	72	72	100.0%	28	26	92.9%	139	135	97.1%
Grand Total	**461**	**436**	**94.6%**	**849**	**733**	**86.3%**	**315**	**264**	**83.8%**	**1,625**	**1,433**	**88.2%**

Water Flushing in general has seen in improvement in reporting and compliance since the complete implementation of the L8Guard water management system. This provides the continued management and risk identification of water stagnation along with the ability to identify concerns and act in a timely manner. Weekly compliance and flushing reports have been circulated to responsible managers with an expectation they will action and rectify any non-compliance within their areas of responsibility.

Acute sites water risk assessments have been instructed due to significant changes and improvements made to the systems. A specialist contractor was appointed in September 2024, and it can be reported the risk assessments are in progress with work overseen by the site Authorised Persons (APs).

The *Pseudomonas* risk assessment completed in July 2024 is monitored via Divisional reporting to the WSG. Some clinical practices that have posed a risk for the growth of this bacteria have been identified, such as disposing of patient wash water in and storing extraneous items on a hand wash basin. There continues to be a concerted commitment to rectify these concerns. There was also refresher training and a revised standard operating procedure (SOP) for the cleaning of this sanitary facility.

A capital development scheme completed in March 2025 has seen the designing and installation of replacement of biocidal water treatment plants with system commissioning. This has included the replacement of dated chlorine dioxide systems of which risks of controls and assurance were not able to be effectively gained. The transition over to silver/copper ionisation will take several months to establish due to the differing ways the technology works to protect water systems from bacterial growth.

In respect of the AE water safety audit action plan tracker, Table 16 depicts the high number of actions undertaken to demonstrate an upward trajectory of progress. The work is backed by robust data and managed through the WSG for completeness as well as to facilitate improvements.

To note, the number of actions compiled were not only the most recent AE audit, but also from historic audits where actions have continued into a new year to ensure the completion of all actions.

Table 16: Authorised Engineer Water Safety Audit Action Plan Tracker

Water	Total No. of Actions	High Risk Actions Outstanding	Medium Risk Actions Outstanding	Low Risk Actions Outstanding	No. of Actions completed	Progress since last report
Trust Wide	26	0	3	2	21	≈
LCH	16	2	2	0	11	≈
PHB	27	4	4	0	19	≈
GDH	25	2	6	0	17	≈
Total No. of Actions	94	8	15	2	68	

Key:	
≈	Improvement – action completion increased over last report
✗	Decline – declines will happen as actions are added following new audits where total action numbers increase
■	Stagnant – no improvement or decline in month

There are some acute sites high risk outstanding actions as detailed in Table 17 with each having an anticipated completion date for the forthcoming year.

Table 17: High Risk Water Safety Outstanding Action and Progress

Site	Risk	Outstanding Actions and Progress
LCH	High	*Pseudomonas* risk assessment has been completed with an action to complete the Legionella risk assessment
LCH	High	The Water Safety Plan document requires reviewing and finalisation by the WSG
PHB	High	Water risk assessment with planning being undertaken. Legionella risk assessment to commence
PHB	High	Water risk assessment to be monitored by Responsible Person/Authorised Person Water
PHB	High	Identification and insulation of unlagged pipework is in progress
PHB	High	Work is progressing for shower records identify what has been completed for each asset
GDH	High	Unlagged pipework has been identified with work to rectify progressing
GDH	High	Water and *Pseudomonas* risk assessment completed, and water contractor reports to be received and presented

10.4   Ventilation

The Ventilation Safety Group (WSG) also meets quarterly and by exception depending on risk and development strategies. It comprises of technical, clinical and Health and Safety teams to ensure a management system is in place to control and mange ventilation-related risks, implement robust maintenance strategies, oversee action and development progress as well as the provision of technical support to capital development schemes. Following each meeting, a report is produced for the IPG to provide assurance and escalate risks outside of the control of the VSG, or those that pose a significant risk to service impact, staff and patient safety.

Through the year, PPM at the three acute sites has remained stable with an average water hygiene completion of 90.7%, achieving the 90% expected target. It also represents a significant improvement over the previous 12 months of 24% average (Table 18).

Table 18: Ventilation Completed Planned Preventative Maintenance 2024 - 2025

Row Labels	Grantham			Lincoln			Pilgrim			Total PPMs Created	Total Completed	Total Completed %
	Created	Completed PPMs	Completed %	Created	PPMs	%	Created	PPMs	%			
Apr-24	31	29	93.5%	53	48	90.6%	28	28	100.0%	112	105	93.8%
May-24	11	8	72.7%	57	42	73.7%	39	36	92.3%	107	86	80.4%
Jun-24	18	18	100.0%	52	47	90.4%	30	30	100.0%	100	95	95.0%
Jul-24	36	36	100.0%	52	43	82.7%	28	28	100.0%	116	107	92.2%
Aug-24	11	11	100.0%	52	48	92.3%	31	31	100.0%	94	90	95.7%
Sep-24	16	16	100.0%	47	47	100.0%	34	34	100.0%	97	97	100.0%
Oct-24	31	30	96.8%	60	45	75.0%	28	28	100.0%	119	103	86.6%
Nov-24	11	11	100.0%	51	46	90.2%	35	35	100.0%	97	92	94.8%
Dec-24	16	9	56.3%	47	47	100.0%	29	29	100.0%	92	85	92.4%
Jan-25	37	36	97.3%	52	35	67.3%	27	27	100.0%	116	98	84.5%
Feb-25	11	11	100.0%	53	38	71.7%	31	31	100.0%	95	80	84.2%
Mar-25	16	15	93.8%	58	50	86.2%	29	29	100.0%	103	94	91.3%
Grand Total	245	230	93.9%	634	536	84.5%	369	366	99.2%	1,248	1,132	90.7%

The AE Audit Report has alluded to a notable improvement in the management and documentation of ventilation systems. During the year, work has progressed for the appointment of site APs.

The age of ventilation equipment has remained a notable concern and a clinical risk process to ensure patient safety is optimised is in place for surgical facilities where an identified air change rate falls below the HTM 02-03 2021. There have been assurance systems undergo periodic inspections and maintenance with a focus on improvements, such as replacement of fan units and motors where able, to improve air flow rates and reduce risk. Further work has been undertaken to seal air handling units to retain air pressure along with building fabric remedial works.

Ventilation systems continue to perform against design for their installation times, with a commitment to improve a system where possible. Validation of critical ventilation continues annually with intermediate validations for Ultra Clean Ventilation systems conducted.

Some treatment rooms across the sites are not ventilation compliant with mitigations of clinical risk assessments and some relocation of clinical services. Longer term solutions of service improvement will be necessary with a large-scale investment requirement.

The first LCHG VSG was held in March 2025 with a focus on expectations and deliverable requirements for assurance and discussion to achieve compliance with ventilation safety and maintenance performance across the Group.

In respect of the AE ventilation safety audit action plan tracker, Table 19 depicts the high number of actions undertaken to demonstrate an upward trajectory of progress. The work is backed by robust data and managed through the VSG for completeness as well as to facilitate improvements.

To note, the number of actions compiled were not only the most recent AE audit, but also from historic audits where actions have continued into a new year to ensure the completion of all actions.

Table 19: Authorised Engineer Ventilation Safety Audit Action Plan Tracker

Ventilation	Total No. of Actions	High Risk Actions Outstanding	Medium Risk Actions Outstanding	Low Risk Actions Outstanding	No. of Actions completed	Progress since last report
Trust Wide	35	1	5	9	20	≈
LCH	50	2	6	13	29	≈
PHB	29	0	8	4	17	≈
GDH	36	3	6	10	17	≈
Total No. of Actions	150	6	25	36	83	

Key:	
≈	Improvement – action completion increased over last report
✗	Decline – declines will happen as actions are added following new audits where total action numbers increase
■	Stagnant – no improvement or decline in month

There are some acute sites high risk outstanding action as detailed in Table 20 with each allocated an anticipated completion date for the forthcoming year.

Table 20: High Risk Ventilation Safety Outstanding Action and Progress

Site	Risk	Outstanding Actions and Progress
Trust Wide	High	Improvement and formalisation of task risk assessment is being reviewed to identify specific jobs on MiCAD as well as any hazards
LCH	High	Quotations for duct work inspection and cleaning programme required
LCH	High	Risk assessment required for working on an air handling unit plant, specifically when accessing the ducts and main body during PPM
GDH	High	Progress risk assessment work to ensure the MiCAD feature to upload a risk assessment for each job is undertaken
GDH	High	Dental Unit requires work to obtain design and cost of installing a compliant air handling unit and is listed on Trust Risk Register. Add to the Capital Replacement Plan
GDH	High	Resus Room requires work to obtain design and cost of installing a compliant air handling unit and is listed on Trust Risk Register. Add to the Capital Replacement Plan

10.5   Decontamination

The Decontamination Lead role continues to develop to take forward a wide range of decontamination work and interventions, to support the Group model.

The embedded quarterly Decontamination Group meetings provide a forum for discussion and resolution of issues, with revised Group Terms of Reference. There is moreover attendance by the AP Decontamination to further strengthen the meeting. The Governance Team support the creation of a decontamination risk dashboard.

An AE Decontamination to support the wider decontamination risks and initiate a decontamination audit to comply with HTM 01 across the Trust is yet to be appointed. There is however an AE for the Endoscopy Service. There has been progress with the identification of a Trust wide AP who is working closely with the Decontamination Lead.

The service for the decontamination of surgical instruments is delivered by STERIS and as a member of the Decontamination Group and with the support of the Contracts Manager produce a compliance, activity and exception report. Their General Manager has provided a detailed update regarding the issues experienced during winter pressures and the changes made to improve resilience and business continuity. Information pertaining to STERIS accreditation and assurance has been received.

The 2025 Institute of Healthcare Engineering and Estate Management (IHEEM) Endoscopy audits have taken place, with the results generating an action plan and Joint Advisory Group (JAG) accreditation has been maintained. There has been a significant amount of Endoscopy Unit ventilation work carried out by the Estates Team to provide the required level of assurance. At the LCH site, a new Endoscopy build is well underway along with the opening of a second procedure room at CHL site, to support service development and offer a better patient environment.

To supplement the information in section 10.4, the work stream regarding the ULTH outpatient treatment rooms has been completed and a summary report submitted. A risk has been added to the risk register due to the aging infrastructure. Scoping work is to be carried out at LCHS premises along with Group-wide operating theatres. Whilst the work primarily concentrated on ventilation and environmental factors, the impact upon decontamination practices was also recognised.

The decontamination of critical and semi-critical ultrasound probes has been subject to a repeat audit to ensure the standardised chemical products and robust decontamination process are embedded in line with the SOP. Remedial actions and re audit were taken place for areas of non-compliance. Staff received education via an online package and follow up face-to-face training.

The care and decontamination of naso-pharyngeal scopes has also been addressed via staff education supported by a SOP.

11.   Occupational Health

The Nurse Led Occupational Health Service (OHS) supports the health and wellbeing of ULTH and System staff in Lincolnshire. It also delivers a programme of staff health assessment to ensure protection against infectious disease through vaccination along with on and in employment screening processes.

11.1   Healthcare Worker Vaccination

The OHS Vaccination Lead working closely with Lincolnshire Public Health and Lincolnshire Immunisation Board and has managed the influenza and COVID vaccination programme. This offers flexibility considering shift patterns, weekend working and co-administration of the 2 vaccines.

Tables 21 and 22 describe the percentage of staff receiving the vaccinations. This represents a decrease from the previous year.

Table 21: Influenza Vaccination Data 2024-25

No. of staff vaccinated	% of all staff	No. of frontline vaccinated	% of frontline staff vaccinated
4936* *Including FDP Data (Externally Administered) 4006* *Administered by ULTH vaccination team	41.90% 32.82%	 3284	 32.62

Table 22: COVID Vaccination Data 2024-25

No. of staff vaccinated	% of all staff	No. of frontline vaccinated	% of frontline staff vaccinated
1185	9.71%	773	7.68

A higher number of staff have declined seasonal vaccinations. Increased demand was however noted when local and national levels of COVID and influenza infection were high and the ULTH and LCHS Partnership Working Vaccination Teams stepped up to provide this service.

Vaccine hesitancy is being explored to identify the barriers and dispel myths in preparation for future seasonal vaccination programmes. This is being progressed via system-wide communication and a survey.

The OHS has continued to deliver a robust occupational vaccination programme, e.g. Measles, Mumps and Rubella (MMR), Varicella (Chickenpox) and Hepatitis B. Training and the use of bank staff to facilitate the programme has resulted in reduced appointment wait times across all sites. Appointments are still pressured with the responsibility for the vaccination of 20,000 individuals.

Non-attendance at vaccination clinics has remained an issue and negatively impacts on valuable clinician time. The OHS has put the following measures in place to manage this:

- Email and text reminders

- Electronic booking

- Ensuring manager contact information and alerting managers of non-attendance

- Adding links to the email appointment letters that enable staff to explore the advised and offered vaccination information.

Further work has included collaboration with ULTH Wellbeing Colleagues to use space for vaccine clinics in the main hospital building to support greater accessibility. If this evidences an increase in attendance, a business case for other sites is to be considered.

The number of staff who do not attend an OHS appointment has continued to present a risk with 894 missed vaccinations costing nearly £52,000 and in respect of 219 missed blood tests almost £12,000. Managers have been progressing work to reduce the number of staff who miss appointments and offer support to attend.

The OHS has provided support to the Trust and IPC Team in respect of investigation and management of outbreaks of infection as well as the investigation screening and management of other infections as they relate to health care workers, such as those associated with TB and latent TB.

Demand has overall continued to outstrip OHS assessment capacity and is likely to continue due to staff hours reduction along with current recruitment restrictions.

11.2   Inoculation Injuries

The OHS leads on the management of the safe handling and disposal of sharps including policy, as well as the day-to-day management of a body fluid exposure incident. The aim has remained to prevent and reduce the incidence of such injuries and promote the requirement to use safer sharps devices.

Table 23 demonstrates the number of reported inoculation incidents from 2005 to 2025. Information up to 2022 showed an encouraging decrease in injuries, in part likely due to reduced activity during the COVID pandemic and subsequent increases could reflect a return to business as usual. Through the year, there has however been further increase with investigation indicating a higher incidence with sharps disposal during procedures and also associated with patient behaviour.

Table 23: Reported Inoculation Incidents 2005-2025 and the Root Causes for April 2024 to end of March 2025

Year	Injuries
2005	90
2006	91
2007	102
2008	91
2009	111
2010	93
2011	104
2012	112
2013	198
2014	208
2015	211
2016	183
2017	220
2018	192
2019	164
2020	157
2021	160
2022	109
2023	198
2024	231
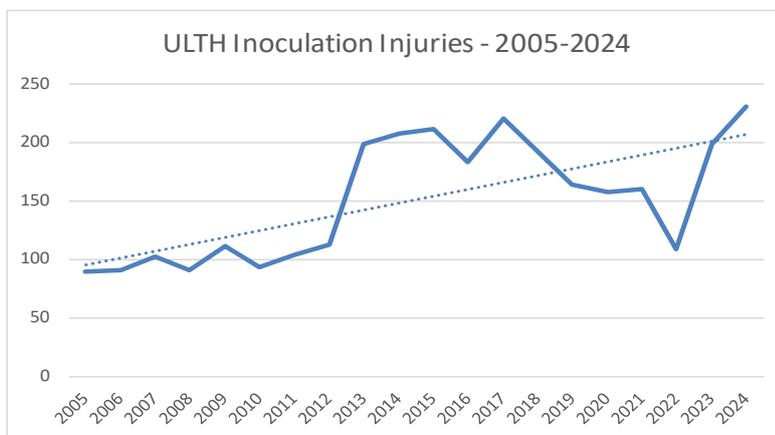
Root Cause	Total
Cleaning	2
Disposal	76
During Procedure	121
Patient Behaviour	17
Post Procedure	13
Staff behaviour	2
Total	**231**

ULTH Inoculation Injuries - 2005-2024

Root Cause for inoculation injuries - 2024
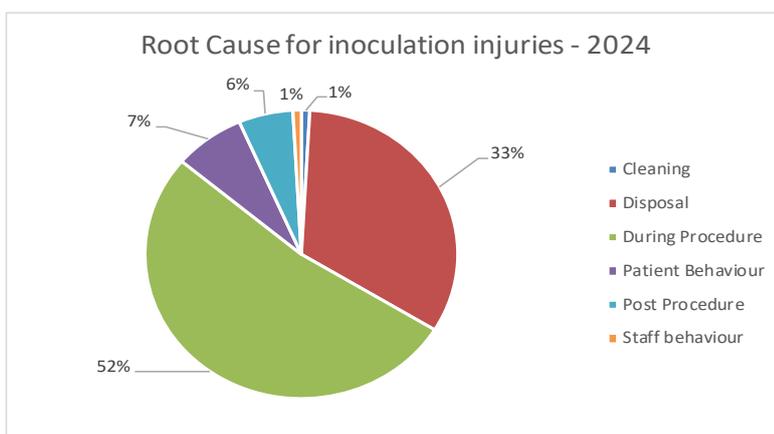
12. Training

Divisional IPC mandatory training (Table 24) describes overall 91.77% compliance representing a small decrease when compared to the previous year of 93.04%.

Table 24: Divisional Infection Prevention and Control Mandatory Training Compliance (%) 2024-2025

Division	% Compliance
Clinical Support Services	93.58%
Corporate	92.92%
Corporate Finance	100.00%
Director of Estates & Facilities	89.15%
Family Health	90.56%
Medicine	91.59%
Surgery	91.20%
Total	**91.77%**

May 2024 celebrated the annual World Health Organisation Hand Hygiene Day with displays for staff, visitors and patients generating interest in the products available, and information provided. The sites are undergoing an installation of new hand hygiene products.

The dissemination of Group wide communications and bulletins provide colleagues with information, updates and education.

Bi-monthly site IPCLA face-to-face meetings have been held, presenting an excellent opportunity to promote and update on IPC initiatives with a particular emphasis on peripheral device management and practice. There has also been discussion of other relevant topics to provide a useful opportunity to put forward and address any areas of concern. Updates from Facilities and other specialised areas have been included.

Divisional bespoke training sessions have supported in respect of hand hygiene, commode cleaning, mattress cleaning and the care of peripheral devices.

13.   Forward Plan 2025-2026

The following forward plan details work and initiatives to be progressed through the next year:

- Continued development of the LCHG IPC Team to take forward the required integrated care to better meet patient needs
- Progress the IPC Key Objectives (Table 25) to provide assurance and monitoring of the overarching IPC requirements
- Development of IPC data sets, audit standards and key performance indicators
- Continue to take forward and monitor compliance with the components of the IPC BAF, NHSE Action Plan and associated work and documents
- Support Care Group (previously Divisional) development of their IPC interventions and next steps to be taken via an IPC Business Partner model
- Prevent and reduce HCAI, and instigate measures to achieve the allocated trajectories
- Progress IPC QI work in respect of HCID, DRIPP, SSI and Gloves Off Campaign
- Continued focus on IPC fundamental clinical practice compliance, e.g. sharps practice and peripheral device management to achieve and sustain the required level of compliance
- Promote patient safety, governance and risk mitigation processes, e.g. PSIRF
- Support the development and implementation of antimicrobial stewardship initiatives.
- Advance education activities with an emphasis and development of the IPCLA
- Expand IPC social media activity
- Support the progression of laboratory-based interventions to achieve enhanced diagnostic and clinical applications for the identification of micro-organisms for medical diagnosis
- Provide IPC expertise to achieve further compliance with environmental cleanliness, water safety, ventilation and decontamination requirements and directives
- Continue Lincolnshire-wide partnership work to further create and sustain consistent and proportionate approaches to the investigation and management of relevant infections.

The above forward plan anticipates the offer of a range of IPC work for the further development of the prevention and reduction of HCAI to achieve a high level of patient safety, governance and mitigation of risk.

Table 25: Infection Prevention and Control Key Objectives 2025-2026

Number	Objective
1	Develop infection prevention and organisational and Care Group Governance arrangements across the Group
2	Continue to progress assessment and gap analysis of The Health and Social Care Act 2008. code of Practice on the prevention and control of infections and related guidance
3	Further development of surveillance of healthcare associated infections and performance
4	Investigate and manage the risks posed by novel infectious diseases to promote patient safety and prevent and reduce the risk of cross transmission
5	Investigate and manage the risks posed by the emergence of multi-drug-resistant organisms to promote patient safety and prevent and reduce the risk of cross transmission
6	Development of governance arrangements for appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
7	Implement and sustain standards of cleanliness in line with National Standards of Healthcare Cleanliness
8	Progress water safety, ventilation and decontamination requirements as sub-groups of the Infection Prevention Group to ensure patient safety requirements
9	Develop programmes of audit, education and the Infection Prevention Champion/Ambassador networks across the Group

14. Conclusion

2024-25 has been another year dominated by progress and challenge to prevent and reduce HCAI. This report describes a wide range of strategic and operational IPC initiatives to offer assurance that a range of interventions are in place to prevent and reduce HCAI and promote a high level of risk-based patient safety. It has also been demonstrated there are areas for improvement and a need to have the consistent application of IPC fundamental practice.
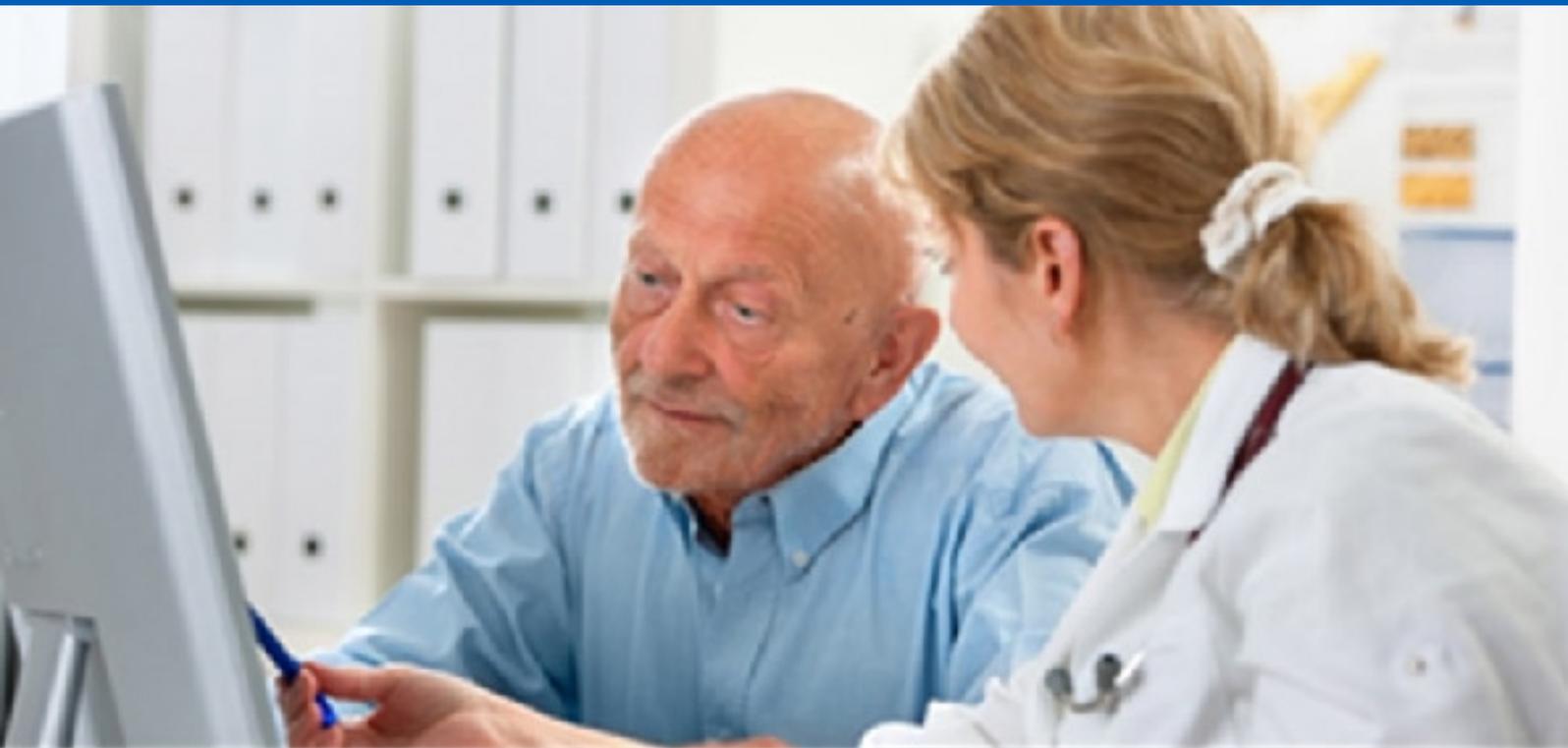
Patient Experience Annual report 2024 - 2025

Prepared by: Jennie Negus. Head of Patient Experience

Endorsed by: Patient Experience & Involvement Group – 02/07/2025

Quality Governance Committee – 15/07/2025

Caring and building a
healthier future for all

Executive Summary

In April 2024 Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) formally came together in a Group arrangement, with the goal of improving the care provided to patients across the county and now called Lincolnshire Community and Hospitals NHS Group (LCHG).

Through 2024 Patient Experience has been at the forefront of the organisation's strategies and this report describes the work undertaken during the year to ensure patient experience continues to sit front and centre in all that we do.

'Patient experience' is what the process of receiving care _feels_ like; it encompasses the range of interactions our patients and their families have with our staff and services. Patient experience includes the aspects of care that we know patients value most, such as timely appointments, easy access to information, being treated with courtesy and respect, being involved in discussions and decisions and receiving clear communication from clinicians and staff.

Agency for Healthcare & Research: _What Is Patient Experience? | Agency for Healthcare Research and Quality_

Imagine an NHS service that starts with the patient. A service that listens to patient and family needs and then utilises the skills and expertise of both the clinician and patient to design the experience to meet these needs. That is what using patient experience information is all about. Ultimately, by consistently asking people whether they are receiving the care they need, and acting on what they tell us, patients will feel more supported and better cared for. We have reached a seminal point in our efforts to improve the experience of people who use health and social care services, and their families. Patient experience and engagement has never held

such a high profile, this report outlines our work to ensure that the patients' voices are actively sought, heard and acted upon in partnership with the patients themselves.

This Annual Report describes our achievements over the last 12 months and our plans and intentions for the coming year. I would like to thank everyone who has worked with us over the past year: the patients, their family members, carers and our volunteers who have shared their insights and challenges to our work, during their experience with the Trust.

Nerea Odongo. Group Chief Nurse

Developing a LCHG model for Patient Experience

In April 2024 a Task and Finish Group was brought together to scope, design and lead the development of a Group-wide Patient Experience & Involvement blueprint and associated workplan. With membership across all ULTH and LCHS divisions, communications, CQC compliance team and Patient Panel, the group met monthly throughout the year.

The key objectives of the group were:

- To undertake a Group-wide deep dive self-assessment of patient experience using national best practice, indicators and frameworks to identify current position, performance and required actions.
- Consider and review our organisational patient experience evidence to meet the new CQC Single Assessment Framework requirements and construct an approach that ensures robust data capture and provision.
- Use the self-assessment and CQC review to develop an LCHG Patient Experience Plan that sets out a shared vision for both ULTH and LCHS, and importantly, for the Group as a whole. This partnership approach places patients and carers at the heart of everything we do, demonstrating our commitment to 'Great Care, Close to Home' and 'Outstanding Care, Personally Delivered.' The aim of this work is to support staff and patients to work together to create an outstanding care experience, delivered by compassionate and skilled professionals, and focused on achieving the best possible outcomes for all who use our services.
- Several additional actions were agreed including development of a training plan, a process for developing and sharing patient stories, supporting LCHS to implement divisional Patient Experience Groups, integration of LCHS data within the SUPERB dashboard to enable Group-wide reporting and importantly consideration of how the existing ULTH Patient Experience Team can be realigned to serve across the Group.

Achievements

- ✓ In April 2025 the final version of the LCHG Patient Experience Plan was approved at Patient Experience and Involvement Group (PEIG). Titled 'Our Commitment to Patient Experience and Involvement' the plan embodies our organisational values and is aligned to other strategies across our organisations. This Commitment to Patient Experience and Involvement is our Group's intention to ensure the best possible experience of person-centred care for all patients. We describe how staff will understand their responsibility in ensuring each patient not only receives excellent clinical care, but that it is delivered in a manner that treats them as an individual, recognises their needs and cares for them with empathy and compassion. We outline how this will be achieved, how progress will be monitored and how we will share how we are doing.

We want our patients to feel:

- Welcome, and reassured.
- Supported and included, listened to, respected as an individual and kept informed and involved in decision making. "No decision about me, without me".
- In safe hands and have trust in all our staff, understand what is happening to them and why.
- That when they tell us about their experiences, we will use that feedback to make changes and improvements.

By having this plan at the heart of everything we do, we can drive long-term success and real change. We have made significant success in many areas, but we need to do much more and this gives us a strong foundation to ensure that a focus on patient experience is at the core of every aspect of our activity in real and measurable ways.

OUR COMMITMENTS

We will strive to deliver care, treatment and services that are fair, inclusive, and accessible for all members of our community.

We will work with patients to improve patient experience through seeking out, listening to, and acting on feedback to identify opportunities for quality improvement.

We will work in partnership with patients, carers, stakeholders, and the local community to codesign and develop accessible, high-quality, and responsive services.

We will meet our commitments to our patients as set out in the NHS Constitution and regulatory frameworks, in relation to patient experience.

We will develop our workforce to put patients at the heart of all that we do and drive person-centred approaches to wellbeing, prevention, care and support.

- ✓ A substantial CQC patient experience evidence library has been created.
- ✓ All seven clinical divisions across LCHG now have monthly local Patient Experience Groups in place that drive, deliver and demonstrate divisional level actions that will lead to measurable improvement and continuous and sustainable learning in outcomes, delivery, performance, sustainability and transformation in patient experience.
- ✓ In September 2024 the first LCHG SUPERB dashboard report was produced. This brought together patient experience feedback from both ULTH and LCHS into one dashboard. Monthly reports and infographics are now sent across all divisions.
- ✓ A process for the development of patient stories has been agreed and implemented; this includes stories being included within all quality, assurance and governance

forums and video stories at Group Board. The process includes not only detailing a patient's journey but understanding their experience and staff experience.

Patient experience

This is the journey from the patient's perspective. Think about asking the patient the following:
• What was good about your care?
• What wasn't so good? What could have been better?
• Think about how involved you were in the decisions made and care planned. How well was this done, what made you feel involved in your care? What would have made this better?
• How did your care make you feel – did you feel safe, listened to, cared for? Scared? What would have made this better?
• What was the environment like – was it clean, safe, noisy? What would make this better?

Staff experience

This is the journey from your perspective. Consider the following:
• What was good about the care given? Was it evidence based? Did it work? Did it need to be altered? How did you innovate?
• How did you make sure the patient voice was heard? Did you involve the patient in decisions made and care planned? How did this feel – was it easy/difficult? Why?
• Was there continuity of care? How was this done? Did it work? What could have been done differently?
• What have you learned and what would you change?

PATIENT EXPERIENCE
Would you like to know more about..........?

Come along to one of our 'bite-size' 30-minute sessions; no need to book, simply click the Teams link to join. Everyone welcome!

Patient Experience Fundamentals with Jennie Negus	
Weds 14th Jan 14:00 – 14:30	Teams link
Tues 11th Feb 15:00 – 15:30	Teams link

Developing a patient story – with Liz Power	
Thurs 16th Jan 10:00 – 10:30	Teams link
Weds 12th Feb 13:00 – 13:30	Teams link

All about Care Opinion – with Sharon Kidd	
Thurs 23rd Jan 10:00 – 10:30	Teams link
Thurs 20th Feb 09:00 – 09:30	Teams link

Creating a patient survey – with Liz Power	
Weds 29th Jan 11:00 – 11:30	Teams link
Weds 5th Mar 14:00 – 14:30	Teams link

Setting up a patient forum – with Sharon Kidd	
Weds 5th Feb 10:00 – 10:30	Teams link
Thurs 6th Mar 13:00 – 13:30	Teams link

Friends & Family Test – with Martyn Staddon	
Weds 22nd Jan 15:30 – 16:00	Teams link
Tues 18th Feb 13:00 – 13:30	Teams link

SUPERB masterclass – with Martyn Staddon	
Tues 4th Feb 11:00 – 11:30	Teams link
Weds 26th Feb 10:00 – 10:30	Teams link

Using data to make a difference – with Jennie Negus	
Tues 28th Jan 15:00 – 15:30	Teams link
Tues 25th Feb 11:00 – 11:30	Teams link

✓ Bite size training sessions with topics requested by staff were well received and are scheduled to be repeated.

Patient Experience and Involvement Group (PEIG)

ULTH had a monthly Patient Experience Group reporting to Quality Governance Committee and LCHS had a monthly Stakeholder Engagement and Involvement Group reporting to Quality Group. As part of the new LCHG joint working arrangements, these groups came together from May 2024 and became Patient Experience and Involvement Group (PEIG) reporting to the new Quality Committee. PEIG provides leadership and oversight of the patient experience and involvement agenda across the Group, ensuring measurable improvements are delivered in line with the strategic objectives set out in the Board Assurance Framework (BAF).

Chaired by the Chief Nurse, PEIG has evolved in membership and format during the year and is a well-attended, energetic, respected and busy forum. The Terms of Reference have been agreed alongside a structured forward reporting schedule that sees divisions and services sharing their performance, achievements and actions giving the Group assurance that patient's experiences are being sought, listened to and acted upon.

Board Assurance Framework (BAF)

The BAF brings together, in one place, all the relevant information on the risks to the Board's strategic objectives. It is an essential tool for Boards and provides an effective methodology to give confidence that they are providing thorough oversight of strategic risk. Each month the BAF is reviewed considering assurance received at PEIG. The Group BAF has been under review and development during the year and now has two fields, one each for ULTH and LCHS.

Strategic objective 1b - Improve patient experience	
ULTH	Controls include the new patient experience plan 'Our Commitments to Patient Experience & Involvement' and associated action plan in development, data, intelligence and reports received into PEIG, Patient Experience Team engagement and leadership within clinical divisions providing support and facilitation.
LCHS	Controls include all the above and also the building of capacity and leadership within the Patient Experience Team to spread across to LCHS. Data systems are being aligned and LCHS processes in development to provide equivalent support and facilitation.

Risks

There are currently three ULTH corporate patient experience risks on the risk register, though at the time of this report these are being reviewed across the Group as they are largely ULTH focused. Quarterly reports are provided to PEIG and controls in place are closely monitored.

Corporate risk 4980

If we do not build the expectation to engage with our patients, then we will not achieve patient centred care and if we do not reach out to 'hard to reach' groups our intelligence will fail to be diverse and inclusive.

What is the risk?	Controls in place	How is the risk measured?
Patient engagement can inform service design and evaluation as well as enhance its delivery and governance. It is the process of building the involvement of patients, families and carers, supporting their active involvement in order to enhance their care, care experience, safety, quality and patient-centredness. **If we do not build the expectation to engage with our patients then we will not achieve patient centred care and if we do not reach out to 'hard to reach' groups our intelligence will fail to be diverse and inclusive.**	• Patient Panel and Expert Reference Group outputs and evaluations. • Codesign workshops. • Upward reports to Patient Experience & Involvement Group. • Patient Experience and Communication training offer has been reviewed to offer include virtual, face to face, self-study and bite size across different staff groups and will roll out in September 24. • in light of the development of LCHG training will be offered across to LCHS staff also and this is currently being mapped by the Patient Experience & Involvement Group Task & Finish Group. • Stakeholder membership and engagement at Patient Experience & Involvement Group • Evaluations and outputs from implementation of 'What Matters to You' initiative. • Evaluations and outputs from You Care We Care to Call initiative • Real time surveying implemented across Waddington & Ingham Wards, ED & UTC and a discharge experience survey across both inpatients and patients recently discharged. Survey volunteers being recruited to support this. • Current 2022-2025 Patient & Carer Experience (PACE) Plan under review and a self assessment underway across ULHT & LCHS to enable development of a Group PACE plan.	• Patient Panel meets monthly and considers a range of projects, service redesigns and evaluations. • Expert reference groups: - Sensory loss ERG group - Breast Mastalgia ERG group - Cancer ERG established & meeting quarterly - Carers Group linking into system groups and will commence carers surveys through the new Carers Hub. - Improvement Academy ERG group - Digital Transformation ERG group developed and meets 1/4rly. Codesign workshops

Corporate risk 4981

If we do not involve our patients and their carers from the outset with our service design and evaluation, then we will not achieve our ambition of person-centred care.

What is the risk?	Controls in place	How is the risk measured?
Co-design shifts the traditional design process where a health care team is independently coming up with ideas for problems. Co-design involves the patients in the design process and works with them to understand their met and unmet needs. If we do not involve our patients and their carers from the outset with our service design and evaluation then we will not achieve our ambition of person centred care.	• Patient Panel meets monthly and considers a range of projects, service redesigns and evaluations. • Expert reference groups o Sensory loss ERG group established and able to convene as needed. o Breast Mastalgia group specifically established for pathway development piece of work and will meet to evaluate. o Cancer ERG established & meeting quarterly o Dementia Carers group being redeveloped and to become the Care Partners ERG. o Improvement Academy group developed and settling well. o Digital Transformation group launched and 2 meetings to date. o Codesign workshops held specifically addressing improvements to outpatients letters and appointments. o Patient Panel members invited to attend QI training to understand the principles and methodologies and enable greater involvement in improvement codesign.	• Patient Panel minutes & evaluations • Divisional assurance reports • Patient Experience Reports

Corporate risk 4629

If we do not listen to the voices of our patients, carers and families through not seeking out, hearing and appreciating their experiences and then acting on them, we will fail in our ambition to deliver patient centred care.

What is the risk?	Controls in place	How is the risk measured?
If we do not listen to the voices of our patients, carers and families through not seeking out, hearing and appreciating their experiences and then acting on them, we will fail in our ambition to deliver patient centred care.	•Patient Experience Group now combined with LCHS Stakeholder Engagement & Involvement Group to develop one LCHG group PEIG - rolling programme of divisional assurance reporting • Patient experience metrics and reporting (FFT, Care Opinion, PALS & Complaints, Healthwatch data, compliments all of which are triangulated through SUPERB). LCHS data incorporated into SUPERB with first combined report scheduled for mid September 24. • National survey reports received as per national programme and reported to Patient Experience & Involvement Group. Overarching thematic review. • Patient Experience & Involvement Group Task & Finish Group convened to identify direction and vision for LCHG Patient Experience culminating in a Group Patient & Carer Experience Plan. • Patient Panel now considered a formal sub group of Patient Experience & Involvement group reporting 1/4rly, codesign workshop held to design LCHG model. • Patient Stories plan and process reviewed. • PLACE annual inspections and internal PLACE Lite visits continue with strong patient involvement. Ward and department assurance visits continue as part of Quality Accreditation programme and now being established across LCHS. • Policies: Development of Written Patient Information, Complaints & PALs Policy, Care Partners, Visiting. • Through Group model opportunities have arisen to combine skills and opportunities for reaching out to seldom heard communities through the Health Inequalities work.	Patient feedback; volume and theme: • PALs & complaints • FFT • Care Opinion • National and local surveys • Healthwatch data • Patient Panels and expert reference groups • Patient feedback through ward assurance and Quality Accreditation programme • Patient stories • Triangulated data through SUPERB

2024 – 2025 Patient Feedback

This section looks at what our patients have told us throughout the past year, as collected via stated data sources and collated into the SUPERB dashboard.

150,167 shared feedback with us, an increase of 55,924 on the previous 12 months.

129,273 people left a rating on Friends and Family Test.

714 stories were told on Care Opinion.

11,631 compliments were received.

1. Friends & Family Test (FFT)

The FFT question is asked of all patients discharged across various streams and services. A text or interactive voice message is sent to eligible patients asking them: "Thinking about [setting]…overall, how was your experience of our service?" and patients respond with one of the following options: very good, good, neither good nor poor, poor, very poor or don't know.

They can then provide a follow up comment to explain why they chose that option. Texts are free and patients can stop them if they wish and indicate whether their comments are private and not for sharing.

From September 2024 we were able to include LCHS FFT data into our dashboard which has had a significant impact in the number of surveys received, seeing a 53,906 increase on 2023-2024. However, LCHS FFT works in a very different way to ULTH as the hospital uses discharge data extracts for sampling whereas LCHS in many cases rely on paper surveys in clinics and community settings. Work is currently underway to explore how to align the two organisations and enable true comparisons.

ULTH positive responses over the 12 months were 88.6% which is slightly up on 2023-2024 which was 87% and 2022-2023 which was 87.4%. Considering the significant pressures across our emergency services, scheduling of appointments and waiting times this consistency across the last 3 years is good to see.

ULTH
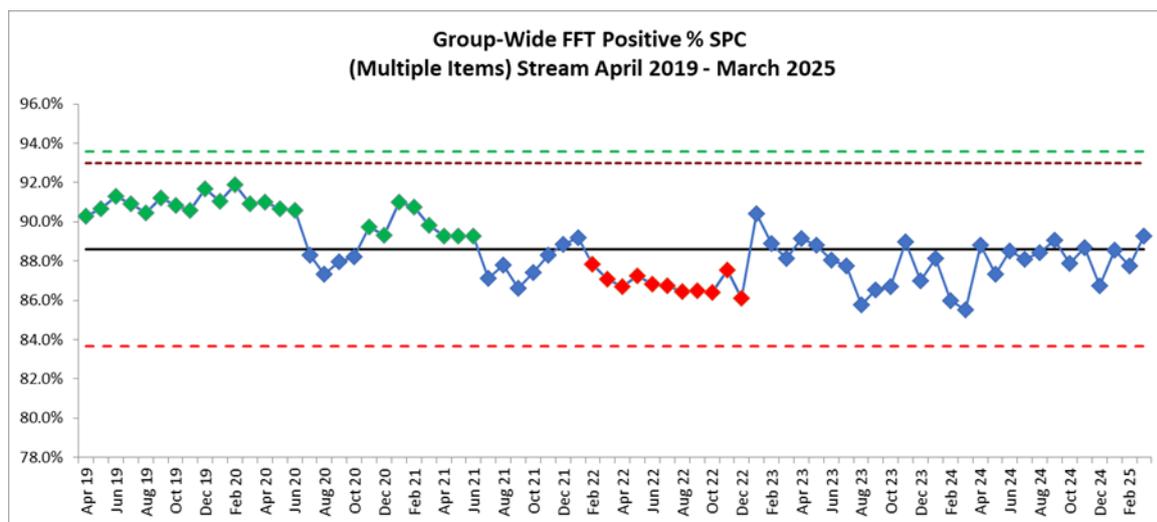
ULTH's positive average is 88.6% overall, with the entirety of the last financial year showing normal cause variation only (mathematically expected behaviour).

LCHS – data only available from August 2024 onwards

Group-Wide FFT Positive % SPC
Community Stream August 2022 - March 2025
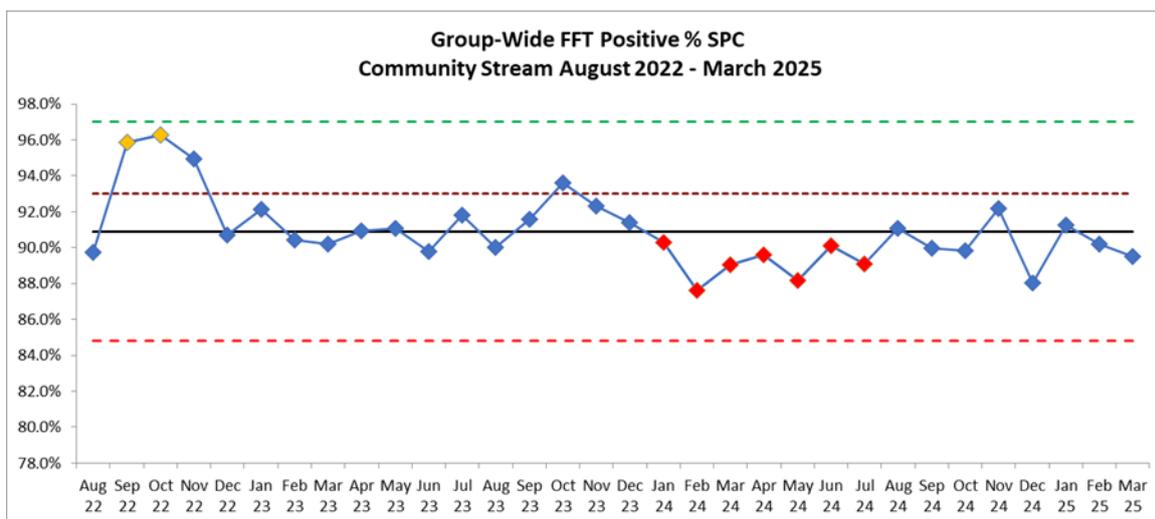
LCHS started off in a run of points below their average (90.9% positive) but recovered.

As with much of our patient feedback, it is the narrative that is most valuable and the comments that are given alongside an FFT score give an insight into why someone chose the response they did, be that a positive or negative experience and how we can learn from that.

Exemplary service in all areas, helped a stressful experience go very smoothly and relaxing | Everything possible was done to make me safe, comfortable and relaxed. The staff were excellent, cheerful and knowledgeable. Explained the procedure in a way that was easy to understand. They understood my fears.

I was triaged and dealt with much quicker than I was expecting, and the staff were all doing a marvellous job against all odds.

Staff were friendly and professional explained what the process was, and debriefed me in detail and explained the follow up process with options The team are Definitely a credit to the trust

The two receptionists I met were both very rude and dismissive. The dr had no idea what was going on and had not read my notes .he tried to send me for tests that had been done then when I pointed this out he flicked over the results without really looking. I felt like an annoyance to him

Very busy not enough staff or space many waiting a long time my time 11hrs caused partly two hours for test results then waiting 1hr or more to look at them. Sent in with very high blood pressure after 1hr got seen then no further checks for 9hrs. I am very happy with the staff they are just so overwhelmed by numbers 110 in the department when I was there.

Because, according to my mother, the Community Nurse did not visit as they should have done! I informed the Community Nurse when she phoned me last week to avoid Tuesday 15th October as my mother would be at an Adult Day Centre in Spalding which is the only time she can leave the house - but she would be available all day on Monday 14th and Wednesday 16th October. When I spoke to my mother last night she said that a Community Nurse never visited on either Monday or Wednesday - for this reason I think the visit was certainly not good!

2. Care Opinion

Care Opinion is a non-profit organisation that shares people's experiences of health and care services online and enables us to engage with the storyteller and respond to their experience. The platform provides analytics and reports that are hugely valued and considered as one of our most powerful data sets.

Whilst ULTH are long term subscribers to Care Opinion, LCHS have not had a subscription to date though are seeking this and have begun to promote the platform. In the meantime, Care Opinion have agreed to give the Patient Experience Team at LCHS responding rights, considering our Group arrangement until we secure a process.
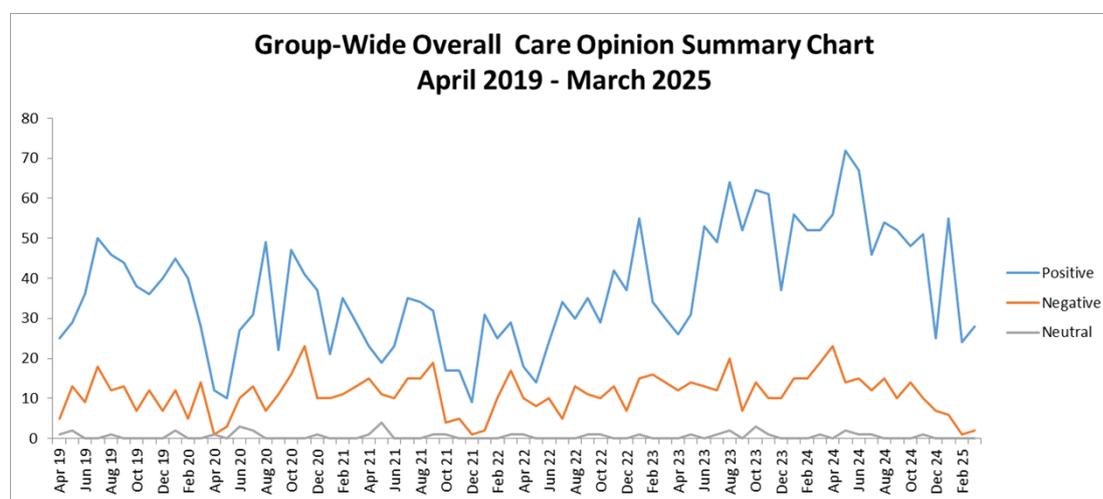
Gradual downward trends in stories overall seen throughout the year and unclear why this is the case as the previous year saw an upturn. Care Opinion stories are a rich source of patient feedback and as such the hope is that story numbers pick back up again. At present the large bulk of this data is ULTH-based. Care Opinion will start gaining traction in LCHS over time as we continue to promote and develop response streams. During the year, 713 stories were received. Responsiveness is important; it shows patients we are listening and 98% of all postings received at least one response. 450 staff have direct subscriber permissions whilst the Patient Experience Team maintains oversight of all activity and posts responses on behalf of staff who do not have direct responding rights. The aim is to respond within 2 working days and the quality of responses is also a key factor; when patients receive a personalised response it shows an openness that is appreciated.

The number of days from publication until the first response to these stories

Number of days from publication until first response (stories with no response are not included)
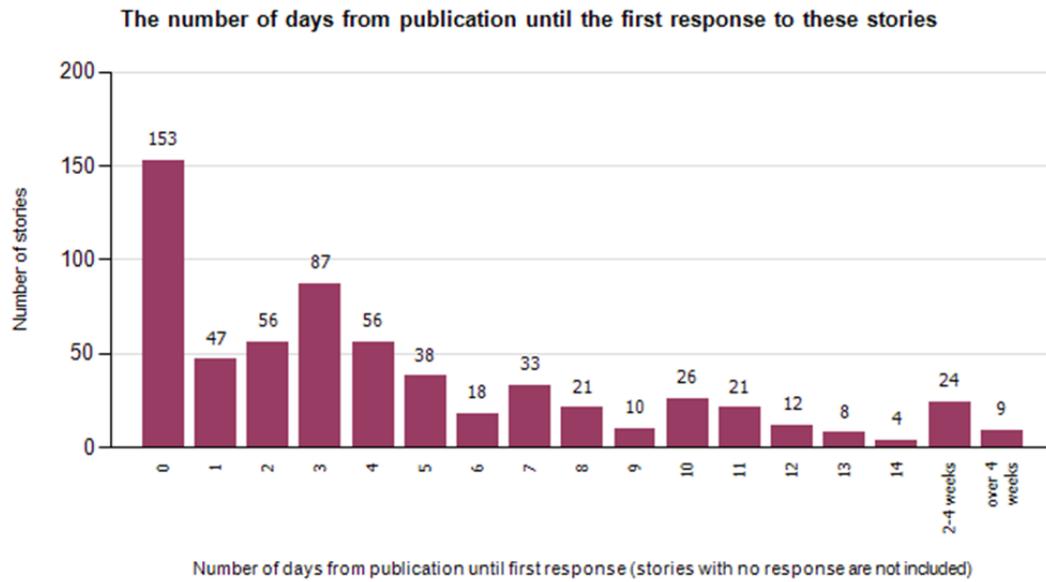
Analysing the stories, we can see what is important to patients and where improvements can be made.
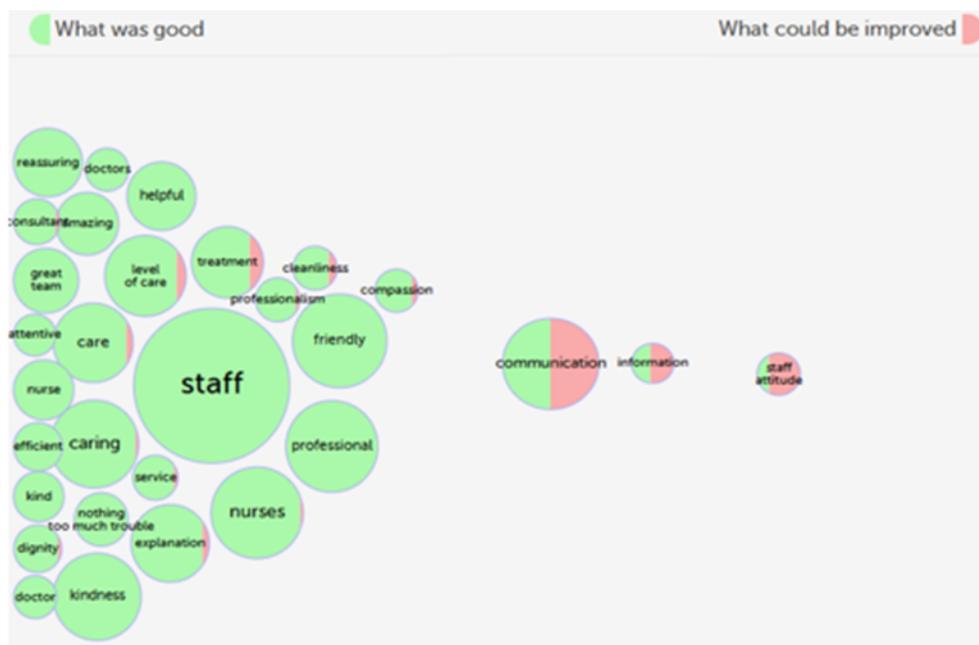
It is important that both positive and negative stories are heard and responded to so patients know we are genuinely listening.

Posted by *silverwareex88* (as the patient), 5 months ago

I was booked in for a procedure at Grantham Hospital, never been in hospital before, i was terrified.

My anxieties were soon reduced from the moment i was welcomed onto the ward and booked in by a lovely lady.

The process was fully explained to me which gave me much needed reassurance, the anaesthetists were really good with me recognising my fright and the nurses who looked after me back on the ward were kind and caring, nothing was too much trouble. Thank you Divoya, Tracy and Jess, even the lady who made lovely toast.

I cannot recommend Grantham Hospital highly enough.

Response from Julie Record, Matron, Surgery, United Lincolnshire Hospitals NHS Trust 5 months ago

Hi silverwareex88

Thank you for your amazing comments and I have shared with Divoya, Tracy and Jess and our amazing housekeeper who does make such lovely toast! The team strive to make sure that all of our patients feel relaxed and well informed about what will happen.

As Matron I am always so pleased to read the comments sent in and yours are proof we are getting it right.

The team work hard to give a high quality journey and thank you for sharing yours.

I hope you are keeping well now the surgery is over and thank you once again for sharing

KR

Julie

Posted via nhs.uk 6 months ago

After my tonsillectomy the surgeon had arranged for me to stay overnight on SAL for observation. When arrived on the ward I sensed a very unfriendly and unwelcoming atmosphere, there was no compassion form the staff and felt like an inconvenience. I spent most of the night off the ward as I felt extremely uncomfortable and not cared for in the slightest so I spent time in the cafe area. In the morning I overheard the nurse discussing me in handover and implying my medical history was false and then went on to say that my mental health disorder would explain the "exaggeration". Referring to the immense pain I was in from my surgery. As NHS staff myself it was heartbreaking to think that patients are being treated like this and I'm ashamed to work for the same service as the staff on this ward. Do better

Response from Jason Green, PODP Theatre Matron, ULHT 6 months ago

Thank you for the feedback I am really sorry you have had this experience.

This is very unusual for SAL, but you have my assurance all feedback is taken very seriously, I will be sharing and discussing your feedback with all the team members to make improvements and implement actions for future patients.

Once again I can only apologies you have had this experience if you would like to discuss I would happy to reach out to you.

PODP Jason Green Theatres Matron

Posted by *HTK2017* (as a service user), 6 months ago

I was referred to Rainforest Ward Lincoln after a trip to a&e because i couldn't stretch my leg out fully and had pain behind my knee. After a stressful 12 hour a&e wait, i was tired and the staff on Rainforest ward was all really kind to me and made sure i had everything i needed and answered all my questions.

Response from United Lincolnshire Hospitals NHS Trust 5 months ago

Dear HTK2017

Thank you for sharing this with us and sorry to read that your leg has been poorly and had to come into our A&E and we do hope that you are now fully mended now.

Our team on Rainforest are really super and its good to know that they answered all the questions that you had.

We've shared your story with the Sister on Rainforest and I know they will be so thrilled to read your very kind words about them

Best wishes

Sharon

Posted by *KerryW24* (as the patient), 6 months ago

This was second time for a follow up post surgery last year, the first appointment was running late by 1.5hrs after which time I left to collect my child.

Last week I attended the Boston Pilgrim hospital for a follow up appointment. I was seen over an hour after my appointment time and I was with the consultant for less than 3 minutes. Complete waste of time and could have been a follow up with my GP or a phone call.

Response from Tanya Wilson, Sister, Outpatients Gynaecology Trustwide, United Lincolnshire Teaching Hospitals NHS Trust 6 months ago

Dear KerryW24

Thank you for taking the time to leave your feedback for our team I would like to apologise for the delay with in the clinic, unfortunately some patients can have complex issues which can take longer than the appointment time. I will discuss the follow up process with the team to see if we are able to make improvements.

Kind Regards

Tanya Wilson

Posted by *Nigel673* (as a service user), 9 months ago

Hi there, I had to use A&E recently. Just to say what a fantastic experience I had, I saw a consultant and had a CT scan and various tests.

A nurse also issued me with pain killers while I was waiting to be seen which was very kind and helped a great deal. A lovely lady came round with hot drinks and sandwiches while we all waited which was very kind.

There were two people who were causing trouble with the staff, I thought security needed to be stationed in A&E to help with this, they must get it all the time. They needed to be escorted out.

The consultant was a very kind man and was very calm. 10/10.

Posted via nhs.uk 9 months ago

I had an appointment 3rd September, a letter confirming my appointment arrived 5th September, lack of communication is a real problem. I tried to book an appointment for 4 weeks time, only to be told if I hadn't, received a letter within 3 weeks to call. Also patient transport is extremely unrealiable, I,ve missed a lot of appointments because they have,nt turned up or because they can,t get me to the clinic on time

Response from Natasha Killingsworth, Sistr, A&E, ULHT 8 months ago

Dear Nigel673

Thank you for this feedback on your recent experience while in the emergency department. We are please this was a positive exerpeince and your feedback will be shared with the team.

Kind regards

Tasha

Response from Laura Kearney, Outpatients Operational Services Manager, Outpatients, United Lincolnshire Hospitals Trust 9 months ago

Please accept my sincere apologies on behalf of ULHT for the letter arriving after your appointment date - poor patient experience caused by communication delays is being reviewed by the Trust as a priority. As well as ensuring physical letters via Royal Mail are sent in a timely manner we are encouraging patients to use our portal to view letters digitally, and further solutions are planned including a 7-day SMS reminder which is to include Outpatient appointment details. For our patients who are not digitally enabled these innovations will alleviate our Outpatient telephone lines to speak to a member of staff in person.

I am sorry to hear of your transport issues, unfortunately Outpatients do not run the service so I am unable to provide a response to this part of your feedback.

Kind regards

Laura Kearney

laura.kearney@ulh.nhs.uk

Negative stories are harder to read, but it is important that we show we have listened and taken the patient's feedback seriously; a personalised, compassionate, open and transparent response helps to do this.

4. Compliments

ULTH Compliments are now combined with LCHS Compliments (from Datix) to give the Group-wide picture. There has been a steady level of compliments each month of the last year. The intention is to reinvigorate Counting Compliments early in 25/26 with a new form and compliments being gathered Group-wide in a more uniform way. It is good to acknowledge the efforts of our volunteers in counting compliments they receive too - shown in orange.

Each month the Patient Experience Team prepare a suite of infographics at Trust and divisonal level which are shared through PEIG and to the divisions and able to be displayed locally. We want our staff and patients to know that we appreciate their feedback and listen and use it.

Your Experience Counts
Our Group - Apr 24 - Mar 25

Friends & Family Test

89%

89% would recommend us
6% would not recommend us
1160288 eligible responders
136010 ratings received

93% National average

90% Community
95% Day case
72% Emergency care
82% Inpatient
100% Maternity
92% Outpatients
94% Therapies

1483 Complaints
7066 PALS enquiries

THANK YOU — 11631 Counting Compliments

Care Opinion
714 Care Opinion stories
578 positive
129 negative

Your Experience Counts
Clinical Support Services Division

Friends & Family Test

93%

93% would recommend our division
3% would not recommend our division

Haematology
Occupational Therapy
Physiotherapy
Dietetics
OP Nursing
Endoscopy

93% National average

414046 eligible responders
46958 ratings received

83 Complaints
969 PALS enquiries

Communication
Appointment
Clinical Treatment
Values and Behaviours
Admin policies/procedures

THANK YOU — 3291 Counting Compliments

Care Opinion
89 Care Opinion stories posted
77 positive
11 negative
1 neutral

Your Experience Counts
Collaborative Community Care Division

Friends & Family Test

96%

95% would recommend our division
2% would not recommend our division

CCC - Hospitals
CCC - Nursing

93% National average

245888 eligible responders
15113 ratings received

79 Complaints
94 PALS enquiries

Access to Treatment or Drugs
Patient Care
Communications
Values and Behaviours
End of Life Care

THANK YOU — 363 Counting Compliments

Your Experience Counts
Medicine Division

Friends & Family Test

77%

77% would recommend our division
115% would not recommend our division

A&E
Acute Medicine
Cardiology
Diabetes
Gastro
HCOP
Respiratory
Rheumatology
Stroke
Renal

93% National average

83290 eligible responders
17920 ratings received

572 Complaints
2213 PALS enquiries

Communication
Appointment
Clinical Treatment
Values and Behaviours
Lost Property

THANK YOU — 2430 Counting Compliments

Care Opinion
119 Care Opinion stories posted
71 positive
47 negative
1 neutral

Realtime Surveying

Whilst we have a large amount of patient experience feedback from our standard sources, with good mechanisms in place for analysing and socialising it, there have been increasing calls for more tailored and timely feedback around certain high-profile areas across the Group. One solution offered towards this goal has been the introduction of various forms of realtime patient surveying. Some of these surveys were built from scratch, others started from a pre-existing framework designed by the teams and services themselves. It was important however that the Patient Experience Team have oversight of the surveys for a number of reasons:

- To ensure, that where possible, tested and unbiased questions are used.
- To use all opportunities to 'plug in' some core questions that we know feature across all areas thereby enabling wider reach.
- To have access to the data gathered to allow for analysis and triangulation against other pre-existing data.

There have been multiple arms and multiple collection methods employed, all making use of Microsoft Forms to gather the data and allow easy access to the data collected to facilitate further analysis. These collection methods have been used to support more relevant feedback covering (but not limited to) the below areas/surveys

Oncology/Haematology Areas Patient Experience Survey

This has been supported by our Voluntary Services team, with volunteers working across Lincoln and Pilgrim gathering feedback from both inpatients and day case patients being cared for by our Cancer Services team across the sites. The questions used were based around weaker areas of the National Cancer Patient Experience Survey (NCPES) and overall have shown positive responses, which in turn should lead to positive changes in the NPCES performance. Volunteer availability has been a factor at times however the clinical teams have really engaged with supporting this and supporting our volunteers.

Your Discharge Experience

This survey had two streams; the first exploring discharge planning experience to be completed whilst in hospital and the second once at home. Both electronic surveys are accessible via QR codes and paper-based surveys and supported and encouraged by both hospital and community staff. Discharge experience is one of the areas where there are consistent struggles and being able to target it in this way means that the feedback gathered can be responded to and acted on more swiftly and have broader impacts.

Your discharge experience (Inpatient)

We are undertaking a review of discharge planning and arrangements across our hospitals and in the community.

As you are currently an inpatient, preparing for discharge and to help us know if we are making a difference, we would be grateful if you could spare a few minutes to answer some questions below.

All responses are anonymous; if you would like us to get in touch so you can tell us more about your experience, please email patient.experience@ulh.nhs.uk

If you are unable to use the QR code and online version, please speak to a member of staff who can provide a paper version.

Urgent & Emergency Care – Quick Feedback

This survey encompasses our Emergency Departments and Urgent Treatment Centres Group-wide and asks a select range of targeted questions regarding specific key areas of reported poorer patient experience where improvement work is underway. Despite some initial trepidation around the wording of the poster, and the feedback that this may attract, the balance of the feedback falls on the positive side. Additionally, the negative feedback is constructive in nature and allows for improvement actions to be taken forward.

Are you sitting comfortably?

We want to know if you felt comfortable and respected during your wait.

Please scan the QR code and click on the link to complete our questionnaire.

Caring and building a healthier future for all

School-Age Immunisation Service

This service had previously been gathering feedback on their own, but have now amended their question set to align with pre-existing methodologies used elsewhere which allows for easier analysis and visualisation of the data via SUPERB.

Community School Age Immunisation Service Overall FFT Score Split Chart
May 2024 - April 2025

Legend:
- Don't Know
- Very Poor
- Poor
- Neither Good nor Poor
- Good
- Very Good
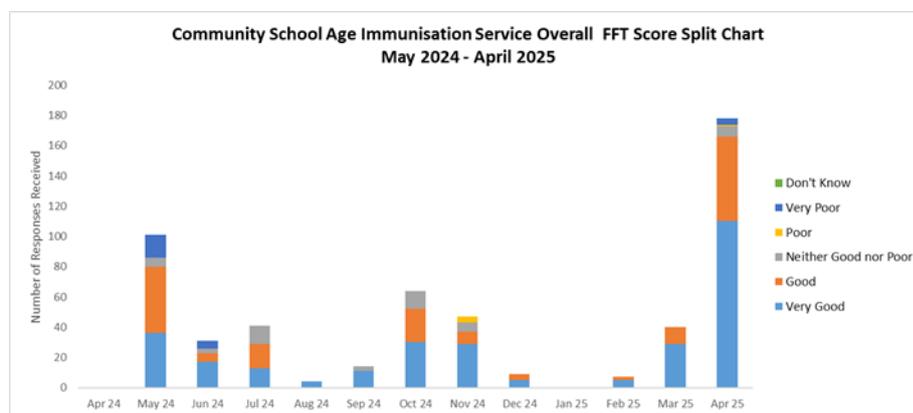
Cardiac Rehabilitation, Heart Failure and Lipidology services

| This service reached out for help to gather feedback across all three services, with the need for a combination of core questions and then supplementary service-specific questions too. Through working collaboratively with the team this was achieved, whilst also aligning questions to allow for clearer and easier benchmarking against prior data. | Patient Service Questionnaire

You have recently been involved with the Community Cardiology service, which includes **Cardiac Rehabilitation and Heart Failure** specialist teams.

This questionnaire is **not** associated with hospital or GP care, but instead focusses on your care from both services named above within the local community. Please support us to improve our service by completing the below feedback questionnaire. You may have been supported by one or both of the services so please answer all the questions that relate to your care.

All information you provide is anonymous and is completely confidential.

If you have any concerns following your treatment from the community cardiology service, please email: LHNT.CardiacRehab@nhs.net or call us on 01522 449900

* Required

General Questions

1. Were you satisfied with the wait time for an appointment with the service? *

◉ Yes
○ No

2. Did you feel supported during your initial contact with the service? *

◉ Yes, fully informed
○ Yes, to some extent
○ Neutral
○ Not really
○ Not at all |

Patient Stories

Sharing patient stories benefits both patients and staff by building connections, fostering empathy and helping us see the person behind the NHS number or diagnosis. Patient stories serve as a powerful tool for raising awareness and offering valuable insight into the patient experience. They can be a bridge between the technical, rational world of scientific practice and the experience of being in that world.

We have seen across the Group how stories are proving to be a useful tool in quality improvement work. Telling the story of one patient's experience of care can memorably illustrate improvements or problems in a care pathway. Statistics and data have an important place in monitoring and understanding services and facilitating improvement, but the right story can also have the power to motivate and change minds.

Unlike surveys, patient stories are collected face-to-face, providing an opportunity to ask for more information or clarity where needed and capture the experiences from the patient's point of view, not from our interpretation of a situation. We can put ourselves in their shoes and focus on what matters most to them. The Patient Experience Team has prepared and delivered digital patient stories for the Trust Board for several years, storing them in a digital intranet library to ensure each story creates a legacy and can be reused to support ongoing learning.

Once ULTH and LCHS came together as a Group, the Communications team have taken responsibility for Board stories reflecting their reach and capacity across both acute and community settings and releasing the Patient Experience Team to champion and promote the use of stories in a much more 'day-to-day' form and have crafted a process for developing stories.

1. Finding your story

Stories need to consider a *message*, for example:
- A lesson learned following an incident or complaint.
- A story of innovation or improvement.
- A story of achievement and pride.

2. Who is telling the story?

Is it the patient or carer themselves or staff on their behalf? Stories can be:
- Filmed
- Verbal recording
- Voice-over

3. Creating the content

Start to document your story onto PowerPoint slides:
- Imagine someone reading them without you to explain the detail.
- Work to 4 or 5 bullet points per slide so they are not too busy
- Have you any photo's you can include?
- Have you spoken to the patient / carer / staff member for consent to share their story?

4. Crafting your story

Contact patient.experience@ulh.nhs.uk or Sharon.kidd@ulh.nhs.uk and someone from the team will meet with you to:
- Help you craft your story
- Discuss content, style and consent
- Work with you to record or film
- Edit the story for you

Timeline

Please bear in mind that these elements will take about 3 or 4 weeks to pull together primarily around scheduling meetings in your diaries, and then editing the film, seeking final consent and approval from both the storytellers and if being used at Trust Board we also need DoN approval.

Divisional governance groups and almost all assurance groups now include a patient story as part of their standard agenda. The online Story Library has continued to be added to and at the time of this report, has over 40 stories in its collection.

Patient Story Catalogue

Diane's story September Trust Board

Lincolnshire Discharge to Assess Service

Diane's story following a serious road traffic accident through to being cared for at home with the Discharge to Assess service.

Phillips Kitten Scanner is the purr-fect way to help children prepare for hospital scans

Phoebe's story....

Nine-year-old Phoebe McCormack from near Lincoln recently had an MRI scan.

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.

This service, run by LCHS, offers specialist assessment, management and treatment for children and adults with complex respiratory conditions. This is done in patients' own homes across Lincolnshire, helping to keep them out of hospital and improve their quality of life. The story described how Ethan (21) has a chronic lung condition, along with other conditions, and how he has had the support of the rapid response respiratory physiotherapists since he was a child, and without whom he and his family's lives would have been much more challenging.

Communication Improvement

Patient experience is like a ribbon that threads its way through a patient's journey, touching points where decisions are made, diagnosis given, investigations and treatment offered, taken or refused and evaluated. At each touchpoint what a patient and family experience can have a profound impact on that patient's journey and our data and feedback tells us that communication is key – the golden thread.

"Good communication has a positive impact, even if the news is bad and poor communication can have a negative impact even if the news is good." *(Lucy Watts MBE. Patient).*

The National Inpatient and Urgent & Emergency Care Surveys published in 2024 ranked ULTH as one of the worst performing Trusts in England in relation to aspects of communication.

It was hard to see us scoring poorly on questions including whether staff explained things in a way the patient could understand or whether they were listened to and being able to raise any worries or fears – none of us would wish this to be ourselves or members of our family and equally not be leaving our patients feeling this way.
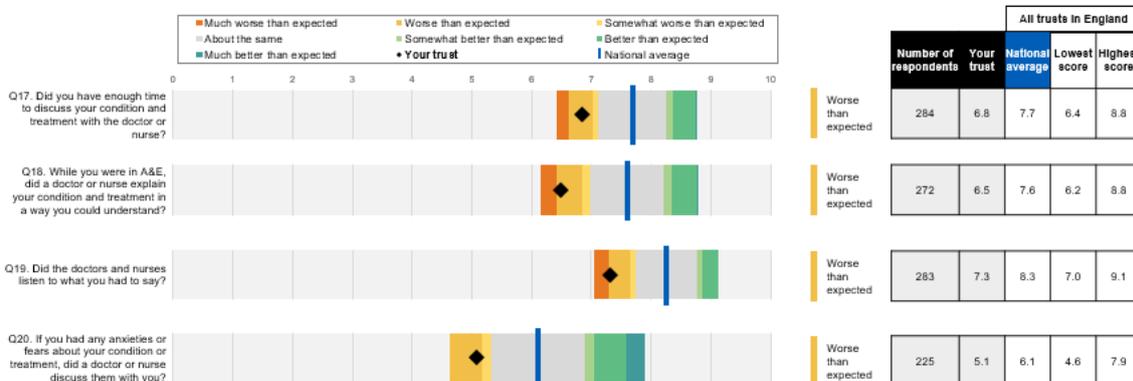
A number of improvement activities were implemented during the previous year and continued through 2024-2025 plus new initiatives commenced.

1. You Care; We Care to Call (YCWCC)

In April 2023 we 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 if a proactive YCWCC call had been made, then that complaint could have been avoided.

YCWCC has continued to be monitored under 'business as usual' (BAU). Communication complaints and PALS concerns overall are back to around the 2022-23 level and the number of avoidable complaints is still under control into 2025.

YCWCC as a project was a finalist at the 2024 Patient Experience Network National Awards (PENNA) held in Birmingham. Jane Thomson-Burt, Patient Experience Manager who led the project attended along with Martyn Staddon, Patient Experience Data Insight Manager. Whilst YCWCC project was not a winner on the day itself, simply to be shortlisted was a great achievement, honour and recognition for all the work that went into the project.

2. Hearing it Your Way (HIYW)

HIYW is an experiential 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 observed themes that are then used as general feedback. A HIYW Faculty was developed early in 2024 with staff recruited to help deliver the programme. Three full day training sessions have been held during the year with 20 attendees at each and feedback has been excellent.

2. Which responses below best describe your experience of the training?

■ Totally agree   ■ Agree a little   ■ Neutral   ■ Disagree a little   ■ Totally disagree

I learned something new today

I enjoyed the training session

I am more appreciative of how patient experience is central to any role

100%   0%
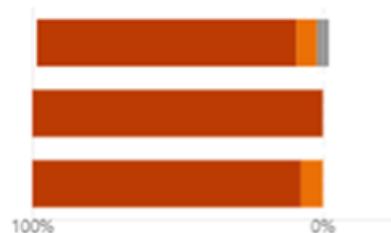
4. How would your rate the session on Shared Decision Making?

More Details   ⚙ Insights

🔵 Very good		24
🟠 Good		2
🟢 Adequate		1
🔴 Poor		0
🟣 Very poor		0

Days are scheduled for 2025-2026 and discussions underway with LCHS colleagues who are keen to participate.

3. Patient stories

As previously described, stories are a powerful way to raise awareness and understand patients' experiences. Several stories have been shared that focus on communication including:

a. William who is part of the Deaf community in Lincolnshire told us of his poor experiences being Deaf when accessing hospital services.

b. Young Carers talked about the importance of communicating with them in their role and not dismissing them as 'just children'.

National Surveys

1. National Inpatient Survey (NIPS)

Undertaken by the CQC, this survey looks at the experiences of people who stayed at least one night in hospital as an inpatient.

People were eligible to take part in the survey if they stayed in hospital for at least one night during November 2023 and were aged 16 years or over at the time of their stay. Responses were received from 524 people at ULTH, and the survey results were published on the CQC website on the 21.08.24. The overall outcome was that ULTH was ranked 'about the same'.

It was encouraging to observe that since 2020 the comparison with other Trusts indicates that our questions ranked 'about the same' are steadily increasing whilst those questions ranked worse are seeing a reduction since 2020 indicating steady, sustained improvement.

	Patient Response	Compared with other trusts
⌄ Admission to hospital	7.0 / 10	About the same
⌄ The hospital and ward	7.6 / 10	About the same
⌄ Doctors	8.7 / 10	About the same
⌄ Nurses	8.5 / 10	About the same

	Patient Response	Compared with other trusts
⌄ Care and treatment	8.2 / 10	About the same
⌄ Virtual wards	6.3 / 10	About the same
⌄ Leaving hospital	6.7 / 10	About the same
⌄ Feedback on care	2.7 / 10	About the same
⌄ Kindness and compassion	9.2 / 10	About the same
⌄ Respect and dignity	9.1 / 10	About the same
⌄ Overall experience	8.2 / 10	About the same

Comparison with other trusts
The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.

Much worse than expected	
Worse than expected	1
Somewhat worse than expected	2
About the same	46
Somewhat better than expected	
Better than expected	
Much better than expected	

Comparison with last year's results
The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2023 vs 2022.

Significantly better	2
No different	36
Significantly worse	

Top five scores   Bottom five scores
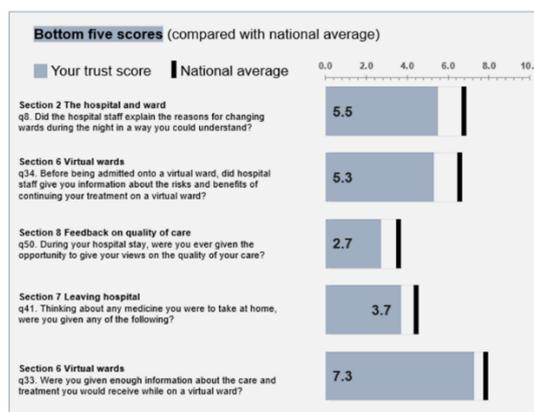
Actions for improvement are being addressed in part through existing and continuing work such as communication improvement and also through the overarching action plan (see below) and driven through the divisional patient experience groups supported by the Patient Experience Team.

2. Urgent and Emergency Care (UEC) Survey

The 2024 results for this CQC survey were published on the 21 November 2024. The Trust were identified as performing 'worse than expected' for Type 1 services because the proportion of respondents who answered negatively to questions about their care across all questions in the survey was significantly above the national average for Trusts. It should be noted that many of the questions have changed to some degree from last year's survey, making it difficult to compare the ratings between this year and last. Additionally, there is a report for Type 3 services (UTC) this year.

Grantham UTC: The 2024 survey for ULTH measured primarily the Type 1 services it provides in Lincoln and Boston. Recognising the Trust has direct responsibility for running the UTC at Grantham, a type 3 service, the survey included Grantham UTC. The findings demonstrate on the whole patient experience in keeping with the national average – with 22 questions marked as 'about the same'. 3 questions the answers demonstrated 'worse than expected' findings, these specifically were around:

- Information about waiting times.
- Updated about waiting times.
- Privacy at reception.

Type 1 Services: Lincoln and Boston Emergency Departments: in 12 questions, the Trust's Type 1 services were rated as 'about the same'. In summary, the remaining questions, compared to the 2023 survey the following changes are noted:

Improvements made since 2023 survey:

- Privacy at reception
- Confidence and trust in doctors and nurses

No improvement noted between 2023 and 2024 surveys:

- Clear explanations about condition or treatment
- Being listened too
- Talking about anxiety or fears
- Involving family, friends, carers
- Information about self-care information to take home

Deterioration since the 2023 survey:

- Time to talk
- Involvement in decisions
- Pain control
- Clear explanations about tests
- Clear explanations about test results
- Safety – not feeling threatened
- Information about medications

- Health and social care support after leaving A&E
- Respect and dignity
- Good experience

These results were very disappointing to receive and whilst a number of existing improvement actions were already in trial, a detailed action plan was developed to specifically address the survey responses.

Improvement action taken since Feb-24	Mapped to specific 2024 survey question
• Nurse staffing ratio has increased, to the point that ED nursing will meet the agreed establishment for the department.	• **Doctors and Nurses:** Time to talk: Feeling they had enough time to discuss their condition with a doctor or nurse
• Increased medical staffing via the tier 1 and tier 2 medical rotas.	• **Doctors and Nurses:** Clear explanations about condition and treatment: feeling the doctor or nurse explained their condition and treatment in a way they could understand
• Split of seated majors into quadrant zones within Lincoln to better allocate dedicated staffing to this area.	• **Doctors and Nurses:** Being listened to: feeling the doctor or nurse listened to what they had to say
• Implementation of area 'co-ordinators' and the ongoing change in culture to empower band 5 nurses to lead these areas and ensure co-ordination of care.	• **Doctors and Nurses:** Talking about anxieties or fears: feeling the doctor or nurse discussed any anxieties or fears they had about their condition or treatment, if needed
	• Doctors and Nurses: Confidence and trust: having confidence and trust in the doctors and nurses examining and treating them
	• **Doctors and Nurses:** Involving family, friend or carer: family, friend or carer having enough opportunity to talk to health professionals, if they wanted to
	• **Care and Treatment:** Involvement in decisions: being involved as much as they wanted to be in decisions about their care and treatment
	• **Care and Treatment:** Pain control: feeling that hospital staff did all they could to help control their pain, if they were in pain
	• **Tests:** Clear explanations about test results: if they received test results while in A&E, feeling staff explained the results in a way they could understand
• Improvement in performance around triage and rapid assessment, so initial care is quick, however waiting post rapid assessment is still a problem with some long waits > 4 hours and a lack of clarity on length of waits for a bed for those needing admission.	• **Waiting:** What would happen next: informed by a doctor or nurse what would happen after first assessment
• Care and comfort work to embed access to food, drink, toilets. Care and comfort packs now provided to patients to allow some measure of ability for patients to freshen up whilst waiting.	• **Respect and Dignity:** Respect and dignity: for being treated with respect and dignity

Improvement action taken since Feb-24	Mapped to specific 2024 survey question
• Fundamentals of care standards: Promotion of fundamental standards of care service aspires for. Progress measured through ED assurance mechanisms (Matrons audit, ward assurance visits, sepsis audit data, complaints and PALS) and reported via Performance Monitoring process (PRM) and UEC Governance. (Illustrated by the improvements made following identification of moisture lesion themes earlier in 2024)	• **Respect and dignity:** Respect and dignity: for being treated with respect and dignity • **Experience overall:** Overall view of A&E services: for feeling that overall they had a good experience • **Care and treatment:** Pain control: feeling that hospital staff did all they could to help control their pain, if they were in pain
• Improved processes around UEC service members meeting face to face with patients/families who have made a complaint to gain a greater understanding of their experience and provide greater assurance and reassurance.	• **Doctors and Nurses:** Clear explanations about condition and treatment: feeling the doctor or nurse explained their condition and treatment in a way they could understand • **Doctors and Nurses:** Being listened to: feeling the doctor or nurse listened to what they had to say • **Doctors and Nurses:** Involving family, friend or carer: family, friend or carer having enough opportunity to talk to health professionals, if they wanted to • **Tests:** Clear explanations about test results: if they received test results while in A&E, feeling staff explained the results in a way they could understand
• Collation of patient stories following complaints to enable greater sharing and learning of lessons from patient feedback.	
• Development of QR code real time feedback mechanisms within the department to get feedback from patients waiting within the service. [More work is needed to embed this, see the additional scoping of actions section for more details]	

• Action in response to patient feedback i.e.:
  o the implementation of the bleep system to enable relatives/carers to be with patients when being assessed / treated if unable to stay with the patient within the department;
  o 'Bus station' for frailty patients to be centrally located in response to feedback.	

• Linked to CQC improvement work, the UEC service has purchased BOE Patient Information resources that enable translation and access using a variety of accessibility features. Available in digital and hardcopy formats. This is available in both sites.	• **Support recovery at home:** Information about self-care: being given enough information to care for their condition at home • **Support recovery at home:** Clear explanations about self-care: being given information on how to care for their condition at home in a way they could understand • **Support recovery at home:** Caring for condition at home: feeling able to care for their condition at home from the information they were given

This plan is led and delivered by the UEC teams supported by the Patient Experience Team. Actions include particular focus on care and comfort, communication and managing waiting times. Regular reports are provided to PEIG and through divisional assurance groups.

It is worth noting that currently all national surveys are based within acute settings though discussions are being held nationally to consider community settings such as community hospitals. Ahead of this, the Patient Experience Team have started exploring a local comparable survey to run 'in house' to enable a view and understanding of experience across the Group.

3. Overarching Action Plan

Recognising that there are core themes across the range of surveys an overarching approach was developed in mid-2023 that brought together actions required on questions where the Trust performed poorly.

In practice, the plan was considered clunky and unwieldy, and during 2024-2025 a more simplified and focused version was agreed through PEIG that provides a much more targeted approach and is based on the three main survey rating categories.

The action plan whilst overseen and led by the Patient Experience Team is to be driven locally by the Divisions and considered through their divisional Patient Experience Groups, reporting upwards to PEIG in scheduled quarterly reports. Its primary function is to consolidate the survey questions that the organisation has identified into a single plan to eliminate the need for multiple individual action plans and duplicate actions and provides a structured approach to monitor and evaluate the organisation's progress in improving our national survey scores and enhancing patient experience.

	Excellent - to promote and maintain.	Average - need to improve.	Worse – urgent action required.
Adult Inpatient	Q.11 How clean was the hospital room or ward that you were in?	Q.31 Thinking about your care and treatment, did hospital staff take into account the following individual needs?	Q.8 Were you ever prevented from sleeping at night by any of the following?
	Q.16 During your time in hospital, did you get enough to drink?	Q.39 Before you left the hospital, were you given any information about what you should or should not do after leaving the hospital?	Q.10 Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?
UEC	Q.32 While you were in A&E, were you able to get food or drinks?	Q.39 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E?	Q.18 While you were in A&E, did the doctor or nurse explain your condition and treatment a way that you could understand?
	Q.36 Before you left A&E, did hospital staff give you information on how to care for your condition at home?	Q.15 While you were waiting, were you able to get help with your condition or symptoms from a member of staff?	Q.30 Do you think the hospital staff helped you to control your pain?
Maternity	B.14 During your pregnancy did midwives provide relevant information about feeding your baby?	C.11 Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	D.6 Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?
	B.11 During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	D.4 Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	
Cancer	Q.41_5. Beforehand patient completely had enough understandable information about immunotherapy	Q.33 Patient was always involved in decisions about their care and treatment whilst in hospital	Q.50 During treatment, the patient definitely got enough care and

Mixed Sex Accommodation

Validation of MSA breach reports: Data is drawn from DATIX and the Mixed Sex Accommodation Investigation report submitted by the wards. When a DATIX is reported the Head of Patient Experience receives an email alert and contacts the team concerned explaining the process needing to be followed and particularly the requirement for an investigation report.

Definition: NHSI and NHSE Guidance Delivering Same Sex Accommodation 2019
- Where male and female patients sleep in separate areas and have access to toilets and washing facilities used only by their own sex. Same-sex accommodation can be provided both in single-sex and mixed-sex wards.
- A bay is a sleeping area which is fully enclosed on three sides with solid walls (not curtains – they offer little privacy and do not provide a safe and secure environment). A fourth side may be open or partially closed. The fourth side might need to be open for patient safety reasons, but the open fourth side should not face into a bay occupied by members of the opposite sex.
- Patients should not need to pass through mixed communal areas or sleeping areas, toilet or washing facilities used by the opposite sex to get to their own. The only exception is fully dressed patients placed in day areas who need to access toilet facilities.

Specialist Units: (ICU, HDU, Acute Stroke Units, Acute Assessment Units and Recovery.
- In these types of units which deliver highly technical care, often in emergency situations, to highly dependent patients every effort should be made to provide single sex accommodation, but it is recognised that in some decisions to mix will occur based on the clinical need of an individual or group of patients. (clinical justification)
- In these settings a breach will occur when an individual or group of patients continue to be accommodated in the mixed environment when their clinical condition no longer requires this.
- Because of the logistics of bed management, a 4-hour time window applies to this breach definition allowing a reasonable time lapse in order to facilitate the patients relocation to more suitable same-sex accommodation.
- Whilst in principle the breach will affect all patients in the unit the practical application will be only to those patients who are now inappropriately placed because of their changed clinical condition.
- The placing of patients in mixed sex assessment units merely to accommodate them or achieve A&E targets, without a valid clinical reason for this "decision to mix" places these patients in the same position as those in general wards.

Without this, the patient level details are not available and as such full validation not possible. DATIX reports require the name of the person that triggered the breach but not everyone affected by it, therefore if a full investigation report is not provided only the initial patient can be included; thereby rendering the validation incomplete.

Reports are received by the Head of Patient Experience and individually reviewed.

The core checks are:

- Was this a breach of sleeping area?

- Did the breach occur within a specialist unit (Critical Care, High Dependency, Acute Stroke Units, Acute Assessment Units and Post-Operative Recovery) where there is a 4-hour window to resolve?
- What was the root cause for the breach?
- Was this authorised by Gold Command?

Once it has been determined whether it was, by definition, a breach, the review focuses on determining whether it was justified or not. The completed MSA investigation report received from wards should provide all this information.

The following is taken into consideration:

- Decisions to mix should be based on the patient's clinical condition and not on constraints of the environment or convenience of staff.
- There are situations where it is clearly in the patient's best interest to receive rapid or specialist treatment, and same-sex accommodation is not the immediate priority. In these cases, privacy and dignity must still be protected.
- Step down from critical care areas (ICU, HDU, acute assessment units) have a 4-hour window for patients to be moved to a single sex area.
- Infection exceptions.
- If the breach is determined to be *unjustified* then it is required to be reported through the national SDCS reporting system. Such reports must include individual patient-level data.
- If the breach is determined as justified, then it is recorded as an 'internal breach' as although not required to be reported it was still a breach of dignity.

Reporting

- A monthly report is compiled detailing all breaches, location, duration, root cause, how many patients affected and whether justified or not. This also includes the MEAU performance. This report is sent to divisional and operational leads and information services.

There have been zero unjustified breaches in the 12-month period 2024 – 2025. All breaches have had Gold Command authorisation.

Performance 01 October – 31 December 2024

Number of incidents	
Jul-24	3
Aug-24	5
Sep-24	2
Oct-24	8
Nov-24	7
Dec-24	8

Q2 and Q3 MSA breaches and root causes

The incidence has increased, not unsurprisingly over the winter months and the need for a specialist bed such as ENT or orthopaedic consistently as the top root cause.
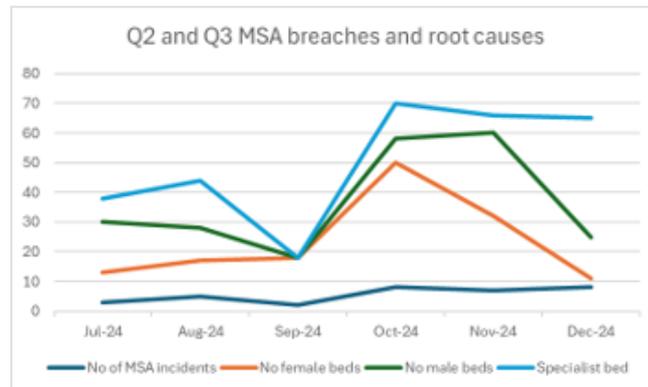
It can be seen that it has taken longer to resolve breaches during Q3 due largely to lack of patient flow.

Duration of MSA breaches Q2 and Q3
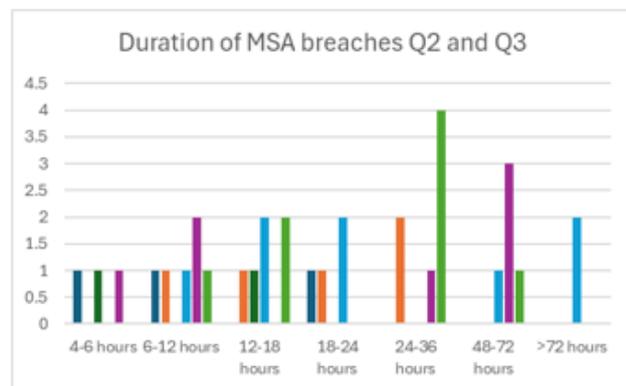
With the exception of ACU at Pilgrim all incidents happened at Lincoln.

No of pts affected	
Jul-24	35
Aug-24	39
Sep-24	16
Oct-24	62
Nov-24	59
Dec-24	57

Of note – Waddington episode was due to IPC precautions and ACU due to the need for a monitored bed.

MSA breaches Q2 & Q3 by location and number of pts affected
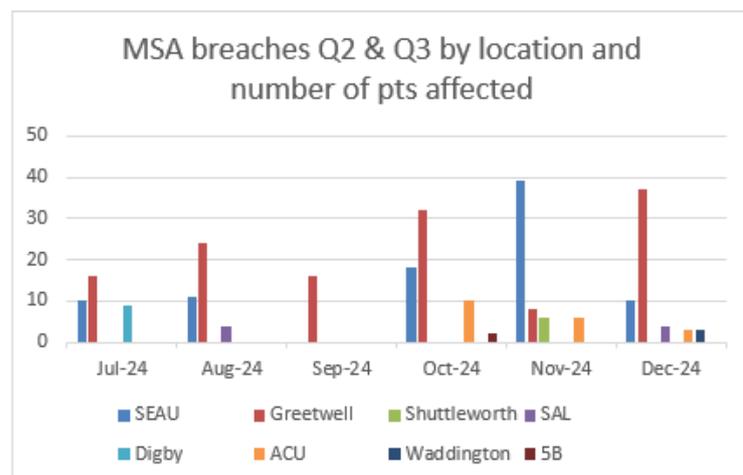
Hatton Ward – Lincoln County

It has now been a year since Hatton Ward developed an 8 bedded L1 bay and started to log those patients who, once stepped down from L1, became a MSA breach after 4 hours. The team keep track of L1 and step-down patients each day; these are then counted and analysed at month end. Four areas are scrutinised:

Number of days each bed had a step-down patient	Oct-24	Nov-24	Dec-24
Bed 17	22	14	27
Bed 18	19	13	23
Bed 19	8	6	0
Bed 20	2	3	12
Bed 21	10	3	6
Bed 22	6	7	10
Bed 23	8	3	6
Bed 24	10	4	7

Beds 17 and 18 consistently have the highest number of days when patients remain in these beds after they have been stepped down. There can be a variety of reasons for this including the patient being end of life care and kinder not to move them, lack of step-down beds, patient still concerning though have stepped down, potential imminent discharge and as other beds available less urgency to move beds.

The vast majority remained in their L1 beds for 1 or 2 days.

Number of days pts remained in L1 bed after stepping down	Oct-24	Nov-24	Dec-24
1	5	18	11
2	11	10	11
3	5	3	4
4	4	0	2
5	3	0	0
6	1	0	1
7	0	1	0
8	0	0	0
>8	1	0	2

Number of days with zero empty beds - full capacity	Oct-24	Nov-24	Dec-24
	10	4	16

Full capacity days are those where there are no empty L1 beds available.
Oct – 31 days = 32%; Nov – 30 days = 13%.
Dec – 31 days = 51%

No of step down pts on full capacity days	Oct-24	Nov-24	Dec-24
0	0	0	0
1	1	2	2
2	1	0	6
3	3	0	5
4	3	0	3
5	5	0	0
>5	1	0	0

On these full capacity days there were step down patients who could have been moved should a L1 bed be required.

MEAU

As an admissions ward MEAU has a 4-hour window to resolve breaches, and the team log start and finish times to monitor resolution rate. This is inevitably dependent upon flow out from the ward and performance reflects the pressures elsewhere across the wards.

Month	Total recorded	Resolved within 4 hours	Avg Total breaches per day	Avg Resolved < 4 hours breaches per day	% of Total Resolved within 4 hours
Jul-24	256	94	8.26	3.03	36.7%
Aug-24	297	86	9.58	2.77	29.0%
Sep-24	291	99	9.70	3.30	34.0%
Oct-24	312	99	10.06	3.19	31.7%
Nov-24	294	120	9.80	4.00	40.8%
Dec-24	224	46	7.23	1.48	20.5%

MEAU moved to Neustadt-Welton Ward in January 2025 and have since eliminated breaches due to different layout enabling segregation and easier bed swaps.

Patient Panel

The ULTH Patient Panel has continued to thrive and has 33 members averaging 17 at each monthly meeting. There have been 6 new members join in the past 12 months and 3 have stepped down.

Topics continue to be varied and over the 12 months there have been more than 35 presentations by staff and services.

Panel date	Topics discussed 2024-2025
Apr-24	New Wayfinding Hospital Site Maps
	Falls
	Aches and Pains Hub
May-24	Group Model workshop discussion & feedback
	Endoscopy update
	National Survey update
Jun-24	AccessAble 360
	Finance Update
	Community Diagnostics Update
Jul-24	Progress & Plans Pilgrim ED
	Just Culture – Patient Safety
	Teachable Moments – Colorectal Cancer
Aug-24	National Survey Update
	Physio Assessments, using video calls
	Pharmacy 7 Day Case
Sep-24	Antimicrobial Resistance & Leaflet
	Falls Prevention & The Big Question
Oct-24	Lincoln Stroke Expansion
	Estates Strategy Update
	CEO & Chief Nurse plans and hopes
Nov-24	OPD and theatre patient feedback
	All things Shared Agreements
	CDC update
Dec-24	PSIRF update
	LCHG Patient Panel Proposal
	NHS 10 Year Plan
	Christmas Quiz
Jan-25	Patient / Public Advertising Survey findings
	Single Point of Access
Feb-25	LCHS introduction and technology appetite discussion.
	LCHG Group strategy
	Improving Paediatric Experience across Diagnostics
Mar-25	Colorectal - Teachable moments
	Radiology Picture Book
	Estates Capital Programme

In October 2024 a codesign day was held with patients and staff from across the Group to discuss what a LCHG Patient Panel might look like as LCHS did not have anything similar.

Patient Panel

What could a LCHG Patient Panel look like?
- One or two Panels?
- Quarterly meeting of both.
- Stand up and stand down teams.
- Topic-focused specialist sub-groups.
- How to keep things succinct and relevant.
- Key players missing from current group.
- GP involvement?
- LPFT, EMAS involvement?
- More people, meet more frequently.

What could it consider / logistics?
- How to stop it from being overwhelmed?
- How to prevent long waits to bring things to panel.
- Sub-panels? More frequent meetings?
- Triage for things hitting Panel?
- Resourcing?
- Use existing model. Any nuances needed for Community side of things.
- Resources!
- Admin + Management is keystone.
- When should it kick off from?

Commitments
- Propose 2 panels & come together 1/4rly
- Upward report to PEIG 6/11/24
- Formal proposal to PEIG December 24
- Aim to launch LCHS panel April 2025.

The decision was to retain ULTH panel as is to be involved in ULTH business and to launch an LCHS panel to focus on LCHS business, and for the two to come together quarterly to look at Group-wide issues and to share and network. Recruitment commenced in early January 2025 and on 27th March 2025 the first meeting was held welcoming 10 LCHS Patient Panel

members. Equality monitoring questionnaires have not previously been completed for panel members but have now been requested; however subjectively, for ULTH members we know the following:

Age:	
15 – 19	0
20 – 24	0
25 – 34	0
35 – 44	11%
45 – 54	29%
55 – 64	37%
65+	22%

- All are white British or White other.
- Sexual orientation is undeclared though 74% subjectively are heterosexual.
- 55% have declared a disability or long-term condition.
- 25% are carers.

Attempts have been made to broaden the diversity of Patient Panels with some targeted advertising saying we would love to have more members and to reach out across our communities to include as many people as possible from different backgrounds and experiences, particularly patients from our minority communities and some younger patients too. It is acknowledged that the panel is not diverse and does not reflect the wider community, however even with meagre equality data as above it can be seen it does represent autistic patients, older patients, carers and particularly dementia carers and people with a wide range of long-term conditions. From its inception it was considered that the Patient Panel model would not be attractive to everyone, either the Group approach, technology or the topics discussed, and it has always been seen to be one 'tool' in our engagement and involvement toolbox.

Our model for working in partnership with community & system colleagues to reach diverse groups and the seldom heard.

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 now 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 discussion 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 by staff to view and 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.
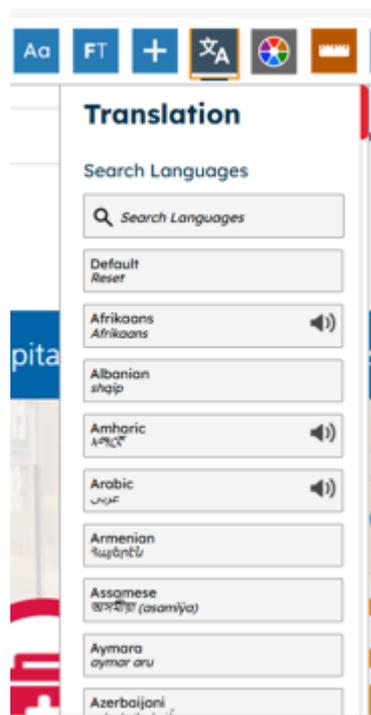
Patient Information for LCHS currently sits within the Communications Team and does not have the supporting processes, checks and balances used within ULTH, discussions are progressing to bring all LCHG information under the same process.

Visiting

Following enthusiastic codesign workshops to review visiting and supporting carers that were held in early 2023 the new Visiting Policy was formally launched. With effect from 2nd May 2023, we introduced new standardised core visiting times for all areas of all our hospitals agreed and developed in partnership with staff and patients. The new policy importantly distinguished between visitors, who may be a friend or family member, and a Carer / Care Partner who we recognise as needing to be there more formally to support a patient.

Every area across all our sites welcomes visitors every day between 14:00 and 20:00, with exceptions in place for Carers / Care Partners, birth partners and in other exceptional circumstances. We acknowledged that visiting may need to be restricted or have additional precautions in place in some areas due to IPC or other issues, on an ad-hoc basis, though Carers / Care Partners would still be supported as we did throughout the pandemic.

Following discussions and enquiries, a staff and public survey was undertaken in February 2025 to explore views on a proposal to extend visiting times across the organisation to 10:00 – 20:00.

- 473 staff responded, mostly ward-based staff across multiple sites. The majority opposed the proposed change, citing concerns over interference with care, therapy, ward rounds, cleaning routines, and patient privacy.
- 66 public respondents also showed mixed views, with some opposing due to concerns over patient rest and fatigue, though many acknowledged the benefits of extended visiting for communication and support.

Themes Identified:

- A number of both staff and public responses suggested 10:00 was too early but to consider 11:00 or midday instead.
- Staff concerns focused on disruptions to care delivery, cleanliness, and logistical strain.
- Public concerns highlighted exhaustion, infection risks, and the need for rest and privacy.
- Some public responses were noted to be nearly identical to staff comments, raising suspicion of potential duplication.

Evidence Review:

- Literature suggests extended visiting can improve communication, patient experience, and emotional well-being.
- However, drawbacks include infection risks, privacy issues, and staff discomfort with managing visitor interactions during care.

At the time of this report the final decision is still to be confirmed.

Caring for Carers

We have worked over the last 3 years with NHS England as one of 12 national pilot sites for the development of a new national Care Partners Policy. As a pilot site we committed to testing the principles and processes and develop local policies and systems and as a member of the advisory board feedback at national level.

Considering the proposed national changes for NHS England, the finalising of the national policy has been paused and publication deferred until such time as the changes with the NHS England and the DHSC have taken place. The Interim Deputy Chief Nursing Officer for England wrote to all pilot sites expressing gratitude for their commitment, contribution, and guidance in shaping the development of the policy to date. For ULTH we continue championing and supporting our carers as expert partners in care whilst we await the outcome at the national level.

ULTH is a member of the Lincolnshire Health and Wellbeing Board Carers Delivery Group system and provides updates on our work. At the June 2024 meeting we presented our aspirations to adopt the Carers Self-Assessment tool across the system. This was well received, and an initial scoping meeting was held with colleagues from the ICB. The plan is to

pilot this and advance issuing of ULTH Care Partner Badges in partnership with two GP practices (Harrowby Lane and Grantham Health Clinic).

Young Carers: in May and October half terms, we welcomed Young Carers for behind the scenes visits to Pilgrim and Grantham hospitals. These were designed to not only give our young carers a chance to see the workings within our services but also for staff to meet them and be aware of their needs. Both visits were huge successes and plans are in place to hold a visit in Lincoln and then repeat annually.

Boston visit: 15 young carers came to visited ED, Xray, pharmacy and theatres. Both the carers and staff gave great feedback and said how valuable it was. The visit ended with an 'Ask the Boss' session where they chatted to our CEO and Deputy Director of Nursing. They asked a range of questions from what inspired our leaders to managing waiting times.

Patient Property & Valuables

The rewritten Patients' Property Policy and Procedure was approved in 2023, and a task and finish group was convened to scope its application in practice and the logistics for implementation.

The group met regularly, led by the Head of Patient Experience and extensive work was required to make the policy workable including the design of new documentation, resources, and process flowcharts.

After several delays, the Case of Need for additional ward stationery funding was submitted and approved by the finance committee. As it was not possible to estimate individual ward allocations, the funding was placed in the Patient Experience budget for year one, with the team responsible for ordering, distributing, and tracking resources. In year two, funding will be redistributed to wards proportionately, based on actual spend.

This new approach commenced March 2025.

Key operational changes:

- Introducing an additional book so we will have a Deposited Property Book (property taken in for safekeeping) and a Retained Property Book (property the patient keeps at their bedside) to differentiate between the two and tighten management and accountability.

- Scoping of ward / department based safe storage and introducing a requirement for every area to have a key-operated dedicated facility for storing patients deposited property – such as a lockable drawer or cupboard (**not** CD cupboards) unless they have a fully functional safe.

- Splitting out of patient pathways to provide clarity of process and responsibilities, for example outpatient, day attenders and diagnostics, inpatients, emergency department & admissions units.

Managing *inpatient* property - process

Property kept by the patient (Retained)	Retained Property Book completed signed by patient and member of staff.	White & yellow copies retained in book. Pink copy given to patient.	Where a patient lacks capacity all valuables should be considered for safekeeping as per section 9.6 of the ULHT Patient Property Policy 2023.	
Property handed in for safekeeping (deposited)	All items listed in Deposited Property Book. Patient verifies and signs. Items placed in green SMARTSAFE bag & details completed. **Section 9.3 of the ULHT Patient Property Policy 2023.**	White copy retained in book. Yellow copy placed in SMARTSAFE bag. Pink copy given to patient.	Property to be deposited in ward safe storage facility. / Property to be deposited with cashier.	Patient Property Safe Storage Log completed & property placed in identified ward lockable storage facility. Maximum stay = 72 hours before transfer to Cashiers / General Office / SMARTSAFE bag and Property Book taken to Cashiers for hand in and signature on receipt.
Patient transferred to another ward	Receiving ward staff take receipt of the patients' property and cross check this against both the Retained & Deposited Property Book. **Section 9.10 of the ULHT Patient Property Policy 2023.**	In the event of missing items the transferring ward will be informed and required to manage.	Receiving ward make a new entry in their property book and patient and staff sign.	Receiving ward inform Cashiers of the transfer if any items are being held there.
Patient transferred to another NHS facility	See section 9.11 of the ULHT Patient Property Policy			

- All valuables taken in for safekeeping will now be placed in a 'SMARTSAFE' Patient Property Bag and sealed. These replace the current practice of using envelopes which invariably get damaged and lend themselves to risk of loss or questions about their security. A patient ID label is placed on the front of the bag. The bag has a unique identification label with a section that should be peeled off and stuck onto the Patient Valuables Safe Storage Log.

It is anticipated that this new policy and procedure will significantly reduce lost property which not only is distressing for patients and families but can also have a direct impact in care and safety such as if dentures or hearing aids or glasses are lost or misplaced.

Healthwatch Lincolnshire

Healthwatch Lincolnshire (HWL) are important stakeholders and provide a valuable source of patient feedback, concerns, experience and insight and as an organisation we need to ensure we are listening, responding and learning. Both ULTH Patient Experience Team and LCHS Complaints & PALs team receive monthly reports from HWL that detail feedback gathered either through events or through their feedback portals. Where questions have been asked there is a statutory 20-day response requirement after which those responses are added to the main report after the 20 days and whether a response has been received from a provider or not. On average, ULTH receive about 18-20 pieces of feedback per month and LCHS about 10-15.

Case No	Details	Hospital	Clinic or Dept (if known)	HWL Question
13545	I waited 6 hours in Accident and Emergency. Blood test results got lost and no further tests were ordered until I enquired. Accident and Emergency understaffed and full . Not really fit for purpose. Sent to same day Urgent Care, once there tests and examinations were undertaken with speed and efficiently.	Lincoln	A&E	
13532	I have today been speaking to the Citizens Advice Bureau who have recommended yourselves to me.I have a terrible problem that is causing me stress, not eating ,and today feeling really low and can have suicidal thoughts due to having been diagnosed with complex Post Traumatic Stress Disorder (cPTSD) in the last two years.I will try and give you a brief outline of what has happened to me.Three years ago	Lincoln	Heamatology/Orthopaedics	For information only - Advocacy information

Pilgrim 21 | ULHT unsure of which Hospital | Lincoln County 21 | Grantham 21

Once reports have been completed and sent back to HWL they are published on their website and circulate to the providers and key stakeholders including the CQC. Within ULTH we share these reports at PEIG and at Patient Panels.

Enter & View Reports and other focused reports. Healthwatch, empowered by the Health and Social Care Act 2012, conducts Enter and View visits to health and social care services to gather on-the-ground perspectives from service users. Currently HWL give notice of intention to both ULTH and LCHS of an intended visit or focused enquiry. This notice comes into the compliance team, and the relevant service lead will be notified. On receipt of the draft report, sent for factual accuracy checking the service leads will go through and respond to questions or recommendations made. The service then holds responsibility for taking the actions forward.

During 2024-2025 Healthwatch Lincolnshire visited Grantham Community Diagnostic Centre (CDC) and Skegness Urgent Treatment Centre (UTC). The visits involved observations of facilities, cleanliness, and accessibility, along with interviews with patients to understand their

experiences. The purpose of these visits was to inform Healthwatch's broader project on diagnostic services and provide insights for improving service delivery.

The findings from the visits to Skegness UTC and Grantham CDC highlighted several key points. At Skegness UTC, patients appreciated the convenience of the location and the professionalism of staff but raised concerns about waiting times and signage clarity. Recommendations include reducing wait times, improving signage and enhancing patient comfort.

Similarly, at Grantham CDC, patients valued the accessibility and cleanliness of the facility but noted issues with signage and communication about appointments. Recommendations for Grantham CDC include enhancing signage and improving communication channels.

Both reports were shared at PEIG and the division reported on actions to address recommendations made.

Additional Projects

As well as focused improvement projects across services and care pathways the Patient Experience Team supported services to develop bespoke initiatives during the year. These include

Sensory bags containing items for patients who have a learning disability or Autism containing distraction gadgets, noise cancelling earphones and fidget spinners etc

Purple bags specifically for women who have suffered a miscarriage and have attended hospital as an emergency, these contain intimate items for them to wash and change as well as comfort items at such a difficult time.

Comfort bags for ED patients who are waiting for a bed. These provide hygiene items so people can freshen up.

Supported the sourcing and procurement of 'Dementia Pets' for patients to 'pet' and stroke for comfort and distraction.

A special thank you is to be extended to the United Lincolnshire Hospitals Charity, for kindly funding the bags and dementia pets for our patients.
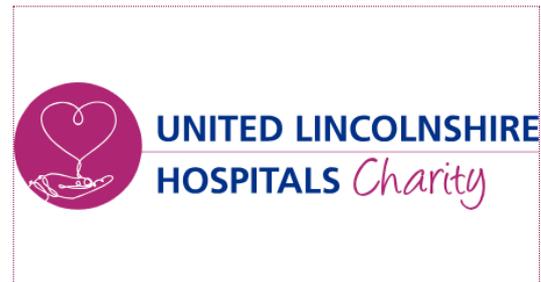
Rewrite and launch of All About Me patient passport. Whilst the original 2015 version had been led by ULTH and made available across the system this new version has been developed in partnership across the system.

Summary

Patient Experience is, and should always be, central to all that we do. This Patient Experience Annual Report demonstrates the commitment to this across LCHG and illustrates the partnership working across acute and community Trusts. The report demonstrates how we draw out the intelligence of the feedback we receive from our patients and their families and use this in a meaningful way to make improvements and how the expertise within the team contributes across all elements of care and service delivery. The continued amazing work of our ULTH Patient Panel and the exciting launch of the LCHS panel illustrates our commitment to ensuring we work hand in hand with our patients and their families.

The year ahead

The year ahead will see joint working, triangulation of data and intelligence as well as individual organisational workplans, it will see an associated workplan to sit alongside our new Commitment to Patient Experience & Involvement that demonstrates action and achievement, it will see progress and improvement across our national surveys and it will, most importantly see our patients' voices clearly sought out, listened to and acted on.

The year ahead

Lincolnshire Community Health Services NHS Trust

Safeguarding and Vulnerability Annual Report 2024 - 2025

Contents

Foreword

As the Executive Lead for Safeguarding within Lincolnshire Community Health Services NHS Trust (LCHS), I am pleased to introduce the Safeguarding and Vulnerabilities Annual Report for 2024/25. Over the past year, the Trust continued to deliver quality and compassionate care and treatment across the communities in which we provide inpatient, community, and urgent care services.

As the Lincolnshire Community Health Services NHS Trust and the United Lincolnshire Teaching Hospitals NHS Trust moved to a Group model (Lincolnshire Community and Hospitals NHS Group) on the 1st of April 2024, the Safeguarding and Vulnerability Teams under the oversight of the Director of Safeguarding and Patient Experience had already been working more closely together for the previous 9 months thereby already delivering the vision that Group working would bring to our Lincolnshire population.

The last 12 month period has provided an opportunity of reflection, to review the safeguarding work undertaken across both Trusts and whilst the past year has continued to be challenging as the NHS continues to experience significant operational pressures, there is a lot to celebrate and be proud of with the safeguarding work undertaken across the two organisations, and by the achievements and progress of the Lincolnshire Safeguarding Partnerships working together. LCHS have continued in their commitment to ensure that we help all residents of Lincolnshire live lives free from abuse and neglect.

Safeguarding can be complex and emotive work, and to safeguard effectively requires all agencies to work together in a collaborative and supportive way to develop seamless and effective safeguarding plans. We would like to thank our safeguarding partners across Lincolnshire for working with us to safeguard the population of Lincolnshire.

This report provides assurance to the Trust Board and our regulators, our patients and their families, and our partner agencies that everyone working at LCHS see safeguarding as part of their core business, and that we recognise that safeguarding children, young people, and adults is a shared responsibility, with the need for effective joint working between partner agencies and professionals, so that vulnerable groups in society are protected from harm. We all have a role to play in ensuring our patients and their families receive outstanding care.

The Trust Board of Directors are committed to ensuring all patients accessing our services are protected from harm and abuse ensuring that safeguarding remains a priority within the organisation. The Trust **has a commitment to Safeguarding which are reflected within the following Safeguarding Declaration LCHS Safeguarding Declaration**

The Trust has specialist Safeguarding staff who lead on and embed the practice of protecting adults and children from abuse, neglect, modern day slavery, domestic abuse, and radicalisation. The LCHS team continue in their transition to take on the wider remit of additional specialist areas of Learning Disability/Autism (Neurodiversity), Dementia and Mental Health.

Over the last 12 months there have been improvements in care pathways from Community to Hospital and back home for some of our most complex patients. The team works tirelessly to ensure that our frontline staff have the required skills and knowledge to protect people, uphold their human rights and assess capacity.

I would like to thank our caring and compassionate Staff, Volunteers and Safeguarding Team for their commitment and dedication in working alongside and providing protection, guidance, and support to people whose circumstances make them vulnerable to abuse, neglect or radicalisation.

Nerea Odongo

Group Chief Nurse / Executive Lead for Safeguarding (LCHS / ULTH)

Statement from Lincolnshire Safeguarding Adults Board (LSAB)

Lincolnshire Community Health Services NHS Trust (LCHS) plays a vital role in supporting the Lincolnshire Safeguarding Adults Board (LSAB) in meeting its statutory requirements. LCHS is committed to safeguarding the health, wellbeing, and human rights of vulnerable adults, ensuring they live free from harm, abuse, and neglect. This commitment is central to high-quality healthcare and aligns with the Care Quality Commission's Essential Standards for Quality and Safety. By adhering to these standards, LCHS helps the Board comply with legislative frameworks such as the Care Act 2014, which mandates the protection of adults at risk of abuse or neglect.

Moreover, LCHS actively participates in LSAB meetings and subgroups, providing valuable insights and expertise that enhance the Board's safeguarding initiatives. Like our other partners, LCHS's use of patient stories to identify best practices and areas for improvement supports the Board's mission to safeguard individuals both in community settings and healthcare environment. This collaborative approach not only strengthens the Board's efforts but also promotes a culture of continuous learning and improvement in safeguarding practices.

Richard Proctor

Lincolnshire Safeguarding Adults Board

Independent Chair.

Statement from Lincolnshire Safeguarding Children's Partnership (LSCP)

Lincolnshire Safeguarding Children's Partnership - Independent Chair.

During the last twelve months LCHS has demonstrated a strong commitment to keeping children safe in Lincolnshire. LCHS are highly respected within the Partnership and play a crucial role on the front line working with other key partners.

Your staff contribute to a number of our Board and subgroup meetings keeping their focus on our strategic priorities.

We have of course all been subject of a change programme introduced by the Department of Education and over many months have been working in partnership to create a new model to strengthen our existing arrangements. As a "Pathfinder" our partnership has worked hard to meet the new requirements, and I am grateful to your staff for their professionalism and enthusiasm during this extremely busy period. Looking forward we will need to evaluate the new framework and assess its effectiveness and practitioners from both trusts will play an important role in this process.

Remember: "The price of doing the same old thing is far higher than the price of change"

Bill Clinton

Chris Cook

1.0 Purpose of Report

The purpose of the report is to provide the Board with an annual update of the work undertaken in 2024 - 2025 with regards to safeguarding children and adults, PREVENT, Mental Capacity and Deprivation of Liberty Safeguards (DoLS), Learning Disability /Autism (Neurodiversity), Dementia and Mental Health and the proposed areas of development for 2025 - 2026.

2.0 Legislative Background

The NHS Outcomes Framework 2020 identifies that sustainable quality improvements are achieved when the focus is on outcomes, rather than being process driven. The DOH Outcomes Framework sets out five overarching high-level outcome domains for quality improvements.

Domain 1 Preventing people from dying prematurely.

Domain 2 Enhancing quality of life for people with long-term conditions.

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

Domain 4 Ensuring that people have a positive experience of care; and

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

In terms of safeguarding the key domains are:

Domain 4 Ensuring people have a positive experience of care,

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

The revised guidance "Safeguarding Children, Young People and Adults at risk in the NHS: Accountability and Assurance Framework (NHS England 2022) sets out the safeguarding roles, duties and responsibilities of all NHS health care organisations.

The Trust has a range of statutory duties including safeguarding children and adults and is required to give assurance to both Local Safeguarding Partners and commissioners of service to demonstrate that we have effective safeguarding arrangements in place.

Safeguarding forms part of the NHS national contract (service condition 32 – Safety and Safeguarding - Safeguarding Children and Adults - 32.1 - 32.9) and the ICB monitors our performance via contract monitoring processes.

2.1   Safeguarding Children

Since the statutory inquiry into the death of Victoria Climbié (2003), and the first Joint Chief Inspectors' report on Safeguarding Children (2002) highlighted the lack of priority status given to safeguarding, there has been a consistent process of review and change of legislation.

In 2024 the face of safeguarding children is very different to that of the late 1990s and an emphasis on early help rather than punitive action is what currently drives the system and as such the number of children on plans continues to vary.

Whilst systems change, at a national level we continue to see tragic cases involving child abuse such as Arthur Labinjo-Hughes aged 6 (Solihull) and Star Hobson aged 1 (Keighley) and more locally Darren Boulton aged 9 (Louth) who all died at the hands of the very people who were expected to protect them.

Safeguarding and promoting the welfare of children is defined in Working Together to Safeguard Children (2018 – *updated 2024*) as

- Providing help and support to meet the needs of children as soon as problems emerge.

- Protecting children from maltreatment, whether that is within or outside the home, including online.

- Preventing impairment of children's mental and physical health or development.

- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care.

- Promoting the upbringing of children with their birth parents, or otherwise their family network, through a kinship care arrangement, whenever possible and where this is in the best interests of the children.

- Taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children's Social Care National Framework.

Safeguarding Children is everyone's responsibility, Section 11 of the Children Act 2004 places a duty on key persons and bodies to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

This is a standard requirement within all LCHS contracts of employment.

At an organisational or strategic level, key features which must be adopted by NHS organisations (monitored by the Local Safeguarding Children Partnerships and Commissioners) are:

- Senior management commitment to the importance of safeguarding and promoting children's welfare.
- A clear statement of the agency's responsibilities towards children for all staff.
- A clear line of accountability within the organisations for safeguarding and promoting the welfare of children and Adults.
- Service developments that take account of the need to safeguard and promote welfare and are informed, where appropriate, by the views of children and families.
- Staff training in safeguarding and promoting the welfare of children for all staff working with or in contact with children and families.
- Safe recruitment procedures in place.
- Effective inter-agency working to safeguard and promote the welfare of children.
- Effective information sharing.
- CQC Fundamental Standards 2024 which have a safeguarding thread running through all.

An audit of Section 11 duties is undertaken by the Local Safeguarding Children Partnership (LSCP) and any subsequent action plans will be monitored in line with the current governance arrangements.

The most recent section 11 submission was completed in June 2024 and the Local Safeguarding Children Partnership notified the Trust in August 2024 that LCHS have passed the audit with 100% of the criteria being rated as green, as agreed with our organisation's moderators showing that your organisation has the required functions to safeguard children as required by Working Together to Safeguard Children 2023.

2.2   Safeguarding Adults

The passing of the Care Act 2014 has meant significant changes in the way adult safeguarding operates across the Trust. The safeguarding process has now been placed on a statutory footing and the requirements placed on our organisations have become more clearly defined.

The term vulnerable adult has been replaced by "Adult at Risk" and the statutory guidance confirms that.

> *"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have*

complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances."

The victim in the process is now the "adult at risk," the perpetrator "the alleged source of risk" and a written "Safeguarding Alert" is now termed a "Safeguarding Concern."

The Act recognises the need to focus on openness and transparency, in the drive to improve the quality-of-care individuals receive. This segues neatly with our own health service requirement for "Candour" as set down in the LCHS Duty of Candour Policy - LCHG-P-CG-04) and in line with the statutory Duty of Candour as defined in Regulation 20 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Act also places the duty on public organisations to act when abuse or neglect is suspected or known and underlines the duty to ensure that all staff are trained in safeguarding proportionate to their roles and responsibilities. Both are explicit in LCHS Safeguarding Policy' and training plans.

2.3   Implications for Safeguarding Adults at Risk

The Act sets out the statutory framework for adult safeguarding, including local authorities' responsibilities, and those of the local partners. In many cases the requirements of the Act are already fulfilled and expand across not just safeguarding but also cover some of our more vulnerable clients such as those with dementia and learning disabilities.

Safeguarding Principles

Principle 1 – Empowerment:	Presumption of person led decisions and consent.
Principle 2 – Protection:	Support and representation for those in greatest need.
Principle 3 – Prevention:	Prevention of neglect harm and abuse is a primary objective.
Principle 4 – Proportionality:	Proportionality and least intrusive response appropriate to the risk presented.
Principle 5 – Partnership:	Local solutions through services working with their communities.
Principle 6 – Accountability:	Accountability and transparency in delivering safeguarding.

2.3   PREVENT

2.3.1   What is PREVENT?

The Counterterrorism and Security Act 2015 placed PREVENT on a statutory footing. The Office for Security and Counter Terrorism (OSCT) in the Home Office is responsible for providing strategic direction and governance on CONTEST. As part of CONTEST, the aim of PREVENT is to stop people becoming terrorists or supporting terrorism and again transitions into vulnerable children & adults who are groomed and exploited to carry out acts of violence against others.

CONTEST is primarily organised around four key principles. Work streams contribute to four programmes, each with a specific objective:

Prevent	Pursue	Protect	Prepare
Safeguard people from becoming terrorists or supporting terrorism	Stop terrorist attacks happening in the UK and overseas	Stregthen our protection against a terrorist attack in the UK or overseas	Mitigate the impact of a terrorist incidents if it occurs
Primary outcome			
Reduce intent	Reduce capability	Reduce vulnerability	Reduce impact
Address strategic factors Extremism Conflict and instability Developments in technology			
Overall effect			
Reduce risk			

The Health Service is a key partner in PREVENT and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients and forms part of the Safeguarding accountability and assurance framework (NHS England 2022)

PREVENT has 3 national objectives:

Objective 1:   Tackling the ideological causes of terrorism.

Objective 2: Intervening early to support people susceptible to radicalisation.

Objective 3: Enable those who have already engaged in terrorism to disengage and rehabilitate.

The Health Sector contribution to PREVENT will focus primarily on Objective 2.

PREVENT training is undertaken in line with the [Prevent Training and Competencies Framework](#) - Department of Health and Social Care (2022)

2.3.2   Why Health care staff?

The overall principle of health is to improve the health and wellbeing through the delivery of healthcare services while safeguarding those individuals who are vulnerable to any form of exploitation. PREVENT is also about protecting individuals.

PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence.

3.0   Designated and Named Professionals for the Trust and its Commissioners.

3.1   Children

The terms designated and named professionals (children) are clearly defined in Working Together 2018 as professionals with specific roles and responsibilities for safeguarding children.

All Integrated Care Boards are required to have a designated doctor and nurse whose responsibility it is to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the commissioned area, which includes all providers. The designated professionals are also in place to provide professional advice on matters relating to safeguarding children for other professionals, NHS Commissioners, Local Authority children's services and the safeguarding children partnerships. The Designated Professionals for Lincolnshire are employed within the ICB and provide this support to the Trust.

All NHS Trusts must identify a named doctor, a named nurse, and a named midwife (where maternity services are provided) for safeguarding with the focus of the named professional being on safeguarding children within their own organisation. Both a Named Nurse and Named Doctor are in post within the Trust.

3.2   Adults

Following the publication of [Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (July 2022)](#) there is an expectation that Designated (ICB) and Named professional (LCHS) for safeguarding adults are in place.

Within LCHS the Group Director of Safeguarding and Patient Experience is the Trust Safeguarding lead with strategic responsibility for both children and adults and the Trust have a Named Nurse responsible for Safeguarding Adults and Mental Capacity supported by a team of specialist nurses.

4.0   The Safeguarding and Vulnerabilities Teams

The Safeguarding Team has been in place for several years and historically was responsible for Child Protection (LCHS), Adult Protection (LCHS) and the PREVENT agenda (LCHS). Since 2024 the teams remit expanded and now takes a stronger lead on Mental Capacity/DoLS and is steadily increasing its remit for Mental Health, Learning Disability, Autism and Dementia.

A full structure of the current teams can be found at appendix 1.

5.0   Safeguarding Governance Arrangements

The responsibility for safeguarding rests with the Chief Executive Officer, supported by the Executive Director with Board responsibility (Group Chief Nurse, Nerea Odongo).

During 2024 and 2025 LCHS embedded its safeguarding governance in the Operational Safeguarding and Vulnerabilities Group (SVOG) chaired by the Named Nurse for Safeguarding Adults. This is a subgroup of the Lincolnshire and Community Hospitals Group SVOG and in turn reports to the LCHG Quality Committee - (figure 1)

Figure 1:
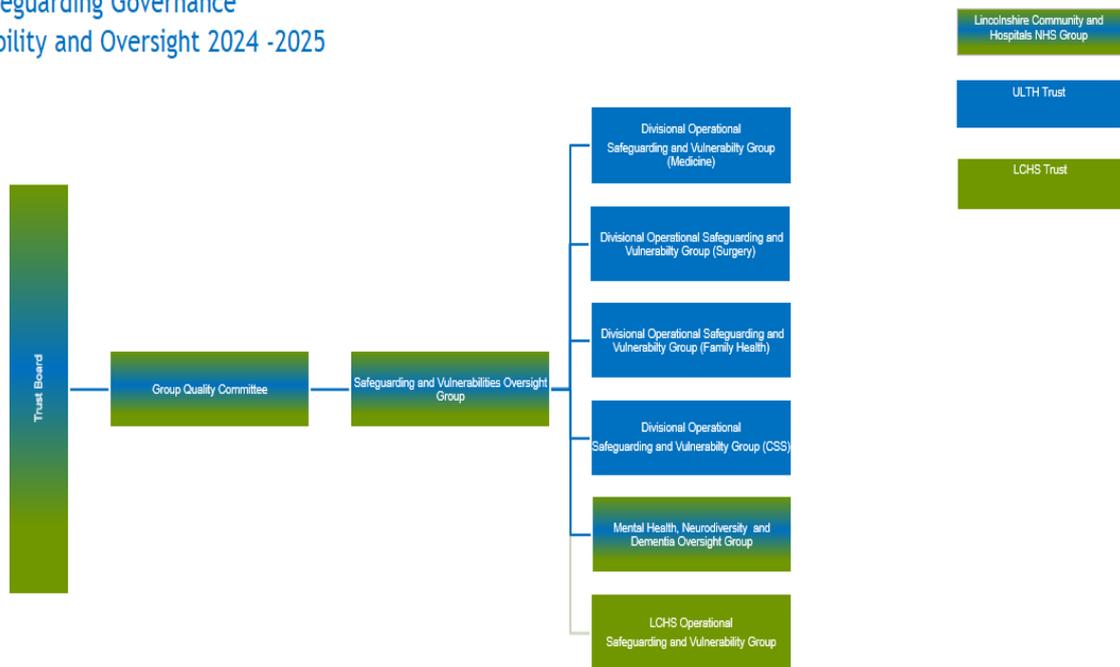
During 2024 to 2025 both LCHS and ULTH SVOG joined to form one strategic group and the ULTH Mental Health, Neurodiversity and Dementia Group expanded to cover both ULTH and LCHS

6.0 Local Safeguarding Children Partnership (LSCP) and Local Safeguarding Adult Board (LSAB)

Safeguarding Children Partnerships and Safeguarding Adults Boards were set up as statutory bodies under a national model led by the local authority until a government review of their role in 2016. This led to changes in relation to Safeguarding children, bringing about a shared responsibility for safeguarding amongst the identified three lead partners (Local Authority, Police, and ICB) and the change to Local Safeguarding Arrangements which allow some flexibility based on local needs.

They are a partnership of the relevant statutory, voluntary and community agencies involved in safeguarding and promoting the welfare of all children and young people /adults at risk of abuse. They do this by coordinating the safeguarding work of member agencies so that it is effective; monitoring, evaluating and when necessary, challenging the effectiveness of the work and advising on ways to improve safeguarding performance.

The Local Safeguarding Children Partnership / Adult Board within Lincolnshire both have Independent Chairs, and membership has been reviewed ensuring that attendance is at the required levels and members have sufficient seniority.

The Trust is represented by the Group Director of Safeguarding and Patient Experience at the Partnership/Board and there is representation by other key safeguarding professionals on the subgroups*.*

6.1 LSCP Key areas of action

- Tackling child exploitation.
- Enhancing the emotional wellbeing of children and young people.
- Promoting healthy and respectful relationships.
- To identify and reduce the impact of neglect on children and young people.
- To identify and reduce the impact of sexual and physical harm.
- Identify and reduce the impact of domestic abuse on children, young people, and their families.

LSCP business plan 2022 - 2025

6.2   LSAB Key areas of action

- Prevention and Early Intervention.
- Making Safeguarding Personal (MSP).
- Learning and shaping future practice.
- Safeguarding Effectiveness.

The Trust is actively involved in all the above areas by way of delivering the topic areas within training and/or sitting on operational groups to actively target the perpetrators and support the victims of abuse.

Lincolnshire Safeguarding Adult Board Strategy 2022 - 2025

7.0   Child Safeguarding Practice Reviews (Previously Serious Case Reviews - SCR) / Safeguarding Adults Review (SAR) / Domestic Abuse Related Death Reviews (DARDR)

7.1   Children

Child Safeguarding Reviews have been in place for many years and nationally about 400 take place every year. A review is always carried out by the Safeguarding Partnership when a child dies and abuse or neglect is known, or suspected, to be a factor in the death. Working Together (2018) guidance also states that LSCP should consider holding a review *where a child has sustained a life-threatening injury through abuse or neglect, serious sexual assault, or through serious and permanent impairment of health or development through abuse or neglect.* The purpose of a review is to establish what lessons can be learnt about the way professionals and organisations worked together, how they will be acted upon and what is expected to change to improve inter-agency working and improve safeguarding practice to children. Reviews are exercises in learning and improving policy and practice and outcomes for children and young people and are not inquiries into how a child died or who was culpable; this is the business of Coroner's and the Criminal Court.

A review is commissioned by the LSCP and involves setting up a multi-agency review panel of senior and experienced managers, with an independent chair, to ensure objectivity and impartiality. The panel must produce a report to the LSCP on lessons

learnt, the LSCP then ratifies the conclusions and recommendations for actioning the lessons.

The report goes to the LCHS Safeguarding and Vulnerabilities Oversight Group, Ofsted / CQC and national oversight panel for their scrutiny and response. All relevant agencies are expected to produce and implement an action plan, based on the recommendations, which is overseen by the LSCP Significant Incident Group.

Figure 2:
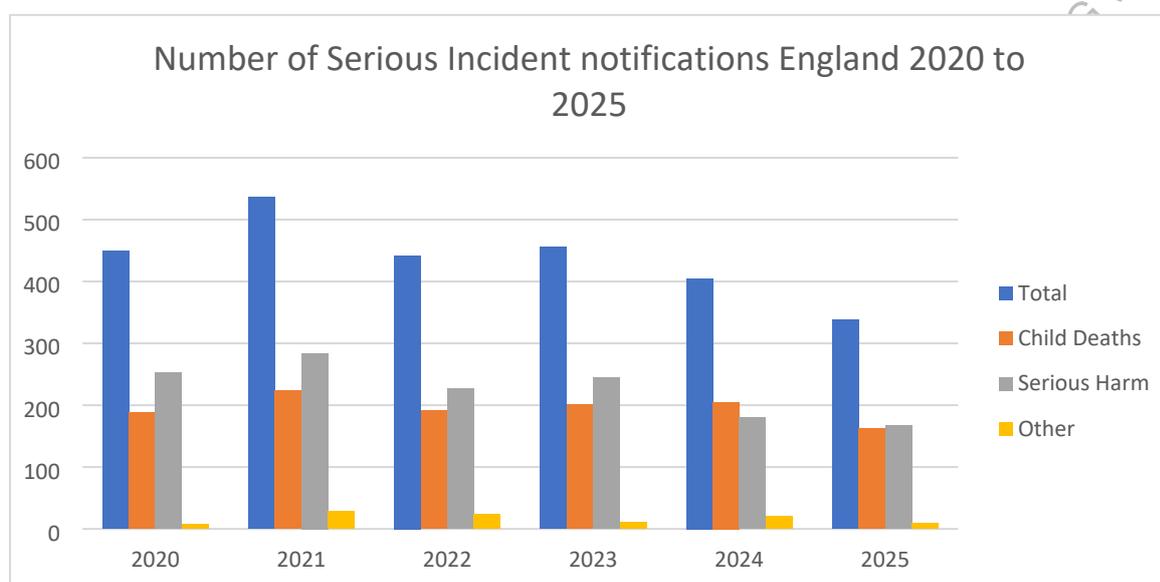
No Child Safeguarding Practice Reviews (CSPRs) have been commissioned by the LSCP during the financial year 2024 – 2025. Two rapid reviews were held, neither of which had a recommendation to progress to CSPR.

7.2   Adults

Safeguarding Adult reviews are part of the safeguarding adult's process and a statutory requirement within the Care Act 2015.

By Law, a Safeguarding Adults Review (SAR) must take place when:

An adult dies because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a SAR is not to assign blame but to promote learning and improvements to prevent future deaths or serious harm.

In addition, safeguarding boards may also arrange a review where it believes there is value in doing so. This can be in any other situation involving an adult in its area with

needs for care and support to promote effective learning and improvement action to prevent future deaths or serious harm occurring.

During 2024 – 2025, the LSAB commissioned a new SAR in March/April 2024 which is currently ongoing. LCHS had little contact with the subject of the review and no actions have been identified for the organisation.

7.3   Domestic Abuse Related Death Reviews (DARDR)

A DARDR is very similar in nature to a children's or adults' review however takes place *when a death occurs in a young person (16 & 17 years), or an adult and the cause is linked to Domestic Violence or Abuse*.

Nationally there were 362 domestic homicides recorded by the police in the three-year period between year ending March 2018 and year ending March 2020. This represents 19% of all homicides where the victim was aged 16 years and over during this period.

Of the 362 homicides, 214 (59%) were female victims who were killed by a partner or ex-partner. In contrast 33 (9%) were male victims who were killed by a partner or ex-partner. The remaining 115 (32%) were victims killed by a suspect in a family category.

The majority of domestic homicide victims (killed by ex/partner or a family member) for the year ending March 2020 to the year ending March 2022 were female (67.3% or 249 victims) and most of the suspects were male (241 out of 249; 96.8%). In the majority of female domestic homicides, the suspect was a male partner or ex-partner (74.7%), whereas in the majority of male domestic homicides, the suspect was a male family member (66.1%) (ONS, 2023a).

When DARDRs started in Lincolnshire, there were 12 notifications during the period of 2012-2017 however since 2018 the number of notifications has doubled leading to 34 cases that have met the criteria for a domestic homicide review in Lincolnshire between 2012 and 2025.

During 2024 - 2025 LCHS has been involved in three newly commissioned Domestic Homicide Reviews (DARDRs) for Lincolnshire.

In total, LCHS is currently involved in fourteen DARDRs; one of which was identified in 2021, one from 2022 and nine from 2023.

During 2024-2025, LCHS submitted information to support three Lincolnshire DARDR decision-making panels at which it was determined that the criteria for undertaking a DARDR had not been met.

The Trust also completed a data trawl for one out of area DARDR decision-making panel, however no information was held by LCHS so there was no further involvement in the Review.

There are no ongoing identified actions for LCHS in any of the reviews, and the newly commissioned reviews have not yet generated actions for individual agencies.

Figure 3: Number of cases referred for discussion to DARDR panel.
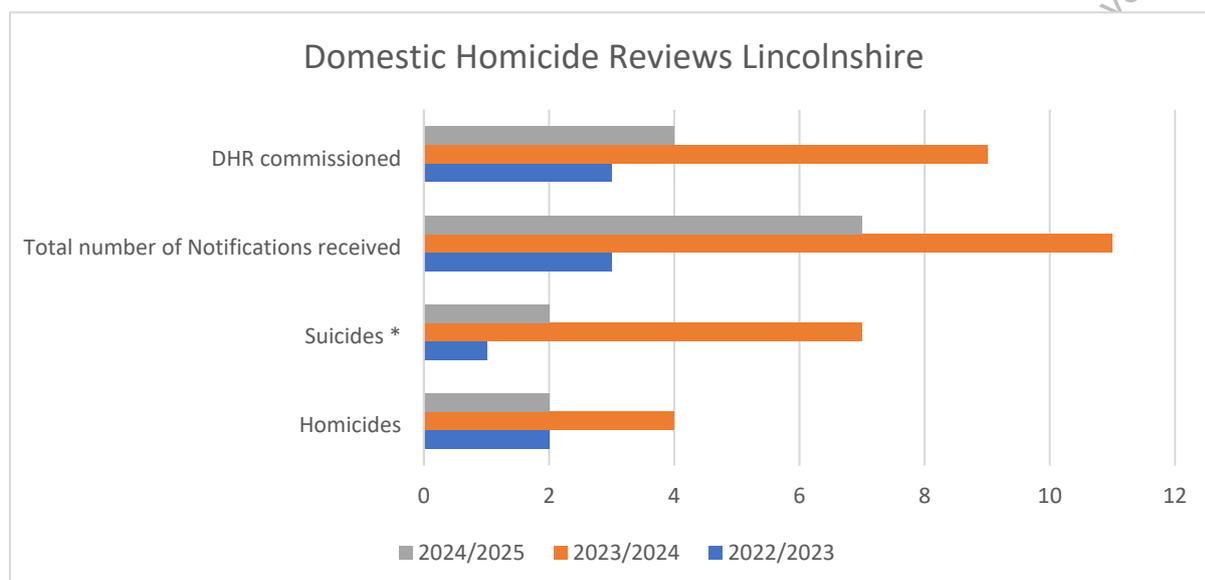
* **Since 2022 DARDR criteria have changed to include all deaths by suicide where there has been a known history of domestic violence within the current/past relationship.**

8.0   Child Protection Cases

Lincolnshire holds Child Protection Conferences on each working day and therefore the numbers for children who currently have a Child Protection plan vary daily Monday to Friday and can be influenced by families moving in and out of the Local Authority. Overall, the numbers of children on plans (figure 4) have slowly risen over the last 5 years whereas the mean for England has demonstrated a downward trend.

Children on child protection plans are identified within the Trust via SystmOne and via the Lincolnshire Care Portal.

During this period there has continued to be a high number of unborn babies who have become subject to child protection / court proceedings and as such a significant impact on the midwifery workload however has not directly impacted on LCHS generic services; however, does impact on the Children Looked after service.

Figure 4: Number of children having a child protection plan within the Local Authority area who may be receiving services from LCHS (April 2020– March 2025) *(England Mean 24/25 not available at time of report)*

Children Subject to a Child Protection Plan at 31st March 2025

Year	Lincolnshire	England (Mean for English LA)
2024/2025	446	
2023/2024	350	567
2022/2023	386	647
2021/2022	377	638
2020/2021	369	626

■ England (Mean for English LA) ■ Lincolnshire

8.1   Child in Need

Some children will not meet the criteria for a Child Protection plan but still require a service which can be met at a lower level 'Children in Need' of support. The data in figure 5 demonstrates the number of Children in Need across Lincolnshire with a decrease in numbers over the last 12 months remains below the England mean.

Lincolnshire has focused its support offer on 'Early Help' which is designed to assist children and families at an earlier stage and prevent them from reaching the Child in Need stage.

Figure 5: Number of children classed as a Child in Need within the Local Authority area who may be receiving services from LCHS (April 2020 – March 2025)

(England Mean 24/25 not available at time of report)

Children in Need at 31st March 2025

Year	Lincolnshire	England (Mean for English LA)
2024/2025	3629	
2023/2024	3678	4941
2022/2023	3480	5251
2021/2022	3634	5186
2020/2021	3192	4973

■ England (Mean for English LA) ■ Lincolnshire

8.2   Children in Care

Children and young people who are looked after are amongst the most socially excluded groups in England and Wales. They have profoundly increased health needs in comparison with children and young people from comparable socio-economic backgrounds who have not needed to be taken into care. These greater needs, however, often remain unmet and as a result, many children and young people who are in care continue to experience significant health inequalities and on leaving care experience extremely poor health, educational and social outcomes.

Many of these children will access the services within LCHS by way of UTC or our Children, Young People and Specialist Services. Research demonstrates that children in care will continue to have an elevated level of Adverse Childhood Experiences (ACEs) which impact on lifelong health and opportunities and therefore continue to access services long into their adult life.

Due to the demographics of Lincolnshire, the Trust will also provide services to other young people who are placed into care within Lincolnshire from other Local authority areas.

The Trust has worked closely with our multi-agency/multi-professional partners to ensure that these children received the best possible care.

Children in Care within the Trust are identified within SystmOne and via the Lincolnshire Care Portal.

Figure 6: Number of children classed as a Child in Care within the Local Authority Area who may be receiving services from LCHS (April 2020 – March 2025)

(England Mean 24/25 not available at time of report)

Number of Children Looked After at 31st March

2024/2025: *Out of area Placed in Lincs* 575, Lincolnshire 808
2023/2024: *Out of area Placed in Lincs* 593, England (Mean for English LA) 1054, Lincolnshire 754
2022/2023: *Out of area Placed in Lincs* 604, England (Mean for English LA) 1064, Lincolnshire 728
2021/2022: *Out of area Placed in Lincs* 583, England (Mean for English LA) 1026, Lincolnshire 736
2020/2021: *Out of area Placed in Lincs* 564, England (Mean for English LA) 1008, Lincolnshire 680

Legend: *Out of area Placed in Lincs* | England (Mean for English LA) | Lincolnshire
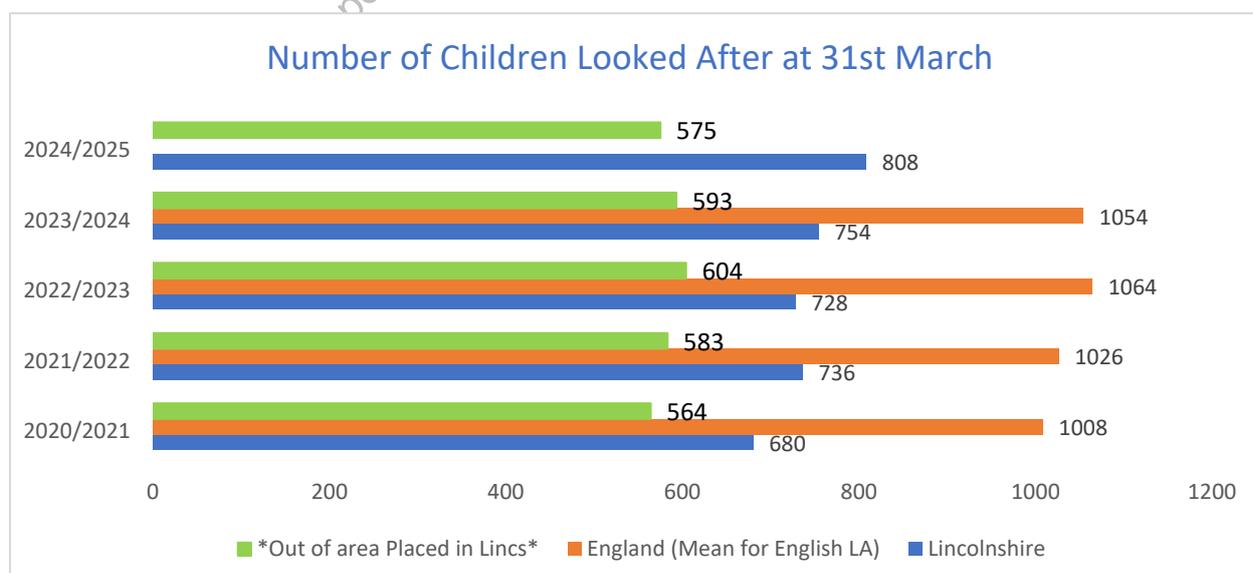
* Out of area placements are reliant on external Local authorities notifying Lincolnshire of the placement and therefore this is likely to be an under reporting and the actual figure being higher*

8.3   LCHS Children Looked After Team.

Within LCHS some of these children will access services such as UTC and LiSH however LCHS is also directly commissioned to provide the Children in Care Service.

The service employs Registered Nurses, General Practitioners, and administrators to support children and young people living in Lincolnshire who are in the care of the Local Authority or placed into Lincolnshire by external Authorities. The service is primarily responsible for carrying out Initial and Review Health Assessments (IHA and RHA) for these children in care. During 2024/2025 the service was also supported by an additional 1WTE Paediatric Doctor at cost pressure to the group to facilitate a greater number of appointments available and IHAs delivered within the 20-working day timescale.

At the end of March 2025 there were 808 children in the care of Lincolnshire County Council, an increase of 7% from the previous year and 21% over the last 5 years - this is higher than the national average increase of 8% over the last 5 years. The introduction of the National Transfer Scheme in November 2021 triggered a significant rise in Unaccompanied Asylum-Seeking Children receiving support from the service. The number of children and young people placed into Lincolnshire by external Authorities also continues to rise significantly putting additional pressure on the team (21% increase over the last 5 years).

The number of Independent Registered Residential Children's Homes in the County has risen in recent years. The majority of the young people living in these homes are placed by external authorities and many are victims of Child Exploitation. This brings specific health needs therefore each home has been allocated a link Nurse from the team. The first we know about a new home is sometimes when we receive a notification that a young person has moved there.

In January 2024, the team began a data transformation project to improve the accuracy of data reporting which was previously very time consuming as it was not fully digitalised. This has involved the service transitioning to their own SystmOne unit bringing all the data and recording into one place. In partnership with the Trust's Digital Health team, SystmOne templates/questionnaires have been developed and implemented to ensure that all information is fully reportable. Dashboards have been developed, and a wide range of real time data is now available for IHA and RHA assessments. The project is still ongoing as further clinical questionnaires have been developed to better capture health outcomes for the young people and Digital Health are currently working on dashboards to report on these outcomes.

As part of future proofing the service to ensure that it can deliver timely and effective care to our children and young people a business case has been developed to consider a new funding model and structure of the team moving forward.

9.0   Adult at Risk

Adult Safeguarding is extremely complex and impacts on much of the day to day work of the Trust, i.e., Complaints/PALS, Serious incidents/PSIRF, pressure ulcers, patient safety and HR. Safeguarding is about more than simply keeping someone safe, it is about respecting and protecting an individual's needs, rights, aspirations and integrity, both mental and physical. It is about making sure the environments they inhabit, and the people and services they encounter within them, reflect these same ideals. There is a fine balance to be struck regarding proportionality and the right of the individual to take risks, and these must be balanced against the duty to protect health and wellbeing. There has been further promotion regarding Health Professionals developing their professional curiosity; asking the right questions when fulfilling their safeguarding duties and helping them to enable patients to live their lives to the full, free from abuse.

There is increased emphasis on 'making safeguarding personal' and involvement of the patient in their safeguarding decisions. Audits from the LSAB and internally continue to suggest that this is an area which requires further improvement so remains a priority for 2025 - 2026.

During the last year, the Safeguarding Team has seen an increase in case complexity, notably in cases of self-neglect, pressure ulcers in community, and addictions. The team has worked proactively to coordinate these cases and prevent unsafe discharges, readmissions, complaints, or safeguarding allegations against the Trust. This approach increases positive outcomes for the patients.

The number of referrals raised during 2024 - 2025 by LCHS was 144, a slight decrease of 11% compared to the previous year however still indicating that the Trust is actively identifying issues of concern. Work continues to ensure that all referrals are appropriate and include the patients views wherever possible.

Figure 7:   Number of safeguarding adult referrals made by LCHS to the Local Authority (April 2024 – March 2025) including divisional breakdown.

Total Safeguarding Adult Referrals

Number of referrals by LCHS Service
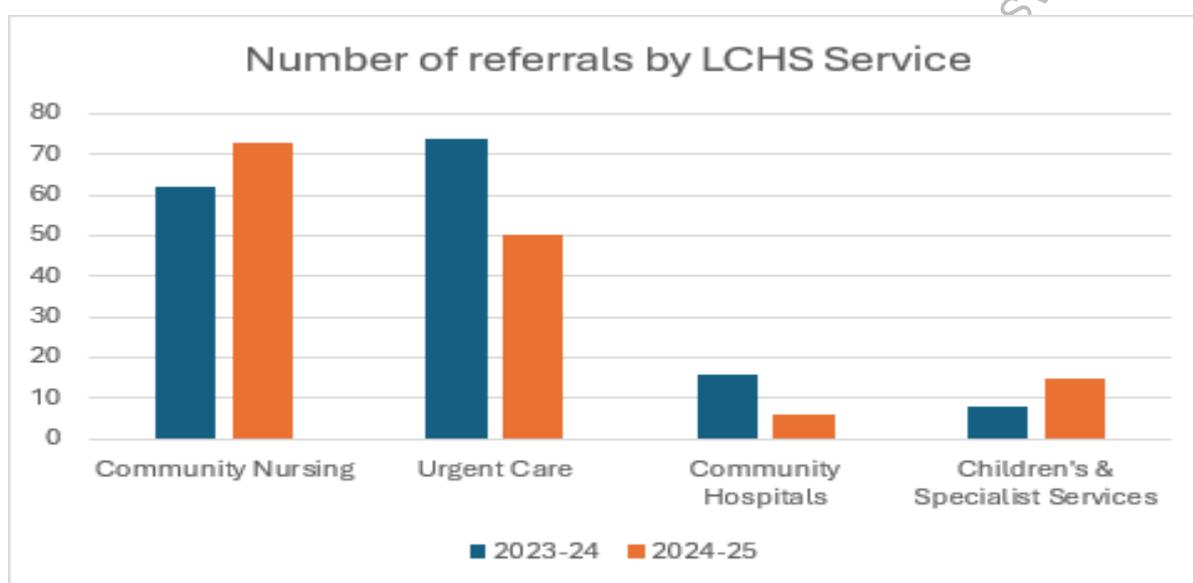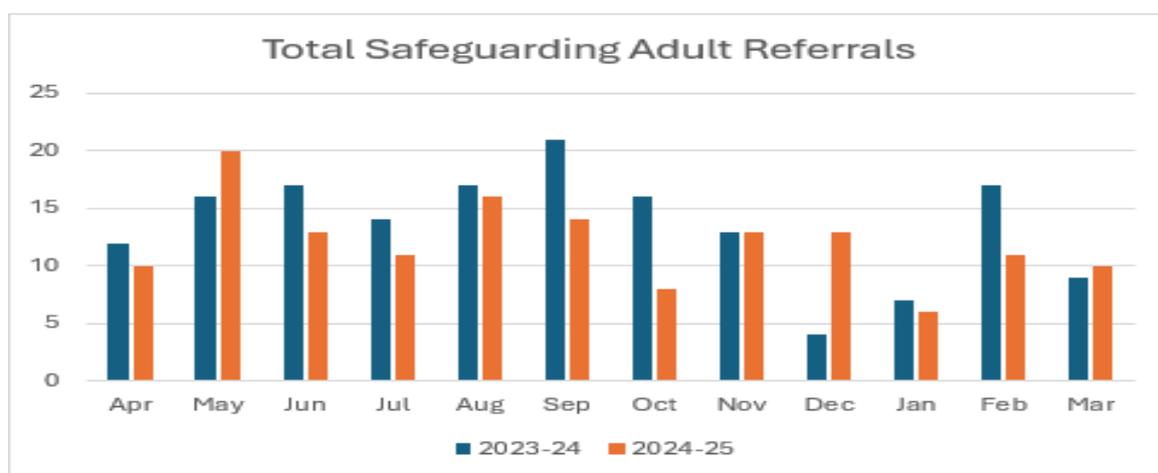
9.1 Safeguarding referrals made against the Trust.

The number of safeguarding allegations raised against the Trust continues to vary; however, over the last 12-month period has increased from 7 in 2023 - 2024 to 34 for 2024 - 2025. This is a significant increase; however, the introduction of the Safeguarding adult's protocol: pressure ulcers and raising a safeguarding concern has played a key part in providing a consist approach to ascertaining when pressure ulcers are negatively impacted on by care provided. This includes a number of self-referrals made by the Trust towards itself based on national criteria and guidance.

Figure 8: Safeguarding Investigations

Section 42 Investigations
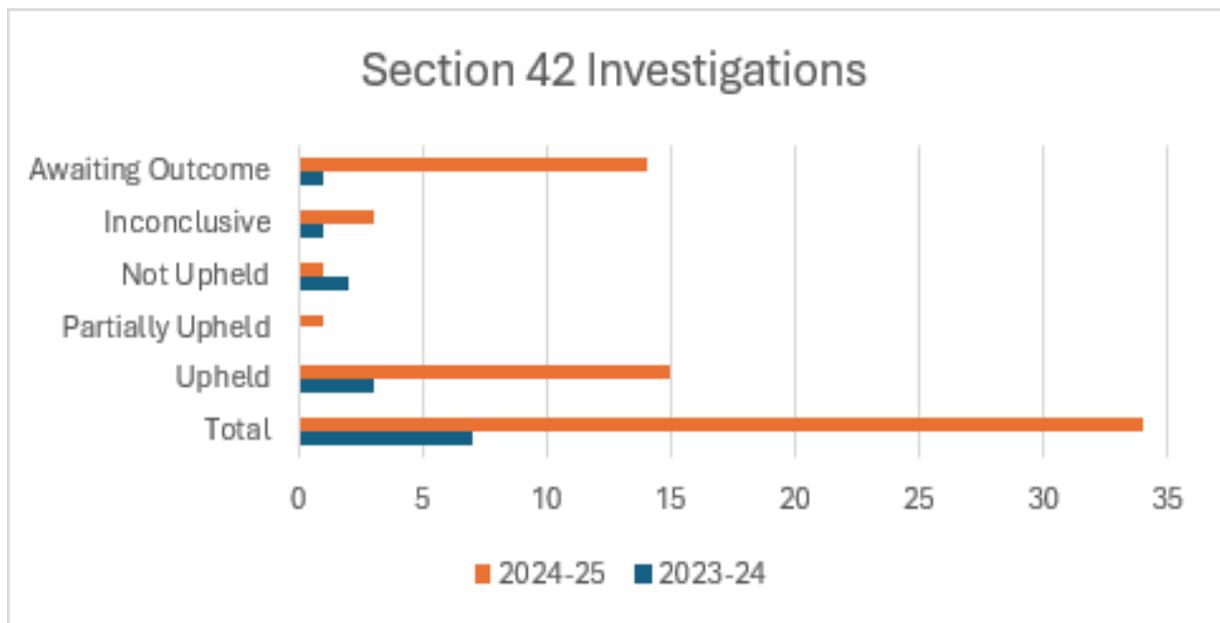
Over the last 12 months the majority of cases under investigation have been pressure related with actions plans in place for each case.

There appears to be a slowing down of section 42 referrals in the last quarter however it is too early to ascertain if this is a trend going forward and will need further monitoring through 2025 -2026.

If the number is reducing, then this would indicate that the action plans in place are being effective, and the number of referrals should settle to a more regular level. The number of upheld allegations remains high at 49% +/- 38% (awaiting final decision / under investigation) meaning a possible 87% max.

Neglect related to pressure ulcer care continues to be the dominant category specifically the themes are -

- Lack of holistic assessment and understanding of the impact of underlying conditions on tissue viability
- Lack of pressure ulcer risk assessment and preventative measures
- Lack of care planning that reflects the needs /changes in condition of the patient.
- Lack of case management and oversight
- Allocation of visits to staff who don't have the knowledge and skills to perform the visit (HCSW when reassessment is needed)
- Failure to recognise deterioration in wound and underlying condition.
- Failure to perform sepsis screening when signs of infection present.
- Failure to recognise the wound as pressure related leading to a delay in appropriate response.
- Poor management of deferred visits and not responding to SOS calls.

- Not following MCA process when patient lacks capacity to make decisions about wound care.

A number of lessons have been learnt, and actions have been put into place to minimise future risks. The Named Professional meets with the CQC and separately with the ICB and LA to ensure that there is an open and honest dialect is maintained and works on the premise of 'no surprises.

Quality Assurance

All referrals are quality assured. Moving forward as the Group develops, these processes will be standardised across the teams.

All safeguarding incidents reported on Datix are reviewed by the Safeguarding Team, providing an immediate quality assurance process, and ensuring that all actions have been completed, and that records & documentation are appropriately completed. The Safeguarding Team provides 'in hours' follow up to incidents that occur out of hours, including liaison with Health Professionals and confirming actions with Social Care and the Police.

The graph below shows that there has been a slight decrease in the number of incidents reported on Datix but not of a significant level. Reporting culture remains positive, and during the most challenging times operationally, reporting culture was not affected.

Figure 9: Safeguarding Incidents
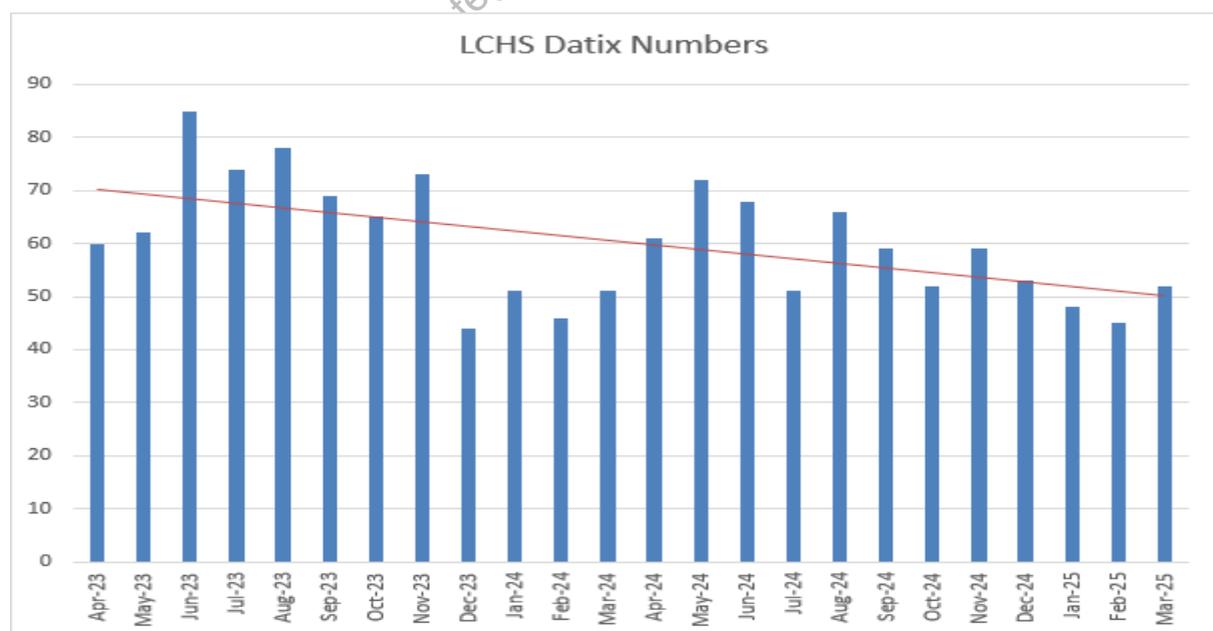
10.0 Legal statements / Court process

The Safeguarding Teams have continued to strengthen and develop their remit of supporting staff in statement writing and Court attendance. The current trend to produce more legal statements / requests for records continues and is also impacted on with the growing area of work from the Court of Protection.

The ongoing supportive relationship / process between Safeguarding and the Legal / Data Protection teams continues to work well.

Other teams adversely affected by this increase are the Children, Young People and Specialist Services and UTC Departments across site with pressures being placed on frontline Clinicians to provide reports and statements in greater detail and in a much shorter timescale.

The Court of Protection (CoP) is a court in England and Wales that can make decisions on behalf of people who lack the capacity to make their own decisions and the Court deals with decisions about a person's welfare, property, or medical treatment.

Whilst the Mental Capacity Act Code of Practice confirms some of the situations when decisions must be taken to the Court of Protection (Section 8.18), not all scenarios are covered including cases where there is a dispute about whether a particular treatment will be in a person's best interests.

The Court of Protection (CoP) has issued guidance which states that if force or restraint is required an application to Court may be required and if the force or restraint amounts to a deprivation of liberty then the authority of the Court will be required to make this deprivation of liberty lawful.

LCHS have not identified any cases requiring CoP; however, have worked with ULTH to assist in transition of some of the more complex Mental Capacity cases from the hospital to the community.

During 2024 to 2025 ULTH commissioned a series of Court craft and Legal updates for staff which currently continue to March 2026 and cover Court skills suitable for Children and Family / Coroners' Courts as well as updates around the Mental Capacity Act and relevant changes in case Law. These events where opened to LCHS staff in 2023 and will continue to be provided across the Group going forward.

11.0 Safeguarding Clinical Supervision

11.1   Children

Effective Safeguarding supervision is important to promote good standards of practice and support individual staff members. Supervision allows time for reflective practice and is a vital component in the protection of children. Supervisors should be available to practitioners as an important source of advice and expertise and may be required to endorse judgements at certain key points in time, and ensure each individual child has an effective plan of action. The Safeguarding teams provide direct supervision to Professionals (Individual and Group) which includes reflecting on, scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the practitioner, and providing coaching, development, and pastoral support.

Safeguarding supervision is mandated to specific staff groups at either 3 monthly or 6 monthly periods and is managed in LCHS by way of the Supervision App. The App has been updated during the year to ensure that Safeguarding supervision is more easily recorded.

As of 31st March 2025, compliance rates are as follows.

Overall compliance 73.02%.

Compliance figures for Safeguarding supervision are notoriously difficult to maintain due to 3 - 6-month time scales and constantly changing staff groups particularly amongst medical staff. In order to proactively manage this challenge, the Safeguarding Team uses the above figures in conjunction with the Safeguarding training compliance figures to identify high-risk areas of concern and target specific staff groups.

Compliance is monitored by the teams with bi-monthly reports provided to Safeguarding Operational Group / Divisional Leads for escalation and via SVOG.

11.2   Adults

Whilst less prescriptive, Safeguarding supervision for adult protection cases is readily available and provided to staff who require it on a needs lead basis. This is often delivered at source on the clinical areas on a case-by-case basis and during the pandemic has been delivered via teams. As Safeguarding adult / MCA is embedded, Safeguarding supervision for adult cases is noticeably a bigger part of the work of the teams and recorded via the Safeguarding App.

12.0   Training and learning

Safeguarding training has always been a high priority within the Trust and is implicit within the National contract and Safeguarding Legislation. A new joint training plan was introduced for Safeguarding Children and Safeguarding Adults in 2023, as the first stage of bringing both Trusts closer together and ensuring compliance with Statutory guidance. As part of this process all training courses were reviewed and

updated as necessary, with the vision that moving forward staff from either Trust could attend any course and still gain compliance.

All training is now face to face delivered either directly or via Microsoft teams. This has improved interaction in training sessions and allows for detailed scenario discussions.

Figure 10: Training levels with the Trust on the 31st of March 2025.

KPI Description (A measurable value that demonstrates the success of your change, to include trajectory to achieve target)	Measures (How will this be Measured)	Target (Desired level of performance)	LCHS END March 2025 figures Trend compared with March 2024	
To reach 90% for Safeguarding children level 1	Monthly training report (MTR)	90%	96%	↓
To reach 90% for Safeguarding children level 2	MTR	90%	86.45%	↓
To reach 90% for Safeguarding children level 3	MTR	90%	81.87%	↓
To reach 90% for Safeguarding children level 4	MTR	90%	100%	→
To reach 90% for Safeguarding adults level 1	MTR	90%	96.39%	↓
To reach 90% for Safeguarding adults level 2	MTR	90%	87.953%	↓
To reach 90% for Safeguarding adults level 3	MTR	90%	89.66%	↓
To reach 90 % for MCA / DOLS **	MTR	90%	83.76%	↑
To reach 90% for PREVENT basic level	Quarterly training report	NHSE/I target 85%.	96.64%	↓
To reach 90% for PREVENT Higher level	Quarterly training report	NHSE/I target 85%	87.95%	↓
Oliver McGowan Specific Tier 1 e-learning (part 1) *	MTR	90%	87.56%	↑
Oliver McGowan Specific Tier 2 e-learning (part 1) *	MTR	90%	62.74%	↑

* **LCHS Commenced 1ˢᵗ March 2023 - Only training delivered is Oliver McGowan part 1 as part 2 is not yet available**

** **Mental Capacity/DoLS training was introduced in LCHS on 1st April 2024**

Oliver McGowan e-learning training continues to be rolled out across the trust however for full compliance staff members must attend a second module which is a face-to-face course.

The uptake is reliant on the availability of the face-to-face course and at present these are limited nationally as the course must be delivered by experts with lived experience.

The Trust is working with the Lincolnshire system partners to commission these modules however whilst tier one (part B) modules are slowing becoming more available as, yet no tier two (part B) module is available.

13.0   Female Genital Mutilation (FGM)

Whilst the issue of FGM affects women / girls across all operational services the main clinic services able to identify the mutilation are midwifery and Gynaecology teams within the hospital and LiSH services within LCHS. In line with national guidance the Trust has in place an FGM policy.

From 1st April 2015, and in line with National Guidance, Hospital Trusts and General Practitioners began to routinely submit FGM data. This data is submitted monthly to NHS Digital.

Nationally, since April 2015, 35,415 individual women and girls had an attendance where FGM was identified.

Between April 2024 and March 2025, 45 cases of FGM were reported within the NHS in Lincolnshire, a decrease of 28% over the last 12 months, however an increase of 115% over the last 5 years: of which 25 were Type 4 (piercings); 5 were Type 1, 1 was type 2, and 14 were of an unknown type. All cases reported were reported by adults and those reporting Type 1 had undergone the FGM as children in their countries of origin.

As a Community Trust LCHS is not required to submit data as part of the National Data Set as Primary Care data is submitted as part of the GP requirement.

LCHS is required however to refer any FGM cases as part of the [mandatory reporting requirements](#).

Figure 11: FGM specific data by WHO type classification.
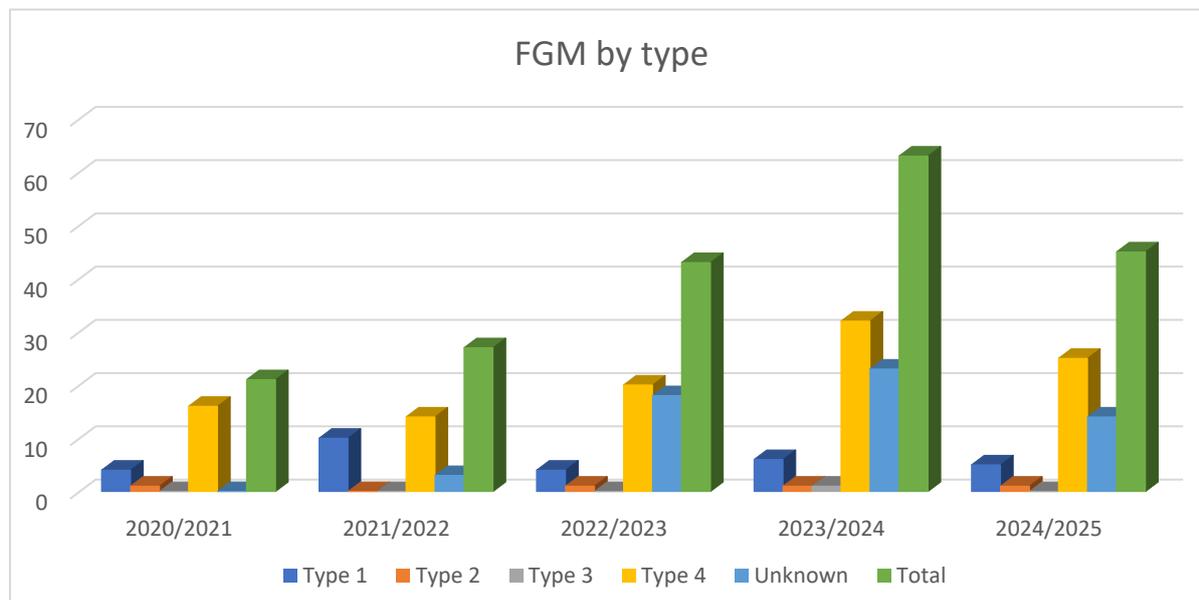
14.0 Domestic Violence / Multi-agency Risk Assessment Conference (MARAC)

Domestic Abuse costs the country's economy £15.8 billion a year. The cost to Health, Housing and Social Services, Criminal & Civil Legal services is estimated at 3.9 billion and of this, the NHS spends £1.73 billion.

The Trust is represented at the twice-weekly MARAC meetings by the Safeguarding Specialist Nurses and at the Domestic Abuse Operational and Strategic Boards by the Named Nurses for Safeguarding and the Director for Safeguarding and Patient Experience, respectively.

14.1 Key Facts

The Crime Survey for England and Wales estimated that 2.3 million people aged 16 years and over (1.6 million women and 712,000 men) experienced domestic abuse in year ending March 2024.

In the Year ending December 2023 the Police recorded a domestic abuse offence approximately every 40 seconds

This equates to a prevalence rate of approximately 5.0% of adults (6.9% women and 3.0% men).

Figure 12: shows a higher percentage of adults experienced domestic abuse by a partner or ex-partner (4.4%) than by a family member (1.8%) in the last year. Of those who experienced partner abuse, 88% experienced non-physical abuse, 9% experienced sexual assault and 16.1% experienced stalking.

Approximately one in 25 people experienced domestic abuse in the year ending March 2023

Prevalence of domestic abuse in the last year, for people aged 16 years and over, by perpetrator-relationship, England and Wales, year ending March 2023

One in 25 people experience domestic abuse in the year ending March 2023

Domestic abuse has a significant impact upon the communities and public services of Lincolnshire.

Domestic abuse remains an under reported issue. CSEW national figures suggest that only 31% of partner abuse victims told someone in an official position about their abuse (i.e., Police, Health Professionals, or local Council department). 18.9% of victims told the Police, 18% told a Health Professional and 5% told a local Council department. The majority of partner abuse victims instead told somebody they knew personally about their abuse. 1 in 4 partner abuse victims told nobody at all about their abuse (27%), a much more concerning statistic amongst males where 1 in 2 (49%) told nobody about suffering abuse at the hands of their partner. (Source: Office of National Statistics).

More than one in four women has experienced at least one incident of domestic violence in England and Wales since age 16 (equivalent to 4.8m women).

- On average a woman will experience **35 assaults** before going to the police
- **2 - 3 women a week** are killed by their current or former partner.

- **1 in 7 males** will experience domestic violence and abuse.
- Domestic Violence and Abuse often starts or intensifies during and after pregnancy.
- 3.7 million women in England and Wales have been sexually assaulted at some point since the age of sixteen.
- Around 2,000 women are raped each week. 34% of all rapes recorded are committed against children under 16 years of age.
- Estimated 66,000 women in England and Wales have undergone Female Genital Mutilation and over 24,000 girls are estimated to be at risk.
- One in four lesbian, gay, bisexual, and transgender people have experienced domestic violence and abuse in their relationship.
- Disabled women are twice as likely to experience domestic violence and abuse than non-disabled women and over a longer period of time, suffering more severe injuries because of the violence.
- Domestic violence and abuse in teen relationships is increasingly recognised as a significant issue. Research now suggests that women between the ages of 16 and 25 are at highest risk.

14.2   Domestic abuse in Lincolnshire

In the last 5 years, on average there are over 12,000 domestic abuse incidents reported to Lincolnshire Police every year. During 2024 – 2025 of these, circa 8,500 are standard risk incidents, equivalent to around 7 in 10 domestic abuse incidents reported. The proportion of reported incidents that are graded as high risk has been falling, while the proportion graded as medium risk has remained relatively static year on year.

Figure 13: Domestic Abuse Cases

14.3   Domestic abuse and children

The true number of victims of domestic abuse is likely to be higher when children are included. CSEW figures suggest that 41% of partner abuse victims suffered abuse while their children were in the house, and that 21% of victims disclosed that the children did see or hear what happened. (Source: Office of National Statistics) If only one child was present at each of the 21% of domestic abuse victimisations in Lincolnshire each year, this would mean that 5,500 children witnessed domestic abuse in their home each year. This means that the true number of Lincolnshire residents affected by domestic abuse each year is likely to be upwards of 35,700 adult victims and child witnesses.

The Domestic Abuse Act (HM Government, 2021) now recognises children and young people living within a Domestically Abusive relationship/household as being victims.

The high rate at which children are present during partner abuse incidents has a number of consequences. At a basic level it places additional responsibility on those Agencies encountering domestic abuse to ensure that appropriate checks, risk assessments and Safeguarding referrals are being made for child witnesses as well as adult victims of domestic abuse. Domestic abuse is the single most prevalent assessment factor identified in Children's Social Care assessments. It is more prevalent than the presence of factors such as mental health, alcohol misuse, drug misuse, disability and illness, emotional abuse, physical abuse, or sexual abuse. In Lincolnshire during 2018-19, 55.1% of assessments identified domestic abuse as an issue. This is higher than the national average of 50.6%, and places Lincolnshire 42nd among the 151 local authorities in England that supplied information. (Source: Department for Education) Domestic abuse has also specifically been identified as a factor in 54% of all Child Safeguarding Practice Reviews, which investigate child deaths relating to maltreatment, abuse, and neglect. *(S Framp, Community Safety Analyst, Lincolnshire County Council, May 2021).*

14.4   MARAC cases

There were 1436 victims who were at high risk of serious harm or death referred into the Multi Agency Risk Assessment Conference (MARAC) by partner Agencies in 2024 -2025. On average 350 referrals are made to MARAC every quarter (last 5 years ending March 2025).

Figure 14: MARAC Referrals – all risk levels
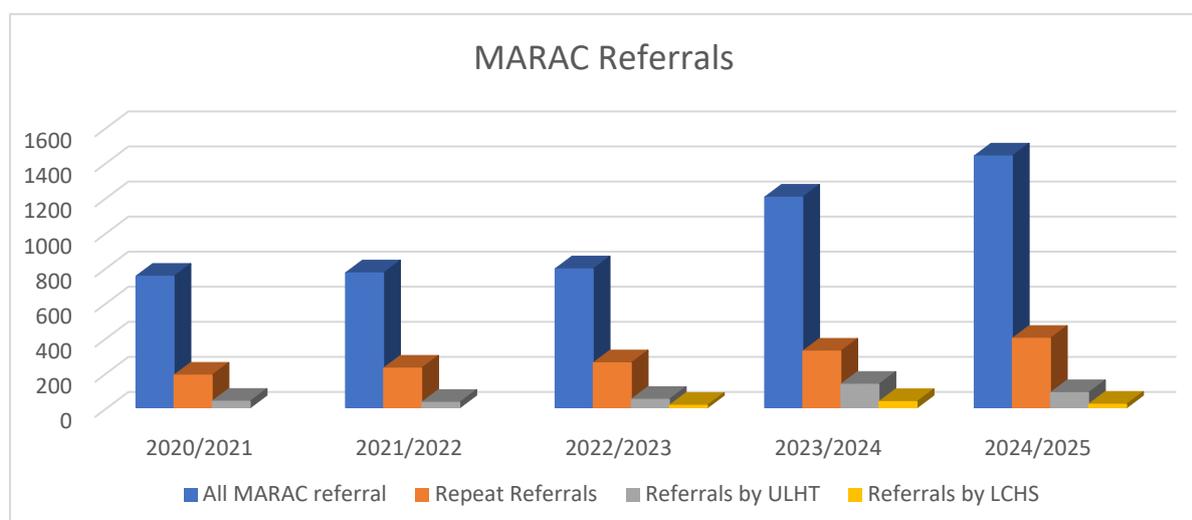
MARAC Referrals

MARAC conferences are held weekly in Lincolnshire on both a Wednesday and Thursday and during the last 12 months the team have continued to attend all MARAC meetings. More recently Legislation has changed to include additional meetings to be held under the Domestic Violence Disclosure Scheme.

Figure 15: MARAC cases attended by LCHS Safeguarding Professionals

14.5   Domestic Abuse support

On the 1st of April 2023, the previous domestic abuse support service ended and a new support service (Lincolnshire Domestic Abuse Specialist Service – LDASS) was launched.

Across Lincolnshire a Total of 2352 adult referrals (18% increase on previous year) were received into LDASS between the 1st of April 2024 and 31st of March 2025 for adult victims of domestic abuse to specialist outreach support services in Lincolnshire – this is a 18% increase from the previous year. Victim Lincs allows for direct referrals from Professionals and self-referrals into LDASS.

A total of 5264 enquiries were received into the service from members of the public and 2522 enquiries from Professionals for advice regarding domestic abuse.

15.0 PREVENT Lincolnshire Profile

The East Midlands continues to experience high volumes of counter terrorism threat with the number of cases continuing to increase over the preceding year. Lincolnshire is still classified as a low-level area however this does not mean that no risk exists.

Self-Initiated Terrorism (S-IT) is the greatest terrorist threat to the UK and defined as those who "threaten or mobilise to violence without material support or personal direction from a terrorist organisation; but who may still be influenced or encouraged by the rhetoric or ideology of a group". An attack in Lincolnshire from a self-initiated terrorist is deemed "unlikely," however it is important we are ALL aware of the national risk. Young people and vulnerable individuals continue to actively engage in online extremism and are often seen to be displaying extremist views. Online remains a primary radical influence for subjects referred into Lincolnshire Prevent. A considerable proportion of subjects are below the age of 21. Analysis shows, individuals have been influenced online by viewing/possessing/sharing extreme media, communicating with unknown individuals online who may have extremist views and conducting their own research into concerning activity such as mass shootings.

The overarching threat to the UK and Lincolnshire is from AQ/IS. Events in the Middle East are increasing the threat from AQ/IS.

LCHS are represented at the PREVENT Steering Group by the Named Professional for Safeguarding and MCA (ULHT) who is also the point of contact for the Regional Prevent Coordinators. It is also the responsibility of the PREVENT Lead to ensure that the Trust is compliant with its reporting requirements including submission of the data required by NHS England (NHSE) to capture PREVENT activities undertaken by the Trust on a quarterly basis.

LCHS have not made any PREVENT referrals; however, have provided research on several cases over the last 12 months in compliance with our PREVENT duty.

Figure 16: Number of PREVENT data analysis cases undertaken by LCHS as part of Channel Process (April 2023 – March 2025)
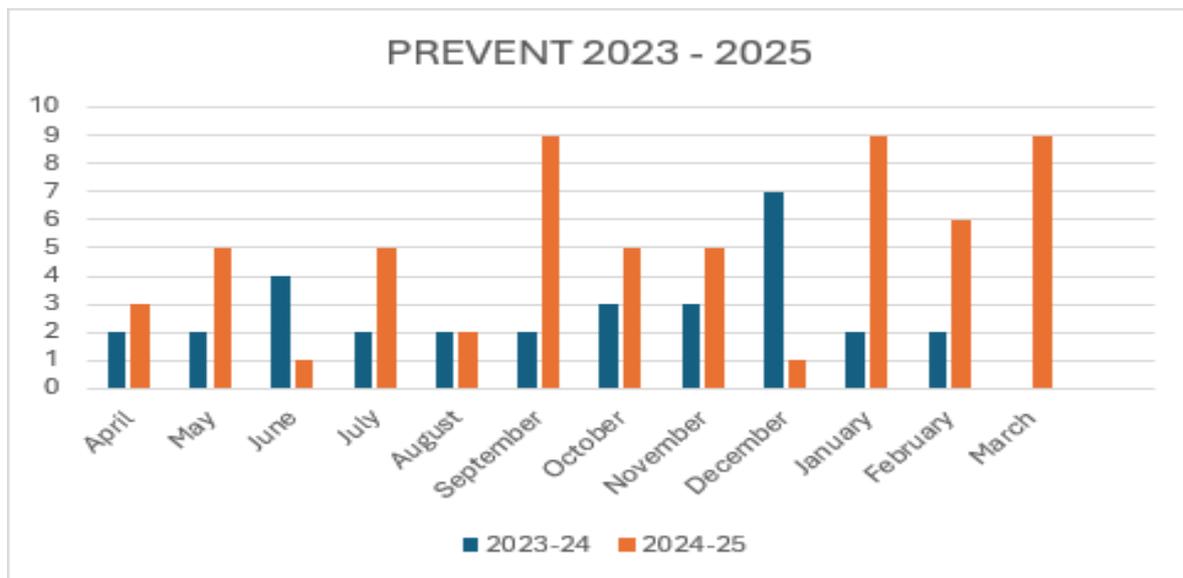
16.0 Multi-Agency Public Protection Panel (MAPPA)

MAPPA (Multi-Agency Public Protection Arrangements) are a set of arrangements to manage the risk posed by the most serious sexual, violent, and terrorist offenders under the provisions of sections 325 to 327b the Criminal Justice Act 2003.

They bring together the Police, Probation and Prison Services and a number of other agencies are under a Duty to Co-operate (DTC) with the Responsible Authority. These include Social Services, Health Services, Youth Offending Teams, Jobcentre Plus and Local Housing and Education Authorities.

There are 4 categories of MAPPA-eligible offender:

Category 1   registered sexual offenders.

Category 2   mainly violent offenders sentenced to 12 months or more imprisonment or a hospital order; and

Category 3   offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm.

Category 4   terrorism convicted and terrorism risk individuals.

All MAPPA eligible offenders are presently flagged with regards to their assessed risks in LCHS with processes in place for potential disclosures based on risk.

Figure 17: Lincolnshire Area MAPPA Eligible offenders on 31st March 2024 (2025 figures are not yet available) *Comparative figures 31st March 2023*

Category 1: Registered Sex offender   917   (+31) ⬆

Category 2: Violent offenders   145   (-1) ⬇

Category 3: Other dangerous offenders   1   (-3) ⬇

Total: 1063   (+27) ⬆

17.0 Persons in Positions of Trust (PiPoT)

People can be considered to be in a 'Position of Trust' where they are likely to have contact with adults at risk and children as part of their employment.

In line with the Children Act 1989 / 2004 and the Care Act 2014 the LSCP / LSAB have a PiPoT protocol which the Trust is signed up to. This Protocol must be followed in all cases where information (whether current or historical) is identified in connection with:

- The PiPoTs own work.
- The PiPoTs life outside work which may raise concerns re contact with adults with care and support needs (for example where a son is accused of abusing his older mother and he also works as a domiciliary Care Worker with adults with care and support needs. Or where a woman is convicted of grievous bodily harm and works in a Residential Home for people with learning disabilities).
- The PiPoT is admitted with drug and/or alcohol use that compromises their ability to undertake their job with children or adults.
- The PiPoTs admission causes concern for wider safety of vulnerable children and adults.

As part of this Protocol the Named Nurse for Safeguarding Adults (LCHS) has been identified as PiPoT Lead and supports Managers and HR with cases where concerns are raised. The role supports with sharing of information and risk management processes. HR relations have been strengthened with an increase in the Safeguarding support offered by the teams, strengthening compliance with Legislation and improving Trust assurance processes.

The PiPoT Lead has a positive working relationship and undertakes significant collaborative working with the Police, enabling timely communication and appropriate information exchange.

During the past 12 months, support and advice has been offered in 6 PiPoT/Staff Safeguarding issues. Of the cases identified, several have resulted in a disciplinary sanction and referral to external Agencies for support.

18.0 Mental Capacity Act and Deprivation of Liberty Safeguards - DoLS

18.1 Background

The Deprivation of Liberty Safeguards were introduced in 2009 and are part of the Mental Capacity Act 2005 (MCA). They are used to protect the rights of people who lack the ability (mental capacity) to make certain decisions for themselves.

The Mental Capacity Act provides the essential framework of guidance for people who need to make decisions on behalf of someone else. It sets out who can take decisions, in which situations, and how they should go about this – making sure they act in the person's best interests and empowering people to make their own decisions wherever possible.

The Deprivation of Liberty Safeguards are set firmly within the empowering ethos of the Mental Capacity Act (MCA). They encourage all Health and Social Care providers to put liberty and autonomy at the heart of care planning, to avoid wherever possible the need to deprive people of their liberty.

This section of the Annual Report provides an update to the Trust in respect of compliance with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) in line with the CQC's approach to regulation under the Health and Social Care Act, 2012.

18.2 Mental Capacity Act

The Mental Capacity Act 2005 (MCA) came into force in October 2007 and provides a Legal framework for assessing capacity and making decisions about the care and treatment of adults who lack capacity. This could be due to a mental health condition, a severe learning disability, a brain injury, a stroke, or unconsciousness due to an anaesthetic or sudden accident. It also created new protections and powers in respect of the decision-making process. The MCA applies to young people aged 16 and over.

The Mental Capacity Act provides:

A duty to treat an incapacitated person in accordance with their best interests.

Limited ability to restrain an incapacitated person in accordance with their best interests but is only lawful where:

- It is necessary to prevent harm.
- Proportionate to the likelihood and seriousness of harm and in the least prohibitive way.

To lawfully deprive an incapacitated person of their liberty, even in their best interests, the trust must follow the statutory DoLS process and obtain an authorisation in line with the Act.

When carrying out acts of care and treatment in the best interests of a person who lacks capacity, staff will be legally protected through Section 5 of the MCA against legal challenges, providing that they:

- Have taken reasonable steps to assess the person's capacity to consent to the act in question.
- Reasonably believe that the person lacks capacity to consent.
- Reasonably believe that the act they are carrying out is in the person's 'best interest.'

The Act is accompanied by a 'Code of Practice' which gives essential guidance on the implementation of the key principles.

Other provisions of the Act include:

- Appointment of Independent Mental Capacity Advocates (IMCAs) to support and represent people without capacity who have no-one to speak for them when decisions need to be made about serious medical treatment or a change in a care home or hospital accommodation.
- The Court of Protection is a specialist Court with powers to deal with complex matters affecting adults who may lack capacity to take a particular decision.
- Lasting Powers of Attorney (LPA) enable people to appoint one or more people they know and trust to make decisions for them on their behalf relating to Personal Welfare (including Healthcare decisions) and Property and Affairs. An LPA must be registered with the Office of the Public Guardian before it can be used.
- Planning for future care – Advance Decisions are applicable when a person who made it does not have the capacity to consent to or refuse the treatment in question; it refers specifically to the treatment in question and the circumstances to which the refusal of treatment refers are present.

18.3   Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards came into effect in 2009 and are part of a Legal framework set out in the Mental Capacity Act. They set out the principles that should guide such decisions, including the need to act in the person's best interests and to achieve the desired outcome in ways that put the least restriction on the person's rights and freedom of action, and empowering people to make their own decisions wherever possible. The reason the Safeguards were introduced was to address the problem that arises if a person does not have the mental capacity to make an informed decision about care or treatment.

There is no simple definition of deprivation of liberty and each decision must be made on a case by case, patient-specific basis. Certain key factors can be relevant in identifying whether the steps taken in caring for a patient amount to a deprivation of liberty. These include:

- The use of restraint (including sedation).
- Staff exercise complete and effective control over the care and movement of a person for a significant period.
- Staff exercise control over assessments, treatment, contacts, and residence.
- Decisions being made that the person will not be released into the care of others or permitted to live elsewhere unless the staff considers it appropriate.
- The refusal of a request by a carer for a person to be discharged to their care.
- The person being unable to maintain social contacts because of restrictions placed on their access to other people.
- The person loses autonomy because they are under continuous supervision and control.

Staff must consider whether the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty.

Staff are required to consider the following factors before considering a Deprivation of Liberty Safeguards application:

- Can the patient receive the planned care or treatment using a less restrictive but still effective care plan which avoids an unauthorised deprivation of liberty?
- Is the patient receiving treatment for a mental disorder?
- If the patient cannot receive the planned care or treatment with there being a risk of depriving them of their liberty, and all practical and reasonable steps have been taken to avoid deprivation of liberty, an application for authorisation of deprivation of liberty must be considered.

The Trust is responsible for ensuring that it does not deprive a person of their liberty without an authorisation and must comply with the Law in this respect.

The Safeguarding Team keeps a live log of the DoLS within inpatient settings and liaises weekly with the Local Authority Mental Capacity team weekly to ensure that all DoLS are appropriately assessed and authorised. All DoLS applications are reviewed by the Safeguarding Team to check that any restrictions are proportionate to the risk, and least restrictive option available. The Safeguarding Team supports with best interest meetings where decisions related to discharge residence are being made. Audit has taken place 6 monthly to ensure that DoLS are in place for all those who require one.

During this review period, LCHS submitted 136 applications for Deprivation of Liberty Safeguards.

Figure 18: The number of LCHS DoLS referral made between April 2021 and March 2025 including a break down for community ward activity.

DoLS Applications Made

	Gloucester Ward	Scarborough Ward	Archer Ward	Scotter Ward	Butterfly Hospice	Welland Ward
2021/22	52	44	25	18	7	28
2022/23	43	18	18	22	6	35
2023/24	19	45	28	17	3	24
2024/25	30	36	15	17	1	31
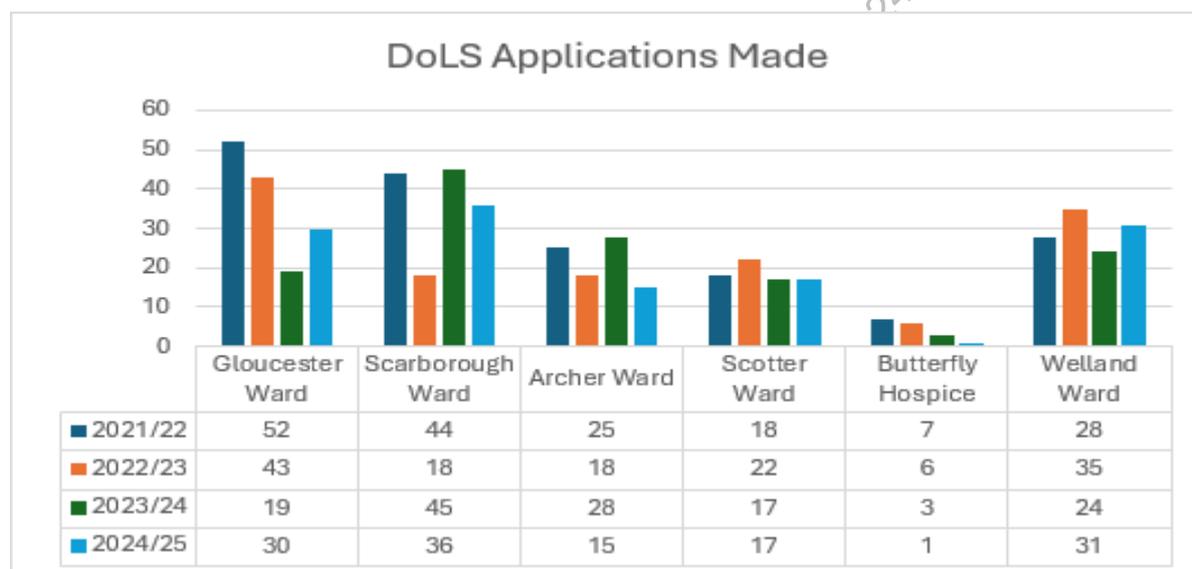
Audits undertaken within the clinical areas demonstrated an improvement from the previous year of understanding of the Mental Capacity Act and completion of DoLS documentation. The Safeguarding Team continues to review each DoLS application and support and audit the MCA/DoLS process. MCA mandatory training delivery continues with additional workshops being offered as follow up to assist staff in understanding the practical application of MCA process.

19.0   Dementia

19.1   What we know about dementia?

Dementia is a worldwide issue, growing significantly every year. It is estimated that over 55 million people have dementia around the world. This figure increases by 10 million annually and is estimated to reach 78 million by 2030 (World Health Organisation (WHO), 2021; Gauthier et al., 2021). In the UK there are currently 944, 000 people living with dementia, of which around 700,000 are in England, these figures are set to increase exponentially over the coming decades (Alzheimer's Research UK, 2021; Wittenberg et al., 2019b).

19.2   The impact of dementia

Dementia has significant psychological, physical, social, and economic consequences for the person living with the disease as well as their families, carers, communities, and society at large (WHO, 2021). Not only can dementia severely impact someone's cognitive functioning, but it also has a debilitating effect on their physical capacity, particularly later in disease progression (Alzheimer's Society, 2021b). The cost implications for Health and Social Care are substantial, in 2019 in England alone the total cost of dementia care was £29.5 billion, of that total cost 14% is attributable to Health care, 46% attributable to Social Care and 40% attributable to unpaid carers (Wittenberg et al., 2019a).

Figure 19: Projected costs of dementia for older people (£million), 2019-2040

	2019	2020	2025	2030	2040	% change
England						
Healthcare	4,100	4,300	5,300	6,700	10,600	156%
Social care	13,500	14,500	18,600	24,000	39,200	191%
Unpaid care	11,700	12,200	15,300	19,400	30,100	157%
Other	150	210	260	340	540	254%
Total	29,500	31,200	39,500	50,500	80,400	173%

19.3   Dementia in Lincolnshire

There are an estimated 12,458 people aged 65 and over living with dementia in Lincolnshire – equivalent to 6.8% of the over-65 population and 1.6% of the entire population. This is predicted to increase to 16,558 by 2030 and 17,949 by 2035 (44.1%), which is higher than the expected national increase of 40.3%. This will equate to 7.86% of the over-65 population or 2.3% of the entire population.

The number of people aged 65 or over in Lincolnshire is projected to increase by 60,000 (33.5%) between 2019 and 2035, with the highest proportion of people in this age group who are living with dementia estimated to be in Lincoln, Boston, North Kesteven and South Holland. South Kesteven is expected to see the greatest increase in people with dementia (66.75%), given a predicted shift towards a higher proportion of older people.

The prevalence of dementia increases with age, and, due to longer life expectancy, this is higher for women than for men. In 2018, an estimated 61.5% of people in Lincolnshire living with dementia were female.

There were also an estimated 211 people under the age of 65 with dementia in Lincolnshire in 2019.

In 2017, National prevalence of dementia for all ages was 0.8%. At this time, Lincolnshire East and South Lincolnshire were higher than the national figure (1.0% and 0.9% respectively), and Lincolnshire West was the same (0.8%). Southwest Lincolnshire was below the National figure. In the over 65 population, the national figure was 4.33% as at December 2018. Locally, Lincolnshire West had the highest prevalence, which was similar to the national figure (4.37%). Recorded prevalence in the other Lincolnshire areas was significantly lower, and Southwest Lincolnshire had the lowest recorded prevalence in the Central Midlands at 3.59%.

In 2018, the highest rate of dementia diagnoses was in West Lincolnshire (68%), and the lowest rate was in Southwest Lincolnshire (52.1%).

The directly age standardised rate of emergency hospital admissions of people with dementia in Lincolnshire for people aged 65+ (3,095 per 100,000 population) is significantly lower than the national rate (3,609 per 100,000 population) for 2017/18. This equates to 5,559 emergency admissions.

Of the 4436 people with a Learning Disability below the age of 65, (0.8%) 35 have a diagnosis of dementia and of the 408 people 65+ with a Learning Disability 43 have been identified as having dementia (10.5%).

In 2017, there were 1,703 (948 per 100,000 population) deaths of people in Lincolnshire aged 65 and over, where dementia was mentioned either as an underlying cause of death or a contributory factor. This is a similar figure to the England rate of 903 per 100,000 population.

A number of behavioural and disease factors are known to increase the likelihood of developing dementia and many of these are more prevalent in Lincolnshire than at

both regional and national levels, including physical inactivity, being overweight or obese, hypertension, stroke, diabetes, CHD, and depression. These factors are not evenly spread across Lincolnshire, which creates inequalities in those populations experiencing deprivation.

19.4   Progress 2024 - 2025

The Safeguarding and Vulnerability team within LCHS assists in promoting dementia understanding across staff groups and will introduce the new dementia training across the Trust in the coming year.

Since the formation of the Group, relationships continue to be developed with LPFT and the wider ICB for collaborative working using skills, experience and services which will support our patients and their families and embed the Dementia Strategy for Lincolnshire.

LCHS has worked with our Partners to the refresh of the 'All About Me' document, to give staff a snapshot of what the patient needs in order to have a positive experience whilst in our care. It allows staff to understand the person's background; their likes and dislikes and any triggers of distress, to support reminiscence conversations, make reasonable adjustments to their Community and Hospital care and transition, reduce the distress and anxiety of being in an unfamiliar environment. The new document will be launched around July 2025

20.0   Learning Disability and Autism

A Learning Disability affects the way a person learns new things throughout their lifetime by affecting the way a person understands and communicates information.

This may mean they can have difficulty with:

- Understanding new or complex information
- Learning new skills
- Coping independently

A visit to a clinical environment can be difficult for anybody, but it is particularly challenging for people who have a Learning Disability or Autism. Reasonable adjustments to the health care of people are not only a Statutory duty under the Equality Act 2010 but are also beneficial for all involved.

20.1 Learning Disability and Autism in Lincolnshire

It is estimated more than 14,000 adults with a learning disability currently live in Lincolnshire, with the number expected to increase to around 15,800 by 2035. However, only 4,500 individuals are on the Learning Disability Register maintained by County GPs. Of those who are registered, around 75% are in receipt of an annual LD Health Check, meeting the national NHS England target.

Learning Disabilities are often confounded with multiple physical and mental health conditions and so there is an increased risk of developing chronic conditions from genetic and lifestyle factors. Evidence suggests rates of numerous major diseases (heart failure, epilepsy, severe mental illness, diabetes and dementia) are higher in adults with a Learning Disability than the wider population. Consequently, average life expectancy for people with a learning disability is significantly lower than for the general population. Continuing to encourage the take-up of Annual Health Checks for people with a Learning Disability is a high priority to support early identification of health needs and take steps to lower risk (e.g., through modifying health behaviours or medication).

The number of people with a Learning Disability in Lincolnshire will continue to increase, particularly in those aged over 65. Being medically better able to sustain life, complexity of needs will increase.

Figure 20: Children with Moderate Learning Difficulties Known to Schools 2020
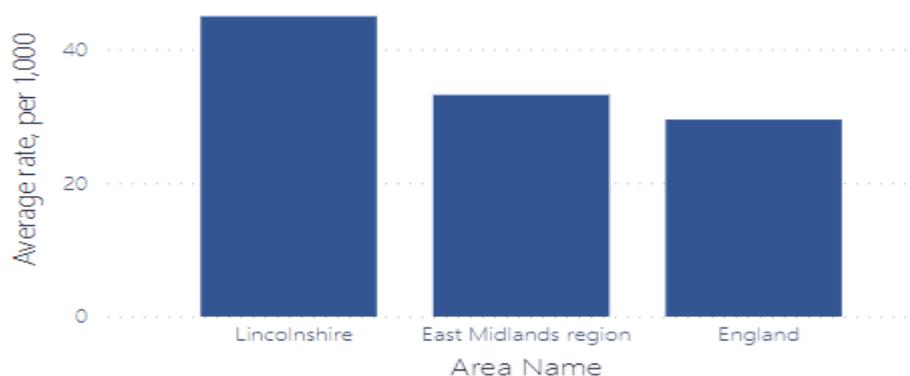
Lincolnshire Health Intelligence Hub 2022

Figure 21: People aged 18-64 predicted to have a learning disability
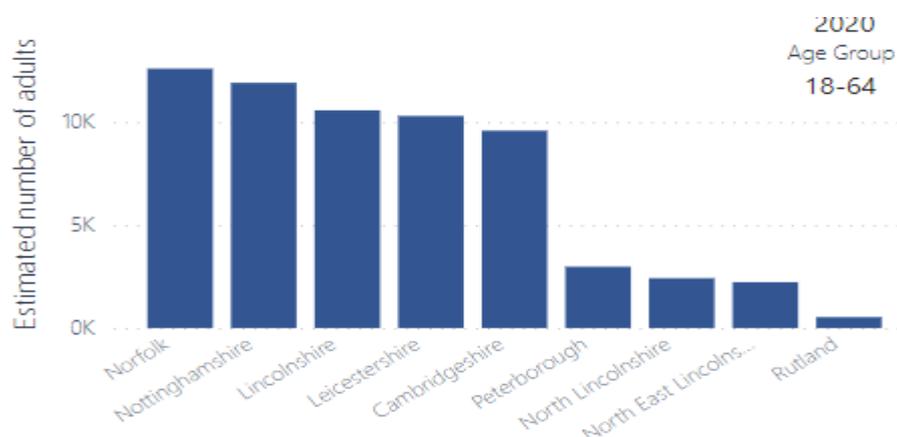
Lincolnshire Health Intelligence Hub 2022

Mechanisms for accurate recording of autism are not consistently available across Health, Education and Social Care systems meaning actual reliable figures are currently unavailable. For example, it may be documented that an individual is identified as having a disability within a particular setting, but not specifically identified that they are Autistic.

In 2021-22, approximately 156 adults (aged 18+) and 192 young people (aged under 16) in Lincolnshire were diagnosed as Autistic, according to Lincolnshire NHS Mental Health data collection. This does not include diagnosis given in Private Practice, by an out of area referral or by any process beyond the standard Autism diagnostic pathways.

Nationally, Autism is underdiagnosed amongst certain groups such as older people, those who identify as females and individuals from Black, Asian and minority Ethnic groups. This is due to the assessment tools used in Autism diagnosis and limited awareness of the ways in which Autism can present in different groups. Estimated numbers of individuals living with Autism in the local community are likely to increase, as improvements to diagnostic pathways and services are made.

Figure 22: Children with Autism Known to Schools 2020
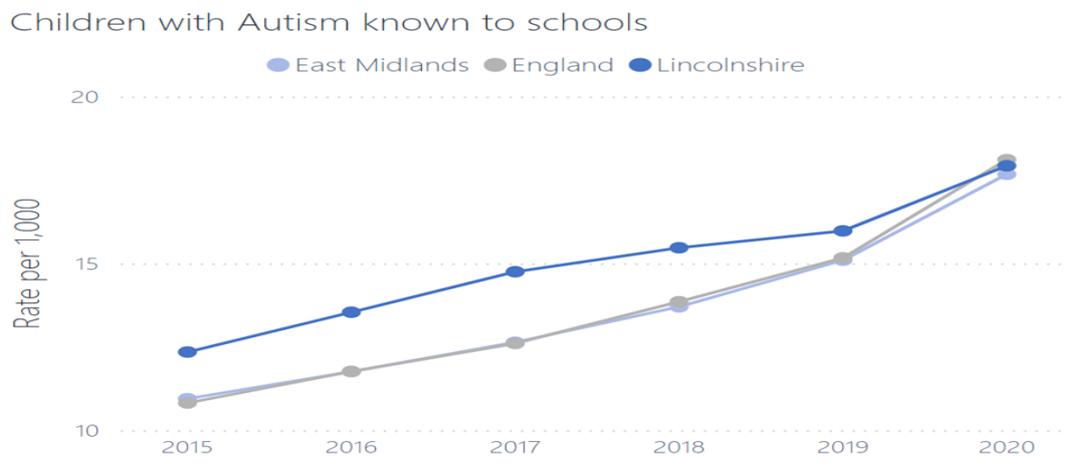
Lincolnshire Health Intelligence Hub 2022

Figure 23: People aged 18-64 predicted to have autistic disorders by 2040.
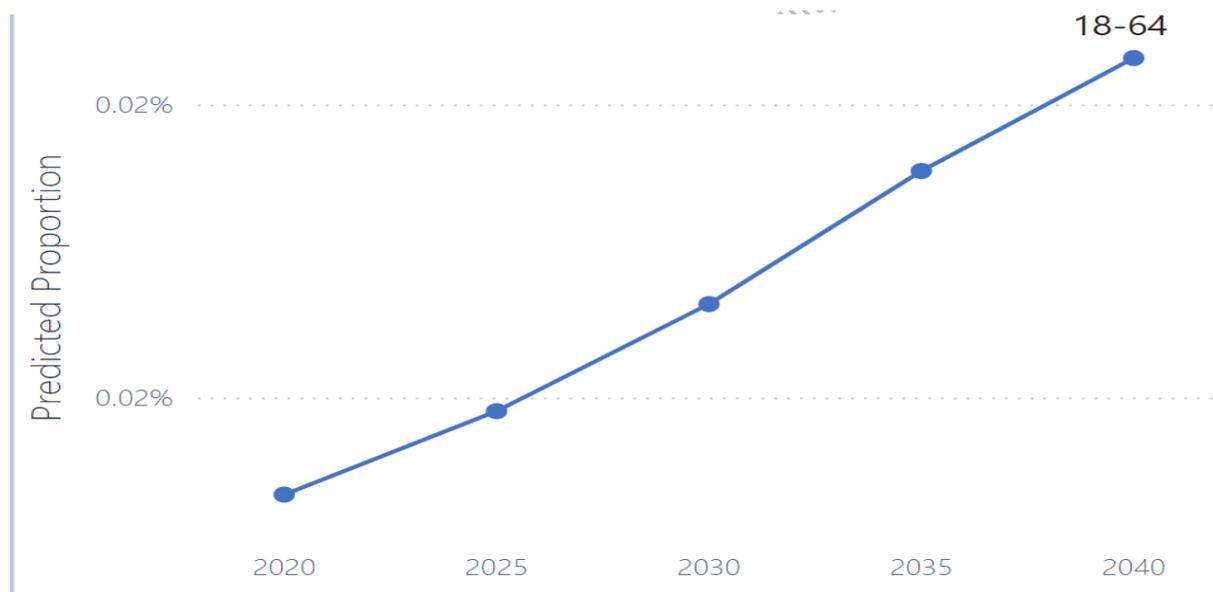
Lincolnshire Health Intelligence Hub 2022

20.2 Learning Disability and Autism

Since 2023 LCHS embedded Learning Disability and Autism within the Safeguarding portfolio and Governance framework and as a result the remit of the Safeguarding Team has expanded and will continue to develop over the coming years.

During 2024 – 2025, the team has worked more closely with our system colleagues to enable improvements in practice for our client groups who need investigations and admission to hospital. Since the formation of the Group there has been a natural

sharing of information across the LCHS and ULTH teams meaning an improved transition of care from Community to Hospital care

In July 2022, the newly legislated 'Oliver McGowan' Training** was announced as a minimum benchmark for NHS Trusts and was launched across the Trust in 2023. Over the last 12 months we have worked together as a System to develop a local process based on the high standards and minimising impact of this training across Lincolnshire. This work is still ongoing and is likely to take a further 2 – 3 years for it to be fully embedded.

'Easy Read' information is being developed in partnership with ULTH and will shortly be available on both external and intranet pages for anyone to access. There are plans to add to this and increase the resources available in Easy Read, although this is just the start of the meeting our Accessible Information Standard requirement.

Whilst the focus of the work has been within the Hospital setting, this work and learning is now cascaded across the group.

Since the development of the group and joint working between LCHS and ULTH Safeguarding teams, many patients who have benefitted from a more joined up approach in transition from Community to Hospital. This includes a system wide approach for developing and embedding the Autism Pathway with specific work undertaken by LCHS regarding the Autism diagnostic observation schedule, improved links with SEND and development of Educational Health Care Plans.

Within LCHS, the Down Syndrome group that was co-produced and launched has expanded to include Skegness, meaning that the groups now run in Lincoln, Sutterton and Skegness offering more availability for families.

Family Hubs have been commissioned for a further year, allowing parents who have children aged 0-5 years with speech, language and communication needs accessing targeted support from a drop-in session. Children with social communication differences have been a high proportion of attendees to the drop-in sessions, allowing families to access this support at a time and location that is suitable for them and their child's needs. The Family Hubs are situated in 10 of the Children's Centres; these 10 centres were identified by LCC as being in areas of high need.

The Team has introduced ISLA; a platform that allows video supported referrals in the Children's Therapy service. This is primarily being used to support Speech and Language Therapy referrals and permits parents to share video footage of their child/young person communicating or interacting; allowing personalised advice to be sent for referrals not accepted, or for the CYP's next steps to be identified in a more timely manner, thus improving the access to communication advice for children with LD and Autism regardless of their acceptance into the specialist SLT service.

20.3   Future plans for 2024 – 2025

LeDeR / SJR / patient safety and mortality – Review and audit the feedback from LeDeR and the actions from governance group to look at LCHS' role in improving the outcomes of people with Learning Disabilities. Feedback will be added to the bi-monthly MHNDD Steering Group Learning Disability report which both Trusts and all Divisions are represented. Individual feedback is also given directly to clinical areas to ensure direct learning for each area is shared across teams.

Increase the number of flags and alerts for people with Autism and Learning Disabilities in line with the NHS Reasonable Adjustment requirements, to ensure more meaningful information is shared.

Explore the possibility of developing a specific Learning Disability /Autism role within LCHS, ensuring clients in community have an equitable service.

21.0   Safeguarding Risks

The Safeguarding teams have proactively used the Risk Register to identify a variety of risks based on current and future predicted changes and have embedded the actions within the day-to-day business of the team.

Figure 24: Summary of current risks and risks scoring for 2024 – 2025.

LCHS 453	Staff are not able to effectively support patients who lack mental capacity/ have cognitive impairments and exhibit challenging behaviours. which places themselves and others at risk of harm/injury.	HIGH (9)
LCHS 670	If there is inconsistent compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) requirements it could have a severe adverse impact on the mental health and wellbeing of the patient and may increase the likelihood of subsequent legal proceedings against the Trust.	LOW (6) REDUCED
LCHS 681	Children in Care - unable to meet IHA and RHA timescales	EXTREME (16)

During 2024 – 2025 the safeguarding teams have been actively involved with working to reduce and manage these risks which are monitored by the Safeguarding and Vulnerabilities Oversight Group.

22.0 A review of 2024 – 2025

The last 12 months have seen a closer working relationship between the Safeguarding teams ensuring workload has, where possible, been shared to improve efficiency and effectiveness ensuring we continue to help support our most vulnerable in society as well as provide a wider level of support to all staff within the trust and the external Safeguarding teams.

As expected, nationally there have been several serious Child Safeguarding Practice/ Serious Adult Reviews which indicate the negative impact on our ability to safeguard our most vulnerable and locally we have seen an increase in Domestic Homicide/Domestic Abuse Related Death Reviews.

- Face to face supervision has expanded, with additional sessions available via Teams to facilitate attendance across both trusts and work is ongoing to improve levels of attendance.
- Safeguarding and vulnerability pathways and processes to support staff in managing safeguarding related concerns are in place and shared working between the two teams is actively underway and will be expended further in the coming year with shared policy and practice being developed
- A shared Safeguarding Training Plan is in place to ensure that there is a commonality within staff groups and that any training sessions delivered will be available to all staff no matter which trust they work for, or which trust is delivering the course. This will increase joint understanding across teams, allow for more flexible delivery and thereby facilitate increased attendance, understanding and knowledge of local processes.
- Maintained and increased our presence in external / partnership processes such as the LSCP / LSAB / LDAP strategy meetings / MARAC etc.
- A joint Safeguarding Governance approach has been embedded across the Group so that both Trusts had a fit for purpose Safeguarding process across all Divisions and ensuring that Safeguarding remained at the forefront of operation business.
- Continued to develop policies and improvements, undertook audits to maintain safety and identify risks.
- Continue to develop and expand Safeguarding roles within the team to ensure that the Trust can deliver a Vulnerability service (Child Protection / Adult Protection / MCA / PREVENT/ Learning Disability / Autism and Mental Health)
- Continue to support staff members who are required to produce statements for, or attend as a witness in, Family or Criminal Court.
- The Safeguarding Team is actively involved in the review of complaints and Serious Incidents with a Safeguarding or MCA aspect.
- Continue to undertake ward spot checks /audits in relation to MCA/ DoLS

- Strengthening the Safeguarding Champions' Network across the Trust.
- Continued support with HR processes in relation to staff members for whom Safeguarding concerns have been raised (LADO/PiPoT)
- Supported the Children's Services Front Door Strategy Discussions process.
- Reviewed the ligature risk assessment process and rolled out the ligature cutter (QUAD) pack across clinical areas alongside new ligature training.

23.0 Safeguarding Developments and ongoing work for 2024-2025

- Maintain momentum to achieve 90% across Safeguarding training areas.
- Finalise and embed pathways for clients with Learning Disability / Autism ensuring smooth transition from primary / community care to secondary care.
- Continue the transition towards fully embedding Oliver McGowan training (3-year plan)
- Continue to embed the training of MCA/DoLS within the Trust ensuring that there is a better understanding of best interest planning, and that staff can more readily identify patients who require extra care and have clear plans to follow in line with legislative requirements.
- Audit adult concerns submissions within the Trust to ensure compliance with 'Making Safeguarding Personal.'
- Continue to embed the new De-Escalation Management and Intervention (DMI) training across LCHS, skilling up staff, ensuring a shared vision of support for our patients.
- Embed the ligature risk assessment process and rollout training to support staff in undertaking assessments and use of the ligature cutter (QUAD) pack across clinical areas.
- Continue to review and roll out MHA procedures.
- Rollout Mental Health training.
- Rollout Dementia training.
- Develop a system of flags and alerts across the trust for people with Autism and Learning disabilities making use of the national 'reasonable adjustment' flags as appropriate.
- Explore the viability of employment of Learning Disability and Autism Support Practitioners across the Group.
- Explore the viability to facilitate the employment of an expert by experience role within the Trust.
- Continue to improve the service delivery of Health Assessments for our Children Looked After by developing a permanent funding model.

24.0 Conclusion

This report demonstrates the continued development and increased awareness of safeguarding and vulnerability issues within the Trust. The Trust continues to respond to the rapid national and local pace of change as well as maintaining an input externally.

The Safeguarding Governance structures have been reviewed to ensure continued effectiveness, actively managing the current action plans as well as moving services forward. These will be continually reviewed to ensure that the structures remain fit for purpose.

The last 12 months have demonstrated the value that the two Trusts working together can add in relation to joint understanding of service provision, shared insight, and improved communication, all of which improve the safeguarding of our most vulnerable patients.

As the new Group develops there will be further advantages and benefits gained from economy of scale with less repetition and duplication ensuring that the Teams can continue to effectively support patients, staff, and the Organisations. The forthcoming year promises to be full of further developments and challenges for both the Teams and the Group.

25.0 Recommendations

It is recommended that the Trust Board

i)   Receive the Safeguarding Report.

ii)   Approve the plans for 2025 - 2026.

Appendix 1:   Safeguarding Team – Structure March 2025

Safeguarding and Vulnerabilities Team

March 2025

Portfolio:

Safeguarding Children

Safeguarding Adults

Mental Capacity and DoLS

Learning Disability / Autism

Dementia

Mental Health

PREVENT

Domestic Abuse

LCHS

Safeguarding and Vulnerabilties Team LCHS March 2025

United Lincolnshire Teaching Hospitals
NHS Trust

Safeguarding and Vulnerability
Annual Report 2024 - 2025

Safeguarding and Vulnerability

Central: Safeguarding and Vulnerability

Surrounding: Domestic Abuse, Adults, Deprivation of Liberty Safeguards DoLS, PREVENT, Think Family, Children and Young People, Mental Capacity, Learning Disability, Slavery and Trafficking, Mental Health, Corporate Parenting, County LInes, FGM, Dementia, Autism, Allegations against Staff PiPoT

Contents

Foreword

As the Executive Lead for Safeguarding within United Lincolnshire Teaching Hospitals NHS Trust (ULTH), I am pleased to introduce the Safeguarding and Vulnerabilities Annual Report for 2024/25. Over the past year, the Trust continued to deliver quality and compassionate care and treatment across the communities in which we provide inpatient, community, and emergency services.

As the United Lincolnshire Teaching Hospitals NHS Trust and the Lincolnshire Community Health Services NHS Trust moved to a Group model (Lincolnshire Community and Hospitals NHS Group) on the 1st of April 2024, the Safeguarding and Vulnerability Teams under the oversight of the Director of Safeguarding and Patient Experience had already been working more closely together for the previous 9 months thereby already delivering the vision that Group working would bring to our Lincolnshire population.

The last 12 month period has provided an opportunity of reflection, to review the safeguarding work undertaken across both Trusts and whilst the past year has continued to be challenging as the NHS continues to experience significant operational pressures, there is a lot to celebrate and be proud of with the safeguarding work undertaken across the two organisations, and by the achievements and progress of the Lincolnshire Safeguarding Partnerships working together. ULTH have continued in their commitment to ensure that we help all residents of Lincolnshire live lives free from abuse and neglect.

Safeguarding can be complex and emotive work, and to safeguard effectively requires all agencies to work together in a collaborative and supportive way to develop seamless and effective safeguarding plans. We would like to thank our safeguarding partners across Lincolnshire for working with us to safeguard the population of Lincolnshire.

This report provides assurance to the Trust Board and our regulators, our patients and their families, and our partner agencies that everyone working at ULTH see safeguarding as part of their core business, and that we recognise that safeguarding children, young people, and adults is a shared responsibility, with the need for effective joint working between partner agencies and professionals, so that vulnerable groups in society are protected from harm. We all have a role to play in ensuring our patients and their families receive outstanding care.

The Trust Board of Directors are committed to ensuring all patients accessing our services are protected from harm and abuse ensuring that safeguarding remains a priority within the organisation. The Trust **has a commitment to Safeguarding which is reflected within the following Safeguarding Declaration ULTH Safeguarding Declaration.**

The Trust has specialist safeguarding staff who lead on and embed the practice of protecting adults and children from abuse, neglect, modern day slavery, domestic abuse, and radicalisation. The ULTH team continue to embed the additional specialist areas of Learning Disability/Autism (Neurodiversity), Dementia and Mental Health.

Over the last 12 months there have been improvements in care pathways from Community to Hospital and back home for some of our most complex patients. The team works tirelessly to ensure that our frontline staff have the required skills and knowledge to protect people, uphold their human rights and assess capacity.

I would like to thank our caring and compassionate Staff, Volunteers and Safeguarding Team for their commitment and dedication in working alongside and providing protection, guidance, and support to people whose circumstances make them vulnerable to abuse, neglect or radicalisation.

Nerea Odongo

Group Chief Nurse / Executive Lead for Safeguarding (ULTH / LCHS)

Statement from Lincolnshire Safeguarding Adults Board (LSAB)

The United Lincolnshire Teaching Hospitals Trust (ULTH) plays a crucial role in supporting the Lincolnshire Safeguarding Adults Board (LSAB) in fulfilling its statutory requirements. ULTH's commitment to safeguarding is evident through its comprehensive approach to ensuring the welfare of vulnerable adults. The Trust actively participates in the development and implementation of safeguarding policies and procedures, aligning with legislative frameworks such as the Care Act 2014 and the Mental Capacity Act 2005. By integrating these legal standards into their practices, ULTH helps the Board maintain compliance with statutory obligations and promotes a culture of safety and protection across its services.

Moreover, ULTH's involvement extends to regular attendance and significant contributions at LSAB meetings and subgroups. This consistent engagement allows the Trust to provide valuable insights and expertise, particularly in areas such as Making Safeguarding Personal and Professional Curiosity. ULTH's proactive stance in reviewing and enhancing these and other protocols ensures that practitioners are well-equipped to assess and address complex safeguarding issues. Additionally, the Trust's dedication to using patient stories to identify best practices and areas for improvement further supports the Board's mission to safeguard individuals effectively, both in hospital settings and the community

Richard Proctor

Lincolnshire Safeguarding Adults Board - Independent Chair.

Statement from Lincolnshire Safeguarding Children's Partnership (LSCP)

Lincolnshire Safeguarding Children's Partnership - Independent Chair.

During the last twelve months ULTH has demonstrated a strong commitment to keeping children safe in Lincolnshire. ULTH are highly respected within the Partnership and play a crucial role on the front line working with other key partners.

Your staff contribute to a number of our Board and subgroup meetings keeping their focus on our strategic priorities.

We have of course all been subject of a change programme introduced by the Department of Education and over many months have been working in partnership to

create a new model to strengthen our existing arrangements. As a "Pathfinder" our partnership has worked hard to meet the new requirements, and I am grateful to your staff for their professionalism and enthusiasm during this extremely busy period. Looking forward we will need to evaluate the new framework and assess its effectiveness and practitioners from both Trusts will play an important role in this process.

Remember: "The price of doing the same old thing is far higher than the price of change"

Bill Clinton

Chris Cooke

1.0   Purpose of Report

The purpose of the report is to provide the Board with an annual update of the work undertaken in 2024 - 2025 with regards to safeguarding children and adults, PREVENT, Mental Capacity and Deprivation of Liberty Safeguards (DoLS), Learning Disability /Autism (Neurodiversity), Dementia and Mental Health and the proposed areas of development for 2025 - 2026.

2.0   Legislative Background

The NHS Outcomes Framework 2020 identifies that sustainable quality improvements are achieved when the focus is on outcomes, rather than being process driven. The DOH Outcomes Framework sets out five overarching high-level outcome domains for quality improvements.

Domain 1   Preventing people from dying prematurely.

Domain 2   Enhancing quality of life for people with long-term conditions.

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

Domain 4   Ensuring that people have a positive experience of care; and

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

In terms of safeguarding the key domains are:

Domain 4   Ensuring people have a positive experience of care,

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

The revised guidance "Safeguarding Children, Young People and Adults at risk in the NHS: Accountability and Assurance Framework (NHS England 2022) sets out the safeguarding roles, duties and responsibilities of all NHS health care organisations.

The Trust has a range of statutory duties including safeguarding children and adults and is required to give assurance to both Local Safeguarding Partners and commissioners of service to demonstrate that we have effective safeguarding arrangements in place.

Safeguarding forms part of the NHS national contract (service condition 32 – Safety and Safeguarding - Safeguarding Children and Adults - 32.1 - 32.9) and the ICB monitors our performance via contract monitoring processes.

2.1   Safeguarding Children

Since the statutory inquiry into the death of Victoria Climbié (2003), and the first Joint Chief Inspectors' report on Safeguarding Children (2002) highlighted the lack of priority status given to safeguarding, there has been a consistent process of review and change of legislation.

In 2025 the face of safeguarding children is very different to that of the late 1990s and an emphasis on early help rather than punitive action is what currently drives the system and as such the number of children on plans continues to vary.

Whilst systems change, at a national level we continue to see tragic cases involving child abuse such as Arthur Labinjo-Hughes aged 6 (Solihull) and Star Hobson aged 1 (Keighley) and more locally Darren Boulton aged 9 (Louth) who all died at the hands of the very people who were expected to protect them.

Safeguarding and promoting the welfare of children is defined in Working Together to Safeguard Children (2018 – *updated 2024*) as

- Providing help and support to meet the needs of children as soon as problems emerge.

- Protecting children from maltreatment, whether that is within or outside the home, including online.

- Preventing impairment of children's mental and physical health or development.

- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care.

- Promoting the upbringing of children with their birth parents, or otherwise their family network, through a kinship care arrangement, whenever possible and where this is in the best interests of the children.

- Taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children's Social Care National Framework.

Safeguarding Children is everyone's responsibility, Section 11 of the Children Act 2004 places a duty on key persons and bodies to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

This is a standard requirement within all ULTH contracts of employment.

At an organisational or strategic level, key features which must be adopted by NHS organisations (monitored by the Local Safeguarding Children Partnerships and Commissioners) are:

- Senior management commitment to the importance of safeguarding and promoting children's welfare.
- A clear statement of the agency's responsibilities towards children for all staff.
- A clear line of accountability within the organisations for safeguarding and promoting the welfare of children and Adults.
- Service developments that take account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families.
- Staff training in safeguarding and promoting the welfare of children for all staff working with or in contact with children and families.
- Safe recruitment procedures in place.
- Effective inter-agency working to safeguard and promote the welfare of children.
- Effective information sharing.
- CQC Fundamental Standards 2022 which have a safeguarding thread running through all.

An audit of Section 11 duties is undertaken by the Local Safeguarding Children Partnership (LSCP) and any subsequent action plans will be monitored in line with the current governance arrangements.

The most recent section 11 submission was completed in June 2024, and the Local Safeguarding Children Partnership notified the Trust in August 2024 that ULTH have passed the audit with 100% of the criteria being rated as green, as agreed with our organisation's moderators showing that your organisation has the required functions to safeguard children as required by Working Together to Safeguard Children 2023.

2.2   Safeguarding Adults

The passing of the Care Act 2014 has meant significant changes in the way adult safeguarding operates across the Trust. The safeguarding process has now been placed on a statutory footing and the requirements placed on our organisations have become more clearly defined.

The term vulnerable adult has been replaced by "Adult at Risk" and the statutory guidance confirms that.

> *"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have*

complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances."

The victim in the process is now the "adult at risk," the perpetrator "the alleged source of risk" and a written "Safeguarding Alert" is now termed a "Safeguarding Concern."

The Act recognises the need to focus on openness and transparency, in the drive to improve the quality-of-care individuals receive. This segues neatly with our own health service requirement for "Candour" as set down in ULTH's Duty of Candour Policy - LCHG-P-CG-04) and in line with the statutory Duty of Candour as defined in Regulation 20 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Act also places the duty on public organisations to act when abuse or neglect is suspected or known and underlines the duty to ensure that all staff are trained in safeguarding proportionate to their roles and responsibilities. Both are explicit in ULTH Safeguarding Policy's and training plans.

2.2.1   Implications for Safeguarding Adults at Risk

The Act sets out the statutory framework for adult safeguarding, including local authorities' responsibilities, and those of the local partners. In many cases the requirements of the Act are already fulfilled and expand across not just safeguarding but also cover some of our more vulnerable clients such as those with dementia and learning disabilities.

Safeguarding Principles

Principle 1 – Empowerment: Presumption of person led decisions and consent.

Principle 2 – Protection: Support and representation for those in greatest need.

Principle 3 – Prevention: Prevention of neglect harm and abuse is a primary objective.

Principle 4 – Proportionality: Proportionality and least intrusive response appropriate to the risk presented.

Principle 5 – Partnership: Local solutions through services working with their communities.

Principle 6 – Accountability: Accountability and transparency in delivering safeguarding.

2.3   PREVENT

2.3.1   What is PREVENT?

The Counterterrorism and Security Act 2015 placed PREVENT on a statutory footing. The Office for Security and Counter Terrorism (OSCT) in the Home Office is responsible for providing strategic direction and governance on CONTEST. As part of CONTEST, the aim of PREVENT is to stop people becoming terrorists or supporting terrorism and again transitions into vulnerable children & adults who are groomed and exploited to carry out acts of violence against others.

CONTEST is primarily organised around four key principles. Work streams contribute to four programmes, each with a specific objective:

Prevent	Pursue	Protect	Prepare
Safeguard people from becoming terrorists or supporting terrorism	Stop terrorist attacks happening in the UK and overseas	Stregthen our protection against a terrorist attack in the UK or overseas	Mitigate the impact of a terrorist incidents if it occurs

Primary outcome			
Reduce intent	Reduce capability	Reduce vulnerability	Reduce impact

Address strategic factors
Extremism
Conflict and instability
Developments in technology

Overall effect

Reduce risk

The Health Service is a key partner in PREVENT and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients and forms part of the Safeguarding accountability and assurance framework (NHS England 2022)

PREVENT has three national objectives:

Objective 1:   Tackle the causes of radicalisation and respond to the ideological challenge of terrorism.

Objective 2:   Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support.

Objective 3:   Enable those who have already engaged in terrorism to disengage and rehabilitate.

The Health Sector contribution to PREVENT will focus primarily on Objective 2.

PREVENT training is undertaken in line with the [PREVENT Training and Competencies Framework](#) - Department of Health and Social Care (2022)

2.3.2 Why Health care staff?

The overall principle of health is to improve the health and wellbeing through the delivery of healthcare services while safeguarding those individuals who are vulnerable to any form of exploitation. PREVENT is also about protecting individuals.

PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence.

3.0 Designated and Named Professionals for the Trust and its Commissioners.

3.1 Children

The terms designated and named professionals (children) are clearly defined in Working Together 2018 as professionals with specific roles and responsibilities for safeguarding children.

All Integrated Care Boards are required to have a designated doctor and nurse whose responsibility it is to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the commissioned area, which includes all providers. The designated professionals are also in place to provide professional advice on matters relating to safeguarding children for other professionals, NHS Commissioners, Local Authority children's services and the safeguarding children partnerships. The Designated Professionals for Lincolnshire are employed within the ICB and provide this support to the Trust.

All NHS Trusts must identify a named doctor, a named nurse, and a named midwife (where maternity services are provided) for safeguarding with the focus of the named professional being on safeguarding children within their own organisation. These

professionals are in post within ULTH and include a lead anaesthetist for safeguarding children as recommended by the Royal College of Anaesthetists (2012).

3.2   Adults

Following the publication of [Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (July 2022)](#) there is an expectation that Designated (ICB) and Named professionals (ULTH) for safeguarding adults are in place.

Within ULTH the Group Director for Safeguarding and Patient Experience is the Trust Safeguarding lead with strategic responsibility for both children and adults, and the Trust has a Named Professional responsible for Safeguarding Adults and Mental Capacity Act supported by specialist nurses with responsibility for Safeguarding Adults, Learning Disability/Autism (Neurodiversity), Dementia and Mental Health

4.0   The Safeguarding and Vulnerabilities Teams

The Safeguarding Team has been in place for several years and historically was responsible for Child Protection (ULTH), Adult Protection (ULTH), MCA/DoLS and the PREVENT agenda (ULTH). During 2021 to 2022 the teams remit expanded and now leads on Mental Health, Learning Disability, Autism and Dementia as well as having strong links in the development of the De-escalation, Management, and Intervention training/team.

A full structure of the current team can be found at appendix 1.

5.0   Safeguarding Governance Arrangements

The responsibility for safeguarding rests with the Chief Executive Officer, supported by the Executive Director with Board responsibility (Group Chief Nurse Nerea Odongo).

ULTH has in place the following safeguarding specific groups:

Safeguarding and Vulnerabilities Oversight Group (SVOG) which reports to the Quality Committee (figure 1). The group is active in the management of the current action plans / issues within the specialist area. The group is chaired by the Group Director of Safeguarding and Patient Experience and the divisional groups are chaired by a senior leader within the division.

Mental Health, Neurodiversity and Dementia Group (MHNDD) which reports to the Safeguarding and Vulnerabilities Oversight Group (figure 1). The group is active in the management of the current action plans / issues within the specialist area. The Named Professional for Safeguarding Adults chairs the group.

Figure 1
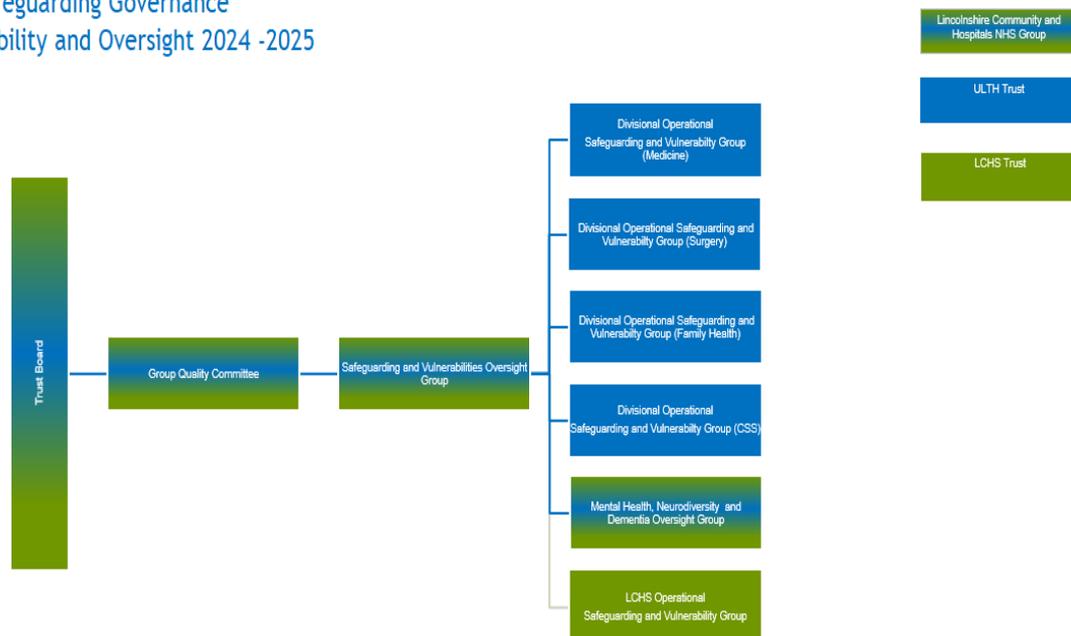
During 2024 to 2025 the SVOG within ULTH and LCHS joined to form one strategic group, and the Mental Health, Neurodiversity and Dementia Group expanded to cover both ULTH and LCHS

6.0 Local Safeguarding Children Partnership Board (LSCP) and Local Safeguarding Adult Board (LSAB)

Safeguarding Children Partnerships and Safeguarding Adults Boards were set up as statutory bodies under a national model led by the local authority until a government review of their role in 2016. This led to changes in relation to Safeguarding children, bringing about a shared responsibility for safeguarding amongst the identified three lead partners (Local Authority, Police and ICB) and the change to Local Safeguarding Arrangements which allow some flexibility based on local needs.

They are a partnership of the relevant statutory, voluntary and community agencies involved in safeguarding and promoting the welfare of all children and young people /adults at risk of abuse. They do this by coordinating the safeguarding work of member agencies so that it is effective; monitoring, evaluating and when necessary, challenging the effectiveness of the work and advising on ways to improve safeguarding performance.

The Local Safeguarding Children Partnership / Adult Board within Lincolnshire both have Independent Chairs, and membership has been reviewed ensuring that attendance is at the required levels and members have sufficient seniority.

The Trust is represented by the Group Director of Safeguarding and Patient Experience at the Partnership/Board and there is representation by other key safeguarding professionals on the subgroups.

6.1 LSCP Key areas of action

- Tackling child exploitation
- Enhancing the emotional wellbeing of children and young people
- Promoting healthy and respectful relationships
- To identify and reduce the impact of neglect on children and young people.
- To identify and reduce the impact of sexual and physical harm.
- Identify and reduce the impact of domestic abuse on children, young people, and their families.

LSCP business plan 2022 - 2025

6.2   LSAB Key areas of action

- Prevention and Early Intervention.
- Making Safeguarding Personal (MSP).
- Learning and shaping future practice.
- Safeguarding Effectiveness.

The Trust is actively involved in all the above areas by way of delivering the topic areas within training and/or sitting on operational groups to actively target the perpetrators and support the victims of abuse.

Lincolnshire Safeguarding Adult Board Strategy 2022 - 2025

7.0   Child Safeguarding Practice Reviews (Previously Serious Case Reviews - SCR) / Safeguarding Adults Review (SAR) / Domestic Abuse Related Death Reviews (DARDR)

7.1   Children

Child Safeguarding Reviews have been in place for many years and nationally about 400 take place every year. A review is always carried out by the Safeguarding Partnership when a child dies and abuse or neglect is known, or suspected, to be a factor in the death. Working Together (2018) guidance also states that LSCP should consider holding a review *where a child has sustained a life-threatening injury through abuse or neglect, serious sexual assault, or through serious and permanent impairment of health or development through abuse or neglect.* The purpose of a review is to establish what lessons can be learnt about the way professionals and organisations worked together, how they will be acted upon and what is expected to change to improve inter-agency working and improve safeguarding practice to children. Reviews are exercises in learning and improving policy and practice and outcomes for children and young people and are not inquiries into how a child died or who was culpable; this is the business of Coroner's and the Criminal Court.

A review is commissioned by the LSCP and involves setting up a multi-agency review panel of senior and experienced managers, with an independent chair, to ensure objectivity and impartiality. The panel must produce a report to the LSCP on lessons

learnt, the LSCP then ratifies the conclusions and recommendations for actioning the lessons.

The report goes to the ULTH Safeguarding and Vulnerabilities Oversight Group, Ofsted / CQC and national oversight panel for their scrutiny and response. All relevant agencies are expected to produce and implement an action plan, based on the recommendations, which is overseen by the LSCP Significant Incident Group.

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Number of Serious Incident notifications England 2020 to 2025
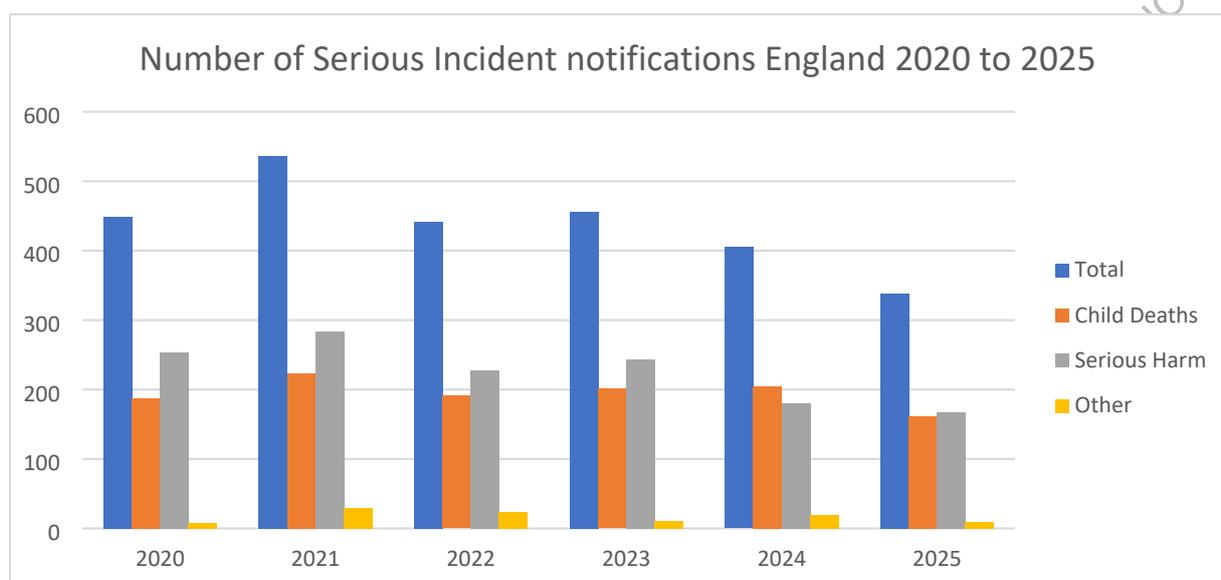
ULTH is not currently involved in any Child Safeguarding Practice Reviews (CSPRs). The County has recently completed (but not yet published) a CSPR. ULTH was not involved in the Review; however, will ensure that any transferrable learning is disseminated within the Organisation, as relevant.

The County has recently completed two Rapid Reviews; for one of which ULTH provided supporting information. As Chair for the Partnership's SIRG Group, ULTH's Named Nurse for Safeguarding CYP also Chairs the arising Rapid Review/Learning Panels and therefore had oversight of both Reviews. Any transferrable learning will be disseminated, as relevant.

7.2   Adults

Safeguarding Adult reviews are part of the safeguarding adult's process and a statutory requirement within the Care Act 2015.

By law, a Safeguarding Adults Review (SAR) must take place when:

an adult dies because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a SAR is not to assign blame but to promote learning and improvements to prevent future deaths or serious harm.

In addition, safeguarding boards may also arrange a review where it believes there is value in doing so. This can be in any other situation involving an adult in its area with needs for care and support to promote effective learning and improvement action to prevent future deaths or serious harm occurring.

During 2024 – 2025, ULTH was involved with one new Safeguarding Adult Review which remains ongoing. We have continued to contribute to learning actions form previous reviews and provided assurance to the LSAB as required.

7.3   Domestic Abuse Related Death Reviews (DARDR)

A DARDR is very similar in nature to a children's or adults' review however takes place *when a death occurs in a young person (16 & 17 years), or an adult and the cause is linked to Domestic Violence or Abuse.*

Nationally there were 362 domestic homicides recorded by the police in the three-year period between year ending March 2018 and year ending March 2020. This represents 19% of all homicides where the victim was aged 16 years and over during this period.

Of the 362 homicides, 214 (59%) were female victims who were killed by a partner or ex-partner. In contrast 33 (9%) were male victims who were killed by a partner or ex-partner. The remaining 115 (32%) were victims killed by a suspect in a family category.

The majority of domestic homicide victims (killed by ex/partner or a family member) for the year ending March 2020 to the year ending March 2022 were female (67.3% or 249 victims) and most of the suspects were male (241 out of 249; 96.8%). In the majority of female domestic homicides, the suspect was a male partner or ex-partner (74.7%), whereas in the majority of male domestic homicides, the suspect was a male family member (66.1%) (ONS, 2023a).

When DARDRs started in Lincolnshire, there were twelve notifications during the period of 2012-2017 however since 2018 the number of notifications has doubled leading to 34 cases that have met the criteria for a domestic homicide review in Lincolnshire between 2012 and 2025.

ULTH is currently involved in 11 Lincolnshire DARDRs and 1 out of County DARDR, involving submission of a chronology and report on former patients who were resident in Sunderland at the time of their death. Some of the Lincolnshire DARDRs are complete however are still awaiting final sign off by the Home Office; however, many remain ongoing or have not yet commenced.

All ULTH actions have been addressed, and the newly commissioned reviews have not yet generated actions for individual agencies.

Figure 2: Number of cases referred for discussion to DARDR panel.
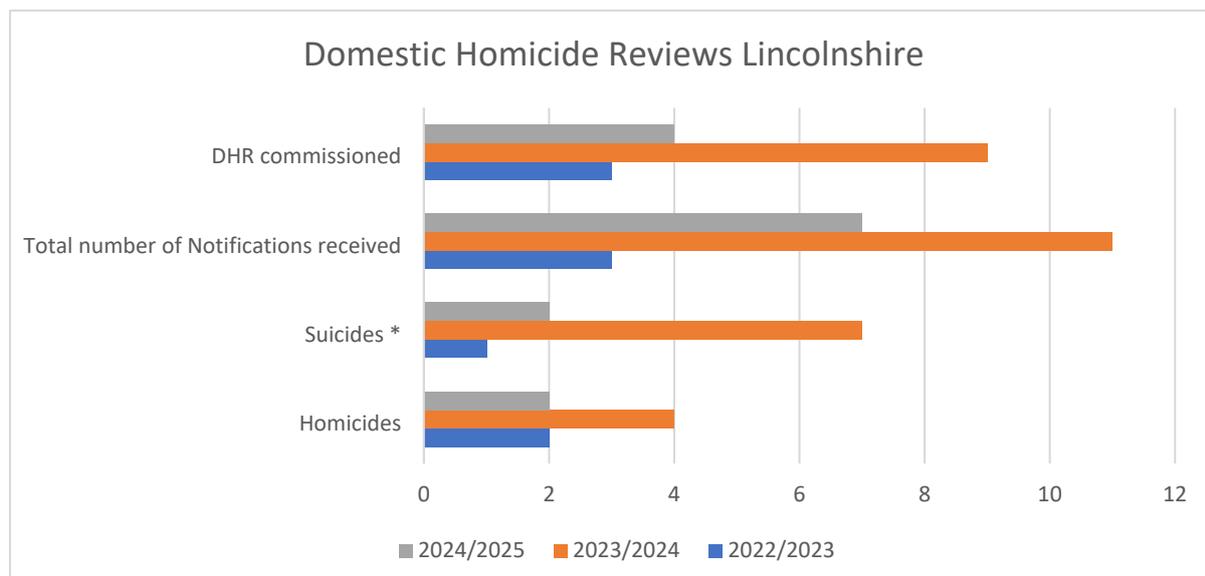
Domestic Homicide Reviews Lincolnshire

* Since 2022 DARDR criteria have changed to include all deaths by suicide where there has been a known history of domestic violence within the current/past relationship.

8.0   Child Protection Cases

Lincolnshire holds child protection conferences on each working day and therefore the numbers for children who currently have a child protection plan vary daily Monday to Friday and can be influenced by families moving in and out of the local authority. Overall, the numbers of children on plans (figure 4) have slowly risen over the last 5 years whereas the mean for England has demonstrated a downward trend.

Children on child protection plans are identified within the Trust on Careflow and via the Lincolnshire Care Portal.

During this period there has continued to be a high number of unborn babies who have become subject to child protection / court proceedings and as such a significant impact on the midwifery workload

Figure 3: Number of children having a child protection plan within the Local Authority area who may be receiving services from ULTH (April 2020– March 2025) *(England Mean 24/54 not available at time of report)*
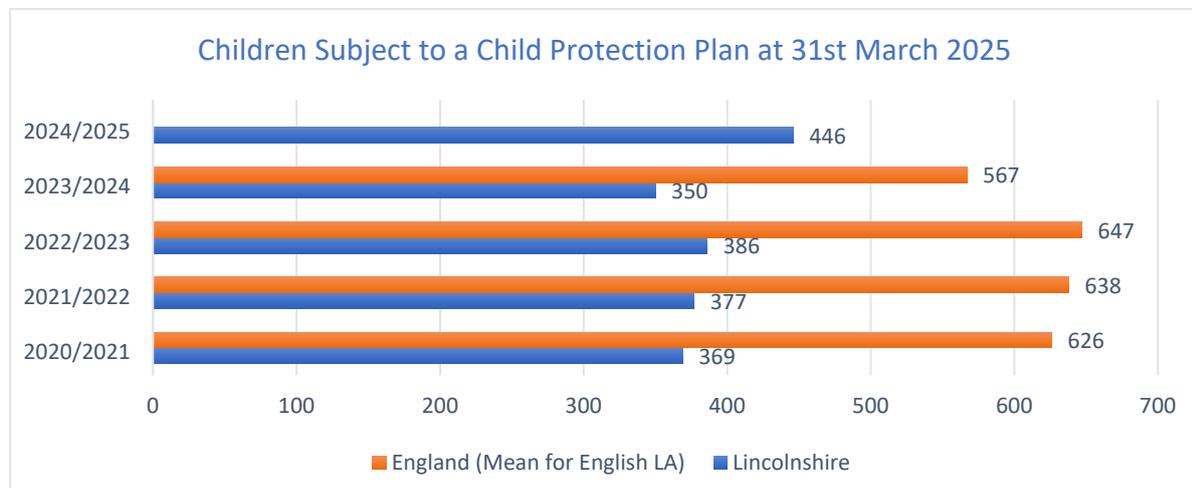
Children Subject to a Child Protection Plan at 31st March 2025

Year	Lincolnshire	England (Mean for English LA)
2024/2025	446	
2023/2024	350	567
2022/2023	386	647
2021/2022	377	638
2020/2021	369	626

■ England (Mean for English LA) ■ Lincolnshire

8.1   Child in Need

Some children will not meet the criteria for a child protection plan but still require a service which can be met at a lower level 'children in need' of support. The data in figure 5 demonstrates the number of children in need across Lincolnshire with a decrease in numbers over the last 12 months remains below the England mean.

Lincolnshire has focused its support offer on 'Early Help' which is designed to assist children and family at an earlier stage and prevent them from reaching the child in need stage.

Figure 4: Number of children classed as a Child in Need within the Local Authority area who may be receiving services from ULTH (April 2020 – March 2025)

(England Mean 24/25 not available at time of report)

Children in Need at 31st March 2024

Year	Lincolnshire	England (Mean for English LA)
2023/2024	3212	
2022/2023	3480	5251
2021/2022	3258	5186
2020/2021	2924	4012
2019/2020	3262	4736

■ England (Mean for English LA) ■ Lincolnshire

8.2   Children in Care

Children and young people who are looked after are amongst the most socially excluded groups in England and Wales. They have profoundly increased health needs in comparison with children and young people from comparable socio-economic backgrounds who have not needed to be taken into care. These greater needs, however, often remain unmet and as a result, many children and young people who are in care continue to experience significant health inequalities and on leaving care experience very poor health, educational and social outcomes.

ULTH does not directly provide the children looked after health service however many of these children will access the services within ULTH by way of A+E or Paediatrics and research demonstrates that children in care will continue to have a high level of Adverse Childhood Experiences (ACEs) which impact on lifelong health and opportunities and therefore continue to access services long into their adult life.

Due to the demographics of Lincolnshire, the Trust will also provide services to other young people who are placed into care within Lincolnshire from other Local authority areas.

During 2024 to 2025 the Trust as provided specific care to several children who have been placed by other Local Authorities and who potentially posed a risk to themselves and others within the paediatric setting. The Trust have worked closely with our multi-agency/multi-professional partners to ensure that these children received the best possible care.

Over the last 5 years the number of children in the care of Lincolnshire Local Authority has risen in line with the England mean, although there was a slight dip during 2022 - 2023. This steady increase is also noted in the number of children placed into Lincolnshire by other Local Authorities.

Children within the Trust are identified within Care flow, SystmOne and via the Lincolnshire Care Portal.

Figure 5: Number of children classed as a Child in Care within the Local Authority Area who may be receiving services from ULTH (April 2020 – March 2025)

(England Mean 24/25 not available at time of report)

Number of Children Looked After at 31st March

Year	*Out of area Placed in Lincs*	England (Mean for English LA)	Lincolnshire
2024/2025	575		808
2023/2024	593	1054	754
2022/2023	604	1064	728
2021/2022	583	1026	736
2020/2021	564	1008	680
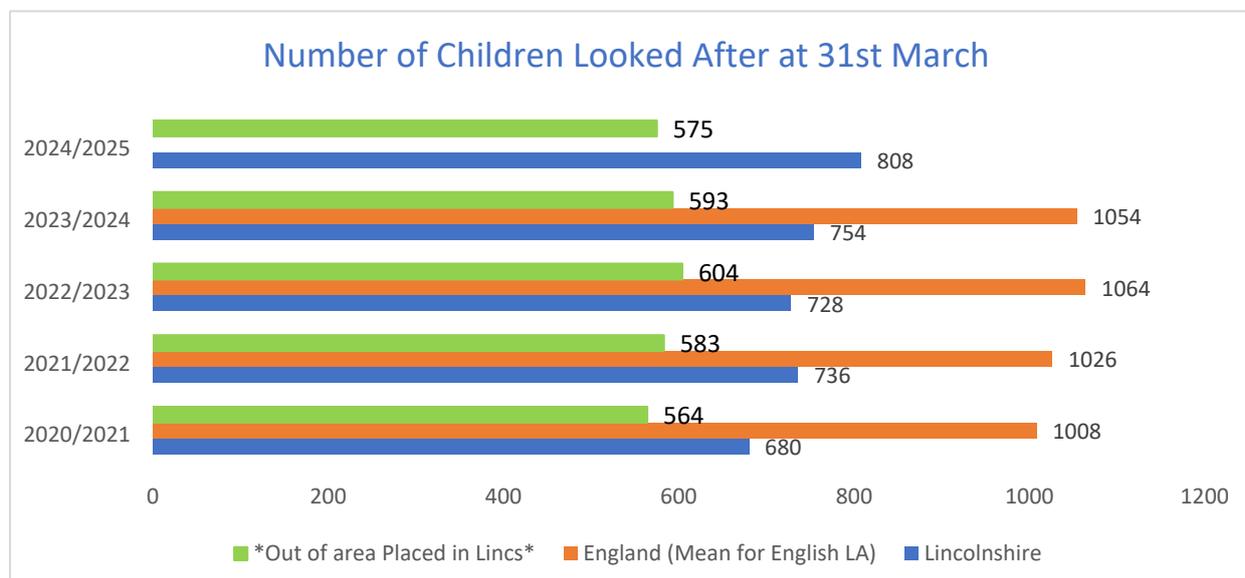
* Out of area placements are reliant on external Local Authorities notifying Lincolnshire of the placement and therefore this is likely to be an under reporting and the actual figure being higher*

9.0   Adult at risk

Adult Safeguarding is extremely complex and impacts on much of the day to day work of the Trust i.e., Complaints/PALS, Serious incidents/PSIRF, pressure ulcers, patient safety and HR. Safeguarding is about more than simply keeping someone safe, it is about respecting and protecting an individual's needs, right, aspirations and integrity, both mental and physical. It is about making sure the environments they inhabit, and the people and services they encounter within them, reflect these same ideals. There is a fine balance to be struck regarding proportionality and the right of the individual to take risks and must be balanced against the duty to protect health and wellbeing. There has been further promotion regarding health professionals developing their professional curiosity, asking the right questions when fulfilling their safeguarding duties, and help them to enable patients to live their lives to the full, free from abuse.

There is increased emphasis on 'Making Safeguarding Personal' and involvement of the patient in their safeguarding decisions. Audits from the LSAB and internally continue to suggest that this is an area which requires further improvement so remains a priority for 2025 - 2026.

During the last year the team has seen an increase in case complexity, notably in cases of self-neglect, pressure ulcers and addictions, and disordered eating within the hospital setting. The team have worked proactively to coordinate these cases and prevent unsafe discharges, readmissions, complaints, or safeguarding allegations against the Trust. This approach increases positive outcomes for the patients.

The number of referrals raised during 2024 - 2025 by ULTH was 225 indicating that the Trust continues to actively identify issues of concern. Work continues to ensure that all referrals are appropriate and include the patients views wherever possible.

Figure 6: Number of safeguarding adult referrals made by ULTH to the Local Authority (April 2024 – March 2025) including divisional breakdown.
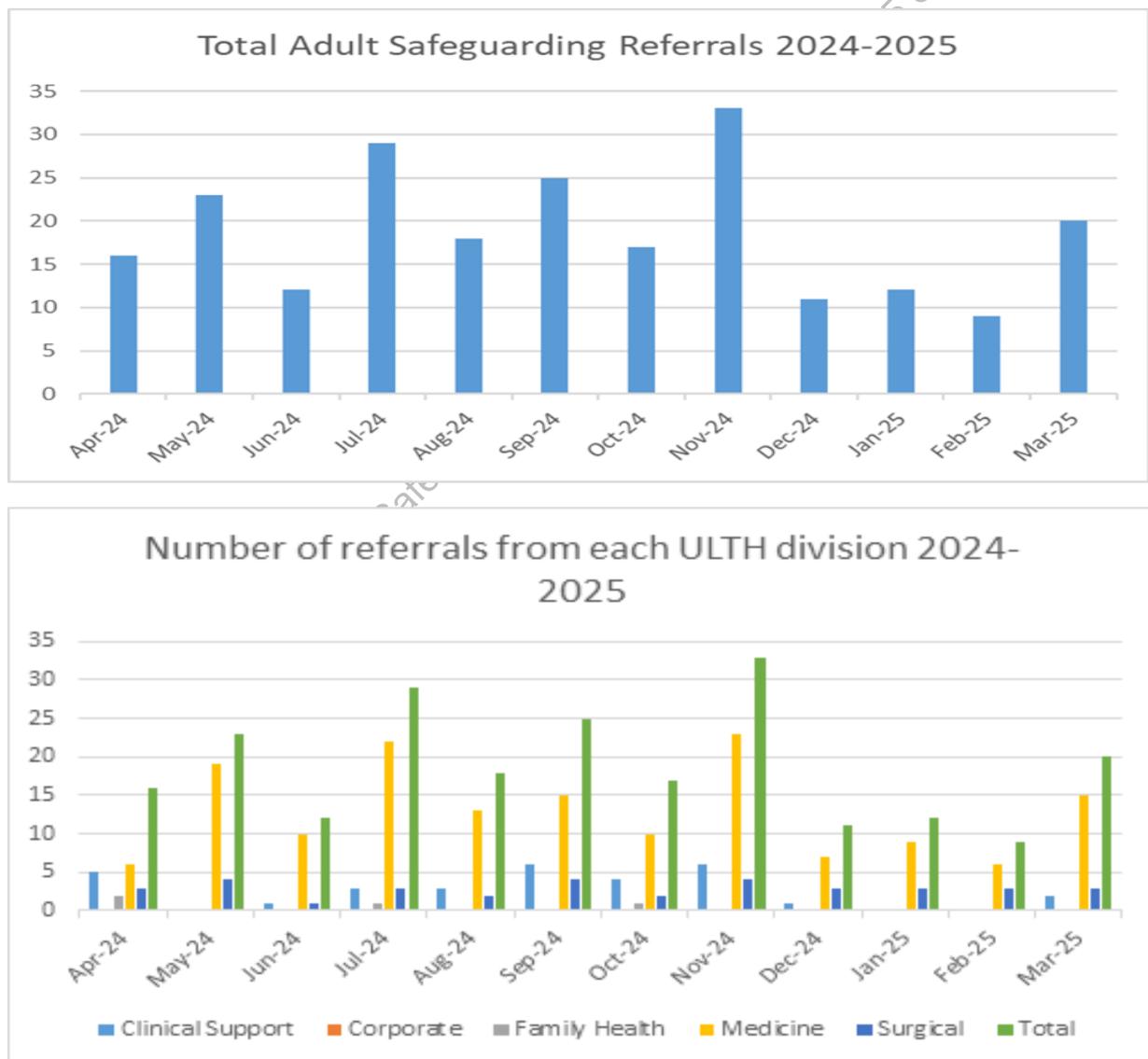
9.1   Safeguarding referrals made against ULTH.

The number of safeguarding allegations raised against the Trust continues to vary however over the last 12-month period was 22, a rise of 27% on the previous year. This includes a number of self-referrals made by the Trust towards itself based on national criteria and guidance.

Figure 7: Safeguarding Investigations

Section 42 investigations relating to ULTH 2024-2025
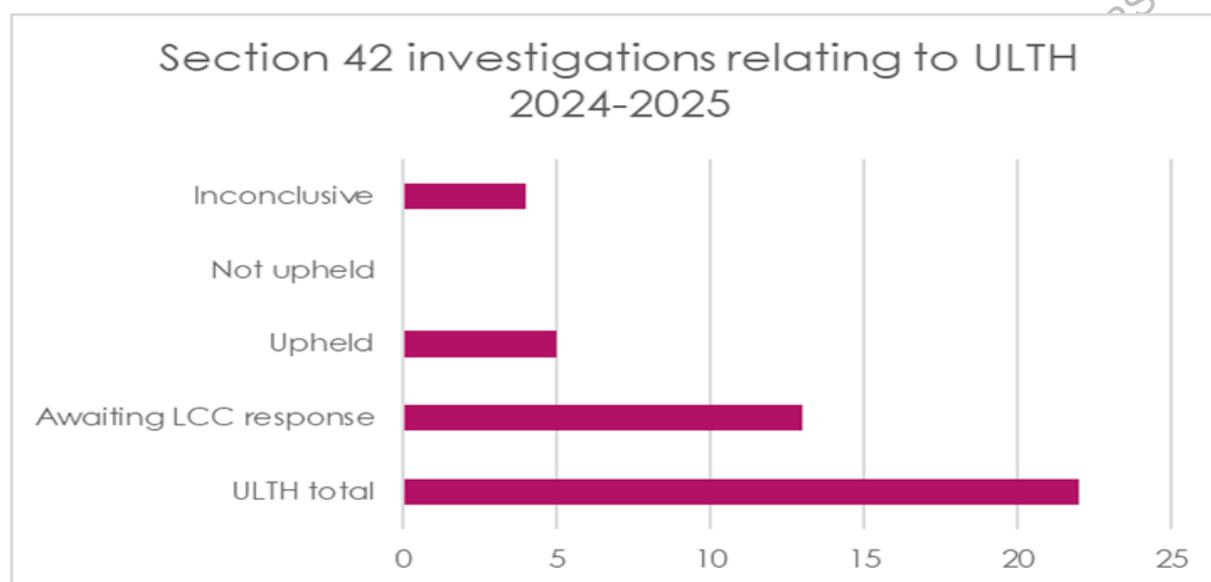
Of the completed investigation the common themes across the areas relate to

- Patients leaving ED / Ward areas when vulnerable and lacking capacity.
- Failure to prevent hospital acquired pressure ulcers.
- Patient left in ED (post discharge)
- Lack of robust discharge planning
- Medication errors

Action plans are in place for all concluded section 42 investigations.

The Named Professional meets with the CQC and separately with the ICB and LA to ensure that there is an open and honest dialect maintained and works on the premise of no surprises.

Quality assurance

All referrals are quality assured. Moving forward as the group develops, these processes will be standardised as much as possible across the teams.

ULTH is reliant on paper records hence the audit of referrals is undertaken in a less timely fashion however follow up contact with the referrer is made when appropriate.

Figure 8: Standards of referral
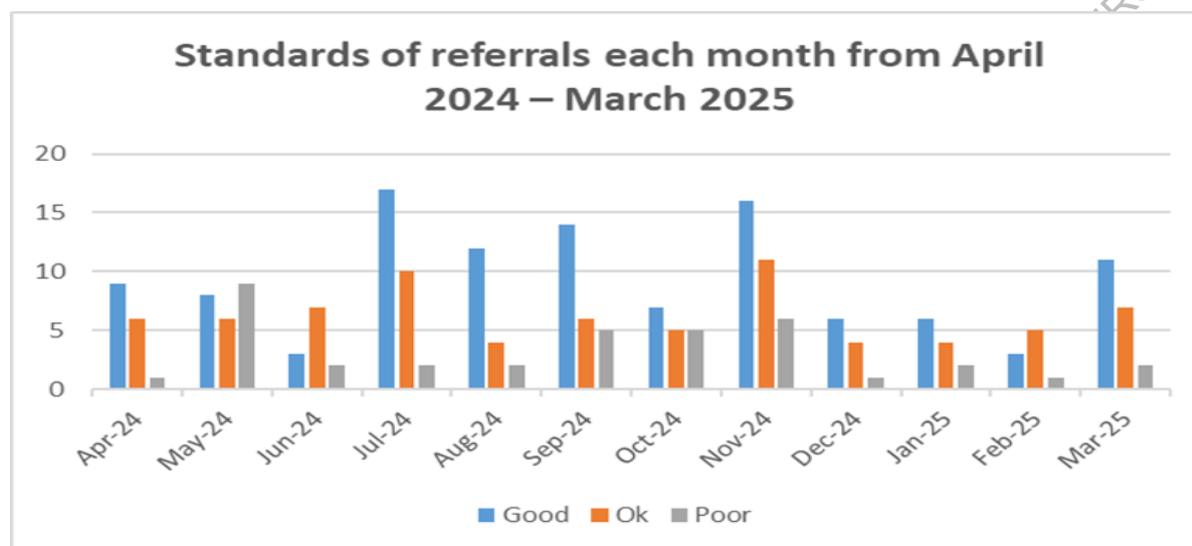
10.0   Legal statements / Court process

The safeguarding teams have continued to strengthen and develop their remit of supporting staff in statement writing and court attendance. The current trend to produce more legal statements / requests for records continues and is also impacted on with the growing area of work from the Court of Protection.

The ongoing supportive relationship / process between safeguarding and the legal / data protection teams continues to work well.

Other teams adversely affected by this increase are Paediatrics, Maternity and Emergency Departments across site with pressures being placed on paediatricians and frontline clinicians to provide reports and statements in greater detail and in a much shorter timescale.

The Court of Protection (CoP) is a court in England and Wales that can make decisions on behalf of people who lack the capacity to make their own decisions and the court deals with decisions about a person's welfare, property, or medical treatment.

Whilst the Mental Capacity Act Code of Practice confirms some of the situations when decisions must be taken to the Court of Protection (Section 8.18), not all scenarios are covered including cases where there is a dispute about whether a particular treatment will be in a person's best interests.

The Court of Protection (CoP) has issued guidance which states that if force or restraint is required an application to court may be required and if the force or restraint amounts to a deprivation of liberty then the authority of the court will be required to make this deprivation of liberty lawful.

ULTH have taken one case to the CoP in the past year and have sought legal advice on several to support the Trust operation within the MCA.

During 2024 to 2025, ULTH commissioned a series of Court craft and legal updates for staff which currently continue to March 2025 and cover court skills suitable for children and family / Coroners' Courts as well as updates around the Mental Capacity Act and relevant changes in case law. These events where opened to LCHS staff in 2023 and are being provide across the Group going forward.

11.0 Safeguarding Clinical Supervision

11.1 Children

Effective Safeguarding supervision is important to promote good standards of practice and support individual staff members. Supervision allows time for reflective practice and is a vital component in the protection of children. Supervisors should be available to practitioners as an important source of advice and expertise and may be required to endorse judgements at certain key points in time, and ensure each individual child has an effective plan of action. The Safeguarding teams provide direct supervision to professionals (Individual and Group) which includes reflecting on, scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the practitioner, and providing coaching, development, and pastoral support.

Safeguarding supervision is mandated to specific staff groups at either 3 monthly or 6 monthly periods and is managed within ULTH by way of ESR (compliance/noncompliance) making the process more transparent and increasing the governance of this aspect of support.

As of 31st March 2025, compliance rates are as follows.

3 Monthly - 69%

6 Monthly – 38 %

Compliance figures for Safeguarding supervision are notoriously difficult to maintain due to 3 - 6-month time scales and regularly changing staff groups particularly amongst medical staff. In order to proactively manage this challenge, the safeguarding team use the above figures in conjunction with the Safeguarding training compliance figures to identify high-risk areas of concern and target specific staff groups.

Compliance is monitored by the teams with bi-monthly reports provided to Safeguarding Operational Groups / Divisional Leads for escalation and via SVOG.

11.2   Adults

Whilst less prescriptive, safeguarding supervision for adult protection cases is readily available and provided to staff who require it on a needs lead basis. This is often delivered at source on the clinical areas on a case-by-case basis and weekly via Microsoft Teams. As safeguarding adults / MCA is embedded, safeguarding supervision for adult cases is noticeably a bigger part of the work of the teams and recorded via the ESR system.

12.0   Training and learning

Safeguarding training has always been a high priority within the Trust and is implicit within the National contract and Safeguarding legislation. A new joint training plan was introduced for safeguarding children and safeguarding adults in 2023 as the first stage of bringing both Trusts closer together and ensuring compliance with statutory guidance. As part of this process all training courses were reviewed and updated as necessary with the vision that moving forward staff from either Trust could attend any course and still gain compliance.

All training is now face to face delivered either directly or via Microsoft teams. This has improved interaction in training sessions and allows for detailed scenario discussions.

Figure 9: Training levels with the Trust on the 31st of March 2025.

KPI Description *(A measurable value that demonstrates the success of your change, to include trajectory to achieve target)*	Measures *(How will this be Measured)*	Target *(Desired level of performance)*	ULTH *END March 2025 figures* *Trend compared with March 2024*
To reach 90% for Safeguarding children level 1	Monthly training report (MTR)	90%	94.78% →
To reach 90% for Safeguarding children level 2	MTR	90%	79.79% ↓
To reach 90% for Safeguarding children level 3	MTR	90%	74,41% ↓
To reach 90% for Safeguarding children level 4	MTR	90%	100% →
To reach 90% for Safeguarding adults level 1	MTR	90%	94.90% →
To reach 90% for Safeguarding adults level 2	MTR	90%	81.16% →
To reach 90% for Safeguarding adults level 3	MTR	90%	83.91% ↑
To reach 90 % for MCA / DOLS	MTR	90%	79.98% ↓
To reach 90% for PREVENT basic level	Quarterly training report	NHSE/I target 85%. ULH target 90%	96% ↑
To reach 90% for PREVENT Higher level	Quarterly training report	NHSE/I target 85%. ULH target 90%	81% ↓
To reach 90% for Mental Health	MTR	90%	96.28% →
To reach 90% for Dementia	MTR	90%	96.96% ↑
To reach 90% for Learning Disability / Autism Tier 1	MTR	90%	82.41% ↓
To reach 90% for Learning Disability / Autism Tier 2	MTR	90%	82.32% ↓
Oliver McGowan Specific Tier 1 e-learning *	MTR	90%	71.36% ↑
Oliver McGowan Specific Tier 2 e-learning *	MTR	90%	69.49% ↑

* (ULTH- Commenced 1ˢᵗ March 2023 – gradual merge with standard Tier 1/ Tier 2 by March 2026)

Oliver McGowan e-learning training is being rolled out across the Trust however for full compliance staff members must attend a second module which is a face-to-face course.

The uptake is reliant on the availability of the face-to-face course and at present these are very limited nationally as the course must be delivered by experts with lived experience.

The Trust is working with the Lincolnshire system partners to commission these modules however whilst tier one (part B) modules are slowing becoming more available as, yet no tier two (part B) module is available.

13.0 Safeguarding issues within Pregnant Women

The Maternity Safeguarding team consists of two midwives, the Named Midwife for Safeguarding and a Specialist Safeguarding Midwife, based within the maternity units on both Boston and Lincoln sites.

The role of the Safeguarding Midwives is to support clinical and managerial staff in performing their safeguarding duties and responsibilities through advice, escalation of concerns to/from other agencies and effective feedback and support from safeguarding meetings and forums. They provide specialised knowledge, guidance, training, and support to all staff within ULTH regarding safeguarding unborn / newborn, children, young people, adults at risk and domestic abuse.

The Safeguarding Midwives maintain a Safeguarding Database that all Midwives and Neonatal staff have access to and holds information on each woman / family where there are safeguarding concerns for unborn and/or siblings to assist staff to safely care for women and their babies with safeguarding risks.

During 2024-2025, ULTH Maternity Services made 366 Social Care referrals due to safeguarding concerns **(a decrease of 77 from the previous year)**

314 babies had an allocated Social Worker **(an increase of 36 from the previous year)**

196 babies were subject to Child in Need plans **(an increase of 25 from the previous year),** 24 were subject to Child Protection plans **(an increase of 2)** and the remaining 94 unborn babies were managed within the legal arena at Pre-proceedings, due to the high level of risk identified **(an increase of 9)**

29 babies being removed on discharge from their mother's care **(a decrease of 5 from the previous year)**

8 babies were discharged into Mother and Baby placements **(an increase of 3 from the previous year)**

The Safeguarding Midwives attend all Strategy Meetings for unborn babies alongside the Police and Social Care in addition to representing maternity services at MARAC, some Child in Need meetings, Initial Child Protection Conferences and Core groups.

They co-ordinate and monitor high risk cases and ensure robust birth plans are in place for all unborn who are subject to Child Protection plans and those within Pre-birth legal proceedings.

Continued communication between Drug and Alcohol Services, Perinatal Mental Health Services, Domestic abuse services and the Named Midwife for Safeguarding, has ensured multi –professional oversight of our most vulnerable families.

The Named Midwife for Safeguarding continues to work in collaboration with partner agencies to improve and standardise the process of the management of unborn within the legal arena, in addition to ensuring that the removal of babies from parent's care within the hospital setting is as empathetic and kind as possible.

The Named Midwife is currently working alongside agencies to review the Pre-birth protocol to ensure all area teams within Children's Services are following the correct process.

The implementation of providing memory boxes to parents and their babies who separated on discharge from hospital, due to proceedings, has recently been launched.

The aim of the boxes is to provide some comfort to the families upon separation and will allow them to capture the special time they spend with their babies prior to discharge from the maternity unit.

The Named Midwife for Safeguarding receives all Police incidents regarding pregnant women (PPN)

468 notifications were received in 2024/25 **(an increase of 93 from the previous year)** the majority being domestic abuse incidents.

Worryingly, 99 pregnant women were heard at MARAC in that period, due to concerns of high-risk domestic abuse **(an increase of 41 from 23/24)**

The sharing of Police notifications with maternity services ensure that any outstanding actions are completed, ongoing monitoring of safeguarding concerns takes place and any required referrals to partner agencies are made.

The Named Midwife has attempted for several years to implement a service within ULTH Maternity that offers Long-Acting Reversible Contraception (LARC) to our most vulnerable women, prior to discharge from hospital.

Funding has now been agreed by Public Health, and we are in the process of sourcing the relevant training for those staff who will be in be trained to offer and provide LARC.

LARC will initially be offered to all pregnant women who's unborn are subject to Child Protection plans, Pre-proceedings or if they birth under the age of 20 years of age, with a long-term vision that this will be offered universally to all women.

The Safeguarding Midwives provide regular Safeguarding supervision to hospital-based Midwives and to the managers of the Community Midwifery teams, who in turn provide supervision to their Community Midwives teams.

During the last 12 months there has been a noticeable increase in the complexities of safeguarding cases identified within maternity services and it has therefore been imperative that all staff work together to ensure the safest outcomes for the families whom we care for.

Figure 10: Safeguarding Specific Maternity data.

Maternity Safeguarding Stats 2021-2025

Legend: 2021-22, 2022-23, 2023-24, 2024-25
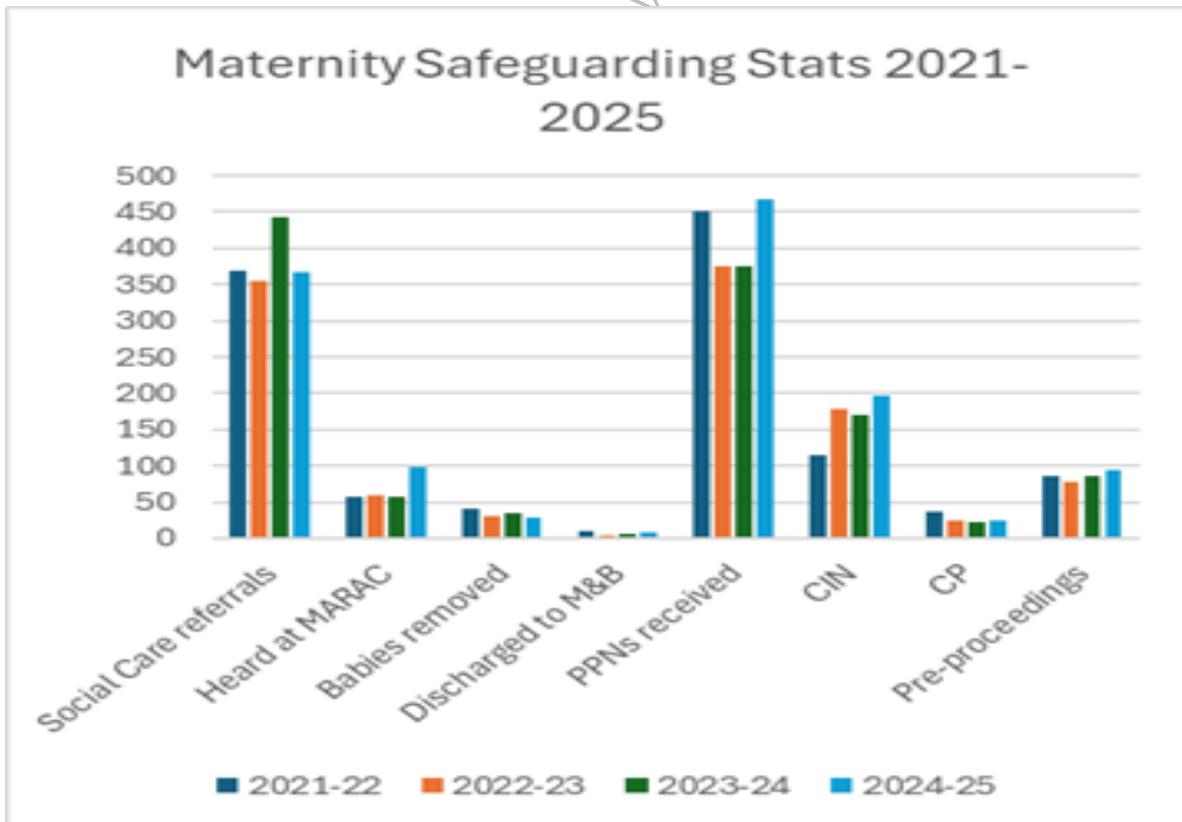
14.0 Female Genital Mutilation (FGM)

Whilst the issue of FGM affects women / girls across all operational services the midwifery and Gynaecology teams are key within early identification and reporting of this specific area of abuse. The Trust has in place an FGM policy and specific working guidance for paediatrics and midwifery.

From 1st April 2015, and in line with National Guidance, ULTH began to routinely submit FGM data. This data is submitted monthly to the Trust's Information Support team for onward submission to NHS Digital. Nationally since April 2015, 35,415 individual women and girls had an attendance where FGM was identified.

Between April 2024 and March 2025, 45 cases of FGM were reported by ULTH, a decrease of 28% over the last 12 months, however an increase of 115% over the last 5 years: of which 25 were Type 4 (piercings); 5 were Type 1, 1 was type 2, and 14 were of an unknown type. All cases reported were reported by adults and those reporting Type 1 had undergone the FGM as children in their countries of origin.

For those Type 1 cases, appropriate safeguards were initiated in respect of the unborn: with the Trust also complying with the appropriate NHSE alerting protocols.

Figure 11: FGM specific data by WHO type classification.
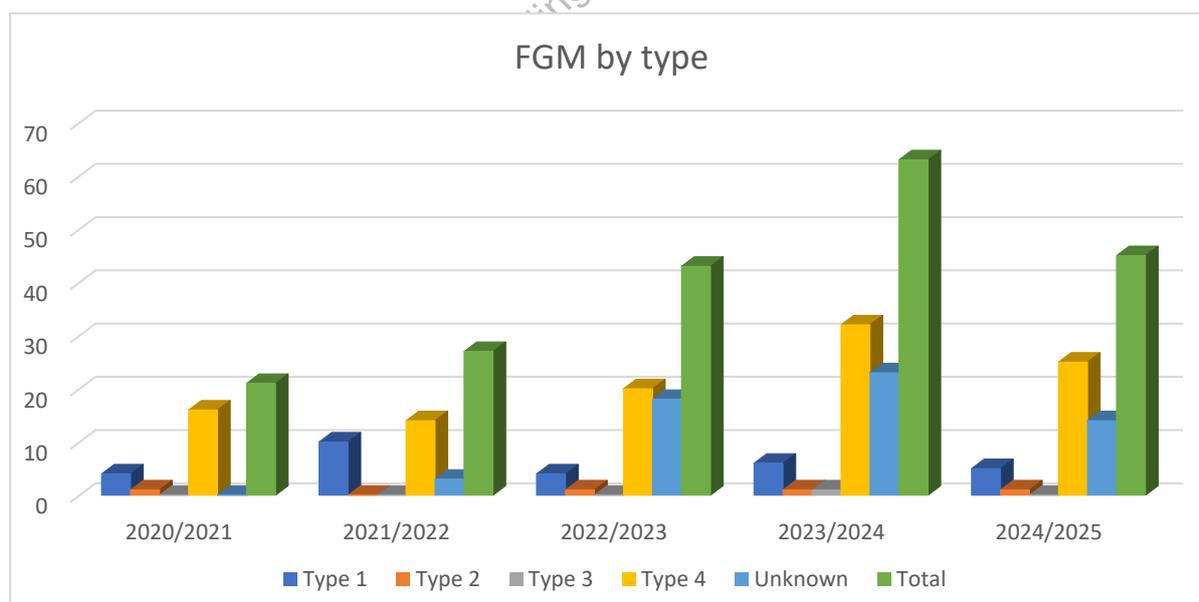
15.0 Domestic Violence / Multi-agency Risk Assessment Conference (MARAC)

Domestic Abuse costs the country's economy £15.8 billion a year. The cost to health, housing and social services, criminal & civil legal services is estimated at 3.9 billion and of this the NHS spends £1.73 billion.

The Trust is represented at the twice-weekly MARAC meetings by the Safeguarding Specialist Nurses and at the Domestic Abuse Operational and Strategic Boards by the Named Nurses for Safeguarding and the Director for Safeguarding, respectively.

15.1 Key Facts

The Crime Survey for England and Wales estimated that 2.3 million people aged 16 years and over (1.6 million women and 712,000 men) experienced domestic abuse in year ending March 2024.

In the Year ending December 2023 the Police recorded a domestic abuse offence approximately every 40 seconds

This equates to a prevalence rate of approximately 5.0% of adults (6.9% women and 3.0% men).

Figure 12: shows a higher percentage of adults experienced domestic abuse by a partner or ex-partner (4.4%) than by a family member (1.8%) in the last year. Of those who experienced partner abuse, 88% experienced non-physical abuse, 9% experienced sexual assault and 16.1% experienced stalking.

Approximately one in 25 people experienced domestic abuse in the year ending March 2023

Prevalence of domestic abuse in the last year, for people aged 16 years and over, by perpetrator-relationship, England and Wales, year ending March 2023

One in 25 people experience domestic abuse in the year ending March 2023

Domestic abuse has a significant impact upon the communities and public services of Lincolnshire.

Domestic abuse remains an under reported issue. CSEW national figures suggest that only 31% of partner abuse victims told someone in an official position about their abuse (i.e., police, health professionals, or local council department). 18.9% of victims told the police, 18% told a health professional and 5% told a local council department. The majority of partner abuse victims instead told somebody they knew personally about their abuse. 1 in 4 partner abuse victims told nobody at all about their abuse (27%), a much more concerning statistic amongst males where 1 in 2 (49%) told nobody about suffering abuse at the hands of their partner. (Source: Office of National Statistics)

More than one in four women has experienced at least one incident of domestic violence in England and Wales since age 16 (equivalent to 4.8m women)

- On average a woman will experience **thirty-five assaults** before going to the police
- **2 - 3 women a week** are killed by their current or former partner
- **1 in 7 males** will experience domestic violence and abuse.
- Domestic violence often starts or intensifies during and after pregnancy.
- 3.7 million women in England and Wales have been sexually assaulted at some point since the age of sixteen.
- Around 2,000 women are raped each week. 34% of all rapes recorded are committed against children under 16 years of age.
- Estimated 66,000 women in England and Wales have undergone Female Genital Mutilation and over 24,000 girls are estimated to be at risk.
- One in four lesbian, gay, bisexual, and transgender people have experienced domestic violence and abuse in their relationship.
- Disabled women are twice as likely to experience domestic violence and abuse than non-disabled women and over a longer period, suffering more severe injuries because of the violence.
- Domestic violence and abuse in teen relationships is increasingly recognised as a significant issue. Research now suggests that women between the ages of 16 and 25 are at highest risk.

15.2   Domestic abuse in Lincolnshire

In the last 5 years, on average there are over 12,000 domestic abuse incidents reported to Lincolnshire Police every year. During 2024 – 2025 of these, circa 8,500 are standard risk incidents, equivalent to around 7 in 10 domestic abuse incidents reported. The proportion of reported incidents that are graded as high risk has been

falling, while the proportion graded as medium risk has remained relatively static year on year.

Figure 13: Domestic Abuse Cases

15.3   Domestic abuse and children

The true number of victims of domestic abuse is likely to be higher when children are included. CSEW figures suggest that 41% of partner abuse victims suffered abuse while their children were in the house, and that 21% of victims disclosed that the children did see or hear what happened. (Source: Office of National Statistics) If only one child was present at each of the 21% of domestic abuse victimisations in Lincolnshire each year, this would mean that 5,500 children witnessed domestic abuse in their home each year. This means that the true number of Lincolnshire residents affected by domestic abuse each year is likely to be upwards of 35,700 adult victims and child witnesses.

The Domestic Abuse Act (HM Government, 2021) now recognises children and young people living within a Domestically Abusive relationship/household as being victims.

The high rate at which children are present during partner abuse incidents has a number of consequences. At a basic level it places additional responsibility on those agencies encountering domestic abuse to ensure that appropriate checks, risk assessments and safeguarding referrals are being made for child witnesses as well

as adult victims of domestic abuse. Domestic abuse is the single most prevalent assessment factor identified in children's social care assessments. It is more prevalent than the presence of factors such as mental health, alcohol misuse, drug misuse, disability and illness, emotional abuse, physical abuse, or sexual abuse. In Lincolnshire during 2018-19, 55.1% of assessments identified domestic abuse as an issue. This is higher than the national average of 50.6%, and places Lincolnshire 42nd among the 151 local authorities in England that supplied information. (Source: Department for Education) Domestic abuse has also specifically been identified as a factor in 54% of all serious case reviews, which investigate child deaths relating to maltreatment, abuse, and neglect. *(S Framp, Community Safety Analyst, Lincolnshire County Council, May 2021).*

15.4   MARAC cases

There were 1436 victims who were at high risk of serious harm or death referred into the Multi Agency Risk Assessment Conference (MARAC) by partner Agencies in 2024 -2025. On average 350 referrals are made to MARAC every quarter (last 5 years ending March 2025).

Figure 14: MARAC Cases
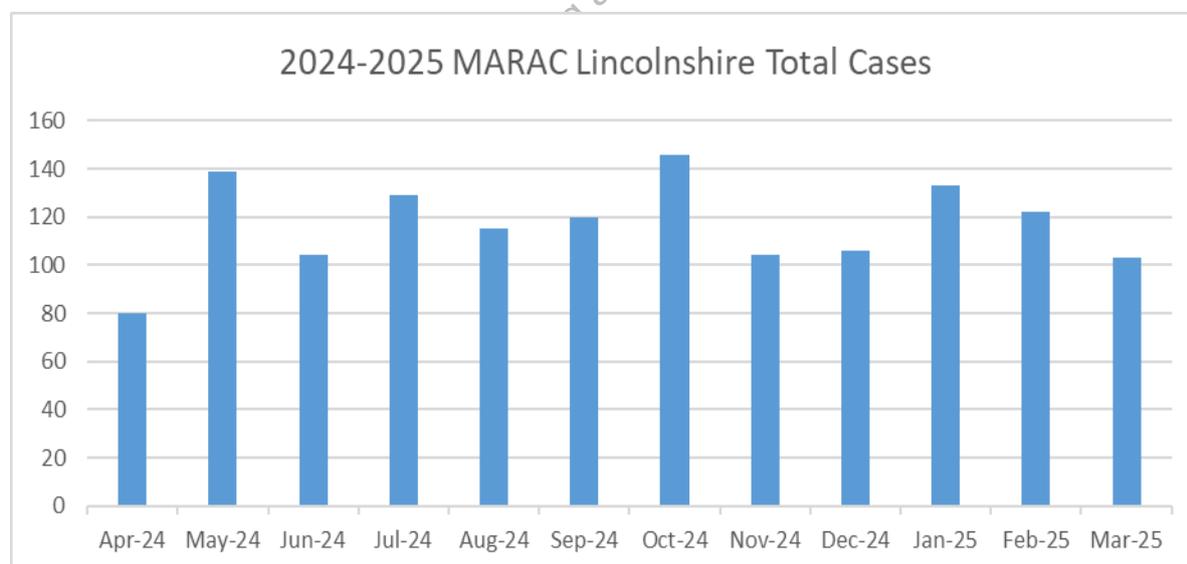
Figure 15: MARAC Referrals – all risk levels
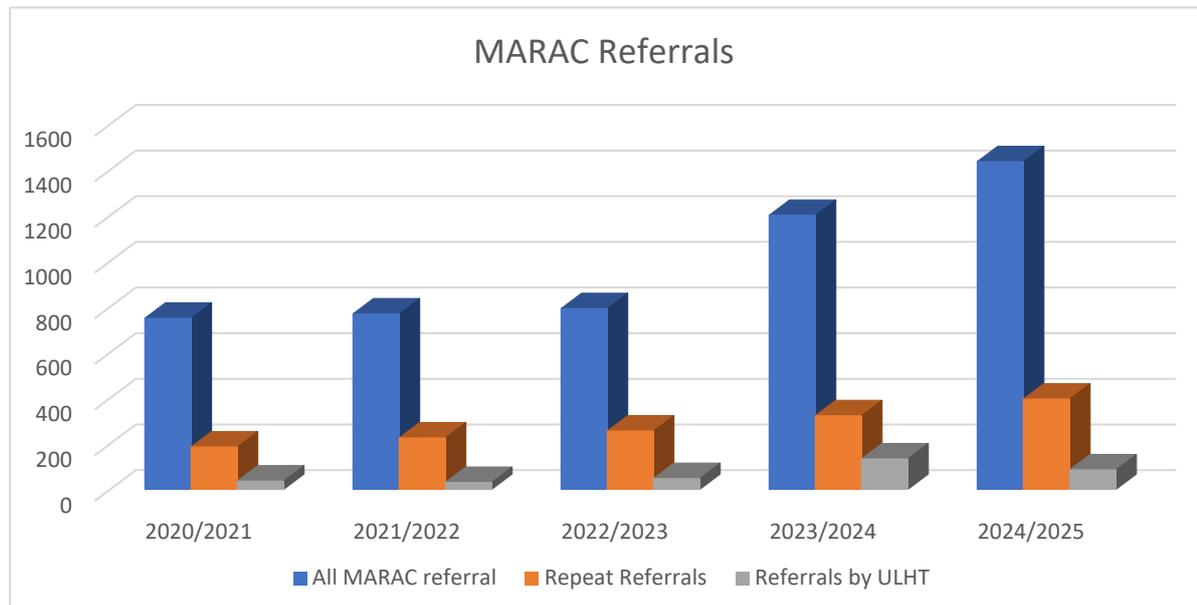
MARAC conferences are held weekly in Lincolnshire on both a Wednesday and Thursday and during the last 12 months both teams have continued to attend all MARAC meetings. More recently legislation has changed to include additional meetings to be held under Domestic Violence Disclosure Scheme.

Figure 16: DASH and MARAC Referrals made by ULTH Safeguarding Professionals

15.5   Domestic Abuse support

On the 1st of April 2023, the previous domestic abuse support service ended and a new support service (Lincolnshire Domestic Abuse Specialist Service – LDASS) was launched.

Across Lincolnshire a Total of 2352 adult referrals (18% increase on previous year) were received into LDASS between the 1st of April 2024 and 31st of March 2025 for adult victims of domestic abuse to specialist outreach support services in Lincolnshire – this is a 18% increase from the previous year. Victim Lincs allows for direct referrals from Professionals and self-referrals into LDASS.

A total of 5264 enquiries were received into the service from members of the public and 2522 enquiries from Professionals for advice regarding domestic abuse.

During 2024 additional funding was identified within ULTH to employ our own Safeguarding Domestic Violence Advocate (SDVA) who commenced in post in July 2024. Since July he has developed a proactive approach to support both staff and patients across the Trust as well as providing additional support within the MARAC process.

Figure 17: Support provided by SDVA to victims of DA.
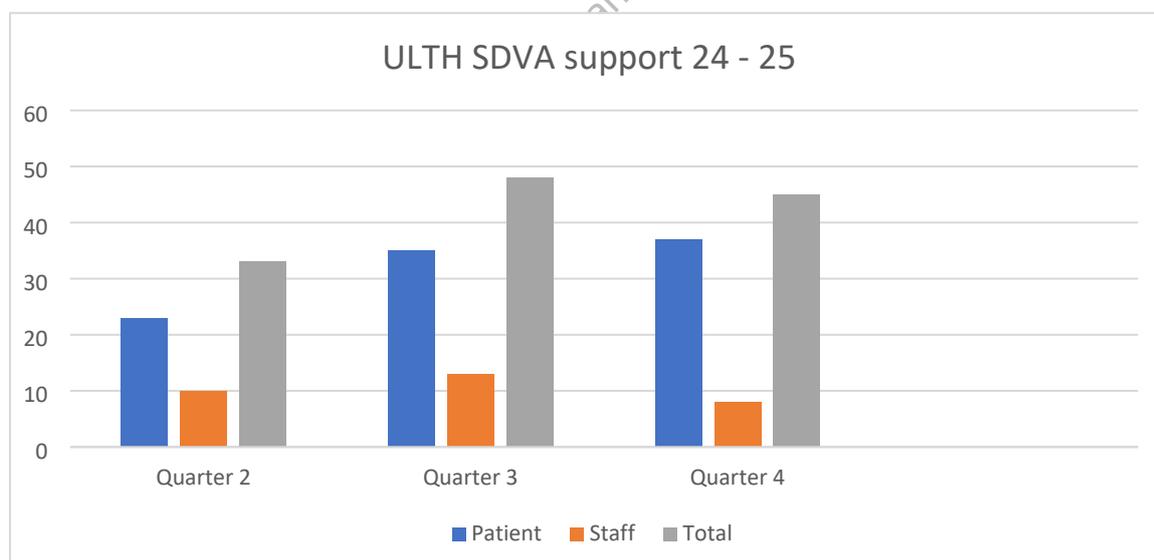
16.0 PREVENT Lincolnshire Profile

The East Midlands continues to experience high volumes of CT threat with the number of cases continuing to increase over the preceding year. Lincolnshire is still classified as a low-level area however this does not mean that no risk exists.

Self-Initiated Terrorism (S-IT) is the greatest terrorist threat to the UK and defined as those who "threaten or mobilise to violence without material support or personal direction from a terrorist organisation; but who may still be influenced or encouraged by the rhetoric or ideology of a group". An attack in Lincolnshire from a self-initiated terrorist is deemed "unlikely", however it is important we are ALL aware of the national risk. Young people and vulnerable individuals continue to actively engage in online extremism and are often seen to be displaying extremist views. Online remains a primary radical influence for subjects referred into Lincolnshire PREVENT. A significant proportion of subjects are below the age of 21. Analysis shows, individuals have been influenced online by viewing/possessing/sharing extreme media, communicating with unknown individuals online who may have extremist views and conducting their own research into concerning activity such as mass shootings.

The overarching threat to the UK and Lincolnshire is from AQ/IS. Events in the Middle East are increasing the threat from AQ/IS.

ULTH are represented at the PREVENT Steering group by the Named Professional for Safeguarding and MCA (ULTH) who is also the point of contact for the Regional PREVENT Coordinators. It is also the responsibility of the PREVENT lead to ensure that the Trust is compliant with our reporting requirements including submission of the data required by NHS England (NHSE) to capture PREVENT activities undertaken by the Trust on a quarterly basis.

ULTH has not made any PREVENT referrals during the year however have provided research on several cases over the last 12 months in compliance with our PREVENT duty.

Figure 18: Number of PREVENT data analysis cases undertaken by ULTH as part of Channel Process (April 2024 – March 2025)

PREVENT 2024-2025
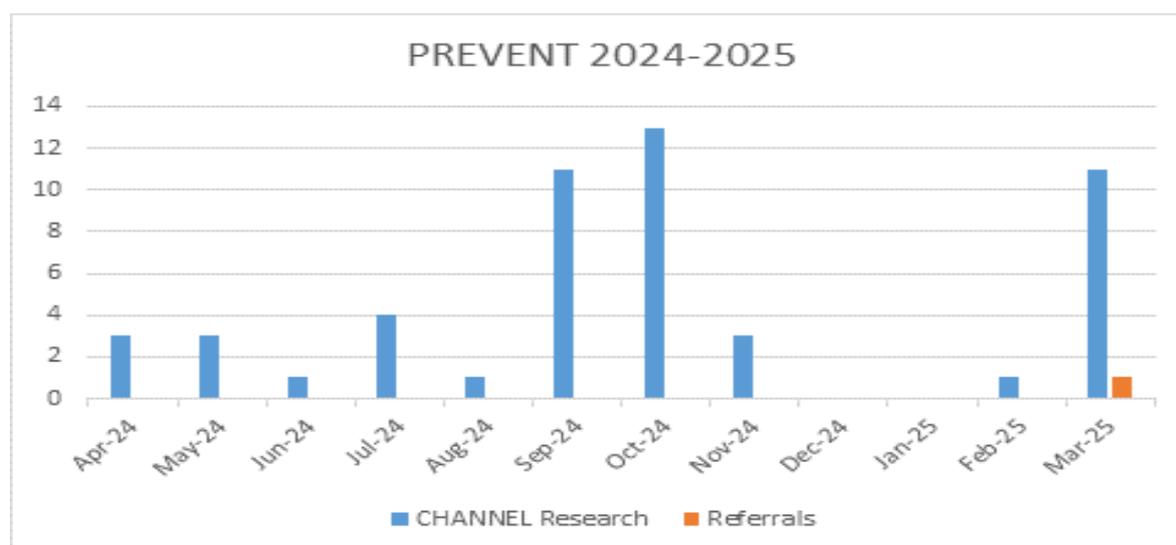
17.0 Multi-Agency Public Protection Panel (MAPPA)

MAPPA (Multi-Agency Public Protection Arrangements) are a set of arrangements to manage the risk posed by the most serious sexual, violent, and terrorist offenders under the provisions of sections 325 to 327b the Criminal Justice Act 2003.

They bring together the Police, Probation and Prison Services and a number of other agencies are under a Duty to Co-operate (DTC) with the Responsible Authority. These include Social Services, Health Services, Youth Offending Teams, Jobcentre Plus and Local Housing and Education Authorities.

There are four categories of MAPPA-eligible offender:

Category one   registered sexual offenders.

Category two   mainly violent offenders sentenced to 12 months or more imprisonment or a hospital order; and

Category three offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm.

Category four   terrorism convicted and terrorism risk individuals.

All MAPPA eligible offenders are presently flagged with regards to their assessed risks in ULTH with processes in place for potential disclosures based on risk.

Figure 19: Lincolnshire Area MAPPA Eligible offenders on 31st March 2024 (2025 figures are not yet available) *Comparative figures 31st March 2023*

Category 1: Registered Sex offender	917	(+31)	↑
Category 2: Violent offenders	145	(-1)	↓
Category 3: Other dangerous offenders	1	(-3)	↓
Total:	1063	(+27)	↑

18.0 Persons in Positions of Trust (PiPoT)

People can be considered to be in a 'Position of Trust' where they are likely to have contact with adults and children at risk as part of their employment.

In line with the Children Act 1989 / 2004 and the Care Act 2014 the LSCP / LSAB have a PiPoT protocols which the Trust is signed up to. This Protocol must be followed in all cases where information (whether current or historical) is identified in connection with:

- The PiPoTs own work.
- The PiPoTs life outside work which may raise concerns re contact with adults with care and support needs (for example where a son is accused of abusing his older mother and he also works as a domiciliary care worker with adults with care and support needs. Or where a woman is convicted of grievous bodily harm and works in a residential home for people with learning disabilities).
- The PiPoT is admitted with drug and/or alcohol use that compromises their ability to undertake their job with children or adults.
- The PiPoTs admission causes concern for wider safety of vulnerable children and adults.

As part of this protocol the Named Professional for Safeguarding adults have been identified as PiPoT leads and support managers and HR with cases where concerns are raised. The role supports with sharing of information and risk management processes. HR relations have been strengthened with an increase in the safeguarding support offered by the teams, strengthening compliance with legislation and improving Trust assurance processes.

The PiPoT leads have positive working relationship and undertake significant collaborative working with the Police enabling timely communication and appropriate information exchange.

During the past 12 months support and advice has been offered in seventy-one possible PiPoT/Staff safeguarding issues. Of the cases identified several have resulted in a disciplinary sanction, some short of dismissal, a small number of dismissal / resignation and referral to external agencies for support.

19.0 Mental Capacity Act and Deprivation of Liberty Safeguards - DoLS

19.1 Background

The Deprivation of Liberty Safeguards was introduced in 2009 and are part of the Mental Capacity Act 2005 (MCA). They are used to protect the rights of people who lack the ability (mental capacity) to make certain decisions for themselves.

The Mental Capacity Act provides the essential framework of guidance for people who need to make decisions on behalf of someone else. It sets out who can take decisions, in which situations, and how they should go about this – making sure they act in the person's best interests and empowering people to make their own decisions wherever possible.

The Deprivation of Liberty Safeguards is set firmly within the empowering ethos of the Mental Capacity Act (MCA). They encourage all health and social care providers to put liberty and autonomy at the heart of care planning, to avoid wherever possible the need to deprive people of their liberty.

This section of the annual report provides an update to the Trust in respect of compliance with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) in line with the CQC's approach to regulation under the Health and Social Care Act.

19.2 Mental Capacity Act

The Mental Capacity Act 2005 (MCA) came into force in October 2007 and provides a legal framework for assessing capacity and making decisions about the care and treatment of adults who lack capacity. This could be due to a mental health condition, a severe Learning Disability, a brain injury, a stroke, or unconsciousness due to an anaesthetic or sudden accident. It also created new protections and powers in respect of the decision-making process. The MCA applies to young people aged sixteen and over.

The Mental Capacity Act provides:

A duty to treat an incapacitated person in accordance with their best interests.

Limited ability to restrain an incapacitated person in accordance with their best interests but is only lawful where:

- It is necessary to prevent harm.
- Proportionate to the likelihood and seriousness of harm and in the least prohibitive way.

To lawfully deprive an incapacitated person of their liberty, even in their best interests, the Trust must follow the statutory DoLS process and obtain an authorisation in line with the Act.

When carrying out acts of care and treatment in the best interests of a person who lacks capacity, staff will be legally protected through Section 5 of the MCA against legal challenges, providing that they:

- Have taken reasonable steps to assess the person's capacity to consent to the act in question.
- Reasonably believe that the person lacks capacity to consent.
- Reasonably believe that the act they are carrying out is in the person's 'best interest.'

The Act is accompanied by a 'Code of Practice' which gives essential guidance on the implementation of the key principles.

Other provisions of the Act include:

- Appointment of Independent Mental Capacity Advocates (IMCAs) to support and represent people without capacity who have no-one to speak for them when decisions need to be made about serious medical treatment or a change in a care home or hospital accommodation.
- The Court of Protection is a specialist court with powers to deal with complex matters affecting adults who may lack capacity to take a particular decision.
- Lasting Power of Attorney (LPA) enables people to appoint one or more people they know and trust to make decisions for them on their behalf relating to Personal Welfare (including healthcare decisions) and property and affairs, an LPA must be registered with the Office of the Public Guardian before it can be used.
- Planning for future care – Advance Decisions are applicable when a person who made it does not have the capacity to consent to or refuse the treatment in question; it refers specifically to the treatment in question and the circumstances to which the refusal of treatment refers are present.

19.3   Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards came into effect in 2009 and are part of a legal framework set out in the Mental Capacity Act. They set out the principles that should guide such decisions, including the need to act in the person's best interests and to achieve the desired outcome in ways that put the least restriction on the person's rights and freedom of action, and empowering people to make their own decisions wherever possible. The reason the Safeguards were introduced was to address the problem that arises if a person does not have the mental capacity to make an informed decision about care or treatment.

There is no simple definition of deprivation of liberty and each decision must be made on a case by case, patient-specific basis. Certain key factors can be relevant in identifying whether the steps taken in caring for a patient amount to a deprivation of liberty. These include:

- The use of restraint (including sedation)
- Staff exercise complete and effective control over the care and movement of a person for a significant period.
- Staff exercise control over assessments, treatment, contacts, and residence.
- Decisions being made that the person will not be released into the care of others or permitted to live elsewhere unless the staff considers it appropriate.
- The refusal of a request by a carer for a person to be discharged to their care.
- The person being unable to maintain social contacts because of restrictions placed on their access to other people.
- The person loses autonomy because they are under continuous supervision and control.

Staff must consider whether the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty.

Staff are required to consider the following factors before considering a Deprivation of Liberty Safeguards application:

- Can the patient receive the planned care or treatment using a less restrictive but still effective care plan which avoids an unauthorised deprivation of liberty?
- Is the patient receiving treatment for a mental disorder?
- If the patient cannot receive the planned care or treatment with there being a risk of depriving them of their liberty, and all practical and reasonable steps have been taken to avoid deprivation of liberty, an application for authorisation of deprivation of liberty must be considered.

The Trust is responsible for ensuring that they do not deprive a person of their liberty without an authorisation and must comply with the law in this respect.

Figure 20: The number of DoLS referral made between April 2024 and December 2024 including a break down for divisional activity, quality of completion and age.

Data for Jan – March 2025 is currently not available

Number of DoLS April 2024-December 2024
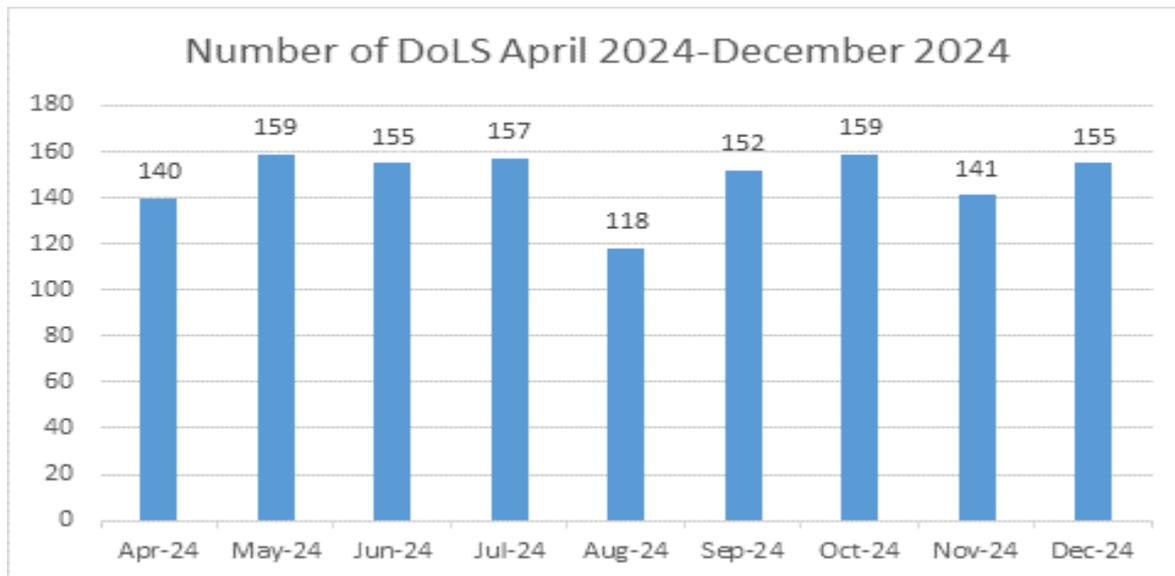
Over the last 5 years there has been a steady increase in DoLS applications.

Number of DoLS from each division April 2024 - December 2024

Number of DoLS age group from April 2024 - December 2024

Standards of all DoLS from April 2024 – December 2024
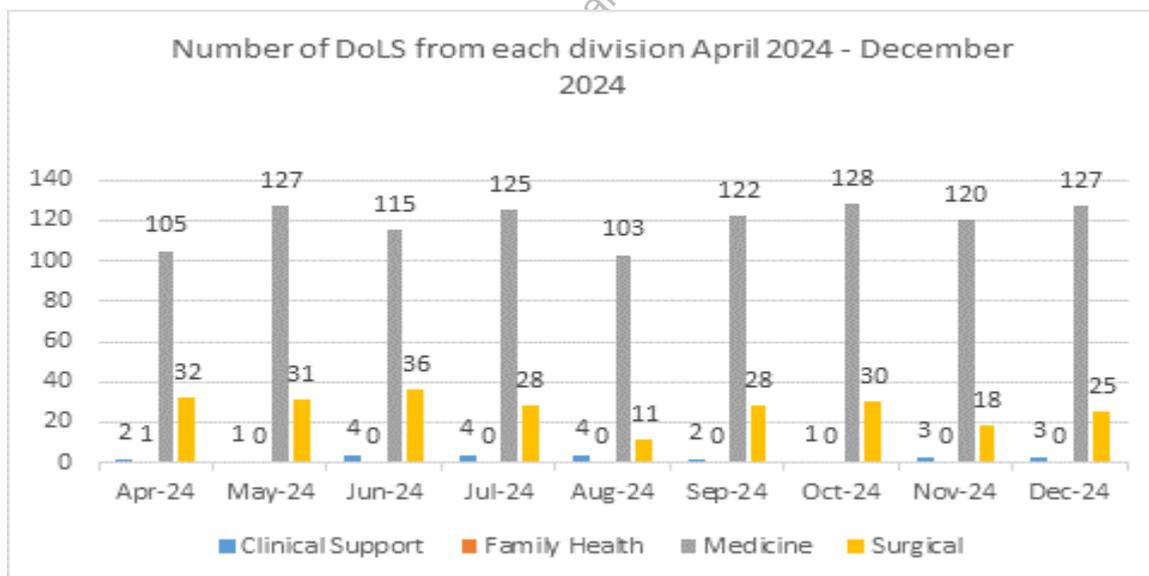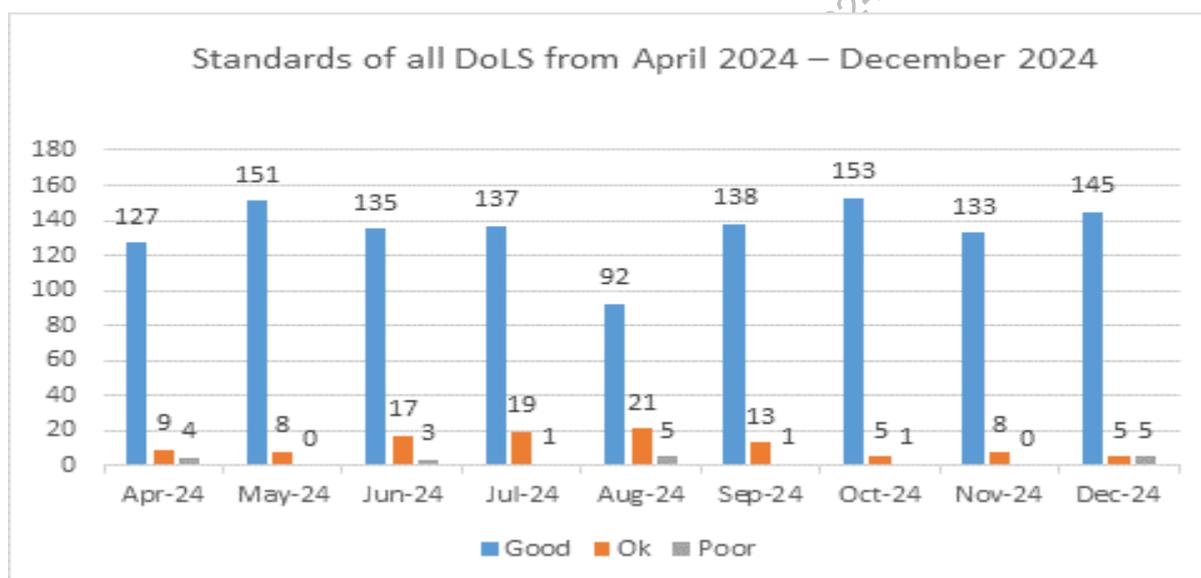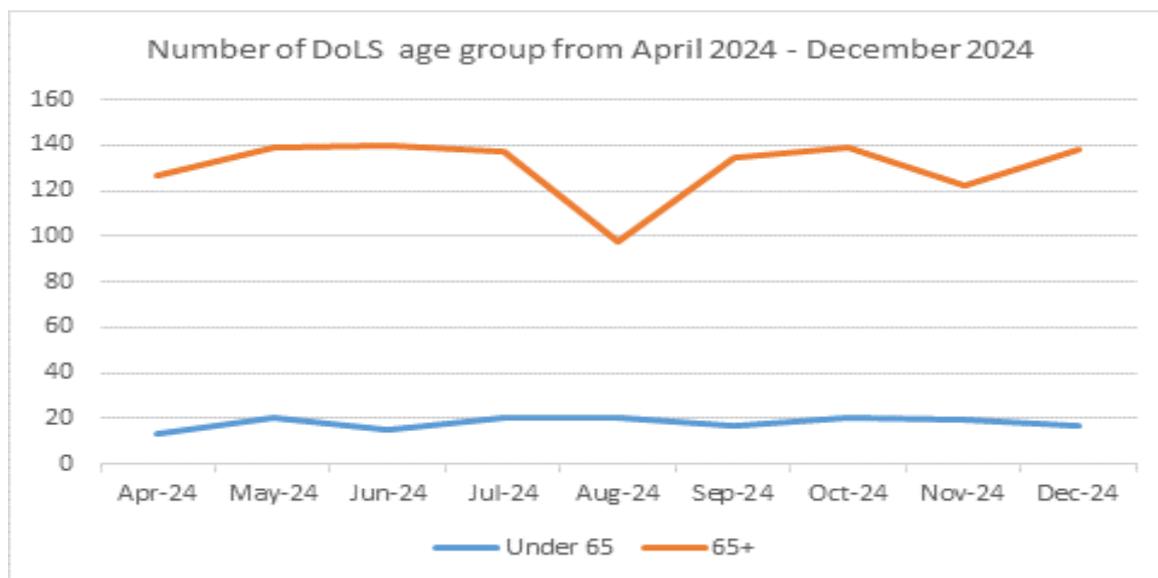
20.0 Dementia

20.1 What we know about dementia?

Dementia is a worldwide issue, growing significantly every year. It is estimated that over fifty-five million people have dementia around the world. This figure increases by ten million annually and is estimated to reach 78 million by 2030 (World Health Organisation (WHO), 2021; Gauthier et al., 2021). In the UK there are currently 944, 000 people living with dementia, of which around 700,000 are in England, these figures

are set to increase exponentially over the coming decades (Alzheimer's Research UK, 2021; Wittenberg et al., 2019b).

20.2   The impact of dementia

Dementia has significant psychological, physical, social, and economic consequences for the person living with the disease as well as their families, carers, communities, and society at large (WHO, 2021). Not only can dementia severely impact someone's cognitive functioning, but it also has a debilitating effect on their physical capacity, particularly later in disease progression (Alzheimer's Society, 2021b). The cost implications for health and social care are substantial, in 2019 in England alone the total cost of dementia care was £29.5 billion, of that total cost 14% is attributable to healthcare, 46% attributable to social care and 40% attributable to unpaid carers (Wittenberg et al., 2019a).

Figure 21: Projected costs of dementia for older people (£million), 2019-2040

	2019	2020	2025	2030	2040	% change
England						
Healthcare	4,100	4,300	5,300	6,700	10,600	156%
Social care	13,500	14,500	18,600	24,000	39,200	191%
Unpaid care	11,700	12,200	15,300	19,400	30,100	157%
Other	150	210	260	340	540	254%
Total	29,500	31,200	39,500	50,500	80,400	173%

20.3   Dementia in Lincolnshire

There are an estimated 12,458 people aged sixty-five and over living with dementia in Lincolnshire – equivalent to 6.8% of the over-65 population and 1.6% of the whole population. This is predicted to increase to 16,558 by 2030 and 17,949 by 2035 (44.1%), which is higher than the expected national increase of 40.3%. This will equate to 7.86% of the over-sixty-five population or 2.3% of the whole population.

The number of people aged sixty-five or over in Lincolnshire is projected to increase by 60,000 (33.5%) between 2019 and 2035, with the highest proportion of people in this age group who are living with dementia estimated to be in Lincoln, Boston, North Kesteven and South Holland. South Kesteven is expected to see the greatest increase in people with dementia (66.75%), given a predicted shift towards a higher proportion of older people.

The prevalence of dementia increases with age, and, due to longer life expectancy, this is higher for women than for men. In 2018, an estimated 61.5% of people in Lincolnshire living with dementia were female.

There were also an estimated 211 people under the age of sixty-five with dementia in Lincolnshire in 2019.

In 2017, national prevalence of dementia for all ages was 0.8%. At this time, Lincolnshire East and South Lincolnshire were higher than the national figure (1.0% and 0.9% respectively), and Lincolnshire West was the same (0.8%). Southwest Lincolnshire was below the national figure. In the over sixty-five population, the national figure was 4.33% as at December 2018. Locally, Lincolnshire West had the highest prevalence, which was similar to the national figure (4.37%). Recorded prevalence in the other Lincolnshire areas was significantly lower, and Southwest Lincolnshire had the lowest recorded prevalence in the Central Midlands at 3.59%.

In 2018, the highest rate of dementia diagnoses was in West Lincolnshire (68%), and the lowest rate was in Southwest Lincolnshire (52.1%).

The directly age standardised rate of emergency hospital admissions of people with dementia in Lincolnshire for people aged 65+ (3,095 per 100,000 population) is significantly lower than the national rate (3,609 per 100,000 population) for 2017/18. This equates to 5,559 emergency admissions.

Of the 4436 people with a Learning Disability below the age of 65, (0.8%) 35 have a diagnosis of dementia and of the 408 people 65+ with a Learning Disability 43 have been identified as having dementia (10.5%).

In 2017, there were 1,703 (948 per 100,000 population) deaths of people in Lincolnshire aged sixty-five and over, where dementia was mentioned either as an underlying cause of death or a contributory factor. This is a similar figure to the England rate of 903 per 100,000 population.

A number of behavioural and disease factors are known to increase the likelihood of developing dementia and many of these are more prevalent in Lincolnshire than at both regional and national levels, including physical inactivity, being overweight or obese, hypertension, stroke, diabetes, CHD, and depression. These factors are not evenly spread across Lincolnshire, which creates inequalities in those populations experiencing deprivation.

20.4   Progress 2024 - 2025

In 2021 ULTH embedded dementia within the safeguarding portfolio and governance framework and as a result appointed a Safeguarding Adults/Dementia Specialist Nurse within the team. There are numerous projects ongoing to improve and develop the services for our patients who have dementia or are likely to have an

undiagnosed dementia and to support those who have a delirium whilst in our hospitals. As part of the ongoing work there has been a notable increase in the need to support dementia patients with MCA – particularly in the outpatients setting as well as patients who come into the Trust for whom there are safeguarding concerns raised.

Relationships continue to be developed with LPFT, LCHS and the wider ICB for collaborative working using skills, experience and services which will support our patients and their families and embed the Dementia Strategy for Lincolnshire.

Work includes supporting all staff to refer patients who we are concerned may have an underlying dementia directly through to the memory clinics, rather than requesting GP referral via EDD. We also refer patients with a dementia, and/or their carers to the Memory Support Services who can help from the point of diagnosis through to end of life. Contact has also been developed with third sector services to engage and support in clearer ways. We have excellent communication with Carers First and the iForget service though AgeUK to ensure the carers of our patients are also supported and advised as required. We are also linked into the Regional Care Providers meeting to discuss and build bridges with care providers where many of patients are transferred from.

Carers are a huge asset to our patients who have dementia, and it is an important part of care that we work with them as care partners, ensuring they are supported. During 2023 – 2024 the Trust launched the Carers Hub at Pilgrim Hospital, a space staffed by volunteers who can offer signposting and advice to the carers as well as a space for them to have a drink and someone to talk to if things are difficult whilst in hospital. Work has also been undertaken to ensure our young carers and informal carers are included too.

The care partner's policy has also been relaunched and promoted heavily for our dementia patients, within this it ensures that carers have open access to their loved one, to be able to support them physically, emotionally or psychologically. The policy also ensures that the carers are supported, including in discussions about the patient, if they are unable to participate, as well as offering food and drink, breaks and free car parking.

Dementia Support Practitioners are in post at both Boston and Lincoln. They work with patients and their families early into the hospital admission to develop a one-page care plan, based around the 'All About Me' document, to give staff a snapshot of what the patient needs to have a positive experience whilst in ULTH. It allows staff to understand the person's background; their likes and dislikes and any triggers of distress, to support reminiscence conversations, make reasonable adjustments to their hospital admission, reduce the distress and anxiety of being in an unfamiliar environment.

With support and guidance from the Patient Experience team the new 'All About Me' document has been developed and is currently with the printers. There will then be a series of work undertaken with the communication teams to publicise the new All About Me document in order to get it used more widely. It is important to note that this document is for all people in Lincolnshire who have or may develop communication difficulties – not just those living with dementia. Once ready for relaunch it is expected that all organisations will embed this as part of the normal care pathway and the document used in a wider way.

Each ward area has a Dementia Distraction Box which are filled with various activities to distract, stimulate, and comfort our patients. We have fiddle mitts, kindly donated by various knitting groups, games such as dominoes, snap, cards. Larger building blocks and musical instruments as well as colouring packs and puzzles. We often find patients with Dementia are concerned that they cannot afford to pay for their stay or for their meals etc. available in the boxes are small purses and coins to alleviate some of these worries. Our dementia support practitioners also have access to other tools to support patients as required.

The distraction boxes are constantly reviewed and will shortly include the introduction of sensory bags within A and E and UTC departments which is a nationally used tool predominately for patients with Learning Disabilities.

Supporting the uplift of band 2 HCSW to band 3 CHSWs with dementia and Learning Disability training is currently under review and will be weekly via TEAMS. It gives a brief overview of each vulnerability as well as the support we offer within ULTH as coming into hospital can be distressing due to a strange, busy environment with different people coming and going as well as losing the routine that they all thrive on. Dementia was removed from the new care camp set up; however, it has been realised that there is a need for the information, so work is planned with the clinical educator's team to develop this programme.

With support from United Lincolnshire Hospitals Charity, we now have Dementia pets across the Trust. These are battery operated kittens and puppies which can provide comfort, reassurance and a conversation opener for someone who has dementia. These are allocated as prescription only by our dementia support practitioners which means that the pets can be discharge home with the patient in order to continue to be a tool that can continue to be used.

A new Dementia eLearning package is written and ready to launch, and embeds information across all staff groups to ensure staff have at least an awareness of dementia and how they can support that person, or their family, from answering the phone, meeting someone in a corridor, through to how we can meet their needs on

our wards and clinical areas as well as being able to support through the discharge process to ensure our patients, and their carers have support.

The Trust took part in the National Audit for Dementia; data collection had a new format and had several challenges. Although to date we have not yet received any information from the audit, we are already aware of aspects that we as a Trust need to review and will be discussing over the next year.

21.0   Learning Disability and Autism

A Learning Disability affects the way a person learns new things throughout their lifetime by affecting the way a person understands and communicates information.

This may mean they can have difficulty with:

- Understanding new or complex information
- Learning new skills
- Coping independently

A visit to hospital can be difficult for anybody, but it is particularly challenging for people who have a Learning Disability or Autism. Reasonable adjustments to the health care of people are not only a statutory duty under the Equality Act 2010 but are also beneficial for all involved.

21.1 Learning Disability and Autism in Lincolnshire

It is estimated more than 14,000 adults with a Learning Disability currently live in Lincolnshire, with the number expected to increase to around 15,800 by 2035. However, only 4,500 individuals are on the Learning Disability Register maintained by County GPs. Of those who are registered, around 75% are in receipt of an annual LD Health Check, meeting the national NHS England target.

Learning disabilities are often confounded with multiple physical and mental health conditions and so there is an increased risk of developing chronic conditions from genetic and lifestyle factors. Evidence suggests rates of numerous major diseases (heart failure, epilepsy, severe mental illness, diabetes and dementia) are higher in adults with Learning Disability than the wider population. Consequently, average life expectancy for people with a Learning Disability is significantly lower than for the general population. Continuing to encourage the take-up of Annual Health Checks for people with a Learning Disability is a high priority to support early

identification of health needs and take steps to lower risk (e.g., through modifying health behaviours or medication).

The number of people with a Learning Disability in Lincolnshire will continue to increase, particularly in those aged over sixty-five. Being medically better able to sustain life, complexity of needs will increase.

Figure 22: Children with Moderate Learning Difficulties Known to Schools 2020
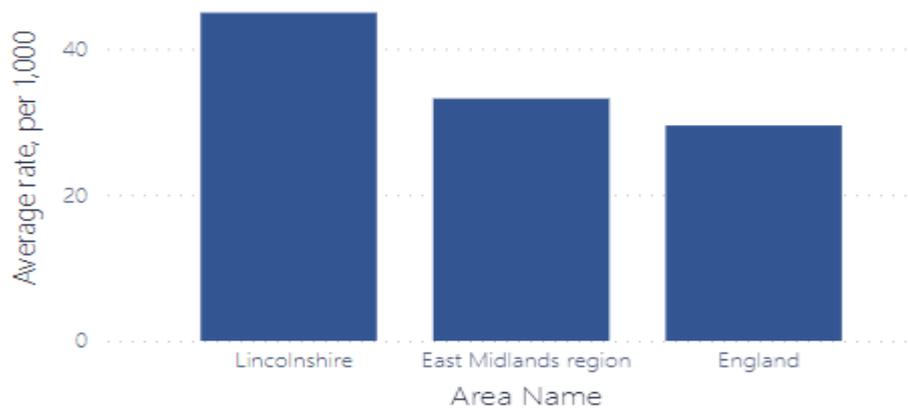
Lincolnshire Health Intelligence Hub 2022

Figure 23: People aged 18-64 predicted to have a Learning Disability
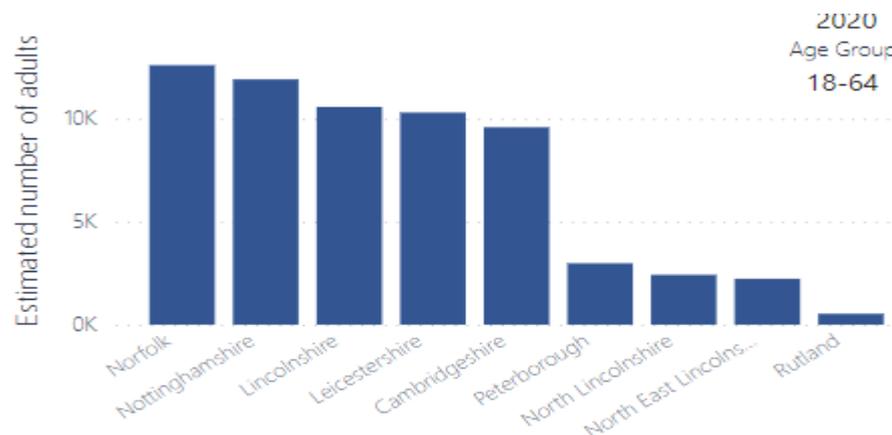
Lincolnshire Health Intelligence Hub 2022

Mechanisms for accurate recording of autism are not consistently available across health, education and social care systems meaning actual reliable figures are currently unavailable. For example, it may be documented that an individual is identified as having a disability within a particularly setting, but not specifically identified that they are Autistic.

In 2021-22, approximately 156 adults (aged 18+) and 192 young people (aged under 16) in Lincolnshire were diagnosed as autistic, according to Lincolnshire NHS mental health data collection. This does not include diagnosis given in private practice, by an out of area referral or by any process beyond the standard autism diagnostic pathways.

Nationally autism is underdiagnosed amongst certain groups such as older people, those who identify as females and individuals from Black, Asian and minority ethnic groups. This is due to the assessment tools used in autism diagnosis and limited awareness of the ways in which autism can present in different groups. Estimated numbers of individuals living with autism in the local community are likely to increase, as improvements to diagnostic pathways and services are made.

Figure 24: Children with Autism Known to Schools 2020
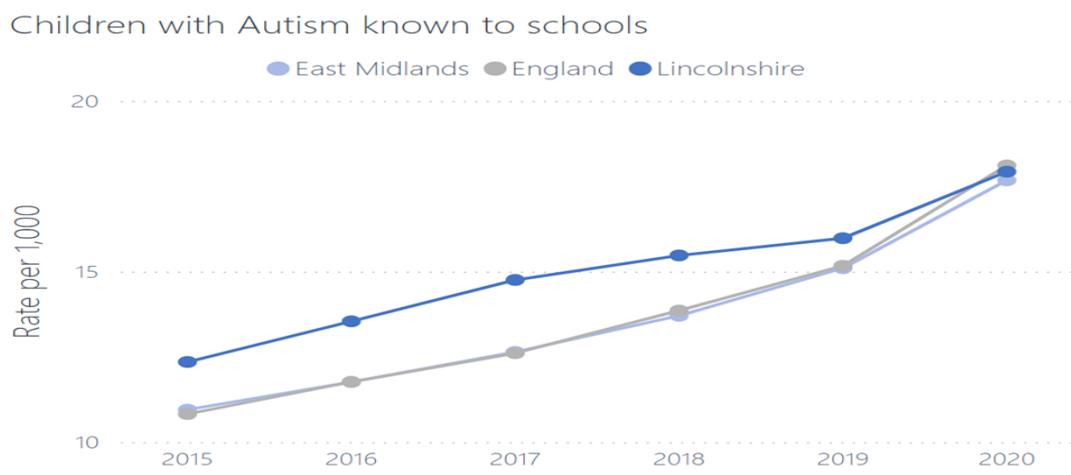
Lincolnshire Health Intelligence Hub 2022

Figure 25: People aged 18-64 predicted to have autistic disorders by 2040.
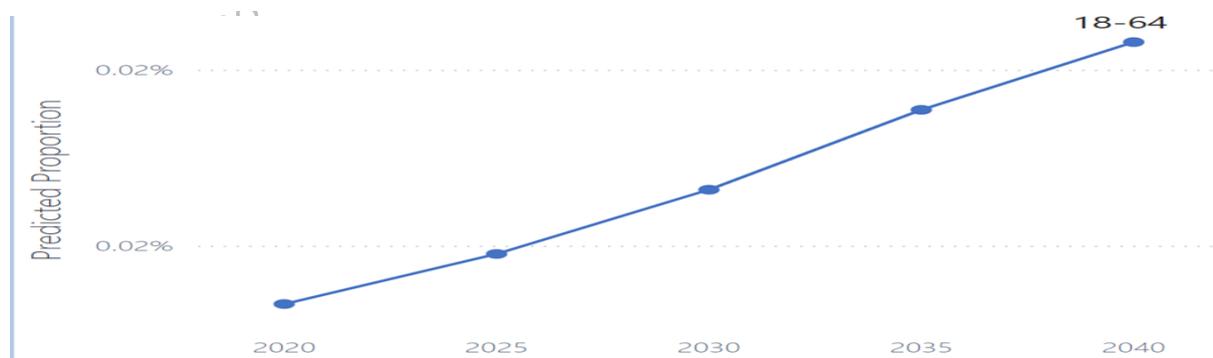
Lincolnshire Health Intelligence Hub 2022

21.2 Learning Disability and Autism

In 2021 ULTH embedded Learning Disability and Autism within the safeguarding portfolio and governance framework and as a result appointed a Safeguarding Adults/Learning Disability Specialist Nurse within the team who continues to develop pathways which make access to the services from ULTH more accessible (at times this will include applications to the Court of Protection).

In December 2021 Learning Disability and autism training was launched for all staff groups in ULTH to ensure staff have an awareness of learning disabilities and autism and know how they can support that person, or their family, from answering the phone, meeting someone in a corridor, through to how we can meet their needs on our wards and clinical areas as well as being able to support through the discharge process to ensure our patients, and their carers have support.

In July 2022, the newly legislated 'Oliver McGowan' Training** was announced as a minimum benchmark for NHS Trusts and was launched across the Trust. Over the last 12 months we have worked together as a system to develop a local process based on the high standards and minimising impact of this training across Lincolnshire. This work is still ongoing and is likely to take a further 2 – 3 years for it to be fully embedded.

**** Oliver McGowan Training was added to the ULTH Trust Risk Register (236 – moderate) in April 2023 due to the significant impact that delivering the training will have on the Trust – work is ongoing at a national and system level to try to mitigate the risk and develop a workable solution**

Since starting in post, the Specialist Learning Disability Nurse has provided additional advice, guidance, and support to patients with a Learning Disability, their carers/ parents, staff within the hospital as well as working collaboratively with health and social care partner agencies to ensure sure a multiagency response to those more complex patients.

The post holder continues to directly support patients, give advice, and make recommendations to health and social care colleagues for a number of patients each month. This has directly improved patient care and experience and supported ward and clinical areas with understand the needs of people with Learning disabilities, educating staff and role modelling interacting with patient with alternative communication needs.

The post holder has also supported a small number of children with additional needs (Autism and or Learning Disability) elective admission via Children's wards or transition 16/17-year-olds attending through the adult elective pathway.

The post holder has chaired a number of Best Interest Meeting and supported staff to ensure MCA is followed and embedded for patients with learning disabilities. Cases have involved complex, finely balanced and disputed decisions along with planning for

cases which have been referred to Court of Protection for approval for care and treatments.

Multi-agency and multi-disciplinary partnership working has been an essential part of the role, establishing strong partnerships with LPFT Learning Disability teams especially the Acute Learning Disability Nurses (ALN) and LCC Learning Disability Social care. The Trust are now involved in a number of proactive physical health meetings across the Lincolnshire services to ensure ULTH are included in plans for people with learning disabilities. This includes attending regular meetings with LPFT LD CAMHS regarding the elective admission for children and Healthy Lives working Group which is chaired and facilitated by people with learning disabilities.

Bespoke Learning Disability and Autism awareness training continues to be delivered across wards and departments as learning is identified though Patient Safety and LeDeR feedback and delivering training within the clinical educator's forums across sites along with bespoke clinical skills session's divisions / ward areas are providing. This bespoke training enhances the knowledge already gained though the Oliver McGowan training as this focuses on resources and support available within ULTH, where to access it, the Learning Disability bundle and how to use it, along with practical advice related to the acute hospital. Thus, enhancing staff confidence and knowledge of how to care and support someone with a Learning Disability and or Autism.

Easy read information is now on the external and intranet ULTH pages for anyone to access. There are plans to add to this, to increase the resources available in easy read and this is just the start of the process to meet our Accessible information standard requirement.

With support from Experts by Experience the team have spent time producing a suite of videos which demonstrate hospital experience from a client perspective which will become available during the summer of 2025.

An example of the filming is attached in the following link.

https://youtu.be/W19l8wmVmxM

Whilst the focus of the work has been within the hospital setting, over the next 12 months this work, and learning will be cascaded through LCHS.

Since the development of the joint working between ULTH and LCHS Safeguarding teams there have been several patients who have benefitted from a more joined up approach in transition from community to hospital and includes a system wide approach for developing and embedding the Autism Pathway with specific work undertaken by LCHS regarding the autism diagnostic observation schedule, improved links with SEND and development of educational health plans.

21.3 Ongoing plans for 2025 – 2026

The 'All About Me' passport is now over 10 years old and has undergone a refresh. Currently waiting for this its return from the printers although an electronic version will be available. This has been a joint piece of work lead by the Dementia Safeguarding Nurse and Learning Disability Safeguarding Nurse with the expertise of Patient Experience Manager for the technical side of the document. The document has been reviewed and feedback gathered from staff within all health and social care systems within Lincolnshire, along with private sector and voluntary sector to ensure everyone has had an opportunity to commitment. Feedback has also been sort from Peer Support Workers and Experts by Experience in LPFT services. The new document will be for all ages and patients with mental health, dementia, physical health conditions and those with Learnings disabilities and or autism. Potentially the list of patients that could benefit from this passport is endless.

There are clear challenges with elective admissions for patient with learning disabilities who have complex needs and require a number of reasonable adjustments to ensure they are fully supported on admission. The Post holder has been supporting the development of the surgical pathway to ensure there is a consistent pathway across all ULTH sites for patients with a Learning Disability. This involves reviewing the current pathways at the start of the process, from listing patient for surgery, pre assessment, anaesthetics, theatre scheduling and adapting it to each hospital site with the different physical environments of theatres / admission wards etc. This will include the introduction of sensory box for theatres and recovery area as part of this process. While this work is ongoing to develop the SOP, theatre lists have been reviewed on a weekly basis to identify any patients who have additional needs, to prevent anyone from being missed. The commitment for this from a number of professionals, has been amazing, including Pre assessment and Waiting list leads along with the PA from TACC who has found a new passion for supporting patients with learning disabilities and been a champion of supporting the development of this pathway.

Transition - young people of 16 and 17 years old with additional needs, learning disabilities and or Autism who are listed for elective admission is also becoming a challenge. Focus on this within the surgical pathway will be added as an area to resolve.

LeDeR / SJR / patient safety and mortality – Review and audit the feedback from LeDeR and the actions from governance group to look at ULTH role in improving the outcomes of people with Learning Disabilities. Feedback will be added to the bimonthly MHNDD Steering group Learning Disability report which all divisions are represented. Individual feedback also given directly to clinical areas, department leads / ward sisters to ensure direct learning for each area is shared across teams. There have been some

common themes emerging and will influence changes to teaching, the review of the care bundle and the ED checklist / resource folder.

Increase the number of flags and alerts across the Trust for people with Autism and Learning disabilities in line with the NHS Reasonable Adjustment requirements to ensure more meaningful information is shared. Continue to promote staff reading these alerts and acting on them.

Increase the Number of ED Reasonable Adjustment Care Plans. All patients referred to ALN service are offered a Reasonable Adjustment Care Plan which is then added as a Flag to remind staff to read it.

Develop a funding plan to facilitate the employment of an expert by experience role within the Trust.

Expand the role into LCHS ensuring clients in community have an equitable service.

Sensory bags and Emergency Department / UTC focused work. Currently producing guidance on the role out of piloting sensory bags for UTC at Grantham and A&E at Pilgrim and Lincoln. These sensory bags have been kindly funded by ULTH Charitable Funds after extensive research and seeking views of people with Learning Disability and or autism. It is hoped they will provide a welcome support, distraction and sensory reducing effect for people who are waiting in these busy areas. From a sensory point of view these are over stimulating with loud sounds, different smells, and bright lights. These bags can be taken home with them or used on the ward if admitted. It is hoped after feedback from the pilot that they will prove beneficial, and a business case can be made to order further sensory bags which can be provided for all our UTC departments.

Further work within ULTH Emergency departments is the development of a stamp to be used on the A&E documents which highlights need for a referral to ALN service, so the patient and staff get support from ALN service in a timely manner. Its widely acknowledged through local and national LeDeR feedback if a patient has the support of a Learning Disability Nurse, they have a better hospital experience and outcome.

A resource folder for UTC/ED is being developed with the support of staff to provide information and resources aimed at improving knowledge of staff. This will be developed with the support of experts by experience. In additional as ED do not use the LD bundle a check list is to be created to remind staff of actions they should take, this is also based on feedback from LeDeR, complaints and staff feedback.

Currently the team are continuing to embed the Care Bundle which every patient with a Learning Disability should have completed on admission to a ward. This will be aligned with the Dementia bundle and in the future the mental health bundle to ensure constantly for staff. The bundle encourages staff to have open and transparent communications with patient and or parent and carer, to identify and plan how they

can meet the needs of people with learning disabilities, including reasonable adjustments when in an acute setting. This includes the use of the carers agreement to look at carers role in hospital to prevent any miss communication in the future.

LPFT ALN nurses now have honorary contracts with ULTH to support them to access ULTH systems and process thus enhancing their role and the support they can offer without barriers of system access. LPFT and ULTH have undertaken a review of the processes and pathways within ALN role was undertaken to ensure they are supported to carry out their role and that the patients (carers and or family) and ULTH staff get the right support at the right time. Following the review a Priority Scoring tool for ALN referrals has been developed to support the increase demand in referrals. This is currently being piloted.

ULTH supported LPFT to present a business case at the ICB for developing and expanding the ALN service. The service is currently for 18 years plus with a diagnoses Learning Disability which runs Monday to Friday 9.00hrs to 17.00hrs. There are currently two whole time ALN nurses and one part time Practitioner for the three main hospital sites. The long-term aim would be for an all-age service, 7 days a week thus proving an equitable service for children and adults and over the whole week. This was declined and in the current financial pressures is on hold, however we continue to collect data and evidence of the need to expand the service when pressures allow.

22.0 Safeguarding Risks

The safeguarding teams have proactively used the risk register to identify a variety of risks based on current and future predicted changes and have embedded the actions within the day-to-day business of the team.

Figure 26: Summary of current risks and risks scoring for 2023 – 2024.

ULTH 359	If the Trust cares for patients with significant learning disabilities and complex needs in a manner that is not appropriate to their needs (e.g., because there is no pathway to achieve a General Anaesthetic for procedures such as blood tests/ MRI, etc.) it could lead to sub-optimal care and delays in diagnosis or treatment with an increased likelihood of serious harm or a poor clinical outcome.	LOW (6)
ULTH 211	If a patient becomes agitated and in response the Trust applies sedation, restraint, chemical restraint, or rapid tranquilisation inappropriately it could result in serious harm to the patient; other patients; or members of staff and could lead to subsequent legal or regulatory action	LOW (6)
ULTH 236	The Trust will be unable to comply with the legal requirement to deliver the Oliver McGowan training across the full staff cohort which came into effect July 2022	LOW (6)

During 2024 – 2025 the safeguarding team have been actively involved with working to reduce and manage these risks which are monitored by the Safeguarding and Vulnerabilities Oversight Group.

23.0   A review of 2024 – 2025

During 2024 to 2025 safeguarding activity remains high particularly in relation to patients admitted due to eating disorders/disordered eating and Mental Health related issues as well as cases being more complex in nature. The successful appointment to a new post focussing on Managing Emergencies in Eating Disorders or Disordered Eating has seen a more streamlined risk assessment of these cases and improved plans of care including support for staff.

As expected Nationally there have been several serious children / adult reviews which indicate the negative impact on our ability to safeguarding our most vulnerable during the post pandemic period and domestic homicide reviews appear to be on an increase.

Since June 2023 both ULTH and LCHS safeguarding teams have had the same manager which has brought improved communication between the two Trusts and a more seamless approach for some of our most vulnerable. This has developed further since the formation of the Group.

- Face to face supervision as expanded, with additional sessions available via Teams to facilitate attendance across the Trust and work is ongoing to improve levels of attendance.
- Safeguarding and vulnerabilities pathways and processes to support staff in managing safeguarding related concerns have been reviewed and shared working across the two teams has expanded making efficiencies across the Group.
- The Safeguarding Hub on the ULTH Intranet site has been revised to improve accessibility for Practitioners requiring support and/or safeguarding-related resources.
- The shared Safeguarding training plan is embedded across the Group, ensuring that there is a commonality within staff groups and that any training sessions delivered will be available to all staff no matter which Trust they work for, or which Trust is delivering the course.
- Maintained and increased our presence in external / partnership processes such as the LSCP / LSAB / strategy meetings / MARAC.
- Continued to develop Group policies and improvements, undertook audits to maintain safety and identify risks.
- Continue to develop and expand safeguarding roles within the team to ensure that the Trust can deliver a safeguarding and vulnerability service (Child

Protection / Adult Protection / MCA / PREVENT/Learning Disability / Autism and Mental Health)

- Provided continued support with chairing complex MDT meetings and best interest meetings.
- Continue to support staff members who are required to produce statements for, or attend as a witness in, Family or Criminal Court.
- Facilitated the delivery of quarterly court craft skills training events and bi-annual Legal updates for staff who are required to attend court delivered by the Trust solicitors.
- Embedding the first phase of Oliver McGowan training across the Trust ensuring a system wide approach to the challenges that delivery brings.
- Safeguarding team actively involved in the review of complaints and Serious Incidents with a Safeguarding or MCA aspect,
- Introduced a dedicated SG CYP Supervision sessions for Managers and Matrons,
- Continue to undertake ward spot checks /audits in relation to MCA/ DoLS
- Reviewed the ligature risk assessment process and rolled out the ligature cutter (QUAD) pack across clinical areas within ULTH alongside refreshed ligature training.
- Continued support with HR processes in relation to staff members for whom Safeguarding concerns have been raised (LADO/PiPoT)
- The new De-Escalation, Management, and Intervention (DMI) training across the Trust was launched in July 2023 and continues to roll out across the identified staff groups.
- Development of accessible information about how to access our hospitals, including videos co-produced by our patients with lived experience of people.
- Successfully appointed to the post of Safeguarding Domestic Abuse Advocate for ULTH.
- Supported the Children's Services Front Door Strategy Discussions process.

24.0 Safeguarding Developments and ongoing work for 2025-2026

- Maintain momentum to achieve 90% across safeguarding training areas.
- Finalise and embed pathways for clients with Learning Disability / autism across ULTH Trust services ensuring smooth transition from primary and community care.
- Continue the transition towards fully embedded the newly legislated Oliver McGowan training (3-year plan)

- Audit adult concerns submissions within the Trust to ensure compliance with 'Making Safeguarding Personal.'
- Review and embed the new Learning Disability bundle and shared care agreements within ULTH.
- Continue to embed a system of flags and alerts across the Trust for people with Autism and Learning disabilities making use of the national 'reasonable adjustment' flags as appropriate.
- Continue to embed the surgical assessment process for patients with a Learning Disability who require a GA (ULTH)
- Explore the viability of employment of Learning Disability and Autism Support Practitioners across ULTH and LCHS.
- Explore the viability to facilitate the employment of an expert by experience role within the Trust.
- Continued work with ED teams to ensure the potential risks to young people (16-17 years) are recognised and managed in accordance with processes including improved data collection.
- Agree a new program of audits covering Safeguarding Adult topics.

25.0 Conclusion

This report demonstrates the continued development and increased awareness of safeguarding and vulnerability issues within the Trust. The Trust continue to respond to the rapid national and local pace of change as well as maintaining an input externally.

The safeguarding governance structures have been reviewed to ensure continued effectiveness, actively managing the current action plans as well as moving services forward. These will be continually reviewed to ensure that the structures remain fit for purpose.

The last 12 months have demonstrated the value that the ULTH and LCHS safeguarding teams working together can add in relation to joint understanding of service provision, shared insight, and improved communication, all of which improve the safeguarding of our most vulnerable patients.

As the Group continues to develop there will be further advantages and benefits gained from economy of scale with less repetition and duplication ensuring that the teams can continue to effectively support patients, staff, and the organisations.

The forthcoming year promises to be full of further developments and challenges for both the teams and the Group.

26.0 Recommendations

It is recommended that the Trust Board

i)   Receive the safeguarding report.

ii)   Approve the plans for 2025 - 2026.

Appendix 1:   Safeguarding Team – Structure March 2025

Safeguarding and Vulnerabilities Team

March 2025

Portfolio:

Safeguarding Children

Safeguarding Adults

Mental Capacity and DOLS

Learning Disability / Autism

Dementia

Mental Health

PREVENT

Domestic Abuse

ULTH

Safeguarding and Vulnerabilites Team - ULHT structure March 2025
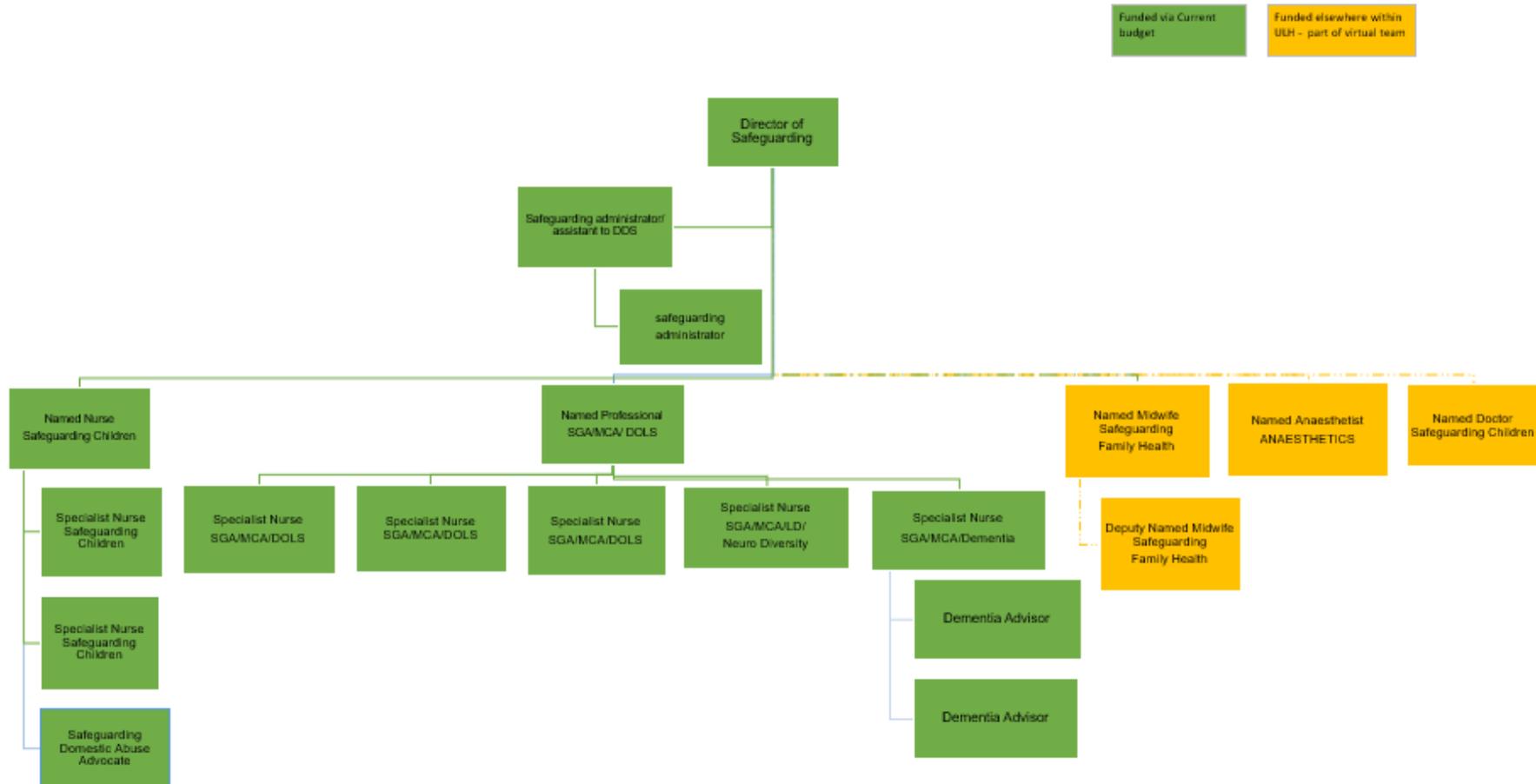
LCHS Annual Complaints Report
2024-2025

Contents

Executive Summary

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- The departments the complaints & PALS relate to
- The main complaint & PALS raised
- The main trends identified
- The actions taken in response or those planned for the future

The report also reviews our performance against agreed response targets and the number of complainants who came back dissatisfied following receipt of their initial response.

As part of the Group model, complaints and PALS teams at ULTH and LCHS have been working in close collaboration to enhance the experience of patients and service users. Recognising the importance of a joined-up approach to patient feedback, both teams have committed to sharing best practices, streamlining processes, and improving communication pathways to ensure timely and effective resolution of concerns.

Introduction

The report provides an overview and analysis of the complaints and PALS received, identified themes and trends, compliance with performance targets, and the learning and changes made in response to complaints.

All staff are encouraged to respond to concerns raised by patients and relatives as soon as they become aware of them, rather than waiting to receive a formal written response and our PALS service supports this process. All formal complaints are responded to appropriately on an individual basis and are fully investigated through the Trusts complaints procedure.

If patients or relatives wish to make a formal complaint, this is dealt with by the Complaints Team. Under the NHS Constitution people have the right to have their

complaint dealt with efficiently. It is the right of every health service user to bring aspects of treatment and care with which they are dissatisfied to the attention of the Trust. They are entitled to have their complaint investigated, to receive a full and prompt, open and honest explanation, as well as an apology if required.

The Trust ensures that complaints and concerns raised by patients, relatives and carers are investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner.

Patients are actively encouraged to provide feedback. This includes being able to raise issues at a local level with services to provide our staff the opportunity to resolve these as they arise, with our patients and family members.

The Trust continues to proactively manage complaints, improving the process and quality of the responses, and embedding the learning from complaints into our services and practice.

Looking Back at the Past Year and our Achievements

The Complaints & PALS Teams across LCHS and United Lincolnshire Teaching Hospital (ULTH) have continued to review and improve their working processes to enhance the quality of service they provide in responding to patient complaints as a Group. The Complaints & PALS Team have collaboratively been supporting the integration of the teams and processes as they work within the Group Model. The Complaints & PALS Teams continue to share best practice and discuss ways in which they can support each other and continually build on a good working foundation.

Standardisation of processes across the Group

As part of the Group Model the Complaints and 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.

Implementation of Datix Cloud

The Trust has successfully implemented DatixIQ for both PALS and Complaints at LCHS. This module gives us the tools we need to register, investigate and respond promptly and effectively to PALS and Complaints. It helps us to identify themes and trends of complaints identifying areas where the quality of our service can be improved.

Divisional Engagement

Our continued focus on building strong relationships within the Divisional teams ensures that we provide an open and transparent response. Complainants are contacted by the Divisional Teams to discuss their concerns and agree on how they would like their concerns taking forward and are able to choose how we provide them with their response. This can include a telephone call to provide verbal feedback, email or a meeting and in many instances resolves concerns without the need for a formal written response.

The Complaints Team continue to work with their dedicated Division and provide support for that Division. This helps to develop good relationships and engagement within the Division and provides consistency when supporting the co-ordination of complaints received by the Trust. The Complaints Team attend meetings to discuss themes and trends that have been identified through their complaints.

Complaints Received

During 2024-2025, the Complaints Team have continually reviewed the processes to ensure timely and high-quality responses are formulated. Our complaints process tries to balance the need to identify actions to improve care with the ability to listen, reflect and recognise that every one of us can learn from the experiences of others. We need to be willing to listen, to hear and validate experiences where we find ourselves as a Trust falling short.

During 2024-2025, the Trust received 204 complaints which is an increase of 60 from the previous financial year. In April 2024 the Trust changed process and no longer use the option of raising concerns, these are now logged as either a PALS or a formal complaint.

The table below shows the number of formal complaints in 2024-2025 in comparison to previous financial years.

Number of Complaints received over previous financial years

234 — 2019/2020
123 — 2020/2021
192 — 2021/2022
154 — 2022/2023
144 — 2023/2024
204 — 2024/2025
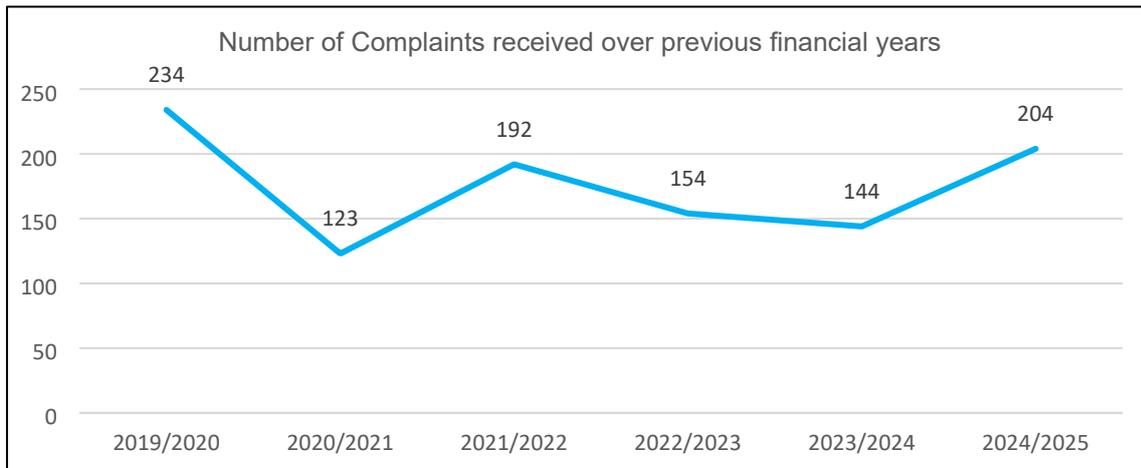
Complaints response times

99% of complaints received were responded to within 3 working days. The Team aims to acknowledge all complaints within the 3-day timescale. The acknowledgement to complainants is confirmed by either an email or telephone call and followed up by a letter. The charts below demonstrate the number of complaints that have been responded within the agreed timescales each month during 2024-2025. The complaints team are continually working to improve the response rates.

Complaints are either registered with a response time of 35 or 50 days for joint complaints with other organisations. The Trust responded to 188 complaints in 2024-2025 of which 69% of complaints were responded to within the agreed timescales. The team are promoting meetings with the complainants to enable a discussion and resolution to complaints. It is felt this is a much more personal response and allows the complainants to ask further questions and receive clarity within the meeting.

% of compliance of complaint responses compared to previous years

- 2022-2023: 61%
- 2023-2024: 50%
- 2024-2025: 69%
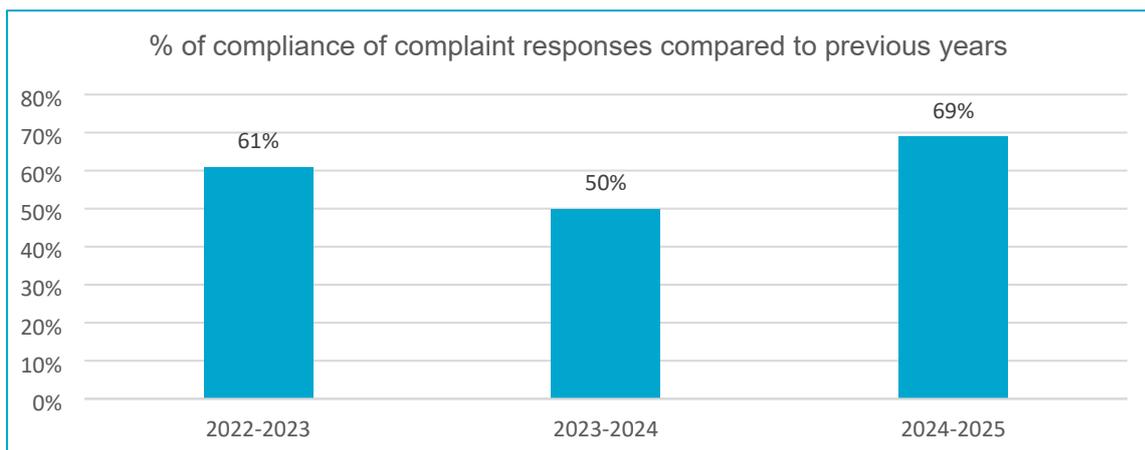
Trust Themes for Complaints

Themes of complaints received by LCHS during 2024-2025.

Complaint Categories	Number received	% of overall complaints
Access to treatment or drugs	98	48%
Patient Care including Nutrition/Hydration	34	17%
Communications	21	10%
Values & Behaviours (Staff)	21	10%
End of life care	9	4%

Complaints Received by Division

The graph below shows the number of complaints received by LCHS by Division over the last 3 financial years.
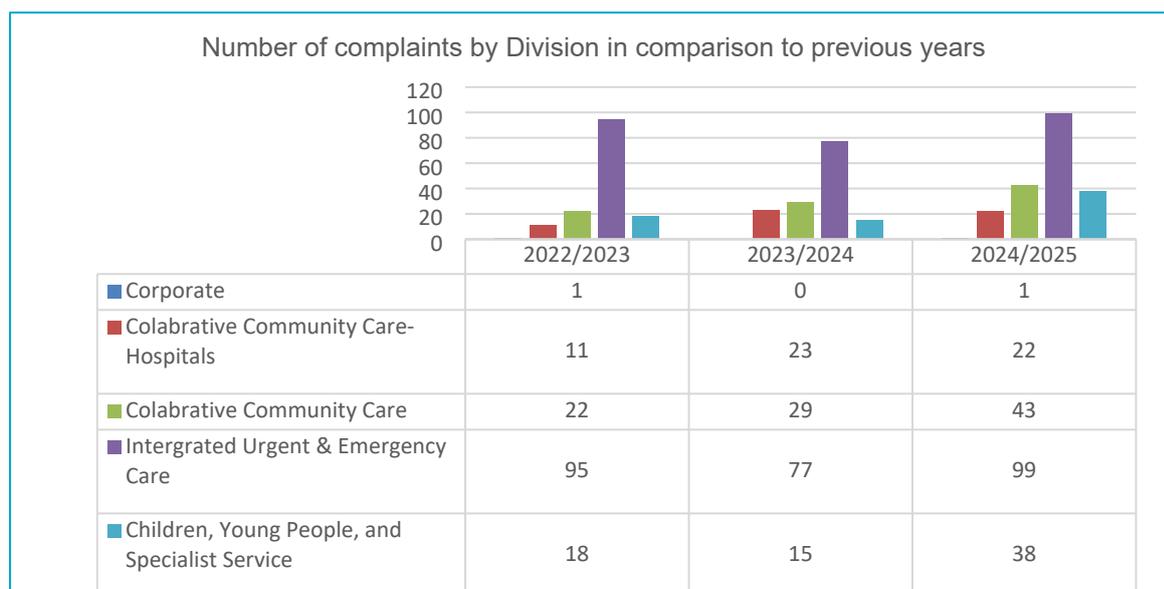
Number of complaints by Division in comparison to previous years

	2022/2023	2023/2024	2024/2025
Corporate	1	0	1
Colabrative Community Care-Hospitals	11	23	22
Colabrative Community Care	22	29	43
Intergrated Urgent & Emergency Care	95	77	99
Children, Young People, and Specialist Service	18	15	38

The table below shows the number and percentage of overall complaints received for each Division in 2024-2025 in comparison to 2023-2024. Whilst the percentage of the overall complaints received by the Trust for each Division is compariable during both financial years, there has been a rise in the number of complaints received for each Division apart from Collobrative Community Care.

Intergrated Urgent & Emergency Care received the highest amount of complaints within the Trust, followed by Collabrative Community Care.

Divisions	Number received 2023-2024	% of overall complaints	Number received 2024-2025	% of overall complaints
Integrated Urgent & Emergency Care	77	54%	99	48%
Collaborative Community Care	29	20%	43	21%
Children, Young people and specialist service	15	10%	38	19%
Collaborative Community Care- Hospitals	23	16%	22	11%
Corporate	0		1	1%

Complaints re-opened

The graphs below demonstrate the number and percentage of re-opened complaints received during 2024-2025 in comparison to previous years.

The Trust have re-opened 8 complaints in 2024-2025 which is 4% compared to 8 (6%) in 2023-2024. The reasons for the reopened complaints are detailed below:

- Complainant dissatisfied with the complaint investigation and disagreed with information shared within the response.
- Complainant unhappy and felt the response given was not accurate or required further clarity.
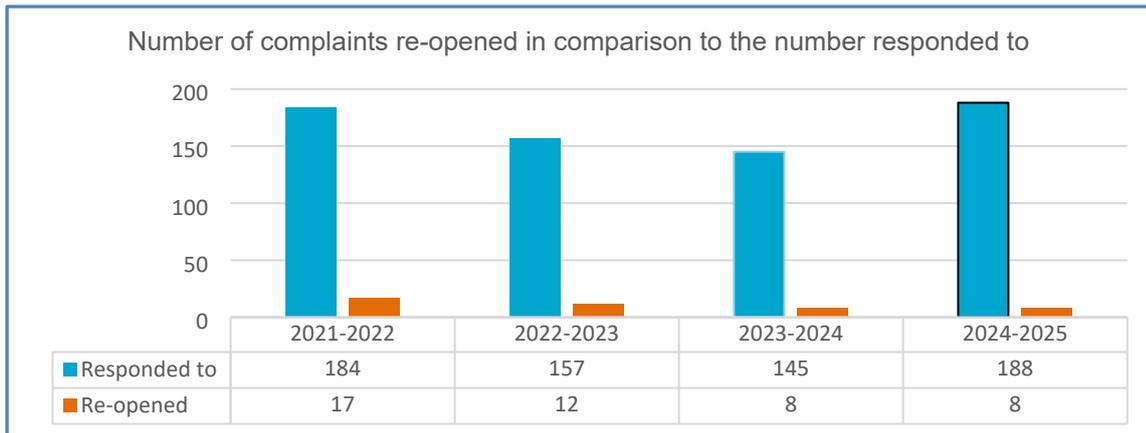
Number of complaints re-opened in comparison to the number responded to

	2021-2022	2022-2023	2023-2024	2024-2025
Responded to	184	157	145	188
Re-opened	17	12	8	8

Complaints referred to PHSO

If complainants remain dissatisfied, they have the right to approach the Parliamentary and Health Service Ombudsman (PHSO). The PHSO will assess each complaint and decide as to whether they will provide an independent review of the complaint.

LCHS had 3 complaints which are being investigated by the PHSO during 2024-2025 of which we are awaiting outcome:

- Quality of End-of-Life - Collaborative Community Care Hospitals
- 2 cases relating to the care provided by Collaborative Community Care

PALS Received

The PALS Team are also commissioned to manage the ICB PALS enquires, these have not been included within the graph below. The graph shows that the number of PALS contacts for LCHS has increased for 2024-2025.

At the beginning of the financial year, LCHS changed process and merged the PALS and Concerns contacts, dealing with all contacts as PALS, as both were to enable quicker resolution for complainants. The PALS team also had many contacts from the public in December 2024 regarding the Trust decision to introduce mask wearing in some clinical areas.

Number of PALS received year on year since 2019-20.

PALS Concerns received over the previous financial years

Financial Year	Concerns
2019/2020	296
2020/2021	305
2021/2022	265
2022/2023	201
2023/2024	150
2024/2025	496
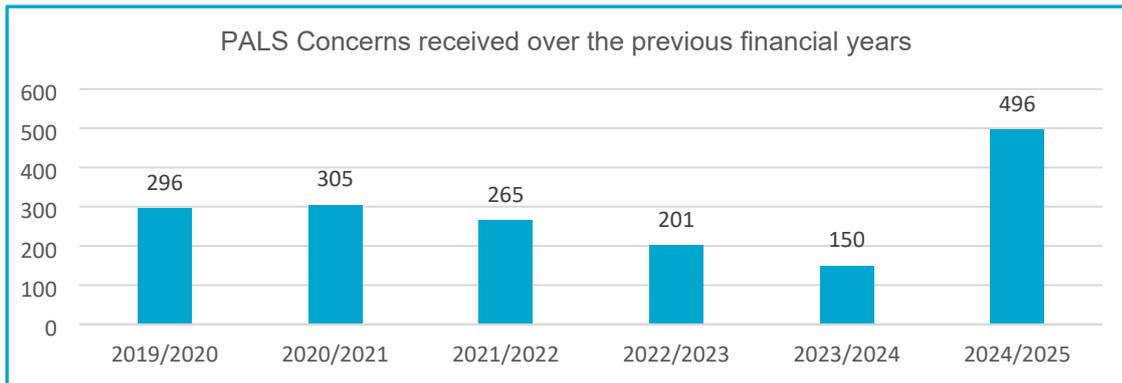
During 2024-2025 LCHS logged 496 PALS enquiries which is an increase of 231% compared to the 150 PALS received in the year 2023-2024. The Trust also received 1060 contacts of signposting to other organisations. LCHS aims to resolve all PALS concerns within 5 working days. During 2024-2025 the Trust responded to 83% of PALS enquires within the timeframe of 5 days. The table below details the themes of PALS received during 2024-2025.

LCHS Trust Themes	Number received	% of overall PALS
Communication	181	36.49%
Access to treatment or drugs	146	29.43%
Patient Care including Nutrition/Hydration	57	11.49%
Appointments including delays and cancellations	30	6.04%
Values & Behaviours (Staff)	22	4.43%

The table below details the PALS received in 2023-24 in comparison to 2024-25 for each Division.

Divisions	Number received 2023-2024	% of overall PALS	Number received 2024-2025	% of overall PALS
Children, Young People, and Specialist Services	36	24%	120	24%
Integrated Urgent & Emergency Care	28	19%	102	20%
Corporate	6	4%	94	19%
Chief Executive Office	41	27%	88	18%
Collaborative Community Care	16	11%	56	11%
Collaborative Community Care – Community Hospitals	23	15%	36	7%

Divisional Learning from Complaints and PALS Received

Complaint regarding provision of electrolarynx.

As a result of a complaint due to the patient not receiving the equipment required for their care, which was due to the company going into administration The Electronic Assistive Technology Service (EATS) Team have reviewed all other patients and have set up a process for procurement to reduce the risk of re-occurrence.

Electronic Assistive Technology (EAT) Service Complaint

The Lincoln EAT service 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. Lincoln EAT service 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".

Complaint regarding wound care.

Following a complaint, it was identified further training was required for staff on negative pressure wound therapy and dressings. Outcome is to ensure that staff in wound clinics are trained on negative pressure wound therapy and dressings. There is a also a new skin integrity process, where teams are requested to do an assessment of 5 patients a week.

Tissue Viability Complaints

Tissue Viability Team to have clinics stocked with appropriate dressings. New skin integrity process for community nurses, where teams are requested to do an assessment of 5 patients a week. Be safe meeting format has changed; Enhanced Practitioners now attend this meeting asking questions and providing more scrutiny regarding patients care.

Provision of Child Therapy.

As a result of a complaint relating to a patient's discharge, a Discharge process has been 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.

Complaints and PALS Objectives 2025-2026

- Working closely with ULTH Complaints& PALS Team to review the integration of our processes as part of the Group Model. Moving towards the Group Model will provide a much more joined up approach designed to improve the care provided to patients across Lincolnshire.
- Increase the percentage of complaints responded to within time. A 35-day response is allocated as a standard for complaints to be responded and 50-day response for investigations which are particularly complex involving multiple areas within the hospital or external partners.
- Increase the number of meetings as the first response for complaints.

Shared Learning and Communication

The Trust have implemented a number of processes to improve shared learning across the Trust.
Listed below are examples of how we are sharing and embedding learning and the future plans:

- Complaints are discussed at their local meetings.
- The Clinical Leads within each Division have oversight of all complaints as they approve the complaint response prior to the Executive Leadership Team sign off.
- The Quarterly and Annual Complaints report is shared at Patient Experience& Involvement. This allows us to share the theme and trends of complaints received and the implementation of agreed actions to improve the care and treatment we provide to our patients.
- Complaints & PALS Manager attends the Mini Patient Experience Meetings for their dedicated division to discuss the number of complaints received, to share themes and trends and be aware of any improvements that are currently being undertaken.

Summary

The themes from the complaints received remain similar to the previous financial year, with the most common subjects being Access to Treatment, Patient Care and Communication. However, the actions outlined in this report demonstrate that trends

are acted upon, and the complaints received in the Trust are used to inform pieces of work aimed at improving the patient experience. The responses provided invariably outline action(s) that have been taken in response to the concerns raised or explain what is planned as a result of issues identified during the investigation.

Policy and procedures and the way in which complaints are recorded and dealt with is harmonised across Trust sites. There are systems in place to systematically review the complaints received and ensure that investigations are undertaken appropriately, in line with legislation, and escalated within the Trust as necessary. The data collected is used to inform reports, is disseminated amongst Divisional Teams and taken to the relevant meetings and committees to inform ongoing work within the Trust.

ULTH Annual Complaints Report 2024-2025

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The Trust continues to proactively manage complaints, improving the process and quality of the responses, and embedding the learning from complaints into our services and practice.

Looking Back at the Past Year and our Achievements

The Complaints & PALS Teams across the ULTH and Lincolnshire Community Health Services (LCHS) have continued to review and improve their working processes to enhance the quality of service they provide in responding to patient complaints. The Complaints Team have collaboratively been supporting the integration of the teams and processes as they work within the Group Model. The Complaints & PALS Teams continue to share best practice and discuss ways in which they can support each other and continually build on a good working foundation.

Standardisation of processes across the Group

As part of the Group Model the Complaints and 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.

Complaints and PALS Masterclasses

During 2024-2025, the Complaints Team have been running Complaint and PALS Masterclasses to support staff with the management and investigations of Complaints and PALS enquiries received at both ward and department level and through formal responses and meetings.

Complaints Meeting Room at Pilgrim Hospital

A dedicated complaints meeting room at Pilgrim Hospital opened during 2024-2025. Having designated meeting rooms at Lincoln County Hospital and Pilgrim Hospital for complaint meetings has allowed us to provide a comfortable and private space away from the main hospital where complainants and families can feel at ease whilst discussing their concerns. Having the room available has enabled us to arrange meetings in a timely manner to aid early resolution. We actively propose meetings as way of an initial response to resolving complaints as this provides a much more personal approach and allows additional questions to be asked within the meeting should they arise. During 2024-2025 we held 96 meetings of which 36 meetings were the preferred initial response to their complaint. The feedback from Complainants and their families has been extremely positive.

Divisional Engagement

Our continued focus on building strong relationships within the Divisional teams ensures that we provide an open and transparent response to our complainants. Having incorporated the Clinical Senior Complaints role within the Complaints Team, this has enabled us to resolve formal complaints quickly and efficiently providing early resolution and preventing the need for a formal written response. Complainants are now contacted by the complaints team to acknowledge and discuss their concerns and agree on how they would like their concerns taking forward and are able to choose how we provide them with their response. This can include a telephone call to provide verbal feedback, email or a meeting and in many instances resolves concerns without the need for a formal written response.

The Complaints Facilitators continue to work with their dedicated Division and provide support as the Complaints Business Partner for that Division. This helps to develop good relationships and engagement within the Division and provides consistency when supporting the co-ordination of complaints received by the Trust.

Business Partners attend Speciality Governance meetings and discuss themes and trends that have been identified through their complaints.

Complaints Received

During 2024-2025, the Complaints Team have continually reviewed the processes to ensure timely and high-quality responses are formulated. Our complaints process tries to balance the need to identify actions to improve care with the ability to listen, reflect and recognise that every one of us can learn from the experiences of others. We need to be willing to listen, to hear and validate experiences where we find ourselves as a Trust falling short.

During 2024-2025, ULTH received 1273 complaints, an increase of 229 from the previous year. There is an increase of complaints year on year.

The graph below shows the number of formal complaints in 2024-2025 in comparison to previous financial years.

Number of complaints recieved over previous financial years
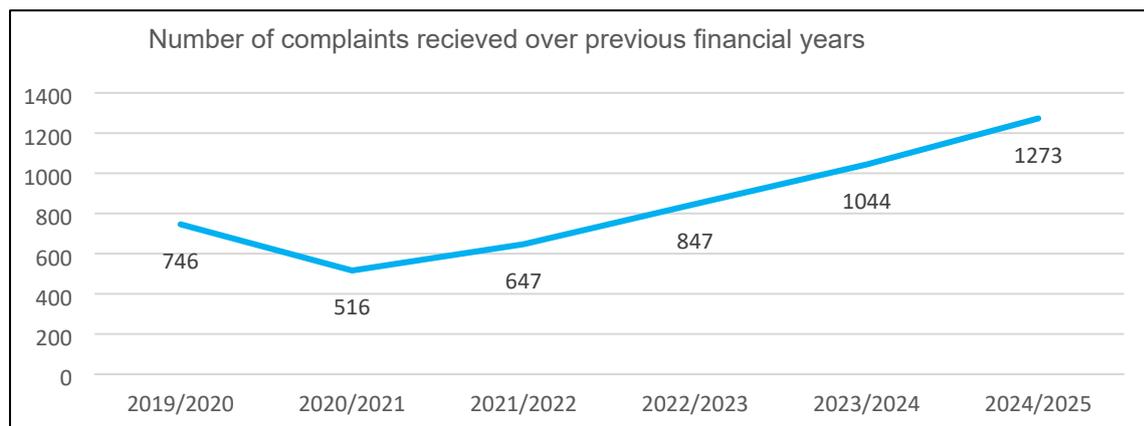
Complaints response times

100% of complaints received by ULTH were acknowledged within 3 working days. The Team aims to acknowledge all complaints within the 3-day timescale. The acknowledgement to complainants is confirmed by either an email or telephone call and followed up by a letter. The graph below demonstrates the number of complaints that have been responded to within the agreed timescales during 2024-2025. The complaints team are continually working to improve the response rates.

The Team continues to strive to improve the percentage of complaints that are responded to in the agreed timescales. The Clinical Senior Complaints Case Managers respond to complaints within 25 days and for complaints where there are multiple specialties or outside organisations involved these have continued to be registered at 35 or 50 days dependent upon the complexity of the complaint.

ULTH responded to 1138 complaints. Of the complaints that were responded, 84% were responded to within the agreed timescale.

% of compliance of complaint responses compared to previous years

Year	%
2022-2023	40%
2023-2024	83%
2024-2025	84%
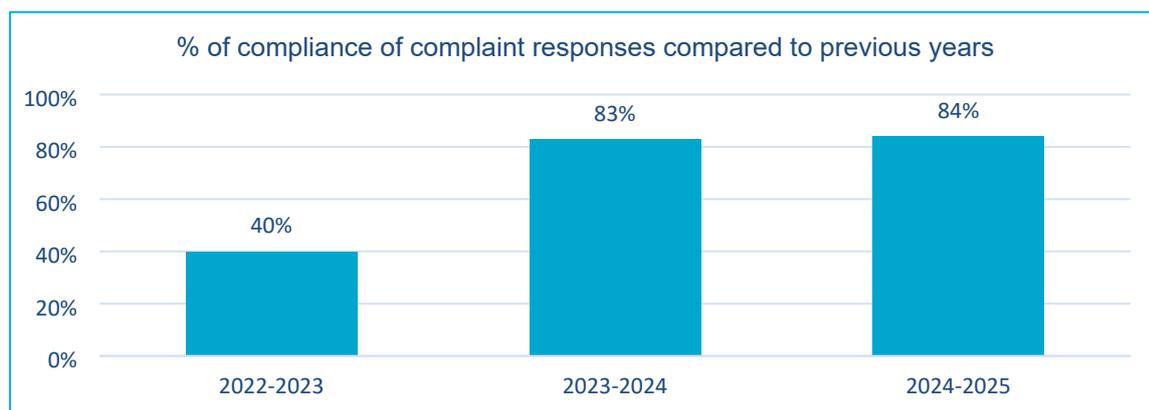
Trust Themes for Complaints

Themes of complaints received by ULTH during 2024-2025.

Complaint Categories	Number Received	% of overall complaints
Communication	408	32%
Clinical treatment	395	31%
Appointments	84	7%
Discharge	73	6%
Values & Behaviours	69	5%

Complaints Received by Division

The table below shows the number of complaints received by ULTH by Division over the previous financial years.
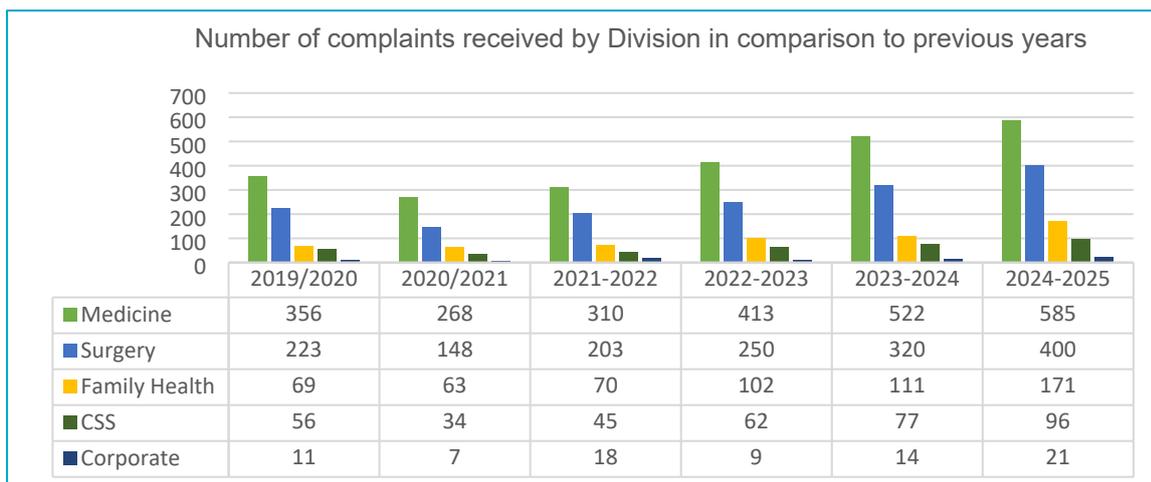
Number of complaints received by Division in comparison to previous years

	2019/2020	2020/2021	2021-2022	2022-2023	2023-2024	2024-2025
Medicine	356	268	310	413	522	585
Surgery	223	148	203	250	320	400
Family Health	69	63	70	102	111	171
CSS	56	34	45	62	77	96
Corporate	11	7	18	9	14	21

The table below shows the number and percentage of overall complaints received for each Division in 2024-2025 in comparison to 2023-2024. Whilst the percentage of the overall complaints received by the Trust for each Division is compariable during both financial years, there has been a rise in the number of complaints received for each Division. The largest increase in complaints is for the Medicine, Surgery and Family Health Divisions.

Divisions	Number received 2023-2024	% of overall complaints	Number received 2024- 2025	% of overall complaints
Medicine	526	50%	585	46%
Surgery	320	30%	400	31%
Family Health	111	11%	171	13%
CSS	77	7%	96	8%
Corporate	14	1%	21	2%

Complaints re-opened

The graphs below demonstrate the number and percentage of re-opened complaints received during 2024-2025 in comparison to previous years.

During 2024-2025 of the responses completed, 113 (10%) were reopened in comparison to 90 (9%) in 2023-2024.

Reasons detailed below why cases were reopened:

- Dissatisfaction with the contents of the first response
- Requesting clarity on information provided

- Accepting an offer of a meeting

- Initial response has raised further concerns
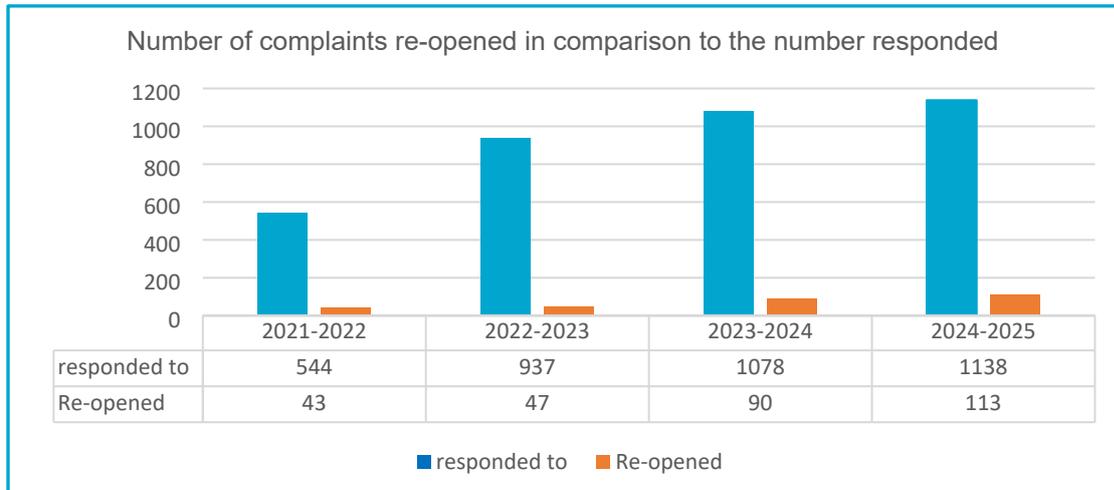
Number of complaints re-opened in comparison to the number responded

	2021-2022	2022-2023	2023-2024	2024-2025
responded to	544	937	1078	1138
Re-opened	43	47	90	113

■ responded to ■ Re-opened

Complaints referred to PHSO

If complainants remain dissatisfied, they have the right to approach the Parliamentary and Health Service Ombudsman (PHSO). The PHSO will assess each complaint and decide as to whether they will provide an independent review of the complaint.

During 2024-2025, ULTH had 12 complaints that were referred to the PHSO which are in the following status:

- 12 are awaiting a decision as to whether the PHSO will take forward for investigation.

The complaints with the PHSO are from the following Divisions:

- 9 Medicine

- 1 Surgery

- 2 Family Health

PALS Received

ULTH continue to log all PALS interactions received by patients including sign posting to other organisations. All enquiries and signposting are also logged onto Datix IQ. This is to ensure that we accurately reflect the number of patients that we are supporting through our PALS Service. There were 19 overdue PALS concerns that

remained open on 31 March 2025. The Trust aims to resolve all PALS concerns within 5 working days. 89% of PALS concerns were responded to on time.

The graph below shows the number of PALS enquiries received by ULTH over previous financial years; the numbers of PALS have decreased in 2024-2025 compared to the previous financial year.

PALS Concerns Received

Financial Year	Concerns Received
2018-2019	5221
2019-2020	6080
2020-2021	4977
2021-2022	5148
2022-2023	4906
2023-2024	8263
2024-2025	8101
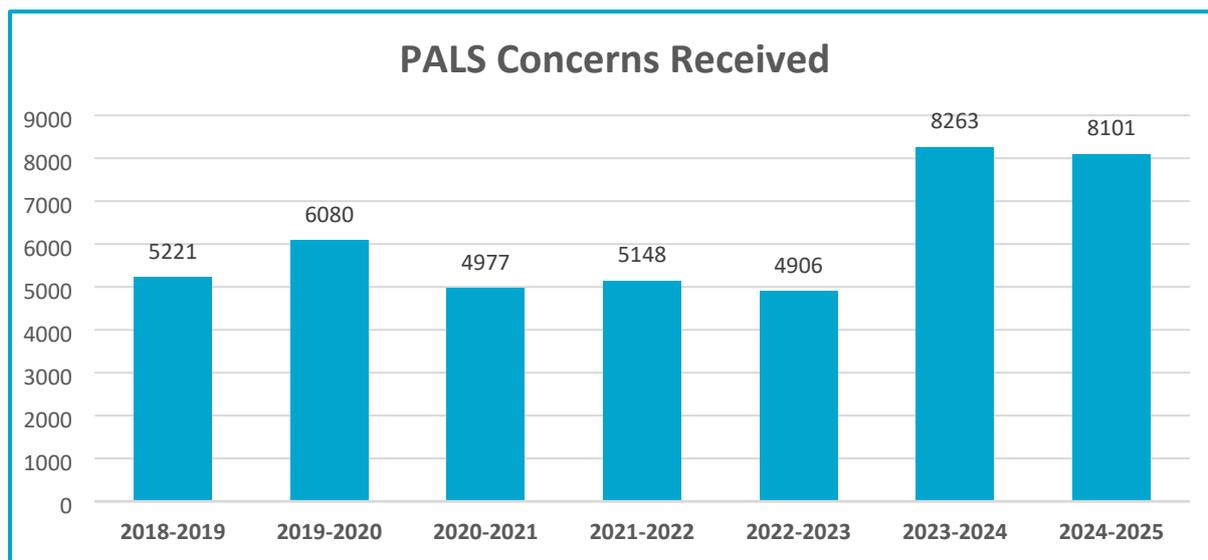
Of the 8101 PALS logged during 2024-2025, 647 were external enquiries. In comparison to 2023-2024 there were 3903 external enquiries logged. Therefore, there has been an increase in the number of PALS received for the Trust. The team log all contacts on Datix IQ system including general/external enquiries

Subject of PALS concerns received during 2024-2025:

ULTH Trust Themes	Number received	% of overall PALS
Communication	2632	29%
Appointments	2218	28%
Clinical Treatment	616	8%
Trust Admin	289	4%
Values and Behaviour	262	3.25%
Facilities	223	2.8%
Lost Property	179	2%

The table below shows the number and percentage of overall PALS received for each Division in 2024-2025 in comparison to 2023-2024. There has been an increase in PALS received for Medicine, Surgery and Family Health Division.

Divisions	Number received 2023-2024	% of overall PALS	Number received 2024- 2025	% of overall PALS
Medicine	1652	37.6%	2475	34.6%
Surgery	1476	33.6%	2580	34.6%
Family Health	390	8.9%	587	7.9%
CSS	649	14.8%	1236	16.6%
Corporate	193	4.4%	576	7.7%

Divisional Learning from Complaints and PALS

Patients being incorrectly added to the waiting list.

As a result of ophthalmology patients being added to the incorrect waiting list by the booking team, a booklet has been introduced by the business unit to be used by the booking teams (along with additional teaching). This booklet and training have been provided to support staff and raise aware of the importance and priority of various appointments as well as Ophthalmology specific codes which will ensure that they are listed on the correct pathway.

Support for patients with complex needs attending ED.

The Trust received a complaint that raised concerns regarding the lack of help and support for an autistic patient with complex needs when attending the Emergency Department (ED). A meeting was organised with the grandparents which enabled the team to understand the challenges their grandchild faced when they accessed our services and what additional support we needed to provide. A meeting was coordinated with the family and the specialist nurse for safeguarding. As a result, the family are now aware that there is support in the ED for patients with autism and neurodiversity as they were not previously aware. The family have been made aware that should their grandchild need to attend in the future for them to ask for a sensory bag and to use the buzzer system if they are not able to wait to be seen. An alert on

our care flow system and a reasonable adjustment care plan is currently in draft form and once this has been shared with the grandparents and they are happy with the plan, this will be finalised. The family will have a copy of the care plan to take with them for any future attendances. The care plan will be shared with staff, and they will be advised if necessary to escalate any concerns.

Parent information on children having laxative treatment

During an admission to a paediatric ward a child was administered an enema and laxatives during treatment for constipation without their parents being advised of the potential effects. Following the procedure, the child spent several hours in significant discomfort. As a result of this complaint the department ensure that the relevant leaflets are always available and given to the parents of children having laxative treatment.

Patient Discharge

The Trust received a complaint regarding an inappropriate 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.

Complaints and PALS Objectives 2025/2026

- Working closely with LCHS PALS and Complaints Team to look at the integration of our processes as part of the Group Model. Moving towards the Group Model will provide a much more joined up approach designed to improve the care provided to patients across Lincolnshire.
- Increase the percentage of complaints responded to within 35 days to 70%. We currently have a 25-day response which applies to the Clinical Senior Complaints Manager, 35-day response which is allocated as a standard for complaints to be responded and 50-day response for investigations which are

particularly complex involving multiple areas within the hospital or external partners.

- Increase the number of meetings as the first response for complaints.
- Increasing the presence of Complaints Facilitators in the clinical area. The purpose of this is to provide training to staff in how to effectively address concerns that are raised and enhance complaint handling. This training will equip staff with a clear understanding of the complaints process and how to effectively investigate and resolve complaints at the time the complaint is being raised at ward and department level.

Shared Learning and Communication

The Trust have implemented a number of processes to improve shared learning across the Trust. Listed below are examples of how we are sharing and embedding learning:

- Complaints and PALS masterclasses are run to support the staff with the management and investigations of Complaints and PALS enquiries received.
- Dedicated learning section on the Clinical Governance intranet page.
- A monthly Divisional Integrated Governance report with executive summary incorporating complaints for each Division.
- Complaints are discussed at Speciality Governance.
- The Triumvirate within each Division have oversight of all complaints as they approve the complaint response prior to the Executive Leadership Team sign off.
- The Quarterly and Annual Complaints report is shared at Patient Experience & Involvement Group. This allows us to share the theme and trends of complaints received and the implementation of agreed actions to improve the care and treatment we provide to our patients.
- Complaints Facilitators attend the Mini Patient Experience Groups for their dedicated division to discuss the number of complaints received, to share themes and trends and be aware of any improvements that are currently being undertaken.

Summary

The themes from the complaints received remain similar to the previous financial year, with the most common subjects being Communication and Clinical treatment. However, the actions outlined in this report demonstrate that trends are acted upon, and the complaints received in the Trust are used to inform pieces of work aimed at

improving the patient experience. The responses provided invariably outline action(s) that have been taken in response to the concerns raised or explain what is planned as a result of issues identified during the investigation.

Policy and procedures and the way in which complaints are recorded and dealt with is harmonised across Trust sites. There are systems in place to systematically review the complaints received and ensure that investigations are undertaken appropriately, in line with legislation, and escalated within the Trust as necessary. The data collected is used to inform reports, is disseminated amongst Divisional teams and taken to the relevant Groups and committees to inform ongoing work within the Trust.

Quality Committee Upward Report

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2 September 2025*
Item Number	*8.1*

Quality Committee Upward Report of the meeting held on 19 August 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 Upward Report
- High Profile Cases
- Maternity and Neonatal Oversight Group Upward Report
- Preparation to support independent review of maternity services at Nottingham University Hospitals NHS Trust – Letter
- Community Nursing Safer Staffing (II) Review 2025/26 Round 1
- Children and Young People Oversight Gorup Upward Report
- Patient Experience and Involvement Group Upward Report
- Clinical Effectiveness Group Upward Report

- Human Tissue Authority Update Report

The Committee noted, through the Patient Safety Group upward report that the consideration was being given to reporting in arears for patient safety incidents to ensure appropriate reporting could be offered.

Concern was noted in respect of community equipment due to a change in provider however reassurance was offered that mitigations were in place to address this. It was noted that there were concerns regarding the safety of medical devices following a recent audit. Whilst mitigations were in place it was recognised that audits required completion across the Group with the Committee noting the need for the outcomes of the audits to be reported.

Infection Prevention and Control (IPC) was discussed with the Committee requesting a focused discussion be held in the coming months covering all aspects of IPC, including antimicrobial prescribing and the reduction plan, due to the trajectories being exceeded for a number of infections.

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 Standards 1 and 2 are on track.

- CNST Standard 3- ATAIN: Note update relating to continuation of the Quality Improvement Project 'Midwives as second checkers for neonatal IV antibiotics' available within **Appendix 1.0.**

- 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 1.0**. Progress for upward reporting and formal recording in Group Board minutes is as follows:

        o Boston is now reporting 66.3% compliance, previously at 73.2%, with a forecast to continue at 66.3% until January 2026 where it is anticipated that this is will be above target at 79.3%.

- Lincoln report static compliance at 59.1%. By January 2026 this should improve to around 64%, followed by month-on-month improvement until June 2027 at which point the target of 70% should be achieved.
- The trajectory to achieve 70% target at both sites was originally set for January 2027 however, owing to inclusion of the TNA (Trainee Nurse Associate), this target will not be achieved at LCH. 70% compliance at LCH is now anticipated by June 2027. The target includes natural wastage of 1.0 FTE at PHB and 2.0 FTE at LCH every year.
- Progress with this action plan is monitored by the ODN and reported regularly via this group and remains on the risk register.

- CNST Standard 5- Midwifery Workforce:
    - For upward reporting and formal recording in Group Board minutes, please note the receipt of the midwifery staffing update, available in **Appendix 1.0**
        - 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.
        - BR+ establishment uplift business case submitted for discussion at CRIG on 29th July which should then go to ICB through Values Framework.
        - Recruitment of newly qualified midwives is underway at LCH. All qualifying students on the PHB site have been offered jobs.

Business case approved by CRIG on 29/7/2025. QIA approved on 04/08/25. Next steps are Values Framework – ICB for system funding approval.

- 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 1.0.**

- CNST Standard 7- MNVP: Note the formal escalation of risk, via the PQSM relating to the MNVP provision (available in **Appendix 1.0**).

    - It has been concluded that current MNVP lead contracted hours, compounded by reduced ICB/LMNS capacity to support is no longer sufficient to meet the year 7 requirement.
    - Mitigations including an action plan, co-produced with the LMNS based on the revised MNVP work plan, will ensure the service continues to listen to women and families in a way that is proportionate to MNVP resourcing available until the MNVP is commissioned in line with guidance.

- CNST Standard 8- Training:
    - A risk to compliance was noted in respect of training consultant anaesthetists, whilst work was ongoing to resolve this there was recognition of the need to support staff through the process and ensure alignment of rotas.

- CNST Standard 9- Floor to Board:
  - For upward reporting and formal inclusion within Group Board Minute progress with the Staff Experience Group (maternity and neonatal culture plan, available in **Appendix 1.0**).

- 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 maternity service review letter (**appendix 2**) was received by the Committee and it was noted that the Group would be supporting with the review, where requested, for Nottingham University Hospitals NHS Trust.

The outcome of the safer staffing establishment reviews were received and the position noted with recognition that further data collections would be undertaken and analysis of the data completed prior to recommendations being made for the Community establishment.

Whilst it was noted that the Children and Young People Group had been stood down the Committee received a detailed report in respect of paediatric cardiology recognising the development of a business case to support progress. The Committee requested that a further update be offered by the service at an appropriate time.

The Patient Experience and Involvement Group Upward report demonstrated the volume of feedback being received across the Group with work ongoing across departments in identification of and action to address themes.

The Patient-Led Assessment of the Care Environment (PLACE) report was received by the group which demonstrated areas for improvement however it was noted that, through the support of Charitable Funds, progress had been made in supporting dementia patients.

The Clinical Effectiveness Group report offered a comprehensive update to the Committee with the recognition of the Human Tissue Authority (HTA) report that had been received.

The Committee was pleased to note that the ongoing work to refurbish the mortuaries was nearing completion which would address a number of actions from the HTA inspection undertaken in 2022. Phase 2 of the outcome of the Fuller report was expected in relation to actions required with work already underway. A revisit by the HTA was noted as complimentary with appropriate governance in place however there was a requirement to strengthen reporting to the Board and Executives.

The reporting route would be from the HTA Governance Group to the Clinical Effectiveness Group and onward to the Board via the Quality Committee. Quarterly meetings were also now being held between the HTA responsible officer and Chief Executive.

The HSMR and SHMI were noted as within expected levels and the Committee considered the position of Structured Judgment Reviews with work required to maintain performance.

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
- Business Case Stratification
- Policy Position Update
- LCHS Data Quality Update
- Quality Impact Assessment Assurance Report
- Committee Performance Dashboard

The 2025/26 Board Assurance Framework was received with the Committee noting the updates offered in respect of the risks and confirmed that the assurance ratings would remain amber. The Committee noted the increased assurances being offered and would undertake a detailed review of the BAF, with a review to proposing a positive change the following month.

The Committee received and noted the risk register recognising the movement in the risks presented and noted the ongoing work in respect of the policy position with a request for all overdue documents to be RAG rated.

The LCHS Data Quality report was received, recognising the administration error that had been identified with validation work being undertaken, alongside a clinical audit review.

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	A	S	O	N	D	J	F	M	A	M	J	J	A
Jim Connolly Non-Executive Director (Chair)	A	X	X	X	X	X	X	X	X	X	X	X	X
Colin Farquharson Medical Director, ULHT	X	X	X	D	A	A	X	D	D	X	X	D	D
Rebecca Brown, Non-Executive Director (Maternity Safety Champion), ULHT/LCHS	X	X	X	A	X	X	X	X	X	X	A	X	X
Gail Shadlock, Non-Executive Director, LCHS	X	X	X										
Nerea Odongo, Group Chief Nurse	X	X	D	X	X	A	D	X	X	X	X	D	X
Caroline Landon, Group Chief Operating Officer	X	X	X	X	A	X	X	X	X	A	D	X	X
Daren Fradgley, Group Chief Integration Officer	X	X	X	D	A	X	X	D	X	A	X	X	D

X in attendance
A apologies given
D deputy attended

7
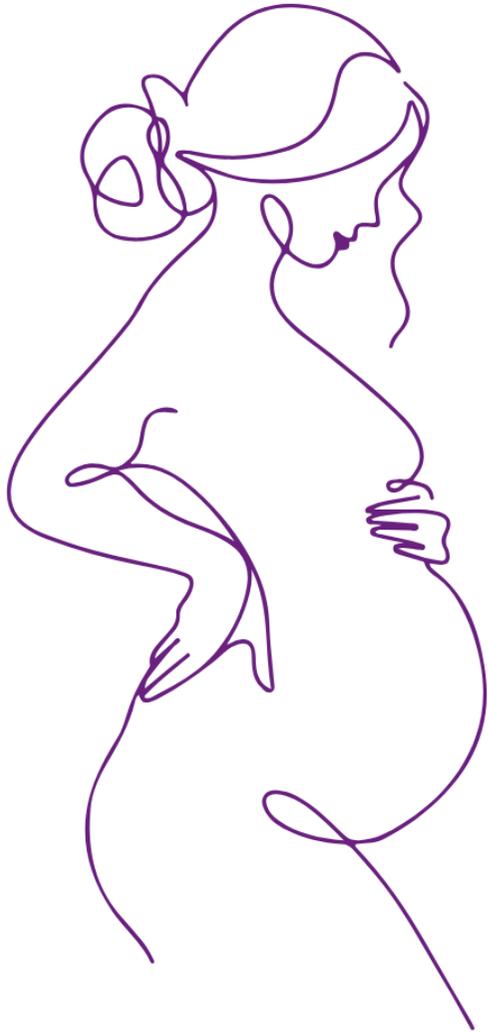
Perinatal Assurance Report

Emma Upjohn

Director of Midwifery

V1.3

July 2025

CQC rating: Good

Caring and building a healthier future for all

Contents

Caring and building a
healthier future for all

Caring and building a
healthier future for all

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.

Caring and building a
healthier future for all

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

NHSE have released, in draft form, a revised Perinatal Quality Oversight Model (PQOM) that will replace the PQSM. In collaboration with the ICB and ODN, ULTH are benchmarking and revising the local document in preparation for the final document release. Once finalised, the assurance reporting template will reflect the changes and the document will be shared.

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		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		

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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 midwife minimum safe staffing planned cover vs actual prospectively	• Maternity and Neonatal Dashboards • Maternity in-month update • Neonatal in- month update • CNST MIS Year 7 update		CNST MIS SA:4 CNST MIS SA:5
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		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		CNST MIS SA1-10

Theme/trend/escalation	Additional actions being taken
MNVP commissioning and funding: • **May 2025:** 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. • **July 2025**: The service, in collaboration with the LMNS, have concluded that the current MNVP lead contracted hours, compounded by reduced ICB/LMNS capacity to support is no longer sufficient to meet the year 7 requirement. Therefore the Trust will not be required to provide any further evidence as detailed below in 7.4 & 7.5 to meet compliance for MIS for this safety action.	• **May 2025:** 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 • **July 2025:** Updated escalation paper under review with LMNS detailing progress with mitigations including action plan to ensure the service continues to listen to women and families in a way that is proportionate to MNVP resourcing available until the MNVP is commissioned in line with guidance. These actions will be added to the Maternity Safety Improvement plan for oversight and monitoring.

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

Safety Action	Anticipated compliance	Comments	Upward reporting
SA1 PMRT	On track to achieve	Compliance remains on track	• Next quarterly report due at September MNOG meeting
SA2 MSDS	On track to achieve	On track No pertinent updates- data collection for July submission on-going	NA

SA3 TC/ATAIN	On track to achieve	On track
		• QIP update- Progress with agreed actions monitored through the NeoSIP:
		  ○ Competency pack under review for local adaptation
		  ○ Environmental updates to both ward areas to minimise unnecessary separation of mums and babies for cannulation
			• Next quarterly report due at September MNOG meeting
			• Note update relating to QIP progress

SA4 Clinical workforce	On track to achieve	On track • Obstetric workforce: Audits underway • Neonatal workforce tool (see appendices) • 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	At risk	On track • BR+ establishment uplift business case submitted for discussion at CRIG on 29th July. Will then go to ICB through Values Framework. • Recruitment of newly qualified midwives is underway at LCH. All qualifying students on the PHB site have been offered jobs.	• Next bi-annual staffing report due at November MNOG meeting
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	See escalation on page 6 and paper	• Note receipt of MNVP escalation paper and progress with mitigations
SA8 Training	At risk	Drop in compliance for PROMPT training owing to DNA's on the day • Majority of all DNA's rebooked. If all bookings come to fruition compliance will be over 90%	

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		• Education team to review compliance following every PROMPT session (twice monthly) and escalate and rebook non-attenders onto a further date • Note very little leeway with certain groups of staff eg. anaesthetists • Escalation to the BU to ensure awareness that the PROMPT day is mandatory and agreed by trust and AoA that all members of this staff group must attend and therefore going forward this leave needs to be allowed into the mandatory training matrix with regards to their time	
SA9 Floor to Board	On track to achieve	On track • Staff Experience Group update within report • NED report: Agenda item	• Next quarterly claims scorecard due at September MNOG meeting • 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 3 months. Next ICB Submission **27/7/25** for April May and June Data. 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.
3: Q4 Jan-Mar 2024 18/03/2024	90%	95%	100%	100%	81%	100%	90%	• Next day scanning for RFM element 3 improved for May and June however we are waiting for 3 consecutive months of compliance before we can say we are fully compliant.
4: Q1 Apr-Jun 2024 24/07/2024	90%	100%	100%	60%	93%	100%	93%	

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5: Q2 Jul-Sep 2024 1/10/2024	90%	100%	100%	80%	96%	100%	96%	Safety team completing deep dive into scan capacity and requirements for Obstetrics, Gynae, and EPAU. (AH update) SLA adjustment and changes needed as outdated.
6: Q3 Oct-Dec 2024 30/12/2024	100%	100%	50%	80%	93%	100%	94%	**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.
7: Dec-Jan 2025 21/02/25	100%	100%	50%	100%	96%	100%	97%	• 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.
8: Feb- March 2025 25/04/2025	100%	100%	50%	100%	96%	100%	97%	
9: April-Jun 2025 31/07/2025								Individual meeting set with all elements leads to review audits, evidence and data prior to submission using the **new compliance tool**. Data monitoring and reviewed for accuracy as using **new IT system** • Areas of improvement will be identified and targeted.
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.
Supporting our workforce	
Developing and sustaining a culture of safety	Please refer to MatNeoSIP headline report – Appendix 1.4 and 1.5. and the 3YDP headline report
Meeting and improving standards and structures	

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2.5 Regional Maternity Heat Map

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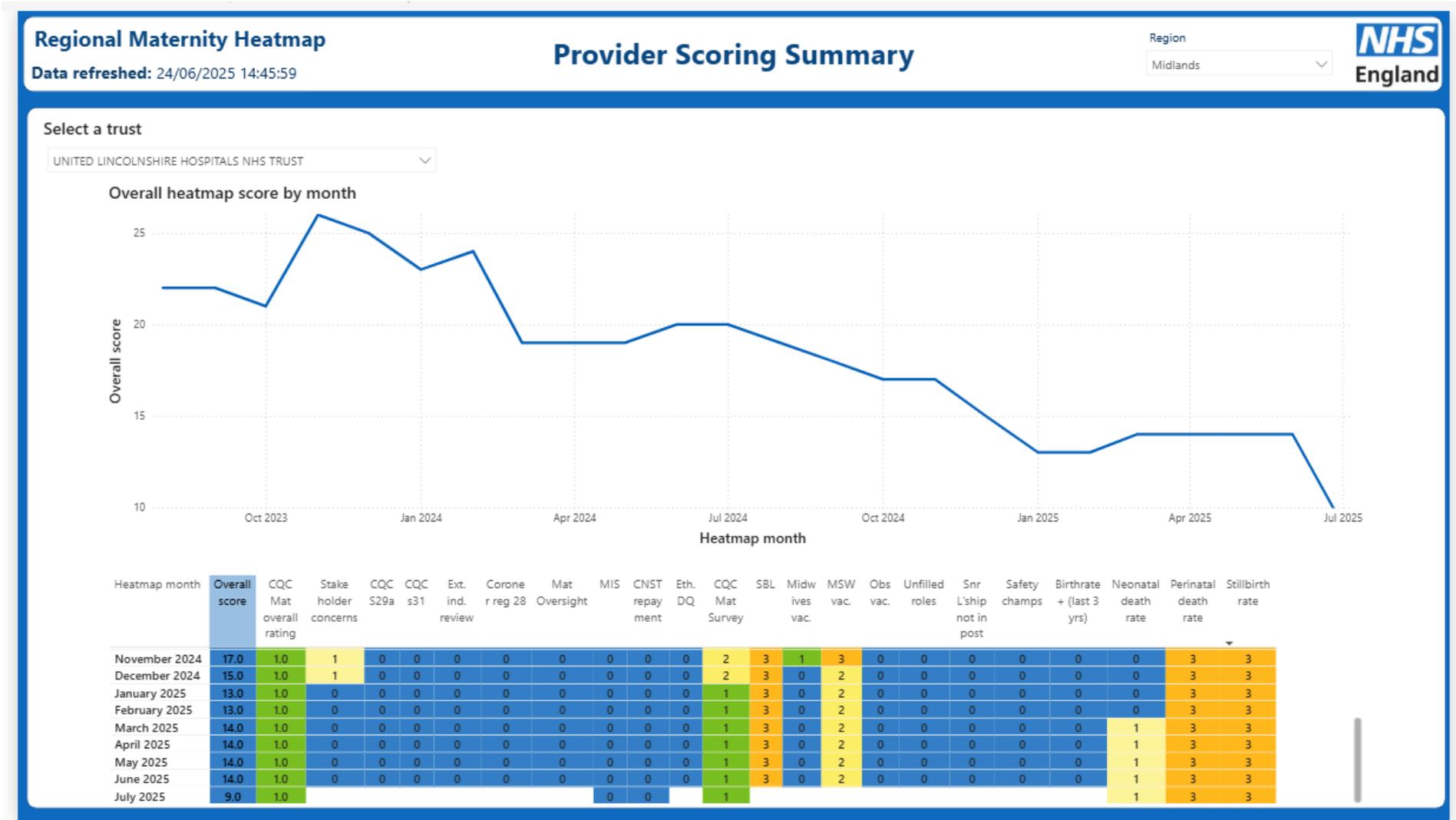
2.6 Care Quality Commission (CQC)

CQC readiness pathway and exception reporting

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

Expressed breastmilk (EBM) storage exception update

Following recent NUH CQC benchmarking we reported to MNOG that we have a good system for storage of EBM on postnatal wards however since then there has been two Datix's at Lincoln related to this. At the point of reporting the EBM storage process was considered robust, however, following identification of a gap the following actions have been and are being undertaken to address this. These will be monitored via the MatSIP and ongoing CQC readiness pathways:

- Identification of incident via Datix by ward manager. Subsequent escalation to infant feeding team, matron, safety team and SLT.
- Core midwife from Nettleham ward, with support from maternity safety team, will undertake a Trustwide quality improvement project to explore EBM fluid balance/passport for mothers- to be monitored as an overarching action via the MatSIP for oversight and assurance.
- Comms shared with staff via email, newsflash and the newsletter reiterating the process of 2-process checking.
- Updated checklist added to both the fridge and freezer to strengthen process of adding and removing EBM to the fridge and to ensure it is given to the correct mother/baby with additional 2-person check with signature at the bedside.
- Review of environment on Nettleham- currently not feasible to replicate NNU milk room however ward manager to explore implementation of milk safe boxes.

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3: Local drivers

3.1 Maternity and Neonatal Safety Improvement Plan (MatNeoSIP)

Appendix 1.4 & 1.5

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.

The BSOT's Triage action plan has been reviewed, and appropriate actions added to the MatSIP for ongoing oversight and processes for escalation with challenges. A number of actions have been reviewed and archived, relating to Ockenden and SBL preterm birth actions, epilepsy improvement activities, increases in medical staffing following recent recruitment, cardiac disease guidelines, Human Tissue Management actions following a safety event, improvements to the recording of Birth Choices appointments on PAS, obstetric leads for EFM, and SLEC student midwife improvements.

Updated CNST MIS Year 7 and Saving Babies Lives actions will be added in due course, once benchmarking has been complete.

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

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Optimise Experience	**12 (-3)**	**0 (=)**	**11 (-3)**	**1 (=)**	**0 (=)**
Optimise Safety	**50 (+14)**	**7 (+7)**	**31 (+6)**	**10 (+1)**	**2 (=)**
Improve Leadership	**4 (=)**	**0 (=)**	**4 (=)**	**0 (=)**	**0 (=)**
Choice & Personalised Care	**3 (=)**	**1 (=)**	**2 (=)**	**0 (=)**	**0 (-2)**
Provide Assurance	**2 (=)**	**0 (=)**	**0 (=)**	**2 (=)**	**0 (=)**
CNST	**10 (=)**	**0 (=)**	**0 (=)**	**0 (=)**	**10 (=)**
SBL	**3 (-3)**	**0 (=)**	**3 (=)**	**0 (-3)**	**0 (=)**
3YDP – ULTH	**47 (=)**	**0 (-1)**	**10 (-6)**	**22 (-1)**	**15 (+6)**
3YDP – ICB	**29 (=)**	**0 (=)**	**11 (=)**	**18 (=)**	**0 (=)**
TOTAL	**160 (+8)**	**8 (+7)**	**72 (+3)**	**53 (-1)**	**27 (-1)**
Archived Actions	**325 (+19)**	Completed, embedded and signed off by MNSC for closure			

The following actions are currently rated red due to expected completion date being passed or there is a concern that compliance will not be achieved by the expected completion date.

	Action No	Action Milestone	Responsible Lead	Due Date	Comments
1	OS.MT1.0	Recommendation 1: Define core emergency triage service, with appropriate senior midwifery and medical decision makers Action: Band 7 Project Lead	Antenatal Services Matron	September 2024	01/10/24 B7 project lead in place, fixed term 12 months. 11/06/25 Project lead remains in post, however, secondment ends September, therefore notice needs providing in July. Capacity will not allow for this project management to continue without the project lead. MNSC discussion; KL to email EU, CC and Felicity (finance) to raise concerns, and to request extension to the B7 contract.
2	OS.MT1.2	Recommendation 1: Define core emergency triage service, with appropriate senior midwifery and medical decision makers Action: Band 7 Triage Manager Trustwide	Antenatal Services Matron	April 2025	01/10/24 Case of need submitted as per system requirements. 11/06/25 Project lead remains in post, however, secondment ends September, therefore notice needs providing in July. Capacity will not allow for this project management to continue without the project lead.
3	OS.MT7.0	Recommendation 7: Uplift in medical, midwifery and support staffing to ensure the safe functioning of both telephone triage and the department; to allow midwifery staff to have	Director of Midwifery	April 2025	01/10/25 Case of need submitted. 11/06/25 We have received a partial uplift for the midwifery and HCSW staffing. We have 5.25WTE of the 12.1WTE

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		primary responsibility to assess and care for those women in triage. Action: Uplift of B6 midwifery establishment plus clinical healthcare assistants.			uplift which is going through recruitment. Finance are supporting how this can be funded. Has been escalated to LMNS board 10/06, who have advised that the business case is reviewed using the values framework, and then back through the internal review process.
4	OS.MTT13.1	Recommendation 13: Ensure calls are taken outside the clinical area in a dedicated and protected quiet space, to ensure confidentiality Action: Midwifery establishment to include sufficient midwives to support a telephone helpline 24/7 apart from the triage clinical area.	DoM / Project Lead	March 2025	01/10/25 Case of need submitted. 11/06/25 Staffing update as above. Also, telephone triage needs reviewing and implementing as a separate project. We have a telephone line, but not a 24/7 triage service as per the recommendations for a dedicated triage line. This has been added to the Risk Register.
5	OS.MTT13.2	Recommendation 13: Ensure calls are taken outside the clinical area in a dedicated and protected quiet space, to ensure confidentiality Action: Identify an appropriate IT system for a Trust wide maternity telephone helpline.	Matron / Project Lead	March 2025	As above. Require independent project, including procuring IT system.
6	OS.MTT13.3	Recommendation 13: Ensure calls are taken outside the clinical area in a dedicated and protected quiet space, to ensure confidentiality Action: Ensure calls are taken outside the clinical area in a dedicated, quiet space ensuring confidentiality and an undistracted midwife.	Matrons / Project Leads	January 2025	As above. Require independent project, including improvements to estates.
7	OS.MTT13.4	Recommendation 13: Ensure calls are taken outside the clinical area in a dedicated and protected quiet space, to ensure confidentiality Action: Ensure calls are taken by a midwife who is clinically active and familiar with maternity triage, but whose duties at that time are solely for telephone triage.	Project Lead / Education Team	March 2025	01/10/24 Case of need submitted. Training package identified through BSOTs programme, and rolled out. 11/06 Midwives are trained, however are not able to provide a midwife solely for a telephone triage line. Requires independent project.
8	CPC19.1	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 MW / Service Leads	September 2024	11/06/25 Individuals chase. Some non-compliance is due to new starters and expiry of previous competence. 18/06/25 Email to obstetric leads to follow up. **Post Mortem Consent**

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| | | Post-Mortem Consent Training | | | 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%, 10/06 92% (Andrejs Smirovs) 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), 10/06 85% (Shazia Mushtaq, Vedha Priya 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%, 10/06 100% 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), 10/06 86% (Aatiqa Naveed & Katherine Phipps) |

The 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.

The full NeoSIP document has now passed through internal governance processes, and work is under way to review the Critical Care Action Plan with the Consultant Neonatologist. Further work has been undertaken to progress the Peer Review Action Plan actions. Meeting arranged with Matron and Lead Nurse in July to review actions for archiving.

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	**39** (=)	**4** (=)	**14** (=)	**12** (=)	**9** (=)
Optimise Safety	**20** (=)	**0** (=)	**4** (=)	**4** (=)	**12** (=)
Improve Leadership	**1** (=)	**0** (=)	**0** (=)	**1** (=)	**0** (=)
Choice & Personalised Care	**0** (=)	**0** (=)	**0** (=)	**0** (=)	**0** (=)
Provide Assurance	**1** (=)	**0** (=)	**0** (=)	**1** (=)	**0** (=)
Peer Review Action Plan	**40** (=)	**0** (-2)	**20** (+3)	**5** (-1)	**10** (=) + **5** (=) Black
Critical Care Action Plan	Under Review **26**				

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GIRFT Action Plan	**14** (=)	**3** (=)	**8** (=)	**3** (=)	**0** (=)
TOTAL	**115** (=)	**7** (-2)	**46** (+3)	**26** (-1)	**36** (=)
Archived Actions		Completed, embedded and signed off by MNSC for closure			

The following actions are currently rated Red due to expected completion date being passed or there is a concern that compliance will not be achieved by the expected completion date.

	Action No	Action Milestone	Responsible Lead	Due Date	Comments
1	N.OE.03.2.5	BFI Action Plan - Stage 1 Accreditation; Implementing & Auditing Information and support for families Development and implementation of a written mechanism for ensuring that expressing reviews take place as per standards and of support for the delivery of care should an issue be identified.	SF/DK/MC/LB	01/01/2026	To be explored When infant feeding booklets reintroduced this would be evidence. Currently accountability hand over not reflective of practice. Plan; Teaching staff regarding use of booklet and assessments. 07/02/2025 RW update; Expressing log not implemented. This requires action. Will need to await BFI lead, as need the launch to be accompanied by training and audit. 13/05 Log not implemented, requires action, however unable to complete without BFI lead in place. Log can be used, however not utilised for all families, and requires improvement work. 04/06 No further update. Require BFI lead.
2	N.OE.03.3	BFI Action Plan - Stage 1 Accreditation; Implementing & Auditing Internal Audit Development and implementation of a programme of internal audit for all BFI standards with results submitted to the Baby Friendly office at regular intervals	SF/LB BFI Lead	30/11/2024 01/01/2026	Audit forms available. Action; to be implemented. 07/02/25 RW update; Audit forms are available from BFI, but these need implementing. Will be undertaken by the BFI Lead, alongside the managers. 13/05 Unable to progress without a BFI lead. 04/05 Unable to progress without BFI lead.
3	N.OE.14	Priority 1; Infection Increase number of babies having IVABX on PN wards Explore "Shared care model"	Inpatient & NNU Matrons & Ward Managers	02/02/2024	Benchmark against BAPM model completed. Designated TC bay with midwife and TC nurse, with IVABX competence between the two staff members. Unable to facilitate with current infrastructure on ward enivronment at present, to revisit following refurbishment 14/05/2025 Action added to NeoSIP.

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					04/06 Meeting held, feedback gathered from ward managers. Date planned for gap analysis on 13/06 for RW and NR. Will complete gap analysis and action plan.
4	N.OE.18	Priority 1; Respiratory Recognition & management of respiratory problems Review evidence for diagnosis and management of TTN vs RDS	ATAIN Lead / ANNP	01/09/2024	Action paused to allow launch of major practice changes across the Trust to include Fetal Physiology and Badgernet 14/05/2025 Action added to NeoSIP. 04/06 No further update. RW to speak to new ATAIN lead, Sam Tinkler.
5	GIRFT.05	Infection data sent to NNAP is not verified and looks to be higher than expected.	Dr Gupta/ Matron	December 2021 01/09/2025	This data must be verified and confirmed to NNAP to ensure all positive cultures are included to allow appropriate comparisons. Blood cultures were reviewed monthly but this had stopped during covid – to restart this practise. To review infection control practices and develop or refine infection care bundles if appropriate. 12.01.24 To undertake deep dive into infection screening and recording of results. 06/02/225 Action added to NeoSIP. 07/02/25 RW updates; RW to discuss action with Dr Gupta.
6	GIRFT.08	The unit does not use probiotics for preterm infants	Dr Gupta	To be agreed	The network has not yet had time to consider developing guidance on this issue. There is reasonable evidence that probiotics reduce incidence of NEC and the unit should support role out of this practise once the network has reviewed this. 12/01/24 Awaiting network guidance in relation to probiotic use within ULHT. 06/02/2025 Action added to NeoSIP. 07/02/25 RW update; Probiotics are included within Peri-Prem, but ULTH will not embed probiotics as there is not enough evidence to support this. Therefore Trust decision to not progress this action.
7	GIRFT.09	Coagulation screens are routinely done on well preterm infants. Platelet transfusion threshold is not in line with latest evidence.	Dr Gupta	December 2021 01/09/25	This does not follow National BSH neonatal haematology guidelines. Please review existing local guidelines to ensure they are in keeping with latest evidence-based guidelines from BSH. 12/01/24 To undertake audit on Coagulation screening. 06/02/2025 Action added to NeoSIP. 07/02/25 RW update; RW to discuss with Dr Gupta.

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3.2 Maternity Dashboard updates

Dashboard item	SPC trigger	Current position	Comments/actions
Rate of stillbirth per 1000 births	3.8 per 1000	**2.98 per 1000**	We are currently at 2.98 per 1000 against a threshold of 3.8 per 1000. 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	**382**	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 ULTH. 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%	8.41%/**7.69%**	We are currently at 8.41% against a threshold of 13% for smoking at the time of booking and 7.69% against a threshold of 6% for SATOD. 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%	**68.32%**	The threshold has increased to 72.9%. Significant investment into infant feeding teams and support is needed to enable improvement- ULTH infant feeding team is significantly smaller than 1) teams in comparable Trusts and 2) other specialist teams at ULTH 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 and Triage areas have laminated parent 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) Some MSWs in community teams are providing 1:1 Antenatal Sessions. Current QIP ongoing to support skin to skin in theatre environment post LSCS.

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Postpartum haemorrhage ≥2000mls/ ≥1500mls	≤1.3%/ ≤3.3%	**2.65%/ 4.24%**	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. Carbetocin has launched at both sites for all Elective LSCS. ROTEM has been approved and going through procurement and POCT processes prior to implementation. Both sites have ensured compliance with the National Patient Safety Action Plan.

3.3 Neonatal Dashboard updates

Neonatal dashboard
• 2 babies born at <30 weeks at LCH • Antenatal steroids compliance showing improvements at LCH • All other areas showing compliance as expected

4: In-month updates

4.1 Maternity updates

Escalations:
- Birth afterthoughts provision: Owing to long term sickness of PMA lead midwife, current review of all outstanding birth after thoughts appointments and ongoing provision for new bookings is being undertaken by Lincoln HoM with support from PMA/safety lead midwife.
- IPC update from LCH Bardney – theatres working through action plan. All MRSA cases have returned as Community Based acquired MRSA.
- LMNS insight visit planned for 10th and 11th September – working through TOR and agenda for days
- Elective pathway at Lincoln moving to first floor – estimated start date of 1st August

Celebrations:
    RCOG recognition – appendix 1.6

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Quality improvement/deep-dives/benchmarking/audit:

- Biomechanics project plan (appendix 1.7): Project aim to implement the use of Biomechanics during labour to safely reduce the number of emergency caesarean sections for delayed first or second stage due to suboptimal fetal positioning. The project was identified through the local audit of postpartum haemorrhages over 1500mls. The majority of the births included within the PPH audit resulted in emergency caesarean sections for delayed first or second stage of labour due to malposition, with complex broad ligament and surgical tears following the birth of the baby. Improving fetal position, through biomechanics in labour may then contribute to reductions in EMLSCS for this reason alone, then leading to a potential reduction in PPH rates, ATAIN admissions, and impacted fetal head at EMLSCS whilst improving women's overall labour experience which may lead to a reduction in birth trauma. Multi-disciplinary task and finish group, action plan and TOR all in place, training underway and video recorded to help support staff.

Workforce:

- Obstetric: Vandana Agarwal continues to support both sites from Obstetric perspective. Ongoing conversations with consultant body with regards to improving trainee feedback. LCH site have been recognised by RCOG for providing excellent trainee support.
- Midwifery: BR+ establishment uplift business case submitted for discussion at CRIG on 29th July. Will then go to ICB through Values Framework.
- Recruitment of newly qualified midwives is underway at LCH. All qualifying students on the PHB site have been offered jobs.

Additional updates:

4.2 Neonatal updates

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– reviewed end of May 2025 and roll out programme being devised. 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.

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- 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 awaiting dates.
- 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 August 25. Awaiting equipment.
- 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 approved at Job matching Rachel to complete QIA

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.

Workforce:
- *Nursing*
    - Registered nurse vacancy at band 5 fully recruited to, however not all staff in post yet. A small amount of vacancy equating to 1.4wte 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 now completed the final decision is yet to be made, 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.
    - Q1 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. Medical staffing section was removed from workforce tool by the national team so the ODN will be sending out to all Neonatal Clinical Leads a revised form to complete for medical staffing compliance quarterly in line with the workforce tool.

- *Medical*

Neonatal medical workforce is staffed to BAPM recommendations:

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- 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

- *Qualified in Speciality (QIS): further information can be found in appendix 1.8*
  - LCH - QIS trajectories showing July at 59.1% this is static until January 2026 where we should see a total of 64.6% with month-on-month improvement due to planned training at both Nottingham and Leicester Universities during 2025 and full compliance by June 2027. The figures include a forecast natural wastage of 2wte.
  - PHB – currently falls below compliance at 66.3% QIS with a forecast to continue at 66.3% until January 2026 where we will be above target at 79.3%.

Trajectory of % QIS staff at PHB

Trajectory of % QIS staff at LCH
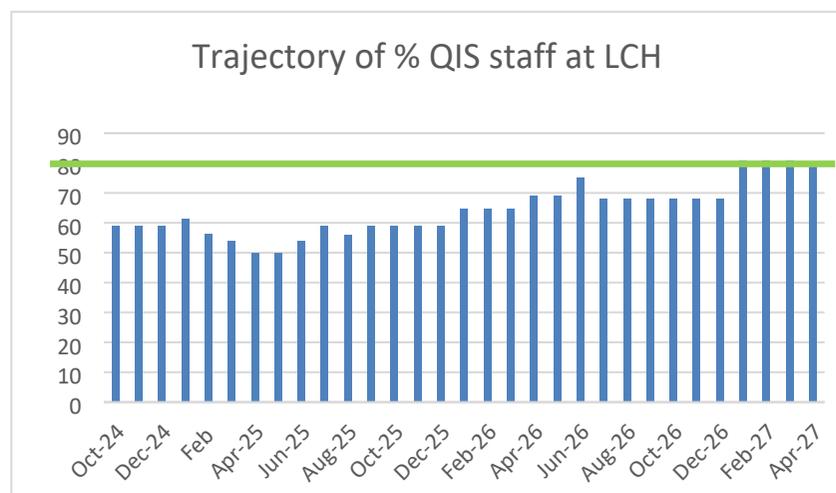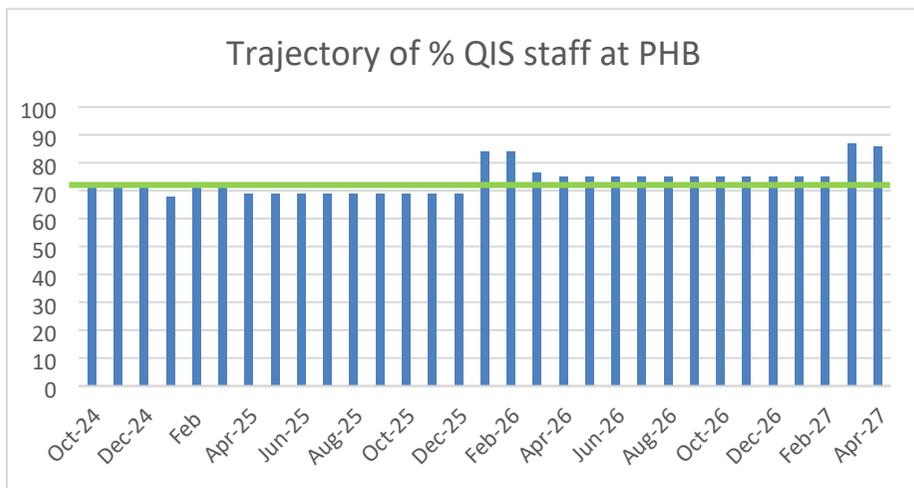
NNAP:
- Quarter 1 report of NNAP data to be presented at CEG – June 25. Appendices 1.9 and 1.10 are the network compassions for NNAP data and NNAP report for 2024.

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Item 6: Learning lessons

6.1 Incidents overview

Incidents *As of 31st June 2025*	Obstetrics and community midwifery	Neonates	Actions being taken
Patient safety incidents reported May - June '25 by severity	No Harm: 164 Low Harm: 29 Moderate Harm: 3 Fatal: 0	No Harm: 17 Low Harm: 3 Moderate Harm: 0 Fatal: 0	
Open incidents on Datix by month	**May:** Closed on time: 62 Not closed on time: 35 Still open: 28	**May:** Closed on time: 10 Not closed on time: 4 Still open: 2	Datix's monitored by the risk team to try and improve the compliance with timeframes.
	June: Closed on time: 42 Not closed on time: 2 Still open: 45	**June:** Closed on time: 5 Not closed on time: 4 Still open: 6	
Open MNSI	5		3 cases published and currently within division to update action plans 2 cases still in process with MNSI
PSII	5 (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	3	0	3 duty of candours have been completed within the timeframes.
PMRT (May – June 2025)	Stillbirths: Late fetal losses: 2 Neonatal deaths: 0 ULHT published: 4 External reviews: 1		For individual actions from published reports, please see quarterly report.
Outstanding actions	16 outstanding actions 9 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 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%)

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Accumulative Patient Event Numbers 1st Dec '24 – 30th of Nov '25 (CNST 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%)

6.2 Learning lessons update

Appendix 1.11

6.3 Detail 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.

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				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 Heard at June's Executive Oversight Group, closed and actions published.
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). Listed August Executive Oversight Group (July's meeting cancelled)

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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
				Report published, MDT held 8/7/24, Action plan to be revised and circulated.
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
				Report published, MDT arranged for 18/7/25

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.
				Awaiting draft report for factual accuracy

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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
				Awaiting draft report for factual accuracy

Datix number and detail	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
38571 – Baby known FGR and short FL (detected at anomaly scan), had been seen in FM and no concerns raised. Anomaly scan completed at fetal medicine appointment (heart), no concerns raised 17/3/25 ? hypoplastic left fetal heart diagnosed at 30+6, Referred to LRI as soon as cardiac concerns identified. LRI have confirmed a cardiac abnormality - coarctation with bilateral SVC's	Obs	Moderate – Taken to PSRP meeting 23/06/25	No further learning response required, to be managed by division. Being dealt with by the divisional Lead Consultant

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LRI have reviewed ULTH images and feel the abnormality was present at the fetal medicine scan.			
39228 – Midwifery Lead Care pregnancy, monitored with IIA thought-out her labour, meconium present only at delivery, baby delivered in poor condition and required resuscitation. Baby transferred out to Coventry with MEC aspiration.	Obs / neonates	Moderate - Following divisional review, downgraded to low harm and to be reviewed with in division.	No care issues identified.
40034 – Ventouse delivery in theatre followed by a 2.6l PPH, transferred to labour ward for post-op care. Over the next few hours further bleeding and clots expelled, transferred to ground floor theatre for EUA and further clots expelled, total WBL 5.1l, Bakri balloon inserted and admitted to ITU.	Obs	Moderate – Taken to PSRP meeting 7/7/25	Agreed no further learning response required, to be handled through the divisional PPH process. It has been asked that the case is taken through the Theatre Safety Group.

6.4 Key themes & trends

Theme/trend	Additional actions being taken
CQC request for confirmation of trust response to MNSI safety prompts.	Following trust sign off of a MNSI report with no safety recommendations a request was made to submit evidence for the trusts response to the 7 safety recommendations especially highlighting any actions in relation to the lack of provisions for teenage patients. Response formulated and to be returned to CQC by the 18/07/25.
	Teenage pregnancy working party set up to explore what we can offer for these patients. To include discussions with specialist teenage pregnancy midwives in the region and explore pre-recorded Antenatal Education sessions teenage specific.
	Task and Finish group to be set up to look at improving the patient experience during IOL on the antenatal ward. To include usage of the national maternity pain score to be used in practice

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There has been an increase in datix numbers for postnatal readmissions.	Cases to be reviewed and compared to the recent deep dive which was undertaken by the patient safety team.

6.5 Maternity and Neonatal Risk Register

Maternity – Appendix 1.12

No new risk added May and June

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.

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Neonatal

1 risk added to the register May and June –

Insufficient number of Advanced Neonatal Nurse Practitioners at Lincoln - 9

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.

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6: Listening to our families

6.1 Maternity Patient Experience report

Appendix 1.13

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)			
MNVP Co-produced patient experience improvement plan	See quarterly report		See quarterly report
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		

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	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		• We welcomed Kay and Alma from East Midlands Health Innovations on the 2nd July to deliver MOMENTS training to 12 members of staff. The group worked through the framework of resources to nurture safety culture development through everyday practice and found the day really useful.
		Three overarching projects ongoing:
		1. Bespoke support by Health Innovations on community midwifery projects based on feedback from community midwives
		2. 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
		    ○ Obstetric induction pack and intranet page co-produced with college tutor SN in response to feedback and escalation via NETS and PG surveys
		3. Co-producing a vision for our perinatal services

Greatix	May and June: 18 Since launch (Nov 22): 508	• 'For being so supportive and proactive with breastfeeding and expressing support. It can be easy to presume someone has just "changed their mind" about breastfeeding if they start giving bottles and formula but so often that is not the case. Keep up the amazing work!' • 'Thanks to Elijah's input, I felt confident, well-prepared, and able to perform at my best. His support made a real difference to both my confidence and the outcome of the process. He exemplifies everything we value in a colleague: collaborative, compassionate, and invested in developing others. I feel very lucky to work alongside someone as thoughtful and committed as Elijah. His contribution deserves recognition.'

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		• 'I am nominating Whitney as she has created a Clinical Education Midwife Handbook that I received but is for anyone joining the Education Team. The handbook is incredibly detailed and a helpful tool for someone new to the role. Whitney is passionate about teaching and education her aim being that as practitioners we are providing gold standard care. I really appreciate all the time and effort she has gone to producing this handbook!'
Staff surveys	NHS Staff Survey	Benchmarking results to feed into staff experience improvement plan
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	PHB NNU Workforce Tool
Appendix 1.3	LCH NNU Workforce Tool

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Appendix 1.4	MatSIP
Appendix 1.5	NeoSIP
Appendix 1.6	RCOG Recognition Certificate
Appendix 1.7	Biomechanics project plan
Appendix 1.8	NNU QIS Report
Appendix 1.9	NNAP network and national comparisons
Appendix 1.10	NNAP Year on Year Compliance and Action Plan
Appendix 1.11	Learning Lessons
Appendix 1.12	Risk Register
Appendix 1.13	PEG Report
Appendix 2.0 and 2.1	Compliance with NICE Guidance in Maternity & Outstanding Recommendations
Appendix 3.0	Overdue Clinical Policies & Guidelines
Appendix 4.0	Deep-dive: Born Before Arrival (BBA)
Appendix 5.0 and 5.1	Maternity and neonatal investigation/taskforce (Letter from Jim Mackey & Duncan Burton) and response to National Maternity Review letter
Appendix 6.0	MNSI – UK Perinatal Deaths
Appendix 7.0	15 Steps Report

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NHS England

To:
- Chief executive officer
- Chief nurse
- Medical director

cc.
- Regional chief nurse
- Regional medical director
- Regional chief midwife

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

6 August 2025

Dear colleague

Preparation needed to support the independent review of maternity services at Nottingham University Hospitals NHS Trust

To maximise learning from the independent review of maternity services at Nottingham University Hospitals NHS Trust (NUH), the review includes babies who were born elsewhere but transferred to NUH for their neonatal care, provided they meet the Terms of Reference.

We have identified cases within the review where mothers received their maternity care at your trust. The review team may require information about the maternity and neonatal care before transfer to support a comprehensive neonatal review.

Therefore, we are writing to inform you that the review team may be in touch to request your support in releasing relevant clinical records to them. We also want to outline the process should these records be required.

The methodology of the review is "opt-out", and all families meeting the Terms of Reference have received details about how they can opt out if they do not wish to be included. By remaining in the review, families have consented for their records to be requested by the review team. No records will be requested where families have chosen to opt out.

If requested, the records can be sent securely to the review team via the Egress system. We would be grateful if you could **please let us know who will manage the upload of records of your organisation** by sending their email address to england.imr-nuhprog@nhs.net. We can then send an invitation to and instructions for using the Egress system.

All cases within the review have a unique identifier, please include this number in all correspondence with the review team to allow the maternal and neonatal records to be matched accurately.

You may also be aware that Nottinghamshire Police have an ongoing investigation (Operation Perth) into deaths and serious injuries related to maternity care at the Nottingham University Hospitals NHS Trust. The police have confirmed that care delivered at hospital trusts other than Nottingham University Hospitals NHS Trust is not within scope of Operation Perth.

As outlined in the review's Terms of Reference, the neonatal care at NUH will be graded. However, the care received before the transfer of the baby to NUH will not be graded.

Should the review team identify any concerns regarding maternal or neonatal care at your organisation, they will write to you describing these concerns, allowing you to investigate and take action as appropriate, including contacting the family in line with your Duty of Candour obligations. This letter will be copied to the regional chief nurse and the senior responsible owner (SRO) of the review (chief nursing officer for England). The regional chief nurse will request assurance that these concerns have been appropriately addressed.

Themes or concerns identified by the review relating to the care provided by other organisations may form part of the review report. However, as the review is focused on the care provided by NUH, those organisations will not be named.

The review team will deliver family feedback on neonatal care in the same way as for all other families included in the review, which ranges from a letter to outline findings to a face-to-face meeting if different care would have resulted in a different outcome.

All families involved in the review can access support with the Family Psychological Support Service (FPSS). This service is bespoke, and families can self-refer or be referred by the review team. Information about this service has already been shared with families; however, for information, they can be contacted at: enquiries@fpssnottingham.co.uk

Once the review team is ready to request records, we would be happy to facilitate a Q&A session if useful. In the meantime, please contact NHS England at england.imr-nuhprog@nhs.net with any questions or concerns you may have.

Thank you for your understanding and support.

Yours sincerely,

Duncan Burton
Chief Nursing Officer for England

Donna Ockenden
Chair, Independent Maternity Review, Nottingham University Hospitals NHS Trust

Finance and Performance Committee Upward Report

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*2 September 2025*
Item Number	*8.2*

Finance and Performance Committee Upward Report of the meeting held on 18 July 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 the development of the RACH reporting system with work being completed to confirm the metrics for the Committee, including the constitutional standards.

The Committee noted the challenges with urgent and emergency care targets which were reported at 72.3% with a target of 77%. Improvements were being seen in respect of 12-hour waits with continued work to reduce below 10% and improvements had been seen across diagnostics in month.

Focused discussion – Community Performance Metrics – redesign of home visiting and urgent community response

The Committee received the report noting that there were seasonal pressures being experienced across the urgent treatment centres due to the expected migration with plans being developed to improve the environment at Skegness.

Transitional care activity was starting to reduce, as planned due to the reduction in transitional care beds, and increased in discharge to assess capacity.

The Committee noted the ongoing work in respect of the urgent community response with developments being made in order to expend the service and provide support to the population through a single point of contact.

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 quarter 1 had been delivered in line with plan at a £11.1m deficit across the Group. Three areas of focus were noted in respect of activity, Cost Improvement Programmes (CIP) and workforce controls.

The Committee recognised that months 4 and 7 would see a step up in the delivery of efficiency programmes and noted the mitigations in place where there was under delivery.

The cash position was noted as ahead of plan however there was recognition of the in-year challenges that would be present with a need to provide focus to maximise the cash position. A cash group would be established to oversee the work being undertaken and would report to the Committee.

There was recognition of the work being undertaken with delivery partners to develop savings opportunities, realise improvements in productivity and achieve transformation.

The Committee noted the significant reduction in bank spend with a continued focus through the temporary workforce group, alongside the shadow board that had been tasked with delivery of reductions.

The Capital, Revenue and Investment Group (CRIG) upward report was received and noted by the Committee, recognising this provided key updates of schemes that had been approved and any changes to the capital plan.

National Costing Collection Annual Return
The Committee received the report noting that a compliant return had been submitted and offered a thorough piece of work undertaken. The submission had been made through the delegated authority that had previously been approved, and the outcome of the reference cost indicator was awaited following the submission.

Post investment case – Surgery Robot
The Committee was pleased to receive the first of the post investment business case reviews which was offered for the surgery robot.

The Committee noted the benefits in respect of time to treatment for patients being reduced from 3 months to 4 weeks with recognition for future programmes that SMART objectives and clear KPIs should be included. This would support identification of benefits.

Productivity Plans
The Committee received the report for information.

Productivity, Improvement and Transformation Oversight Forum Upward Report
The Committee received the report noting the work of the oversight forum in monitoring the CIP schemes and progressing work on additional schemes to address the current forecast gap. Active management of those schemes rated high, or medium was underway to de-risk and improve confidence in delivery.

The Committee was pleased to note the progress in temporary staffing recognising that there was no agency spend in nursing, resulting in a stable workforce with no vacancies.

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 the Group was in the process of commissioning a Group wider strategy that was hoped to be in place by the end of the financial year.

The recent power failure had been resolved through increase of capacity, which should ensure future issues would not be experienced. The Committee noted positive trends in respect of water safety and the work underway to further improve compliance with medical gases through designated nurses and medical officer training.

The works associated with the enforcement notice for confined spaces was progressing with the anticipation of requesting a visit from The Health and Safety Executive in quarter 4 to review progress which should result in the closure of the notice.

Fire safety works continued however a review would be undertaken to determine the position of actions which were now believed to be complete. An external review of planned preventative maintenance was being commissioned with recognition that the Community Diagnostic Centres were now included within this.

The Committee noted that all Authorised Engineer positions had been recruited to and awaited the outcome of reports as these became available.

Emergency Planning Group Upward Report inc BCP Upward
The Committee received the report noting there were no escalations and recognised a number of incidents requiring business continuity plans to be enacted, which demonstrated an upward trajectory in the completion, testing and use of these.

Health and Safety Committee Upward Report
The Committee received the report noting that work was taking place to improve the quality of the report to the Committee in order to provide greater assurance.

The Committee noted the need for the health and safety of the workforce wellbeing to be considered by the Health and Safety Committee, particularly in relation to community staff.

Assurance in respect of other areas

Referral Feedback – Discharge
The Committee received feedback in respect of the referral made regarding discharge to the Integration Committee noting the new digital system, Optica, which would support improvement that would be seen through performance reporting.

EDMS Update
The Committee noted that the Electronic Document Management System (EDMS) programme had been signed off through the appropriate governance routes and was being represented due to the intent to deliver an accelerated programme to this originally presented.

The Committee noted that there would be an increase of onsite scanners to support the delivery timeframe and whilst this attracted capital additional costs, savings of £2.9m could be realised.

The Committee supported the rephasing of the programme of work noting the need for additional capital to purchase the scanning equipment.

Board Assurance Framework 2025/26
The Committee received the Board Assurance Framework noting the position and 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 position in respect of the documents overdue and the RAG ratings.

Information Governance Group Position Statement – inc DSPT submission

The Committee received the report noting that the Data Security Protection Toolkit (DSPT) submissions had been made for both ULTH and LCHS with 'Standards Not Met' and 'Standards Met' reported respectively.

It was noted that as a result of ULTH submission the Trust was requires to produce an improvement plan which had been submitted as part of the final submission. Once approved it was anticipated that the Trust status would be amended to show 'Approaching Standards – Improvement Plan'.

Internal Audit Recommendations

The Committee received and noted the internal audit recommendations as presented with recognition of the work required to ensure submissions had been received to enable closure of open recommendations.

CQC Quarterly Report

The Committee received the report noting the requirement for progress to be reported on the open actions relevant to the Committee with actions being addressed through the Performance Review Meetings.

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	J
Dani Cecchini Non-Executive Director (Chair)				X	X	X	X	X	X	X	X	X
Sarah Buik, Associate Non-Executive Director				X	X	X	X	X	X	X	X	X
Ian Orrell, Associate Non-Executive Director				X	X	A	X	X	A	X	X	X

Paul Antunes-Goncalves, Group Chief Finance Officer				X	X	X	X	X	X	X	X	X
Caroline Landon, Chief Operating Officer, ULHT/LCHS				D	X	D	X	X	D	X	D	X
Daren Fradgley, Group Chief Integration Officer				D	X	X	X	D	X	X	X	X
Mike Parkhill, Group Chief Estates and Facilities Officer				X	X	X	X	X	D	X	X	X
Claire Low, Group Chief People Officer						X	X	X	X	A	A	X

X in attendance
A apologies given
D deputy attended

Finance and Performance Committee Upward Report

Great care, close to home

OUTSTANDING CARE *personally* DELIVERED

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*2 September 2025*
Item Number	*8.2*

Finance and Performance Committee Upward Report of the meeting held on 21 August 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 and considered the new format of the Committee Performance Dashboard, offering feedback on the layout and requesting additional inclusions within the report. The Committee noted the benefits being offered through the new format and welcomed the development of this.

The Committee received the operational performance report noting the position and received an update in respect of current performance. It was noted that A&E 4-hour waits had achieved 73.78% against a target of 77% in

July. Improvements were expected for August and there was recognition of seasonal impact on the position as well as the impact of Industrial Action, which had been well managed.

12-hour waits were noted as an area for improvement with 12% of patients exceeding 12-hours in the emergency departments. Actions were in place to identify a sustainable solution.

DM01 was reported as performing well with no concerns and 62-day waits were off trajectory but were being brought back on track.

There was a forecast for 18 65-week waiters at the end of August however there was recognition of the challenges being faced in ENT and Neurology due to staffing. Neurology was considered a fragile service and work was taking place with the Improvement Team to identify solutions.

The unvalidated position for 52-week waits at the end of July was noted by the Committee with the expectation that following validation this would be closer to trajectory.

18-week referral to treatment (RTT) performance was moving closer to plan, once validated, however the Committee noted that the plan would not be achieved, and a national validation sprint had been implemented. Due to the national sprint there was recognition of the impact on the position.

A verbal update was received with the Committee noting the movement in the total waiting list from 70,366 at the end of June to 69000, at the time of the meeting. Work was in place to address the 52-week waits for children's and young people services.

Cancer services were noted as performing well despite some challenges impacting on the 28-day faster diagnosis standard and pressures associated with colorectal. There had been an increase seen in breast and gynaecology referrals during August with work being undertaken to understand the rise.

From a community perspective the Committee noted the position in respect of performance with no concerns being raised however it was noted that delays continued to be seen in community beds and equipment availability.

There was recognition of the transformation programmes of work being undertaken across the Group with the Committee raising concerns about the capacity, capability and culture to support the level of change required. A referral would be made to the Integration Committee to consider a wider risk for inclusion on the risk register against transformational change.

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 the year-to-date deficit for the Group at £12.4m, in line with plan. Efficiency savings of £15.1m had been delivered, £0.9m higher than plan. There was recognition that there had been 5 days industrial action in month however the Group had applied learning from prior periods of action, minimising activity loss and additional costs whilst maintaining safe services.

It was noted that the ULTH baseline position was £2.4m adverse to plan, being driven by underperformance of activity, industrial actions and slippage against Cost Improvement Programmes (CIP). In order to address the position technical efficiencies had been brought forward as it was anticipated that the activity position would be recovered but with some possible risk around CIP and the costs of industrial action..

The Committee noted the work in place to continue to develop the CIP work to support the step change required to support delivery.

The cash position was £1.9m ahead of plan however the position remained challenging due to the application of the (non-cash) technical efficiencies with actions being development in order to mitigate the cash position.

Whilst capital was reported behind plan the position could be recovered with forecasting of full delivery in place. Reporting of the final position, following the conclusion of the Mutually Agreed Resignation Scheme (MARS), was expected at month 5, where the full impact could be reported.

Post investment case – Microsoft 365
The Committee received the report noting that the programme of work had been approved at CRIG in June 2024 with the review completed July 2025, scoring 19 out of 30 with 3 objectives included for achievement.

It was noted that cost reductions of circa £900k were achieved as well as standardisation of systems across the Group. The final objective to optimise platform use required further work to deliver. Cost avoidance was also noted as a benefit due to the avoidance of cost rises in future years.

The Committee noted the achievement of the programme of work and commended the communications and delivery of the digital teams noting the learning that needed to be shared from this in future projects.

Nursing Establishment Review – for information
The Committee received the report for information.

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 the progress in respect of actions associated with Authorised Engineers (AEs) as well as the appointment of all LCHS AEs.

Progress was being made in respect of the Estate's strategy, which would incorporate the clinical strategies and the Planned Preventative Maintenance (PPM) external audit had been commissioned and would commence in September.

Concerns were noted in respect of ventilation, medical gases training and the lack of information associated with asbestos reports for LCHS properties which were being addressed. There was recognition that the risk associated with fire should be re-considered as most high-risk areas had been addressed. A proposal would be made, to downgrade the risk, following review of the position.

The Urgent Treatment Centre cleanliness audit for Pilgrim has raised concerns however this was in part due to the service operating out of a temporary area during the Emergency Department build.

Assurance in respect of other areas

Board Assurance Framework 2025/26
The Committee received the Board Assurance Framework noting the position and confirmed that the assurance ratings would remain as reported with no changes made in month. There was recognition of the need to ensure clarity of the assurances being received in order to enable the Committee to consider movement in the assurance ratings.

Risk Report
The Committee received the risk register noting the current risks presented and the movement in month with consideration of the reports received by the Committee to confirm that all high and very high risks were being considered.

Internal Audit Reports
The Committee received the internal audit reports for LCHS and ULTH noting that these offered reasonable levels of assurance in respect of the ULTH Financial Management and Urgent Care and Emergency – Standard Operating Procedures.

The Data Security Protection Toolkit Assessments offered for both LCHS and ULTH were noted as providing low overall risk assurance as well as the independent assessment returning high confidence in the veracity of the self-assessment.

Internal Audit Recommendations

The Committee received and noted the internal audit recommendations as presented noting the ongoing work to address these.

Policy Position Update

The Committee received the report noting the position in respect of the documents overdue and the RAG ratings offered with some movement seen in month.

Cyber Compliance report to inc. National Benchmarking of IT patches and EPR approval letter

The Committee received the report noting that a review of available data, to consider national benchmarking, had been undertaken and had not identified that ULTH was an outlier.

The Committee noted some risks in respect of unsupported and legacy systems in place at the Trust with recognition that the Electronic Patient Record (EPR) and Electronic Document Management System (EDMS) would significantly reduce the number of systems.

The Electronic Patient Record (EPR) approval letter and detail of conditions were received with the Committee noting this offered formal approval. The conditions were being actioned with a number already addressed.

LCHS Data Quality

The Committee received the report for information.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

The Committee referred to the Integration Committee the potential risk to delivery of transformation programmes in year.

Attendance Summary for rolling 12-month period

Voting Members	S	O	N	D	J	F	M	A	M	J	J	A
Dani Cecchini Non-Executive Director (Chair)			X	X	X	X	X	X	X	X	X	X
Sarah Buik, Associate Non-Executive Director			X	X	X	X	X	X	X	X	X	X
Ian Orrell, Associate Non-Executive Director			X	X	A	X	X	A	X	X	X	X
Paul Antunes-Goncalves, Group Chief Finance Officer			X	X	X	X	X	X	X	X	X	D

Caroline Landon, Chief Operating Officer, ULHT/LCHS			D	X	D	X	X	D	X	D	X	X
Daren Fradgley, Group Chief Integration Officer			D	X	X	X	D	X	X	X	X	D
Mike Parkhill, Group Chief Estates and Facilities Officer			X	X	X	X	X	D	X	X	X	X
Claire Low, Group Chief People Officer					X	X	X	X	A	A	X	A

X in attendance
A apologies given
D deputy attended

Finance Briefing

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2 September 2025*
Item Number	*8.3*

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. • Note the impact of the Junior Doctor Industrial Action that has been mitigated in month by bringing forward non-recurrent efficiencies to allow for in year mitigations to be developed.

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

3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	
4b Successful delivery of the Acute Services Review	
4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	
5c Tackle system priorities and service transformation in partnership with our population and communities	
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	

Trust Board is asked to note the following:

- **2025/26 Revenue position M4 YTD (Year to date)**
  The Group delivered a £12.3m deficit (£0.1m better than planned).

- **2025/25 Capital position M4 YTD**
  The Group delivered capital expenditure of £3.3m (£1.7m lower than planned).

- **2024/25 CIP position M4 YTD**
  The Group delivered savings of £15.1m (£0.9m better than planned).

- **M4 Cash position**
  The Group ended the month with a cash balance of £36.8m (£1.9m **higher** than planned).

Lincolnshire Community and Hospitals NHS Group
Trust Board – 2 September 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 £0.9m. 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 £1.9m ahead of plan, with a cash balance at the end of month 4 of £36.8m. The Group will need to ensure we are monitoring our cash position linked to the revenue profile during the financial year.

In M4, our Junior Doctor workforce undertook industrial action over a 5-day period, this impacted the position through a combination of reduced activity/income and increased costs due to cost of backfilling staff who were absence from work. Non-recurrent efficiency savings have been brought forward to mitigate the position in month and allow for mitigations to be developed in the year to go.

Summary Position

Month 4 Position	Group performance Year to Date			LCHS performance Year to Date			ULTH performance Year to Date		
	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m
Surplus / (Deficit)	(12.4)	(12.3)	0.1	(1.9)	(1.7)	0.1	(10.6)	(10.6)	0.0
CIP Delivery	14.2	15.1	0.9	1.3	1.4	0.1	12.9	13.7	0.7
Capital Spend	13.8	9.2	(4.6)	2.1	1.7	(0.4)	11.7	7.4	(4.2)
Agency Spend	(5.4)	(6.0)	(0.6)	(0.5)	(0.3)	0.3	(4.8)	(5.8)	(0.9)
Cash Balance	34.8	36.8	1.9	24.6	27.5	2.8	10.2	9.3	(0.9)

Revenue Position

The Group's financial position is an £12.3m deficit after four months, this position is £0.1m better than our planned position. Our month 4 deficit position has significantly improvement from the M1-3 position. A further improvement in run rate is anticipated in month 7 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 stepped up in month 4 and a further step up in 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 4, ULTH is behind our planned level and requires 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 4, 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. Our MARs scheme will improve this position during Q2 and Q3 depending on notice periods.

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.

The month 4 position, includes the impact of the Junior Doctor Industrial Action which started at 7am on 25 July and finished at 7am on 30 July. This impacted ULTH in two ways, first reduced our activity/income in month due to reduced planned care activity and secondly through increasing our pay costs due to the premium paid to backfill staff that were absent from work. Non-recurrent efficiency savings have been brought forward to mitigate the position in month and allow for mitigations to be developed in the year to go.

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 4 the Group were £4.6m 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.

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.

People Committee Upward Report

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2 September 2025*
Item Number	*9.1*

People Committee Upward Report of the meeting held on 14 July 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 for information noting the position in respect of the level 7 apprenticeship levy with activity brought forward to minimise the immediate impact.

Safer Staffing Nursing and AHP
The Committee received the joint report for information, noting the position presented with no escalation due to be made to the Committee.

Midwifery Bi-Annual staffing report to inc. age profiles
The Committee received the report for information noting that this had been considered through the Maternity and Neonatal Oversight Group and Quality Committee.

Assurance in respect of Objective 2b – Empower our people to continuously improve and innovate

Workforce Strategy Group Upward Report to inc Fire Safety training and Committee Performance Dashboard – LCHS and ULTH
The Committee received the upward report and performance dashboards for information noting that fire safety training was reported to the Group.

Workforce Hub Upward Report to inc Temporary Staffing Position Update
The Committee received the second report from the hub noting the work to bring together HR, recruitment, wellbeing and medical recruitment teams.

It was noted that Cost Improvement Programmes were being centralised through the hub to ensure timely processes and support was in place for those affected. An analysis of change programmes had highlighted peaks in July and October with work being supported by Staff Side in relation to the schedule for change.

There was recognition of the progress being made in respect of temporary staffing spend which needed to continue to achieve the change required. A central register was now in place for redeployment of staff.

A digital HR helpdesk was currently in development with an expectation that this would be in place during August to support 24/7 access for staff, with future AI integration planned.

Freedom to Speak Up Quarterly Report – LCHG
The Committee received the Group report noting an increase in concerns related to recruitment processes and relationships between staff being appointed and recruiting.

The Committee recognised the audit due to be undertaken in respect of the recruitment process as well as the changes made to the recruitment training.

There was recognition of similar themes across the Group and the Committee noted the level of trust staff had in the Freedom to Speak Up Guardians due to the low numbers of staff coming forward anonymously.

Assurance in respect of Objective 2c – Nurture compassionate and diverse leadership

Culture and Leadership Group Upward Report
The Committee received the report noting the recent Group Leadership Team (GLT) roadshows that had been completed with positive engagement from staff attending.

The Committee noted that the themes from the roadshows were being captured in order that feedback could be provided and action taken where required. There was also recognition of the popularity of the Executive Leadership Team (ELT) Live sessions, with recent sessions being viewed by 3000 staff, enabling staff to ask and receive responses to questions posed. Plans for ongoing roadshows, learning from the feedback, are now underway.

The health and wellbeing offer across the Group was noted with a recognition of offer in place however a request was made for the Committee to be sighted on the plan for the year.

The Committee noted the work underway in respect of the development of the Staff survey action plan with recognition that further support was required in some areas to ensure completion of these. There was positive ownership of the action plans and recognition that the development of the action plans would then support change programmes where required.

NHS and System People Plan Update
The Committee received a verbal update noting the change in position due to the national direction of travel in respect of Integrated Care Board (ICB) cluster footprints and the NHS 10-year plan.

Local plans that had been developed were now being reviewed in line with the national plan with the Committee supportive of the direction of travel for the development of a People strategy across the Group, aligned to the 10-year plan.

AAC Recruitment
The Committee received an update in respect of the AAC recruitment process noting the work being undertaken in order to strengthen this.

There was recognition that the process needed to remain in line with the royal colleges however additional leadership questions had been included in the process. Development to ensure inclusivity on the panels was in place with an expectation that consultants would meet with network leads to support the onboarding process. A further update would be received by the Committee in 2 months.

Workforce Race Equality Standards (WRES) Annual Report and Action Plan

The Committee received the WRES annual reports for LCHS and ULTH with **assurance** noting the development of the action plan as a result of the data analysis.

The Committee noted the increases in data related to the relative likelihood of white staff being appointed from shortlisting across all posts as well as the increase in staff experiencing bullying, harassment and abuse from patients and relatives, staff or managers. Whilst these remained below the national average the Committee noted the work required to improve the position.

Staff networks would be supporting the implementation of the action plans.

Workforce Disability Equality Standards Annual (WDES) Report and Action Plan

The Committee received the WDES annual reports for LCHS and ULTH with **assurance** noting the development of the action plan as a result of the data analysis.

There was recognition of the increase, above national average, associated with staff likely to enter formal capability processes for LCHS however an increase was also noted for ULTH.

The action plan was aligned across the Group from the outputs of the National Staff Survey, WRES and WDES data, resulting in a single high level action plan.

Equality, Diversity and Inclusion (EDI) Annual Report

The Committee received the EDI annual reports for LCHS and ULTH with **assurance**, noting that these had been completed utilising the same templates that had highlighted the differences in data collection between the organisations.

The Committee was pleased to note the position presented through the annual reports, particularly recognising the involvement of the staff networks which had come together across the Group.

Assurance in respect of Objective 2d – Recognising our people through thanks and celebration

Staff Story

The Committee received a staff story in relation to the apprenticeship offer available across the Group noting the impact this had had on a member of staff achieving qualifications and a career in nursing.

The Committee was delighted to note the recent achievement of the Talent Academy with ULTH being ranked 50th in the Sunday Times top 100 apprenticeship employers. In previous years the Trust had not been ranked.

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 report noting the current risks related to the Committee with the recognition of the need to undertake a dep dive into the risks for the Committee to ensure these were appropriate.

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 and recognising the ongoing work with internal audit to ensure the closure of recommendations for which evidence had been submitted.

Quarterly CQC Report
The Committee received the report noting that work continued in respect of evidence gathering to support the organisations, should there be a CQC inspection undertaken.

Issues where assurance remains outstanding for escalation to the Board

None

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	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	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	X

Colin Farquharson Group Chief Medical Officer			D	X	X	A	D	X	X	X	X	D
Nerea Odongo, Group Chief Nurse			X	X	X	X	D	X	X	X	X	X

X in attendance
A apologies given
D deputy attended

People Committee Upward Report

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2 September 2025*
Item Number	*9.1*

People Committee Upward Report of the meeting held on 12 August 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 that statutory and mandatory learning compliance was above the 90% target and discussions were held in respect of changes to the national training packages with a focus on the increased learning burden on staff.

The Committee noted that Continuing Professional Development (CPD) funding had now been allocated and confirm for both Trusts with invoicing taking place for quarter 1 and spending plans in place.

There was utilisation at 118% of the apprenticeship levy across the Group with further discussions held around the promotion of the apprenticeship offerings across the Group.

The Committee noted the achievement of ULTH being 50th in the Sunday Times top 100 apprenticeship employees, with 6% of the workforce on apprenticeship training.

The work in respect of clinical education was noted with key pieces of work including the safe learning environment charter, preceptorship becoming a multi-professional quality. Further clinical education activity was being presented to the group in order to ensure greater oversight.

There was recognition of the change to the medical school at the University of Lincoln working more independently with an enhanced focus on the medical tariff.

The Committee was pleased to note the progress being made by the group and the increased assurances being received as a result of the work being undertaken and the strengthened reporting.

Nursing Establishment Review
The Committee received the nursing establishment review recognising the volume of work undertaken in a short period of time and the ownership of the process by ward managers.

The output of the review identified a relatively positive position for LCHS however there was recognition of the needed to consider skill mix. Due to the output of the review a recommendation was not being made at this time, and the review would be repeated in October, with the ongoing work associated with the operation model being noted.

55 clinical areas were reviewed for ULTH, following the development of a new data pack which also captured quality indicators and outcomes. The change to the roster templates was noted, moving from short to long days which had achieved a number of savings, without impacting on the ability for staff to work flexibly and had been offered for cost savings.

The Committee noted the changes to ward manager funding to support more non-clinical hours being delivered in order to strengthen people development and HR management, moving to an 80/20 split.

The review had indicated a reduction in the overall nursing workforce of 7.3 WTE with the recognition of the review of enhanced care due to increased spend on security seen for the wards.

The Committee received the report noting that a further review would be undertaken in October 2025, prior to any recommendations being made in respect of changes to the community nursing establishment.

Safer Staffing Medical

The Committee received the report noting the ongoing developments in the data being offered. Medical vacancies were noted at 5.8% for ULTH and 27% for LCHS however there was recognition of the whole-time equivalents differed due to the workforce size in each organisation.

Agency and bank spend continued to be higher that other Trusts however had continued for ULTH due to the Extra Contractual Rate (ECR) being higher and therefore it was more cost effective to utilise bank and agency.

The Committee noted the fragile services which had been detailed and the work being undertaken to define the services and triangulate data appropriately.

Appraisal rates remained high across the Group and sickness rates were considered positive due to the low numbers.

Medical Revalidation

The Committee received the annual medical revalidation reports for both LCHS and ULTH, which were recommended to the Board for approval with the Committee noting the variance in the data being due to size of the workforce in each organisation.

There was recognition of actions having been completed from the previous years submission and it was noted that the ULTH revalidation policy had been update and was now fit for purpose.

A new quality assurance framework had been developed in respect of the revalidation process, coming from exemplars of good practice with positive feedback offered from NHS England on the progress made.

It was noted that the Maintaining High Professional Standards Policy had been updated for the Group, updating the process and ability to better record outcomes.

Further work was required to increase the number of appraisers to have the correct ratio, in order to close the associated action however the Committee was assured this would be completed in year.

Assurance in respect of Objective 2b – Empower our people to continuously improve and innovate

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

The Committee received the report noting that the meeting had been impacted by the recent industrial action, with a number of members unable to attend however updates were sourced outside of the meeting enabling the report to be offered to the Committee.

Detailed discussions took place in relation to sickness absence with the Committee noting the plateau of absence rates in ULTH and slight increase for LCHS. However, there are some areas of nursing showing higher rates of short term sickness which are now being explored in terms of additional support.

Turnover rates were performing better than target and whilst pleasing, this was impacting on the workforce plan assumptions. Despite the Vacancy Control Panel being in place positive progress was noted in respect of AHP vacancies, with a 2.6% reduction.

The group was able to consider the 10-year health plan, that had been released prior to the meeting, and how it would be able to influence the work being undertaken, particularly in respect of the digital solutions.

Workforce Hub Upward Report to inc Temporary Staffing Position Update
The Committee received the report noting that of those staff seeking redeployment, 23% were in the process of being redeployed. Assurance was offered that those still awaiting redeployment were not at risk of redundancy and colleagues were being supported to find suitable roles. Wellbeing support and interview preparation was also in place.

The Committee noted the work of the shadow Board in respect of the temporary staffing work with the recognition that this had not been progressing as hoped. There were now clear controls and principles in place across all of the care groups in respect of how temporary staffing was reviewed.

There was recognition that whilst there had been a positive position at the end of month 3 in terms of temporary staffing, additional use would be reported as a result of industrial action. Early indications at the time of the meeting however indicate a worsening position against the workforce plan which continue to be supported by weekly reporting to ELT and the Shadow Board.

Pulse Survey Feedback
The Committee received the report noting that this offered the output of the quarter 1 responses with themes from positive comments noted alongside the consistent concerns and recommendations.

The Committee noted that the output of the quarter 2 survey had been received and would be analysed, with a slight increase in response rates noted along with declines in some areas.

It was recognised that there was an overall plan focusing on internal leadership and culture, which was overseen by the Culture and Leadership Group, as well as being monitored through the PRMs and Group Leadership Team (GLT). The Committee requested a review of the actions, noting that there was a need to consider a different approach to achieve improvements.

Guardian of Safe Working Quarterly Report

The Committee received the quarterly report noting the ongoing concerns being raised in respect of rest space for resident doctors recognising that this was an issue associated with those doctors who were not members of the mess or were locum doctors.

The Committee requested an executive action be taken to discuss and better understand the impact this was having in order to support resolution of the issue.

Assurance in respect of Objective 2c – Nurture compassionate and diverse leadership

Equality, Diversity and Inclusion Group Upward Report

The Committee received the report noting the discussions held in respect of the annual report and comprehensive updates received by the group from the staff networks.

The Committee was pleased to note the engagement of the staff networks and the development of these across the Group with significant amounts of work being undertaken by the staff networks.

Equality, Diversity and Inclusion Deep Dive

The Committee received the EDIT deep dive, following receipt of the annual reports and action plans the previous month and noted the dashboard presented that offered the trends over the past 3-years, national benchmarking and direction of travel.

It was noted that there was a need to ensure actions were in place to provide assurance that those areas of decline were being appropriately addressed. It was proposed that wider accountability was required to support delivery of the actions and therefore this would be shared at the next Better Together event.

Culture and Leadership Group Upward Report

The Committee received the report and noted the discussions held in respect of the GLT roadshows, focus on employee support and the forthcoming winter vaccination programme.

The Committee recognised the decrease in morale for community colleagues however noted that work was ongoing and discussions were being held in various forums to support staff.

Employee Exclusions

The Committee noted that there were currently 4 exclusions within ULTH and 2 within LCHS. It was recognised that the work being undertaken to progress cases was having an impact with preventative measures being put in place more quickly.

The Committee received and noted the professional registration report, noting the position.

Health and Wellbeing Offer Update (appended)
The Committee took the report as read noting that the discussions had taken place, in respect of the Health and Wellbeing officer, through the staff story that had identified the support in place for staff.

The Committee was pleased to note, through the staff story, the positive outcome for a member of staff following the undertaking of a health MOT and utilisation of the health and wellbeing offer. The health and wellbeing offers were now being offered across the Group with work taking place on the remaining areas to ensure consistency.

Assurance in respect of Objective 2d – Recognising our people through thanks and celebration

No items 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. The Committee was please to recognise the increases in assurances being provided, due to the quality of reports, in respect of objective 2a and recommended to the Board that the assurance rating be moved from Amber to Green.

Risk Report
The Committee received the report noting the current risks related to the Committee with work continuing on the review of risks to ensure these remained relevant, accurate and reported to the correct Committee. It was noted that the Committee would formally receive reassigned risks in September.

Policy Position Update
The Committee received the report noting the position presented and the ongoing progress to develop documents across the Group.

Internal Audit – Vacancy Controls
The Committee received the report noting this offered reasonable assurance with a number of recommendations which were being actioned.

Internal Audit Recommendations
The Committee received the report noting the open recommendations that remained following the completion of a number of overdue recommendations.

Issues where assurance remains outstanding for escalation to the Board

None

Items referred to other Committees for Assurance

None

Attendance Summary for rolling 12-month period

Voting Members	S	O	N	D	J	F	M	A	M	J	J	A
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	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	X	X
Colin Farquharson Group Chief Medical Officer		D	X	X	A	D	X	X	X	X	D	X
Nerea Odongo, Group Chief Nurse		X	X	X	X	D	X	X	X	X	X	X

X in attendance
A apologies given
D deputy attended

Health and Wellbeing Offer Overview

Meeting	*People Committee*
Date of Meeting	*12th August 2025*
Item Number	*9.5*

LCHG Health and Wellbeing Offer Overview – August 2025

Accountable Director	*Nico Batinica, Deputy Chief People Officer*
Presented by	*Kerry Swift – Deputy Director of People*
Author(s)	*Michael Du Rose – Interim Head of Education, Learning & OD*
Recommendations/ Decision Required	*The Committee is asked to: - Note the report for information*

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	
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	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	
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

Wellbeing directly impacts staff performance, engagement, and retention. In the NHS, it supports both mental and physical health and wellbeing, boosts productivity, fosters a positive culture, and ensures compliance with duty of care.

The Group offers a comprehensive wellbeing programme with the aim that this is accessible to all staff where possible.

The Employee Assistance Programme (EAP), provided by Health Assured, is available 24/7 and includes counselling, legal and medical advice, bereavement support, and online CBT resources. It also extends to immediate family members living in the same household above the age of 16.

Around 286 Wellbeing Champions promote services and campaigns across teams, with plans to expand further. Mental Health First Aiders are trained to support colleagues in distress and signpost to appropriate services, with harmonisation of training underway.

A doctor-led menopause service is now available across the Group, offering tailored support. The Physio For You service, currently exclusive to LCHS, supports staff to manage musculoskeletal issues and is planned for wider rollout across Group.

ULTH's Critical Incident Peer Support group provides trained responders for staff affected by traumatic events, with plans to revisit uptake in LCHS. Mini Health MOTs are offered during Twilight Talks, providing basic health checks and promoting wellbeing services.

Wellbeing teams conduct regular site visits to promote services and offer direct support. Free flu vaccinations are available to all staff, while COVID-19 vaccines must be booked externally this year. Our wellbeing teams also provide guidance on vaccine side effects to help staff make informed decisions.

There is still further harmonisation work to undertake and in the coming months a revised Group wellbeing offer will be rolled out.

Purpose

This paper outlines the approach taken to support employee wellbeing across the Group, highlighting both the commonalities and distinctions between the two organisation's respective offers. It also details the ongoing efforts to align and harmonise the wellbeing offer for Group. The paper explores the key wellbeing workstreams that form the foundation of the Group's health and wellbeing provision and showcases the breadth of support available across four core areas: emotional, physical, financial and social wellbeing.

Key messages

Both organisations' wellbeing support services are critical because they directly affect how our people feel, function, and perform both personally and professionally. In a workplace such as the NHS, prioritising wellbeing can lead to significant benefits including:

Improved Mental Health
Reducing stress, anxiety, and burnout, whilst also supporting/strengthening emotional resilience and coping skills in the workplace. Additionally, it offers support to colleagues both personally and professionally.

Enhanced Physical Health
Encourages healthy habits (eg, exercise, sleep, nutrition) and supports the reduction of absenteeism and long-term health issues.

Increased Performance and Productivity
People who feel well are more engaged and motivated, which leads to a higher quality of work and better outcomes.

Positive Workplace Culture
Fosters a sense of belonging and support and improves teamwork and communication.

Retention and Recruitment
A strong wellbeing offer makes organisations more attractive and helps retain skilled staff, especially in high pressure areas such as emergency departments.

Compliance and Duty of Care
Meets legal and ethical responsibilities for staff welfare and aligns with NHS values and policies on staff health and wellbeing.

The Core Wellbeing Offer
Wellbeing offers across the Group are very similar in terms of their approach and intent. The LCHS focus is clearly in relation to a 'holistic health' approach and as such is seen in their service branding. The same can be said for the ULTH offer, however this is a softer approach to the same offer.

The core offers across the Group are made up of some key components as described below.

<u>Employee Assistance Programme (EAP) Group Wide</u>
The Employee Assistance Programme (EAP) provided by Health Assured offers a complete wellbeing and support network for our people, including the offering of expert advice and compassionate guidance on a 24 hours a day, 7 days a week basis covering a wide range of issues.

- **Psychological support:** Access to counselling for emotional problems and a pathway to structured therapy sessions (employees only offer) at colleagues' convenience.

- **Legal information:** For issues that cause anxiety or distress including debt management, consumer, property or neighbour disputes (employees only offer).

- **Bereavement support:** access to qualified and experienced counsellors who can help with grief, plus legal advisors to help with related legal matters.

- **Medical information:** Qualified nurses are on hand to offer support on a range of medical or health-related issues offering practical information and advice.

- **Online CBT:** A range of CBT self-help modules, informative fact sheets and invaluable advice videos from leading qualified counsellors.

The EAP provided by Health Assured also offers support to the immediate families of our colleagues, such as spouses/partners and children aged 16 to 24 in full-time education, living in the same household, 24 hours a day, 7 days a week, 365 days a year basis. Appendix 1 contains details on the EAP usage across both organisations.

<u>Health and Wellbeing Champions (HWBC)</u>
As part of both ULTH's and LCHS's wellbeing approach, there is a growing team of health and wellbeing champions to support staff within their teams and wider, with currently around 286 (250 in ULTH and 36 in LCHS). There is an ambition to have one in every ward, department or team.

HWBC are provided with regular updates and weekly contacts which facilitate the sharing of all wellbeing offers within the Group. The focus is on maintaining quality and accessibility of services, and we actively promote campaigns across the Group, prioritising the champions' involvement in these efforts.

<u>Mental Health First Aiders</u>
The Mental Health First Aider (MHFAider) plays a vital role in supporting the mental wellbeing of staff by acting as a first point of contact for colleagues experiencing emotional distress or mental health challenges.

Across the Group, colleagues are supported to train and qualify as a mental health first aider via an approved training framework, currently there are separate training schemes in place via Mental Health First Aid England (MHFAE) for community colleagues and FAA Level 3 award in supervising First Aid for Mental Health for acute colleagues. This is currently being reviewed in terms of Group harmonisation.

Key roles of the MHFAider:
- Spot early signs of mental ill health (e.g. anxiety, depression, stress).
- Start supportive conversations with colleagues in a non-judgemental way.
- Listen actively and empathetically, without offering clinical advice.
- Assess risk (e.g. suicide or self-harm) and escalate if necessary.
- Signpost individuals to appropriate professional help or internal support services.
- Maintain confidentiality while respecting safeguarding protocols.
- Promote a culture of openness and reduce stigma around mental health.

Menopause Service
LCHG is committed to supporting employees who are affected in any way by the menopause and to educating and supporting managers so that employees reporting issues are treated fairly and given appropriate support.

The menopause is a natural process and for many can be positively managed through lifestyle adjustments. However, LCHG recognises that for some, the menopause is not always an easy transition.

Some employees may need additional considerations to support and improve their experience at work. The Doctor led menopause service has been established to support those very needs and continues to draw in a lot of positive feedback from service users.

From the 18th July, this service is now open to colleagues from across the Group. Prior to this date, nurse-led support only was available to LCHS colleagues.

Physio For You Service
This service has historically been exclusive to LCHS staff members experiencing musculoskeletal issues whilst at work. The aim of the service is to support colleagues to be well at work and provide support close to the area of work in order to keep people at work.

Discussions are underway to enable this service across Group and talks with ULTH physiotherapy services are also taking place to ensure that the services complement each other, as opposed to overlap and confuse.

Critical Incident Peer Support Group (CIPS)
ULHT Critical incident peer support group members have completed Critical Incident Stress Management (CISM) and provide a network of skilled responders trained to provide support to staff trust-wide that have been exposed to traumatic events or circumstances. The opportunity to access such training was promoted within LCHS, however there was no uptake previously, but this is to be revisited.

Mini Health MOTs
Mini Heath MOTs are available to all staff working across group as an element of the Twilight Talks initiative. These checks are voluntary. The service offered via a mini health MOT is a check on weight, height and blood pressure. It also covers brief advice, signposting and guidance to those colleagues using the service and offers an opportunity for wellbeing colleagues to promote the offers available via the EAP.

The vision remains for the service to be extended and offered to colleagues across the Group during core working hours, in addition to evenings, to ensure it is accessible to all colleagues irrespective of working patterns. This has been the case historically but is currently restricted due to the financial constraints of the organisation.

Wellbeing visits
Our wellbeing teams regularly visit all sites across Group to offer support to colleagues and showcase all of ULHT and LCHS wellbeing offers to support staff.

These visits are both planned and ad hoc in response to direct requests for support, but the presence of wellbeing services alongside clear routes of accessibility is critically important.

Our wellbeing team are now link contacts for any staff undergoing HR processes, offering support and signposting.

The wellbeing team support is influenced by the National Wellbeing Calendar, determining national promotion focuses. The team collaborate with our staff networks and outside agencies.

Winter Vaccinations
Winter is one of the busiest times for the NHS, and each year across Group, we encourage all staff to prioritise getting their COVID booster and flu vaccinations.
It is important to note, however, that this year COVID-19 vaccinations will not be offered, as organisationally we do not meet the criteria. COVID hubs have now closed, but frontline health and social care workers can still book their COVID jabs should they still want one by booking through the NHS website.

Staff are offered free winter vaccinations to help restrict the transmission of the virus, support staff wellbeing and prevent sickness, and to help keep our colleagues and patients safe. This offer will be across the group and the vaccinating teams work closely together to offer a united service.

Wellbeing Apps
There are a range of wellbeing apps such as those listed below that are accessible across Group and provide in hand solutions to support colleagues' mental and physical wellbeing. These applications available via smartphone or tablet, offer a range of services from financial guidance and support to mental wellness exercises and self-help guides.

These applications have been built in conjunction with the NHS so they are sector specific in their approach and fit for purpose.

Wisdom App - https://www.healthassured.org/wisdom-app/
Headspace - https://www.headspace.com/
Shiny Minds- https://shinymind.co.uk/

The broader wellbeing offering

To a certain extent, the broader offer currently differs between organisations, this is very much due to the differences in organisational systems of work historically and colleague needs. For ease this has been identified for each organisation in appendix 2 under each core wellbeing element.

The wellbeing approaches offer a level of similarity, particularly across the EAP services and then the same across mediation and coaching, with this being offered going forward from a Group perspective.

There are also areas of the offer such as podiatry for instance that are not available in the acute part of the Group and it will be important to work on these offers to size them up for Group delivery where possible as we move forwards.

The wellbeing offer in the community also incorporates some staff benefits to some elements of the wellbeing offer, however, in the acute sector, this offer is more distinct from that of the core wellbeing offer.

The information in appendix 2 will be the starting point for combining offers and moving forward towards a Group wellbeing offer.

Summary

The wellbeing core approaches are very much aligned across both organisations in terms of objectives and to a certain extent, the approaches taken. As we move forward, these approaches will become more integrated, and the wider offers assimilated to provide one overarching Group wellbeing approach and offer.

The current offer is a very robust offering, with some very structured forms of support, however the offer is also flexible and carries enough breadth to ensure that it offers the correct support at the appropriate level.

The wellbeing offer shows consistency across EAP, mediation, and coaching services, which can be accessed Group wide. However, services like podiatry are only available in the community sector, so scaling them up for Group delivery should be explored. Some wellbeing services in the community are linked to staff benefits, while in the acute sector, these are distinctly separate. Aligning these approaches will strengthen the overall Group wellbeing offer.

The services are both proactive in terms of horizon scanning the needs of our colleagues and also reactive when needed in order to respond to the critical needs of our colleagues and services.

Appendix 1

LCHS EAP Usage statistics for Q1 2025-26

ULTH EAP Usage stats Q1 2025-26

Appendix 2

Emotional Wellbeing

United Lincolnshire Teaching Hospitals

- 1-1 Health and wellbeing interventions
- Stress risk assessments
- MHFA's
- Health and wellbeing champions
- Sleep disorder support
- Night light café – mental health crisis support
- Gambling advice
- EAP
- Guided meditation
- Mediation
- Parental support
- Counselling support
- Coaching
- Staff networks
- Bereavement Journey
- Cancer peer to peer
- Recovery college
- Steps to change referral pathway
- Wellness action plans
- Critical incident debriefs
- Twilight Talks

Lincolnshire Community Health Services

- 1-1 Health and wellbeing interventions
- Stress risk assessments
- MHFA's
- Health and Wellbeing Champions
- Sleep disorder support
- Night light café – mental health crisis support
- Gambling advice
- EAP
- Guided meditation
- Mediation
- Parental support
- Counselling support
- Coaching
- Staff networks
- Bereavement journey
- Cancer peer to peer
- Recovery college
- Steps to change referral pathway

Physical Wellbeing

United Lincolnshire Teaching Hospitals NHS Trust

- Winter Vaccinations
- Wisdom app
- Recovery college
- Healthy Eating
- Menopause Doctor led service
- Staff Physio referral pathway
- Direct referrals -One you Lincolnshire .Weight loss / smoking cessation support. Gym access.
- Health MOT
- Twilight Talks
- Staff OT referral pathway
- Massage and Reflexology – Grantham site only

Lincolnshire Community Health Services

- Winter vaccinations
- Wisdom app
- Recovery college
- Healthy eating
- Menopause Doctor led service
- Physio For You
- Direct referrals -One you Lincolnshire. Weight loss/smoking cessation support. Gym access
- Simply Health
- Podiatry Support
- Pilates Classes
- Cervical screening
- PCOS support network

Financial Wellbeing

United Lincolnshire Teaching Hospitals NHS Trust

- EAP- Financial component
- Gambling advice / sign posting and direct referrals to Add Action services.
- Financial wellbeing guides
- NHS Discounts
- Practitioner Health

Supported by OD in ULTH:

- Wage Stream
- Salary sacrifice
- VIVUP
- Fleet Solutions

Lincolnshire Community Health Services NHS Trust

- EAP – Financial component
- Gambling advice

- Financial wellbeing guides
- NHS Discounts

- Wage Stream
- Salary sacrifice
- VIVUP
- Fleet Solutions
- Salary finance

Social Wellbeing

United Lincolnshire Teaching Hospitals NHS Trust

- EAP
- Hobby Health
- Book Club community
- Staff Network / sign posting
- Craft Groups
- Cancer peer to peer support group
- Mediation
- Guided meditation
- Parental support
- Coaching
- Mission Menopause online support
- HW Road shows / extravaganzas
- HW Intranet pages
- Walking Groups

Lincolnshire Community Health Services.

- EAP
- Hobby Health
- Book club community
- Staff Networks / sign posting
- Craft Groups
- Cancer peer to peer support
- Mediation
- Guided meditation
- Parental support
- Coaching
- Mission Menopause online support
- HW Road shows / extravaganzas
- HW Intranet pages
- The Shed – Men only
- Craft clubs

Community Nursing Safer Staffing (II) Review 2025/2026 Round 1

Meeting	*Public Trust Board*
Date of Meeting	*2 September 2025*
Item Number	*9.2*

Community Nursing Safer Staffing Establishment Review 2025/26 Round 1

Accountable Director	*Nerea Odongo, Chief Nurse*
Presented by	*Nick Mulholland, Deputy Chief Nurse*
Author(s)	*Janine Gargett, Head of Nursing Workforce* *Nick Mulholland, Deputy Chief Nurse*
Recommendations/ Decision Required	*The Board is asked to:- Accept the recommendations of the report*

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	
1c: Improve productivity and deliver financial sustainability	
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	

The Community Nursing Safer Staffing Tool (CNSST II), developed by NHS England, is a decision support tool designed to help community nursing teams determine appropriate staffing levels to meet patient care needs safely and effectively. It uses an evidence-based methodology to assess workload and staffing requirements. The CNSST was developed by NHS England nursing workforce and community nursing specialists and independent academic workforce planning consultants in collaboration with NHS England community service managers and practitioners.

The tool should also be utilised to support establishment setting and reviews and facilitate benchmarking when two separate data collections (census) are carried out (census is 14 consecutive days) in two individual months to capture seasonal variations, including a triangulated approach including professional judgement and a review of patient and staff outcomes in line with National Quality Board (2016) and Developing Workforce Safeguards guidance (NHSI 2018).

During 2nd – 15th June 2025 all 11 community nursing teams participated in the CNSST II census where the activity delivered to patients was captured via an app in readiness to input into the CNSST II activity sheets.

All staff on duty during the 14 days undertook training prior to commencing census for CNSST II which is an essential requirement of CNSST II

A validation process was developed to ensure that data capture was valid

Final validation occurred within 2 days after census to ensure full accuracy of data entry into the activity sheets.

It has been agreed that there will be 3 census points in LCHS for Community Nursing each year, these will feed into establishment reviews, however after October (census 2), we can start to use the data we have to support the triangulated approach of decision making for establishment setting.

There is some noted variance against national benchmarking with the % of care descriptors seen in LCHG Community Nursing service.

When layering on co-ordination the data output demonstrated that there was an under establishment in community nursing teams of 9.09WTE with variance across each team of correct skill mix.

As this is the first census it is recommended we acknowledge the work and outcome but await the outcome of the October census before taking any action around considering adjusting establishments.

1. Background

The Community Nursing Safer Staffing Tool (CNSST), developed by NHS England, is a decision support tool designed to help community nursing teams determine appropriate staffing levels to meet patient care needs safely and effectively. It uses an evidence-based methodology to assess workload and staffing requirements. The CNSST was developed by NHS England nursing workforce and community nursing specialists and independent academic workforce planning consultants in collaboration with NHS England community service managers and practitioners.

The tool should also be utilised to support establishment setting and reviews and facilitate benchmarking once two separate data collections (census) have been carried out for 14 consecutive days in a minimum two individual months to capture seasonal variations, including a corroborated approach of professional judgement and a review of patient and staff outcomes in line with National Quality Board (2016) and Developing Workforce Safeguards guidance (NHSI 2018).

Compliance against Standards

Governance
Executive and Clinical Quality Boards, Chief Nurses, Directors, etc., are engaged and supportive, i.e., adhering to National Quality Board (2016) safe, sustainable and productive staffing policy and Developing Workforce Safeguards requirements (NHS Improvement, 2018). Ensure most up to date version of CNSST II and its associated Implementation guidance is available and in use by all staff and is information from NHSE is cascaded to the CNSST II lead.

LCHG can offer assurance that this has been adhered to and all updates have been considered and implemented on the journey of CNSST II.

Infrastructure
Data collection and analysis systems are in place that allow recording, storing and reporting.

LCHG can offer assurance that this has occurred due to good stakeholder engagement and involvement and robust validation processes that have been implemented throughout the journey.

Development and awareness
Community staff fully understand CNSST's II rationale through training and are also able to access the Fundamentals of Safer Staffing eLearning . Where necessary staff are able to seek further support from the NHS England CNO Safer Staffing Faculty and Community Nursing Team.

LCHG can offer assurance that this has occurred due robust training standards aligned to NHSE train the trainer approach which have been adhered to and training monitoring processes that have been implemented throughout the implementation.

Quality assurance
Senior community nursing managers and practitioners are trained to check local data collection processes to ensure data accuracy and consistency, which should be planned into data collection cycles.

LCHG can offer assurance that this has been adhered to and continue to engage with the regional team for any updates and shared learning.

Quality standards
Ensure CNSST II management and application is in line with 'Developing Workforce Safeguards' (NHSI, 2018).

LCHG can offer assurance that this has been adhered to and CNSST II will form part of safe staffing and bi-annual establishment reviews once we have 2 data points.

Implementation Plan
The national implementation model is a train a trainer cascade. The roll out was led at a national level with a clinical and workforce lead identified in each region.

Each staff member who will participate in the census (at work during census period) are mandated to attend CNSST training. Training was developed in line with CNSST II standards and additional narrative added to avoid confusion about the difference in language used in CNSST II v language used to communicate in the local teams about activity being delivered.

Training provided ensured accuracy of data collection by clinicians identifying the correct patient acuity and dependency for their activity each day in census. The attendees complete an interrater reliability assessment, to ensure consistency. Training was delivered throughout May 2025 to all clinical staff on duty.

LCHG can offer assurance that this has been adhered to and continue to engage with the regional team for any updates and shared learning.

2. **Progress**
- LCHG received the license to implement CNSST II toolkit
- Development of programme of work to aid successful implementation
- Access and utilisation of stakeholders inc. digi health, rostering and resourcing and FBI
- Robust validation process developed, and local leads trained on how to implement to ensure consistency and accuracy
- Development of app which aligned to CNSST II workbook for ease and accuracy of data entry for clinical teams and data analysts
- Training developed in line with the train the trainer approach
- Pilot run in 1 team for rapid learning before full implementation
- Training delivered
- Daily training compliance capture
- Full engagement at all levels within the service
- Clear and consistent engagement from operational teams involved

- Communications within teams
- Quick access support chats for all individuals involved in census
- Data captured over 14 days
- Full validation of data capture for accuracy
- Data output entered into workbooks

3. Outcomes

Staffing Outcomes (appendix 1&2)

Due to the robust validity process implemented with local leaders, assurance was obtained that data entry was accurate.

Final validation was completed before the data was pulled from the app entries into the data sheets supplied by NHSE.

Rostering and Resource team entered all staffing data as per NHSE guidance into the data sheets.

Each team had their data entered into individual data sheets to demonstrate the local information about 1. Acuity and dependency of activity provided to patients. 2. Current workforce. 3. Workforce information at time of census. 4. Compare current position with output of CNSST II data.

Appendix 1 inc. Further breakdown per band of current workforce v CNSST II output data and layered benchmarking on this to breakdown per team the recommended band.

As CNSST does not recommend breakdown of registered staff bandings, benchmarking has been layered onto the data recommendations at B6 (23.9%) and B5/RN (63.1%) (see blue section)

1. Peach – current RN and HCSW funded establishment
2. Purple – CNSST recommendations of RN and HCSW inc. overall total WTE
3. Yellow – variance of CNSST and Current funded establishment
4. Green – all band variance CNSST and Current funded establishment
5. Blue – split of CNSST recommendation and benchmarking of B6 & B5/4 (NA)
6. Rose – variance of CNSST and current funded establishment of B6 & B5/4 (NA)

Total funded establishment	RN currrent	HCSW current		CNSST RN	Minus CTL	CNSST HCSW	CNSST recommendations total	Variance RN	Variance HCSW	Variance WTE total exc. Co-ordinator	B6 23.9%	B5/NA 63.1%	variance B6	variance B5/ NA
24.19	16.54	7.65	Boston	19.36	18.36	6.45	25.81	-2.82	1.2	-1.62	4.39	13.97	-0.41	-2.41
33.37	25.67	7.7	SL	27.1	26.1	9.03	36.13	-1.43	-1.33	-2.76	6.24	19.86	-0.88	-0.55
27.75	21.37	6.38	4C	16.93	15.93	5.64	22.57	4.44	0.74	5.18	3.81	12.12	-0.74	5.18
22.83	17.95	4.88	Sleaford	16.01	15.01	5.34	21.35	1.94	-0.46	1.48	3.59	11.42	0.41	1.53
27.46	21.28	6.18	Grantham	20.3	19.3	6.77	27.07	0.98	-0.59	0.39	4.61	14.69	-0.19	1.17
19.32	13.97	5.35	Horncastle	14.95	13.95	4.98	19.93	-0.98	0.37	-0.61	3.33	10.62	-0.06	-0.92
29.37	22.53	6.84	Skegness	20.44	19.44	6.81	27.25	2.09	0.03	2.12	4.65	14.79	0.15	1.94
27.05	23.05	4	Lincoln Nth	19.86	18.86	6.62	26.48	3.19	-2.62	0.57	4.51	14.35	0.49	2.70
18.25	15.25	3	Gainsborough	11.81	10.81	3.94	15.75	3.44	-0.94	2.5	2.58	8.23	1.49	1.95
38.54	29.56	8.98	Lincoln Fen	32.34	31.34	10.8	43.12	-2.78	-1.8	-4.58	7.49	23.85	-1.04	-1.74
19.75	15.2	4.55	Louth	15.53	14.53	5.18	20.71	-0.33	-0.63	-0.96	3.47	11.06	0.58	-0.91
288.08	226.17	61.91	Totals	214.6	203.6	71.5	286.17	11.54	-9.63	1.91	48.67	154.96	-0.20	7.94

- Community Nursing is funded for a total 288.08 WTE B7 (CTL only), B6, B5, B4, B3, B2
- CNSST first census is recommending 286.17 WTE across all bands,
- The recommendation does not include any triage/co-ordination as phone-based triage was not one of the activities recorded in the data collection and is not included in the tool. CNSST II recommend this activity during the census period is included and added as professional judgement, during census period (and every other period) co-ordination/ triage is provided 37.5 hours per team per week. 11WTE, costing £686,805 at present as provided at B6. Other options could include differing registered bands undertaking triage at a cost of £555,656 B5 and £441,677 B4 NA
- For each team there is some level of variance from the current establishment, even where this is close to CNSST outcomes there is skill mixing recommendations
- The total WTE including co-ordination of CNSST II data output is recommending 297.17WTE against a current funding of 288.08

Please note that the current Enhanced Practitioners have not been included in the data.

Actual timeout was noted to be higher than benchmarking at 30.6% v 25.1%, with 12.7% temporary staffing utilisation against benchmarking of 6.45%.

Activity Outcomes (appendix 2)

LCHG Community Nursing teams care descriptor activity is broken down below
Care descriptor 1 – 69.5% against national benchmarking of 19.3%
Care descriptor 2 – 14.5% against national benchmarking f 35%
Care descriptor 3 – 14.6% against national benchmarking 0f 33.8%
Care descriptor 4 – 1.4% against national benchmarking of 12%

The significant variance between the LCHG outcome and national benchmarking for several factors:

- Benchmarking is undertaken on more than just traditional Community Nursing services i.e. specialist services where the complexity of the visits is greater
- LCHG community nursing is delivering an increase in task-based care due:
  - Lack of caseload ownership and accountability
  - Lack of caseload reviews
  - Lack of assurance that all caseload holders have the skills and competency to deliver holistic care mapped to best practice with the application of professional judgement
  - Lack of assurance that self-care has been fully explored and supported
  - Lack of a delegation policy for patients/ family/ carers to manage their care and support risk-based decision making
  - Lack of skills and competence across all bandings in the service meaning the right person is not seeing the right patient and there is a lack of continuity.

Due to the variance against the CNSST II benchmarking and the noted contributing factors to this, a programme of work is being initiated to look at how we can address these areas with the directorate leads.

Additionally, a meeting is scheduled with the regional CNSST lead to identify specific community nursing teams that we can compare our findings with.

4. Recommendations and conclusion

- To support establishment setting two data sets are required. When two data collections have been completed the results can be used to support biannual establishment setting as part of a triangulated approach alongside professional judgement and review of quality and safety outcomes in line with Developing Workforce Safeguards requirements (NHSI 2018).

- As this is the first full census data of CNSST II it is advised that we use the data with caution as we have no local data to compare to. A second census is scheduled for October 2025.
- Once we have 2 data points, we should cost up the variance between current funded establishment, census 1, census 2 and the varying options identified.
- It is worth noting the data output from CNSST II census and the variance between current funded establishment and the recommendations.
- Consider the role of the co-ordinator and what is required to deliver safe and effective co-ordination and triage.
- Consider if we will use benchmarking to determine the banding split of the recommended RN WTE inc. NAs.
- A programme of work to deliver actions to support benchmarking alignment.

Appendix 1

Division	Area	Sum of Current Registered Budget WTE	Sum of Registered Change WTE	Sum of Proposed Registered WTE	Sum of Registered Impact £	Sum of Current Unregistered Budget WTE	Sum of Unregistered Change WTE	Sum of Proposed Unregistered WTE	Sum of Unregistered Impact £	Sum of Total Impact WTE	Sum of Total Impact £
CSS	LCH Ashby	17.28	(0.26)	17.02	(13,400)	21.49	(0.45)	21.04	(19,400)	(0.71)	(32,800)
CSS	LCH Waddington	26.67	(2.09)	24.58	(105,100)	17.15	(1.37)	15.78	(58,100)	(3.46)	(163,200)
CSS	PHB Bostonian	19.58	(0.26)	19.32	(13,500)	16.69	(0.91)	15.78	(39,200)	(1.17)	(52,700)
Family Health	LCH Rainforest	39.67	(0.45)	39.22	(23,400)	7.26	(0.00)	7.26	0	(0.45)	(23,400)
Family Health	Nettleham Ward	26.67	0.20	26.87	12,000	14.61	(0.00)	14.61	0	0.20	12,000
Family Health	Ward M1 Maternity	14.98	0.20	15.18	12,000	8.00	0.00	8.00	0	0.20	12,000
Family Health	PHB Ward 1B Womens Health	14.32	(0.26)	14.06	(12,400)	9.60	(0.45)	9.15	(8,600)	(0.71)	(21,000)
Family Health	PHB Ward 4a	27.96	(0.26)	27.70	(12,800)	6.86	(0.00)	6.86	0	(0.26)	(12,800)
Family Health	LCH Branston	16.61	(0.59)	16.02	(29,800)	9.60	(0.45)	9.15	(18,700)	(1.04)	(48,500)
Family Health	LCH NNU & TC	34.81	(0.25)	34.56	(12,600)	13.26	(0.46)	12.80	(22,600)	(0.71)	(35,200)
Family Health	PHB Neonatal Unit	16.84	(0.26)	16.58	(13,800)	7.44	(0.46)	6.98	(21,700)	(0.72)	(35,500)
Medicine	LCH ED	113.90	(0.05)	113.85	(46,700)	47.33	0.00	47.33	0	(0.06)	(46,700)
Medicine	GDH EAU	25.30	(0.72)	24.58	(28,500)	13.72	(0.46)	13.26	(21,400)	(1.18)	(49,900)
Medicine	GDH SDEC	5.46	(0.00)	5.46	2,300	2.63	(0.00)	2.63	0	0.00	2,300
Medicine	GDH Harrowby Ward	16.83	(0.25)	16.58	(12,700)	13.72	(0.46)	13.26	(19,300)	(0.71)	(32,000)
Medicine	LCH (M)EAU	35.81	(0.45)	35.36	(22,800)	23.09	(0.45)	22.64	(19,100)	(0.90)	(41,900)
Medicine	LCH SDEC	8.89	(0.00)	8.89	0	5.26	(0.00)	5.26	0	0.00	0
Medicine	PHB AMSS (9th Floor)	27.55	(0.25)	27.30	(12,800)	18.98	(0.46)	18.52	(19,100)	(0.71)	(31,900)
Medicine	PHB IAC	27.95	(0.45)	27.50	(22,400)	16.23	4.81	21.04	207,200	4.35	184,800
Medicine	PHB SDEC	7.90	(0.00)	7.90	0	2.63	(0.00)	2.63	0	0.00	0
Medicine	PHB Ward 1	18.64	(0.26)	18.38	(13,100)	13.72	(0.46)	13.26	(14,600)	(0.72)	(27,700)
Medicine	LCH Burton	23.71	0.20	23.91	10,000	16.98	0.00	16.98	0	0.20	10,000
Medicine	PHB Ward 8B	19.12	0.20	19.32	22,100	16.01	2.51	18.52	104,100	2.71	126,200
Medicine	LCH Lancaster	13.86	5.46	19.32	280,400	15.78	(2.52)	13.26	(107,100)	2.94	173,300
Medicine	LCH AMSS A Side	22.30	(0.26)	22.04	(12,600)	18.98	(0.46)	18.52	(19,100)	(0.72)	(31,700)
Medicine	LCH AMSS B Side	22.30	(0.26)	22.04	(13,000)	18.98	(0.46)	18.52	(19,100)	(0.72)	(32,100)
Medicine	LCH Clayton & FAU	14.32	(0.26)	14.06	(12,200)	13.72	2.06	15.78	85,100	1.80	72,900
Medicine	LCH Carlton Coleby Ward	19.58	(0.06)	19.52	(1,500)	21.49	(0.45)	21.04	(19,300)	(0.51)	(20,800)
Medicine	LCH Scampton	14.32	(0.26)	14.06	(13,100)	16.23	(0.45)	15.78	(19,000)	(0.71)	(32,100)
Medicine	PHB Ward 6A	20.04	(0.72)	19.32	(34,900)	19.47	1.57	21.04	73,700	0.85	38,800
Medicine	PHB Ward 6B	20.04	(0.72)	19.32	(37,400)	19.47	1.57	21.04	71,900	0.85	34,500
Medicine	LCH Witham & RSU	31.95	0.69	32.64	33,700	21.49	1.15	22.64	47,800	1.84	81,500
Medicine	PHB Ward 7B	24.84	(0.26)	24.58	(12,200)	14.44	1.34	15.78	54,300	1.08	42,100
Medicine	LCH Cardiac Catheter Lab	17.86	0.20	18.06	10,000	3.10	0.00	3.10	0	0.20	10,000
Medicine	LCH Cardiac Short Stay	22.59	(0.19)	22.40	(9,300)	10.52	(0.00)	10.52	0	(0.19)	(9,300)
Medicine	LCH Johnson Ward	32.36	0.20	32.56	10,100	13.26	0.00	13.26	0	0.20	10,100
Medicine	PHB Acute Cardiac Unit	13.86	0.20	14.06	9,900	10.52	(0.00)	10.52	0	0.20	9,900
Medicine	PHB Ward 8A	24.84	(0.26)	24.58	(10,100)	18.98	(0.46)	18.52	(19,000)	(0.72)	(29,100)
Medicine	LCH Dixon	18.44	(0.26)	18.18	(13,000)	16.46	(0.45)	16.01	(18,600)	(0.71)	(31,600)
Surgery	GDH Surgical Unit	36.50	0.01	36.51	400	16.47	(0.79)	15.68	(32,200)	(0.78)	(31,800)
Surgery	LCH Digby	19.58	(0.26)	19.32	(12,900)	16.23	(0.45)	15.78	(19,400)	(0.71)	(32,300)
Surgery	LCH Greetwell	19.58	(0.26)	19.32	(12,900)	13.72	(0.46)	13.26	(19,100)	(0.72)	(32,000)
Surgery	LCH Hatton	25.30	1.80	27.10	90,300	16.23	(2.97)	13.26	(127,700)	(1.17)	(37,400)
Surgery	LCH SEAU	21.38	(0.26)	21.12	(13,200)	14.99	(0.00)	14.99	0	(0.26)	(13,200)
Surgery	LCH SAL	25.76	(2.65)	23.11	(119,600)	8.46	2.38	10.84	98,500	0.27	(21,100)
Surgery	PHB Ward 2B Elective Surgery	27.39	(0.59)	26.80	(27,900)	8.57	(0.21)	8.36	(8,500)	(0.80)	(36,400)
Surgery	PHB Ward 3A	22.09	(0.25)	21.84	(12,100)	16.46	2.06	18.52	84,600	1.81	72,500
Surgery	LCH Shuttleworth	24.84	(0.26)	24.58	(13,600)	16.92	(0.91)	16.01	(37,500)	(1.17)	(51,100)
Surgery	PHB Ward 3B	19.58	(0.26)	19.32	(15,000)	18.98	(0.46)	18.52	(19,200)	(0.72)	(34,200)
Surgery	PHB Ward 5A	25.30	(0.72)	24.58	(27,200)	18.98	(0.46)	18.52	(19,400)	(1.18)	(46,600)
Surgery	PHB Ward 5B	22.78	(0.71)	22.07	(35,200)	13.72	(0.46)	13.26	(19,100)	(1.17)	(54,300)
Grand Total		1,210.03	(7.50)	1,202.53	(361,500)	754.88	0.18	755.06	22,100	(7.31)	(339,400)

Appendix 2

Division	Area	Impact of changing Early & Late shifts to Long Days WTE	Impact of changing Early & Late shifts to Long Days £	Impact of Ward Manager Non Clinical time change WTE	Impact of Ward Manager Non Clinical time change £	Impact of other proposed changes WTE	Impact of other proposed changes £
CSS	LCH Ashby	(0.91)	(43,100)	0.20	10,300		
CSS	LCH Waddington	(3.66)	(173,200)	0.20	10,000		
CSS	PHB Bostonian	(1.37)	(63,100)	0.20	10,400		
Family Health	LCH Branston	(1.24)	(58,600)	0.20	10,100		
Family Health	LCH NNU & TC	(0.91)	(45,300)	0.20	10,100		
Family Health	LCH Rainforest	(0.45)	(23,400)	0.00			
Family Health	Nettleham Ward	0.00		0.20	12,000		
Family Health	PHB Neonatal Unit	(0.92)	(46,100)	0.20	10,600		
Family Health	PHB Ward 1B Womens Health	(0.91)	(30,500)	0.20	9,500		
Family Health	PHB Ward 4a	(0.46)	(22,600)	0.20	9,800		
Family Health	Ward M1 Maternity	0.00		0.20	12,000		
Medicine	GDH Assessment & Ambulatory Centre (SDEC)	0.00		0.00			2,300
Medicine	GDH Emergency Assessment Unit	(0.92)	(37,300)	0.20	9,600	(0.46)	(22,200)
Medicine	GDH Harrowby Ward	(0.91)	(42,200)	0.20	10,200		
Medicine	LCH (M)EAU (Ex Neustadt-Welton)	(0.90)	(41,900)	0.00			
Medicine	LCH AMSS A Side	(0.92)	(41,400)	0.20	9,700		
Medicine	LCH AMSS B Side	(0.92)	(42,100)	0.20	10,000		
Medicine	LCH Burton	0.00		0.20	10,000		
Medicine	LCH Cardiac Catheter Lab	0.00		0.20	10,000		
Medicine	LCH Cardiac Short Stay	0.00		0.20	9,800	(0.39)	(19,100)
Medicine	LCH Carlton Coleby Ward	(0.91)	(40,000)	0.40	19,200		
Medicine	LCH Clayton & FAU	(0.92)	(40,600)	0.20	9,400	2.52	104,100
Medicine	LCH Dixon	(0.91)	(41,600)	0.20	10,000		
Medicine	LCH ED	0.00		0.00		(0.06)	(46,700)
Medicine	LCH Johnson Ward	0.00		0.20	10,100		
Medicine	LCH Lancaster	0.00		0.20	10,100	2.74	163,200
Medicine	LCH Same Day Emergency Care (SDEC)	0.00		0.00			
Medicine	LCH Scampton	(0.91)	(42,200)	0.20	10,100		
Medicine	LCH Witham & RSU	(1.36)	(63,100)	0.00		3.20	144,600
Medicine	PHB Acute Cardiac Unit	0.00		0.20	9,900		
Medicine	PHB AMSS (9th Floor)	(0.91)	(42,100)	0.20	10,200		
Medicine	PHB Integrated Assessment Centre (IAC)	(0.91)	(42,300)	0.00		5.26	227,100
Medicine	PHB Same Day Emergency Care [SDEC]	0.00		0.00			
Medicine	PHB Ward 1	(0.92)	(37,800)	0.20	10,100		
Medicine	PHB Ward 6A	(1.87)	(75,900)	0.20	9,500	2.52	105,200
Medicine	PHB Ward 6B	(1.87)	(78,900)	0.20	9,800	2.52	103,600
Medicine	PHB Ward 7B	(0.92)	(40,200)	0.20	9,400	1.80	72,900
Medicine	PHB Ward 8A	(0.92)	(38,900)	0.20	9,800		
Medicine	PHB Ward 8B	0.00		0.20	9,500	2.51	116,700
Surgery	GDH Surgical Unit	(0.78)	(31,800)	0.00			
Surgery	LCH Digby	(0.91)	(42,200)	0.20	9,900		
Surgery	LCH Greetwell	(0.92)	(41,900)	0.20	9,900		
Surgery	LCH Hatton	(1.37)	(47,400)	0.20	10,000		
Surgery	LCH SEAU	(0.46)	(23,400)	0.20	10,200		
Surgery	LCH Shuttleworth	(1.37)	(61,600)	0.20	10,500		
Surgery	LCH Surgical Admissions Lounge	(1.78)	(85,500)	0.20	9,000	1.31	55,400
Surgery	PHB Ward 2B Elective Surgery	(1.00)	(45,900)	0.20	9,500		
Surgery	PHB Ward 3A	(0.91)	(40,600)	0.20	9,700	2.52	103,400
Surgery	PHB Ward 3B	(0.92)	(45,700)	0.20	11,500		
Surgery	PHB Ward 5A	(1.38)	(57,000)	0.20	10,400		
Surgery	PHB Ward 5B	(1.37)	(64,200)	0.20	9,900		
Grand Total		(41.90)	(1,881,600)	8.60	431,700	25.99	1,110,500

Establishment Review
July 2025
Data Pack

Lincolnshire Community and Hospitals NHS Group

Ward/ Department: Cardiac Catheter Lab

Care Group:

Ward Manager: Lucy Jones

Matron: Alison Strutt

Divisional Nurse: Clare Spendlove

Caring and building a
healthier future for all

Establishment Review 2025/2026

Welcome to the first of three establishment reviews for 25/26. This is your data pack and your story. Please consider the information within the pack as we will use it to ensure we work towards building nursing establishments that reflect the needs of our patients.

Most services will have used a tool to gather data however those services undertaking tabletop reviews will need to provide additional information around activity and demand etc.

SNCT:

• An evidence-based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms.

• Appropriate for use in any acute or community hospital within the UK.

• Used in conjunction with Nurse Sensitive Indicators (NSI) such as patient falls, and pressure ulcer incidence, which can be linked to staffing

• Able to support benchmarking activity in organisations when used across Trusts. This will assist in facilitating

consistent nurse-to-patient ratios in line with agreed standards across similar care settings in England.

If you feel there is additional information you would like to include in the data pack, please do include it. It is vitally important we focus not only on the outputs of information collected during the data collection period, but also focus on quality indicators alongside the wider context such as the environments in which we work.

Compassionate

Collaborative

Innovative

Service Description

The Lincolnshire Heart Centre was established in 2012. Prior to this, care was provided to the county though a single lab with limited hours. In 2012, a new and innovative Heart Centre was launched, consisting of 2 new labs, and 2 recovery areas. We treat an average of up to 1200 angioplasty patients and perform 1500 angiograms annually. Our purpose built Resuscitation Bay receives acutely unwell patients arriving by ambulance – avoiding the need for A&E, which relieves the burden on our Emergency Department. We receive acutely unwell patients suffering ST Elevation Myocardial Infarction (STEMI) via ambulance, helimed and self presentation to ED. Many of these patients have suffered cardiac arrests in the community and require haemodynamic and ventilator support. The Service responded to demand for an introduction of a PPCI on call team, a highly skilled team of our Cardiology professionals who are called 24/7 to provide life – saving, time - critical care to patients experiencing a heart attack. We currently treat approximately 400 Primary Percutaneous Coronary Interventions (PPCI) annually. The Service provides specialist care to 750,000 patients across Lincolnshire covering a large geographical area, which is a challenge when our work is time - critical.

In addition to this, our Device Service has developed significantly, implanting various complex devices to provide cardiac rhythm management. We have implanted 620 devices of varying complexity within the last year, with demand increasing year on year. With the introduction of Conduction System Pacing and further developments planned, including subcutaneous implantable cardioverter defibrillators omitting the requirement for patients to travel to Tertiary Centres.

We have 2 Cardiac Catheter Labs, and 2 recovery areas, each with 5 bed spaces with a high patient turnover. This allows efficient patient flow within the department, Cardiology wards and ED. Our working hours are 07:30 – 20:00 with labs active and procedure lists between the hours of 08:00 - 18:00. The remaining hours are utilised with recovering elective patients to go home and the transfer of inpatients to the Cardiology wards. In addition this time period is used for essential restocking and preparing the lab for any potential out of hours activity. It is not unusual for the Labs to be in use beyond 18:00.

We have currently found that the struggle for storage space is increasing. This is due to the loss of our breaking bad news room to provide essential storage and materials management spaces. We are not co – located with the cardiology wards, which adds time and risk when transferring acutely unwell patients, diverting nursing staff from the department for up to 30 minutes at a time.

The allocation of 2 NQNs brings additional challenges as they adapt to a highly specialised area and caring for acutely unwell patients .

Section 1

Workforce

Current Establishment Template on 30th June 2025

AfC Band	Budgeted	Actual	Difference
Band 7	1.00	1.00	0
Band 6	6.48	6.91	-0.43
Band 5	10.38	10.45	-0.07
Band 4	0	0	0
Band 3	3.10	3.08	0.02
Band 2	3.00	3.04	-0.04
TOTAL	23.96	24.48	-0.52

Skill mix – registered	Skill mix – registered : unregistered
Budgeted: 74:25	Actual: 75:25

Cardiac Catheter Lab Length of Days
ELD: 11.5 hours

Currently slightly over established due to the allocation of 2 NQN Nurses to the lab team

1 x B6 cardiac devices seconded role funded by Medpoints at 0.48 WTE

1x B5 seconded into B6 role backfilling cardiac device secondment at 0.61 WTE – with B5 hours reallocated to B6 budget

2x B2 ward clerks. 1 clerk redeployed from CBU at 0.80 WTE with additional hours reassigned to Cath Lab from CBU

Lab 1: 2 x nurses
Lab 2: 2x nurses
Recovery 1 - 1 x nurse & 1x CHCSW
Recovery 2 - 1 x nurse 1 x 1x CHSW
1 x B6 scheduler
1x B6 co – coordinator

Nursing 1:5 patients (both elective & inpatients) in each recovery regardless of acuity

Staff Attrition and Sickness Rates – position on 31st May 2025

Unavailability		
Sickness – short term	%	6
Sickness – long term	%	0
Maternity leave	%	0
Other leave (e.g. career break)	%	0
Funded apprentices	WTE	0
Turnover rate	%	
Expected leavers	WTE	0
Pipeline (recruitment pending)	WTE	0

Rostering and Finance

Current Budget

Lev 9 CC	Lev 9 CC Name	Lev 9 A/c	Lev 9 A/c Name	Budget	Contracted
UL1367	Cardiac Catheter Lab Nursing	20605	Nurse B5	10.38	10.45
UL1367	Cardiac Catheter Lab Nursing	20606	Nurse B6	6.48	6.91
UL1367	Cardiac Catheter Lab Nursing	20607	Nurse B7	1.00	1.00
			Registered	**17.86**	**18.36**

Lev 9 CC	Lev 9 CC Name	Lev 9 A/c	Lev 9 A/c Name	Budget	Contracted
UL1367	Cardiac Catheter Lab Nursing	26103	Nursing B3	3.10	3.08
			UnRegistered	**3.10**	**3.08**

Previous 15 month pay spend . Total = 12 months(July 24 - June 25)

Lev 9 CC Name	Cardiac Catheter Lab Nursing
Lev 4 A/c Name	Staff And Exec Directors Costs

Row Labels	Sum of M1	Sum of M2	Sum of M3	Sum of M4	Sum of M5	Sum of M6	Sum of M7	Sum of M8	Sum of M9	Sum of M10	Sum of M11	Sum of M12	Sum of M1 2526	Sum of M2 2526	Sum of M3 2526	Sum of Total July 24-Jun 25
Bank Nurse Registered	2,844	3,700	4,724	5,496	3,469	5,701	5,839	2,560	364	245	2,109	5	0	0	0	25,789
Bank Nurse Unregistered	0	114	18	260	666	292	81	0	0	135	240	14	112	0	0	1,802
Nurse B5	31,841	26,917	27,243	18,378	26,679	27,407	37,072	34,083	32,935	30,904	36,031	34,864	35,280	35,368	35,485	384,485
Nurse B6	28,463	28,028	28,319	29,620	30,693	30,474	41,629	32,339	32,834	31,841	32,559	32,405	32,915	32,065	32,779	392,154
Nurse B7	5,085	4,092	3,736	4,285	4,023	4,578	6,669	5,334	4,958	5,428	5,405	5,046	5,399	5,487	5,385	61,995
Nursing B2	6,285	6,096	6,348	6,709	6,987	7,090	9,551	0	0	0	0	0	0	0	0	30,338
Nursing B3	0	0	0	0	0	0	0	7,984	8,445	26,477	7,830	8,114	8,221	8,221	8,414	83,706
Nursing B4	0	0	0	0	0	0	4,362	0	0	0	0	0	0	0	0	4,362
Grand Total	74,517	68,947	70,388	64,748	72,518	75,543	105,202	82,300	79,536	95,031	84,173	80,448	81,927	81,141	82,062	984,630

Unit	Department	Name	Duration Ir	Number Of	Roster Type	Registered Budgeted WTE	Registered Mandatory Demand W	Unregister	Unregister	Other Budg	Other Man	Is Obsolete
LCH Cardiac Catheter Lab UL1367	Cardiovascular	LCH Cardiac Cath Lab - Sep25	7	0	Nursing	17.86	15.37	3.10	2.67	3.00	3.24	-

Temporary staffing Spend 2024/2025

Lev 9 CC Name	Cardiac Catheter Lab Nursing
Lev 4 A/c Name	Staff And Exec Directors Costs

Row Labels	Sum of M1	Sum of M2	Sum of M3	Sum of M4	Sum of M5	Sum of M6	Sum of M7	Sum of M8	Sum of M9	Sum of M10	Sum of M11	Sum of M12	Sum of YTD Actuals (£)
Bank Nurse Registered	2,844	3,700	4,724	5,496	3,469	5,701	5,839	2,560	364	245	2,109	5	37,056
Bank Nurse Unregistered	0	114	18	260	666	292	81	0	0	135	240	14	1,822
Grand Total	2,844	3,814	4,742	5,756	4,136	5,993	5,920	2,560	364	381	2,349	19	38,878

Additional Duties: 1st April 2025 – 30th June 2025

Additional duties	
Total number	**11**
Reason: Enhanced Care	
Reason: Escalation Beds	
Reason: Over-establishment	
Reason: Patient Escort	
Reason: Shadowing	
Reason: Skill Mix	
Reason: Staff Redeployment	
Reason: Supernumerary	
Reason: Temporary Uplift	

Narrative:

Between 1st April 2025 and 30th June 2025, the Department created 11 additional duties over its template.

Additional duties are assigned differently to inpatient ward settings. Compensatory rest hours are included as optional duties for PPCI on call.

9 of these duties were to provide staff for additional activity for the monthly Implantable Loop Recorder lists. These lists are overtime and not funded out of the nursing budget.
2 duties for an outpatient POTS Clinic

Bed Occupancy & Actual Vs Planned Direct Care Hours:
1st April 2025 – 30th June 2025

Narrative:

CHPPD 1st April 2025 – 30th June 2025

Narrative:

Section 2

Quality and Safety Overview

Patient Safety Events – 1st April 2025 – 30th June 2025

Incident Type	No harm	Low harm	Moderate harm	Severe harm	Grand Total
Accident (Excluding falls)	0	1	0	0	1
Appointment/Admission/Transfer/Discharge/Referrals	5	0	0	0	5
Monitoring/Care of patients	1	0	0	0	1
Treatment/Procedures (inc. operations/surgery)	3	4	0	0	7
Grand Total	**9**	**5**	**0**	**0**	**14**
Grand Total					

Narrative:

No Harm:

5x Appointment/admission - Patients incorrectly referred or cancelled on the day due to PPCI or equipment failure

3x Procedures/Treatments – Patients cancelled due to equipment failure

1 x Monitoring – Patient monitoring failed in Cath Lab

Low Harm:

4 x Treatment – these related to Tissue Viability incidents on Cath Lab table using the adhesive fenestrated drapes – Preventative measures taken included consulting TV team and manufacturer of product.

1 x accident – patient accident whilst climbing on to cath lab bed resulting in laceration to foot and delayed procedure

Patient Complaint/PALS Data

Narrative:

The Cardiac Catheter Lab delivers consistently high care. We receive numerous compliments with the main themes being friendly, approachable staff, efficient care and superb communication. Providing care with Dignity, Humility and Great Skill

Staff are described as cheerful and clearly enjoying their job taking the time to chat with patients and ensure an anxious time is made a little bit easier.

NHS Staff Survey Information and Pulse Q4

Q1. I look forward to going to work — 52.2%
Q2. I am enthusiastic about my job — 66.0%
Q3. Time passes quickly when I am working — 70.2%
Q4. There are frequent opportunities for me to show initiative in my role — 57.1%
Q5. I am able to make suggestions to improve the work of my team / department — 58.6%
Q6. I am able to make improvements happen in my area of work — 48.5%
Q7. Care of patients / service users is my organisation's top priority — 64.1%
Q8. I would recommend my organisation as a place to work — 50.6%
Q9. If a friend or relative needed treatment I would be happy with the standard of care provided by this ... — 52.2%

		Annual Average Scores		This year			
	Acute						
	Question	2023/24	2024/25	2025/26			
		%	%	Q1	Q2	Q3	Q4
Core (Mandated) Questions	Q1 - I look forward to going to work	71%	53%	50%			
	Q2 - I am enthusiastic about my job	69%	66%	63%			
	Q3 - Time passes quickly when I am working	66%	70%	68%			
	Q4 - There are frequent opportunities for me to show initiative in my role	51%	64%	61%			
	Q5 - I am able to make suggestions to improve the work of my team/department	68%	63%	61%			
	Q6 - I am able to make improvements happen in my area of work	52%	51%	49%			
	Q7 - Care of patients/service users is my organisations top priority	49%	67%	63%			
	Q8 - I would recommend my organisation as a place to work	71%	50%	45%			
	Q9 - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	54%	48%	46%			
Local Questions	4a. My immediate manager (who may be referred to as your 'line manager')...encourages me at work.	n/a	n/a	67%			
	1b. I am involved in deciding on changes introduced that affect my work area / team / department.	n/a	n/a	41%			
	3a. I receive the respect I deserve from my colleagues at work.	n/a	n/a	64%			
	2a. I have unrealistic time pressures*	n/a	n/a	25%			
	2b. I have a choice in deciding how to do my work	n/a	n/a	55%			
	2c. Relationships at work are strained*	n/a	n/a	42%			
	5a. I often think about leaving this organisation**	n/a	n/a	32%			
	5b. I will probably look for a job at a new organisation in the next 12 months**	n/a	n/a	25%			
	5c. As soon as I can find another job, I will leave this organisation**	n/a	n/a	20%			
	1a. I always know what my work responsibilities are	n/a	n/a	79%			
	1c. I am able to meet all the conflicting demands on my time at work.	n/a	n/a	45%			
	1d. I have adequate materials, supplies and equipment to do my work	n/a	n/a	54%			
	1e. There are enough staff at this organisation for me to do my job	n/a	n/a	34%			

Ward Accreditation/Quality Commentary 1ˢᵗ March 2025 – 31ˢᵗ May 2025

	March	April	May
Safeguarding	Green	Green	Green
Deteriorating Patient	Green	Green	Green
IPC	Green	Green	Green
Risk Assessments	Green	Green	Green
Medication	Green	Green	Green
Patient Experience	Green	Green	Green
Quality Governance and Safety	Green	Green	Green
Workforce	Green	Green	Green
Overall Score	Green	Green	Green

Narrative:

Achieved Bronze accreditation in April 2025.
Safeguarding: 100% staff are confident when dealing with Safeguarding concerns.
Deteriorating Pt: 100% Collabarative working with MDT to manage acutely unwell patients
IPC: 100% Staff are proud of our IPC compliance and challenge any poor practice when observed. Flo audits undertaken monthly and MiCAD consistently high
Medication: 100% Medication is managed, stored and administered within the lab environment adhering to medication management policy, labs perform positively when CD audit performed
Pt Experience: 100% Staff are proud of the care we provide
Quality Gov & Safety: Uniforms compliance is good and deviations challenged within the entire MDT.
Workforce: Mandatory training is good (98%) Appraisal compliance is excellent

Section 3

SNCT Overview including Professional Judgement and Recommendations

SNCT Data Capture Outputs

This will be provided before 4th July and shared with teams DO NOT CHASE

Professional Judgement from Ward/Department

Use Professional Judgement document to aid completion

Recommendations from SNCT Review to Board

Designated Body Annual Board Report and Statement of Compliance 2024-25
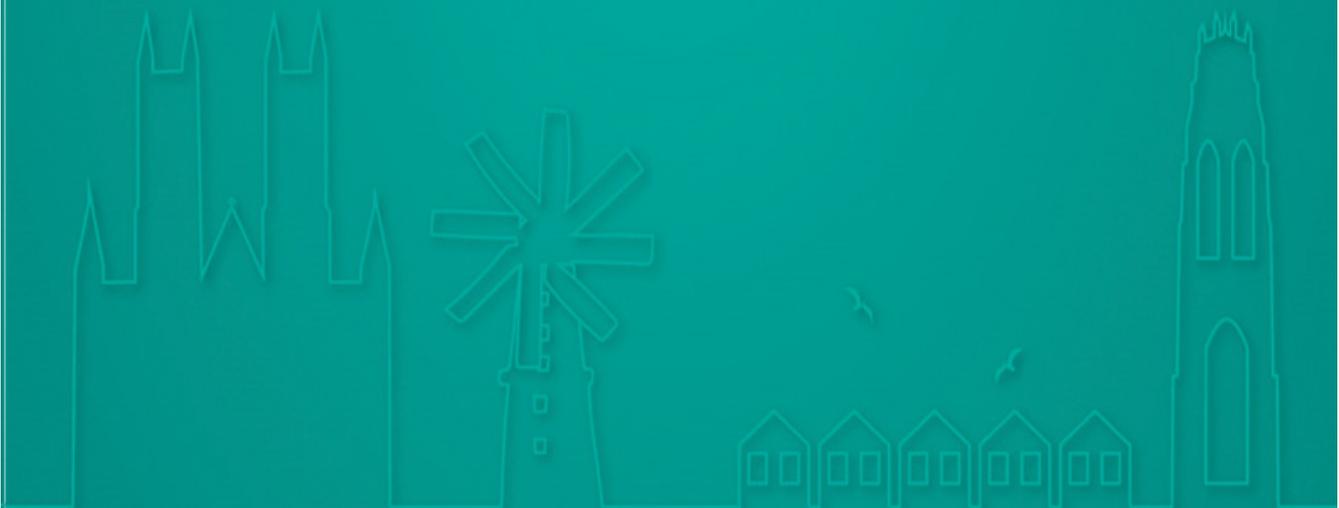
Great care, close to home

OUTSTANDING CARE *personally* DELIVERED

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2 September 2025*
Item Number	*9.3*

Designated Body Annual Board Report and Statement of Compliance 2024-25

Accountable Director	*Professor Colin Farquharson, Group Chief Medical Officer, LCHG*
Presented by	*Professor Colin Farquharson, Group Chief Medical Officer, LCHG*
Author(s)	*Dr Gomathi Margabanthu, Director of Professional Standards*
	Mrs Poonam Panjwani, Medical Professional Standards Manager
	Mrs Clare Frank, Business Manager to the Group Chief Medical Officer
Recommendations/ Decision Required	*The Board is asked to: -*
	Review the content of this report and confirm that the Trust is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013). The report will be shared with NHS England (East Midlands).

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	
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	

This paper provides an update on the Group Medical appraisal and revalidation function, with the two documents for both ULTH and LCHS. These highlight key achievements, current challenges and strategic priorities. The Responsible Officer (RO) function is now fully embedded within the Trust's governance framework, underpinned by a digitally mature infrastructure and a culture of professional accountability. The focus now shifts to sustaining quality, building capacity, and aligning with the Group's long-term workforce strategy.

There is also the ambition to nurture a culture of collective growth and reflective practice, the team will strategically collaborate across appraiser training, the appraiser pool, network events, and GMC workshops. This integrated approach will foster a shared mindset rooted in compassionate leadership; one that values listening, learning, and leading together. Through intentional interphase reflections between acute and community settings, we aim to mature our practices and support the system-wide journey toward the 'left shift,' ensuring care is increasingly proactive, person-centred, and community-based

Purpose

The Group is expected to demonstrate quality assurance and improvement each year in line with the new Professional Standards Framework for Quality Assurance and Improvement (FQAI).

Key messages

A.   United Lincolnshire Teaching Hospitals Trust (ULTH)

Appendix 1 contains the return for the ULTH Annual Board report and Statement of Compliance for 2024-25 and presents the information and metrics that the Trust is required to report upwards to the Higher-Level RO (HLRO), to assure the Trust's compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Highlights from this are listed below:

- Professor Colin Farquharson is the Group Chief Medical Officer and Responsible Officer for ULTH
- Dr Gomathi Margabanthu is the Director of Professional Standards.
- The ULTH Professional Standards team is working collaboratively with the LCHS Professional Standards Colleagues in a Group model.

Completed Actions since the last board report:

- Revalidation policy to be released by 31st January 2025 – The policy is now available on the Trust intranet.

- Replace ASPAT with new QA procedures to be implemented to drive value with people and process, reflect a continuous learning culture and maintain accountability of senior appraisers and divisional leads. The QA framework will include feedback review and impact assessment of the training workshops, appraisers' network meetings, appraisals' compliance, and revalidation evidence – with new QA procedures partially implemented and ongoing. GMC-led workshops have been held on a range of topics including GMC Good Medical Practice, becoming a Reflective practitioner, giving fairer feedback, Professional behaviours and patient safety, and these all contribute towards the implementation.

- Regular communications with divisions to ensure timely compliance and follow up for an action plan and report – this will be an ongoing rolling action.

- The amended MHPS Policy was presented, ratified and agreed at the JNF and published on the Trust intranet.

- Record outcome of 'You said, We did' name change to "Thought Showers" forum, which functions as an open discussion forum with discussion of future improvements

- The Revalidation policy has been amended accordingly and released.

- Clear action plan for quarterly assurance and improvement as per the Professional Standards FQAI – ongoing.

- Strengthen collaboration as the Group structure evolves and with neighbouring Trusts (Governance, training, resources, standardisation of locum medical workforce) – ongoing work to ensure Group collaboration.

Actions Still Outstanding:

- Ensure that the Trust has sufficient trained appraisers to maintain a minimum appraiser: appraisee ratio of 1:7 with continued quarterly monitoring – the reduction in appraisers is due to retirement or change of job plan. Work is ongoing to increase numbers (see action below)

Actions for 2025-26:

- Ensure that the Trust has sufficient trained appraisers to maintain a minimum appraiser: appraisee ratio of 1:7 with continued quarterly monitoring – Appraiser training event organised in October 2025 to cover the shortage of appraisers.

- Continue planning and implementation of new QA procedures as per the Professional Standards FQAI, to uphold accountability of senior appraisers and divisional leads for timely completion and quality of appraisals and mandatory training compliance.

- National Consultant Information Portal to embed for active governance, productivity reflections by surgical teams and individuals.

B.   Lincolnshire Community Health Services (LCHS)

Appendix 2 details the LCHS Annual Board report and Statement of Compliance for 2024-25 and presents the information and metrics that the Trust is required to report upwards to the Higher-Level RO, to assure its compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Highlights from this are listed below:

- Professor Colin Farquharson is the Group Chief Medical Officer.
- Dr Anne-Louise Schokker is the Responsible Officer for LCHS
- LCHS is working collaboratively with the ULTH Professional Standards Colleagues in a Group model.

Completed Actions since last board report:

- Continue to collaborate with ULTH for access to training and resources

- Renewal of Electronic appraisal tool

Actions still ongoing:

- Alignment of policies and practice to develop Group working

- To work on alignment of processes to develop Group working

Actions for 25-26:

- Maintain up-to-date policies following national guidance

- Maintain appraiser training

- Participation to continue with peer review, regional meetings and GMC ELA

- Alignment of electronic portfolios and process with group.

Conclusion / Recommendations:

The Group has a robust system in place to ensure compliance that Professional Standards are being maintained in line with relevant NHSE/I recommendations and guidance.

The People Committee / Group Board are being asked to receive the reports, note their content, and following sign-off by the Group Board, both reports will then be submitted to NHS England (East Midlands).

Enclosures:

Appendix A – ULTH Annual Board Report and Statement of Compliance 2024/2025

Appendix B – LCHS Annual Board Report and Statement of Compliance 2024/2025

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of:

United Lincolnshire Teaching Hospitals NHS Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	None.

Comments:	The Group Chief Medical Officer, Dr Colin Farquharson (GMC Registration: 4033541) continues as the appointed Responsible officer.
Action for next year:	None.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	To continue to maintain capacity
Comments:	The Trust provides adequate funding and resources including trained medical appraisers with appropriate SPA time to support the Chief Medical Officer and Director of Professional standards to discharge their duties as RO.
Action for next year:	To ensure the appraiser: appraise ratio is maintained at a minimum of 1:7.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	To continue to maintain accurate records.
Comments:	An accurate record is maintained using the SARD software and regularly validated against the Trust-wide list of staff in post and GMC list of practitioners with a prescribed connection to the Trust.
Action for next year:	None.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	Revalidation policy to be released by 31st January 2025. To continue with group alignment.

Comments:	The policy has been ratified, presented, and agreed at the JNF and released.
Action for next year	None.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	N
Action from last year:	Introduce the QA audit tool.
Comments:	A peer review has not been requested by the NHSE. The ASPAT has been replaced with a quality assurance revalidation tracker via SARD that reviews appraisal, governance with complaints and incidents, CPD reflections, and mandatory training. Appraisers and practitioners receive written QA feedback.
Action for next year:	Continue to embed QA procedures as per the Professional Standards FQAI and uphold accountability for senior appraisers and divisional leads.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	None.
Comments:	All doctors including locum or short-term placement are supported in their induction, CPD, appraisal, revalidation, and governance. All doctors, including those with a prescribed connection to another organisation, are empowered to own their governance data and supported to collect supporting evidence for appraisals. Led by the Director of Professional Standards, the Trust shares relevant information including Datix incidents, complaints and compliments with appraisals.
Action for next	None.

year	

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	Continue.
Comments:	'Supported governance' is facilitated by the Medical Professional Standards team as explained in 1A(vi). All doctors have access to a SARD account that follows the Medical Appraisal template incorporating GMP 2024. The template enables doctors to declare their full scope of practice and reflect on any complaints, significant events and outlying clinical outcomes within an annual appraisal. Doctors receive relevant training through GMC led workshops, appraiser network meetings and internal CPD.
Action for next year:	National Consultant Information Portal to embed for active governance, productivity reflections by surgical teams and individuals.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	Strengthen process not just providing support but also monitoring meetings held alongside robust data capture, divisional ownership, categorising themes for support and training.
Comments:	Any doctor who has not engaged with annual appraisal process has been identified, remedial action and support arrangements mutually agreed and captured on the SARD system. This is facilitated by the Medical Professional standards team and escalated to the Director of Professional standards in line with the Trust Revalidation policy.
Action for next year:	None.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	Policy to be released by 31st January 2025.
Comments:	The policy has been ratified, presented, and agreed at the Trust MSNF and the JNF and released on the Trust intranet for doctors to access.
Action for next year:	None.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Y

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[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	Ensure that the Trust has sufficient trained appraisers to maintain a minimum appraiser: appraise ratio of 1:7 with continued quarterly monitoring.
Comments:	The Trust policy expects each appraiser to undertake between 7 and 10 appraisals per year to maintain proficiency. Any shortfall of appraisers due to new recruitment and appraisers stepping down is covered by organising a two days' structured appraiser training event, encouraging doctors to undertake an appraiser's role. The Appraiser: appraisee ratio is monitored and reviewed with CBUs for divisional involvement to ensure equitability and diversity of process.
Action for next year:	To ensure the appraiser: appraise ratio is maintained at a minimum of 1:7.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	Replace ASPAT with new QA procedures to be implemented to drive value with people and process, reflect a continuous learning culture and maintain accountability of senior appraisers and divisional leads. The QA framework will include feedback review and impact assessment of the training workshops, appraisers' network meetings, appraisals' compliance, and revalidation evidence.
Comments:	Ongoing performance review of medical appraisers is facilitated through feedback from appraisees on the SARD system. Further feedback on quality of appraisal summaries and PDP, supervised appraisal for new appraisers and further appropriate support is available from Senior appraisers and the Director of Professional standards. All appraisers are expected to attend at least one Trust organised appraisers' network meeting each year to share good practice, performance data, peer experiences (both good and challenging ones) and prioritise targeted areas for improvement. Additional senior appraisers' network meetings are organised to develop a work plan for next year.

Action for next year:	Continue to embed QA procedures as per the Professional Standards FQAI and uphold accountability for senior appraisers and divisional leads.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	Regular communications with divisions with a target timeline, to ensure timely compliance and follow up for an action plan and reporting standards.
Comments:	Quality Assurance process of appraisals is undertaken. The Trust has introduced new QA procedures in 2024-25 as in 1A(v). A monthly report of appraisals' compliance is sent to the Responsible officer, the Workforce and OD Trust Board assurance committee and the individual Divisions. Divisions now collaborate with the Professional standards team ensure compliance and create action plans for their non-compliant doctors. Timely appraisal completion is facilitated by the Trust as in 1B(i) and 1B(ii). During 2024-25, 98.7% appraisals were completed and only 2 of 858 appraisals were an unapproved miss.
Action for next year:	None.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	Continue.
Comments:	A detailed SOP has been created outlining the process for pre-recommendation preparation, recommendation details and post-recommendation updates captured on the SARD system including reasons for any deferrals.

	Alongside appraisals and 360 MSF, the doctors owned governance information, job plan status, mandatory training, SI/complaints and reflections are recorded to support the QA framework for revalidation recommendations by the RO and Director of Professional standards. Any concerns related to a doctor's practice and relevant communication with the GMC, ELA and PPA are also considered.
Action for next year:	None.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	None
Comments:	The SOP is in place as in 1C(i). For deferrals and non-engagement, doctors are notified in suitable time to discuss the reasons for deferral or non-engagement with the Director of Professional standards, agree a plan of action and highlight any additional support requirements, which is communicated to the doctor and documented on the SARD system. Health and wellbeing data is captured alongside the rest of the supportive evidence to enhance staff support and experience.
Action for next year:	None.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	None

Comments:	Governance leads have been appointed in each clinical division (Clinical support services, Medicine, Family health and Surgery). The PSIRF framework is well embedded in the Trust. Relevant (national and local) learning is cascaded both for information and learning. Trust Grand rounds are well utilised for learning. Patient Advice and Liaison Service (PALS) and Complaints service ensures learning from incidents. The Trust has a dedicated Medical Examiner team to identify, report, investigate and learn from deaths within our care. The Patient Safety and Improvement team ensures that we enhance a SEIPS learning culture in the Trust. The Clinical Effectiveness team ensures implementation of nationally agreed guidance, standards and clinical performance indicators reflecting 'best practice.' It also incorporates a range of mechanisms required to measure and assess 'effectiveness' (e.g. clinical audit, clinical outcome measurement, service evaluation, benchmarking data, "clinical indicators" data capture). All Trust doctors are encouraged to attend Clinical governance meetings with reflections saved in their appraisal portfolio.
Action for next year:	None.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y
Action from last year:	The Conduct, Capability, Ill health policy draft to be amended to embed Just, Restorative & Learning Culture, including Preliminary Just Culture Assessment.
Comments:	The amended Policy has been presented, ratified and agreed at the MSNF and JNF and released on the Trust intranet with Just Culture principles embedded. The Responsible Officer Advisory Group (ROAG), including the Responsible officer, Director of Professional Standards, Deputy medical directors from the group, HR and legal representatives meets weekly to monitor the conduct and performance of all doctors. Safeguarding lead, LADO, OD team involved with the process based on case needs. The ROAG process has been strengthened with improved stakeholder communication (once a month divisional updates), consistent accurate documentation (ROAG log, individual case monitoring and assurance log, archived

	individual doctor log once completed). This helped with developing themes for supporting doctors, for example, focussed OD workshops are being conducted in the ED.) ELA and PPA are involved for discussion and updated for effective and robust case management. All internal and external case discussions are shared, discussed and plan agreed and captured at ROAG that offers the consistency and assurance to the process for the group. The Trust has undertaken further initiatives to improve conduct such as GMC led workshops incorporating GMP 2024 principles, Human factors training and 'Hear it your way'. To improve performance, the 'Work together, train together' initiative promotes multi-professional teaching and training at ULTH at all levels.
Action for next year:	None.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	**Y**
Action from last year:	None.
Comments:	The Medical professional standards team, aided by the SARD software, supports doctors to collect supporting evidence for their appraisals such as 360 feedback and CPD. They are further supported by providing theatre logbooks with any PII redacted and promoting individual ownership and accountability of their governance reflections i.e. SI/complaints data that is owned by the doctors.
Action for next year:	None.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	The Conduct, Capability, Ill health policy draft to be amended to embed Just, Restorative & Learning Culture, including Preliminary Just Culture Assessment.
Comments:	As 1D(ii).

Action for next year:	None.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	The Conduct, Capability, Ill health policy draft to be amended to embed Just, Restorative & Learning Culture, including Preliminary Just Culture Assessment.
Comments:	The amended Policy has been presented, ratified and agreed at the MSNF and JNF and released on the Trust intranet with Just Culture principles embedded. The Medical Director and Responsible Officer reports to the Executive Committee regarding any concerns about doctors in the organisation. Reports shared detail the concerns raised, investigation, risk assessment and mitigation, outcome and action plan. Safeguards have been included in the policy draft in the form of Equality analysis. Just culture team inputs have been used in policy development. Safeguarding teams are involved for robust engagement based on need. Datasets collects and analysis of numbers, type and outcome of concerns as well as aspects of protected characteristics shared in ROAG and to the board.
Action for next year:	None.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	None.
Comments:	Medical Practice Information Transfer (MPIT) forms are used for the data transfer of information about a doctor's

	practise to and from the doctors designated responsible officer. Additional medical roles are captured using an online form. The SARD system generates a Transfer of information report for each doctor. Effective communications are in place between Responsible Officer, Director of professional Standards and deputy medical directors within hospitals with shared workforce. The Responsible Officer and Director of Professional Standards continue to attend the Responsible Officer Network meetings and have close working relationships with GMC, ELA and PPA regional advisor at regular intervals and ad hoc by need.
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Y
Action from last year:	The Conduct, Capability, Ill health policy draft to be amended to embed Just, Restorative & Learning Culture, including Preliminary Just Culture Assessment.
Comments:	The Policy has been released. Safeguards have been included in the policy in the form of Equality analysis. Just culture, OD involvement and Safeguard team input has been encouraged to enhance the interphase working to match the needs. ROAG governance is robust with multiple stakeholders and communications in place with the medical revalidation team and reflections with training sessions.
Action for next year:	None.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	None.

Comments:	GMC GMP 2024 updates have been incorporated into the Trust policies. Annual review and responsive action information are shared with regional teams and GMC. Collaboration with Quality and Governance teams to celebrate success with staff awards (learning through excellence); encourage external review feedback, good practice (for example, Grantham GIRFT hub for Orthopaedics, GIRFT for Diabetes with a System working group in place, interphase working with Boston Pilot, CYP system oversight group with internal and external stakeholders.) The organisation is keen for change and a learning culture to be embedded through a range of initiatives: Embedding Human factors, Hear it your way, Work together Train together, OD and cultural workshops, Just Culture and Agenda for Change in all our policies and processes. A number of simulation sessions led by medical, nursing and MDTs have been organised. There is a Trust-wide improvement programme and 'Give it a go' campaign to encourage 'You said, we did' framework with change and sustainability reflected in the work streams. Robust job planning is in place to ensure accountability and assurance of process.
Action for next year:	None.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Y/N	Y
Action from last year:	None
Comments:	Training workshops have been organised for new doctors joining the Trust to explain the nature and purpose of medical appraisals, the link with revalidation and to encourage early engagement in the process. The Appraisal process has been strengthened with effective communications, a generic email for all communications, process in terms of SOP, reminders and support meetings for doctors in difficulty, assurance with quality of appraisals that are monitored, reviewed, reflected, and shared at appraisers' network meetings. To improve appraisal outcomes and ensure consistency, the appraisers' network meetings (quarterly) include Senior appraisers' inputs to identify and share appraisal best practice. Further, to maintain high professional standards,

sessions such as FTSU, human factors training have been embedded in appraisers' network meetings.
There is collaborative working with the Nursing lead to ensure workplace environments and behaviours are managed in line with policy and trust values.
Workshops facilitated by the GMC outreach team have been organised for all doctors including Implementation of Good Medical Practice 2024, Raising concerns and challenging behaviours, sexual harassment, Leadership and management and Professional behaviours and patient safety.

The Trust has appointed a full-time FTSU Guardian who has been invited to training sessions to embed organisational values and share the EDI journey. This promotes transparency of Freedom To Speak Up within the staff groups. There are 35 FTSU champions in the Trust from various departments.

The Trust is compliant with all its statutory and contractual Equality, Diversity, and Inclusion duties. Full details are provided in the Equality, Diversity, and Inclusion Annual Report on the Trust website. To embed inclusive leadership practice as the responsibility of all leaders, the Trust has, since 2022, rolled out the nationally recognised Leading Inclusively with Cultural Intelligence programme. At the end of August 2024 over 450 leaders completed the programme. The Trust is also embedding the NHS Equality, Diversity, and Inclusion Improvement Plan (2023) which contains specific actions in relation to inclusion for very senior leaders. Further, the Trust is currently undertaking the NHS Culture and Leadership Programme which supports the Trust in embedding a collective, inclusive, and compassionate approach to leadership. Cultural Ambassadors are a central part of the NHS Culture and Leadership Programme, and the Trust currently has 12 Cultural Ambassadors.

The ULH Talent Academy delivers initiative-taking services to aid recruitment and skills development of the workforce, whilst also ensuring the portability and integration of skills across the health and care system. It offers opportunities for current staff to enhance their careers and help professional progression.

Portfolio Pathway / CESR and LEDs - access to study leave and supervision have been supported. The Trust has appointed LED leads who support the IMGs through induction and mentoring. There is a SAS tutor to target challenged areas such as medicine, oncology, and

	anaesthesia with CESR support. The ED and Acute medicine departments have a successful and structured Portfolio pathway programme.
Action for next year:	None

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	**Y**
Action from last year:	None
Comments:	Pre-employment background checks are completed for all doctors. Clear processes are in place and the RO and DMD continue to work closely with HR, locum agencies and doctors to identify process concerns and ensure risk mitigation and actions are in place. There are six NHS Employment Check standards that outline the type and level of checks that the Trust conducts before recruiting staff into NHS positions. 1. Identity check standards 2. Criminal records check standards. 3. Right to work checks standards 4. Work health assessment standard. 5. Professional registration and qualification check standards 6. Employment history and reference checks standard
Action for next year:	None

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	**Y**
Action from last year:	None
Comments:	As 1D(ii) and 1D(ix).
	Continuous Professional development is encouraged and supported for staff individual needs and reflected in the appraisal process. Staff development and training calendar is available on the intranet that is updated regularly for easy access and information sharing.
Action for next year:	None

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	**Y**
Action from last year:	The Conduct, Capability, Ill health policy draft to be amended to embed Just, Restorative & Learning Culture, including Preliminary Just Culture Assessment.
Comments:	As 1D(ii) and 1D(ix)
	The policy has been released on the Trust intranet.
	The Dignity and Respect at work policy is extensively advertised on the staff intranet and followed. DES/WRES data is shared, reviewed at all levels and actions taken recorded.
	National and quarterly Staff surveys are benchmarked and reviewed with action plans.

| | Staff well-being Team offer is wide and is well promoted and accessed by medical staff to support their psychological safety and well-being.

DI work is aligned to Equality Act and the Trust meets the NHS Contractual Requirements. Equality Objectives are well captured on the Trust Website. |
|---|---|
| Action for next year: | None |

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	**Y**
Action from last year:	None.
Comments:	The Freedom to Speak up Guardian (FTSU) acts as an independent and impartial source of advice for staff and is further supported by FTSU champions across the Trust. There are 35 FTSU champions within the Trust that span across all areas.

The staff sessions (MSNF and JNF both once in 2 months) promote openness and transparency and are well attended by the board members and clinical staff to ensure the values are behaviours are shared at all levels. The agenda includes Trust policies to be presented, ratified and agreed.

MAC is once a month and well attended by the staff and senior leadership team facilitating open conversations embedding the learning culture.

JDR forums (bi-monthly) through the Guardian of Safe Working and DME office also facilitates FTSU visibility to the junior doctor body to share and improve the satisfaction and experience journey.

HR process with Safeguarding whistle blowers' policy is in place. Exit interviews are conducted and themes shared with RO. |
| Action for next year: | None. |

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	**Y**
Action from last year:	Record outcome of 'You said, we did' forum to inform future improvements and Trust revalidation policy.
Comments:	The Datix Risk Management System is the software used by the Trust to report and investigate incidents, manage risks, record, and respond to complaints and manage requests for information. The Clinical leads and Divisional Directors are accountable and support the incident and complaint management process with the Trust PSIRF and Complaints framework with all doctors. They offer both formal and informal feedback to help reflection, learning and prevention work within their team and interphases. They are supported by ROAG when it meets the threshold for oversight, mitigation, investigation, action and support for the individuals and teams as needed. Issues arising from appraiser network meetings are escalated internally to the RO or Director of Professional standards, to inform in-year changes to the medical appraisal programme, and the annual report and action plan considered by the board. The Trust has started a 'You said, we did' forum. For example, as suggested by an experienced medical appraiser, it was arranged to redact all PII from theatre logbooks that are now directly supplied to doctors to facilitate collection and reflection of supporting evidence for their appraisals and own their data.
Action for next year:	None.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	**Y**
Action from last year:	None.

Comments:	Safeguards have been included in the policy draft in the form of Equality analysis. DI work is aligned to meet the requirement defined by the Equality act and the Trust Equality objectives are described on the Trust website. There is a Freedom to Speak up – Voicing your concerns Policy that helps to establish an open culture of a learning organisation.
Action for next year:	None.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	Clear action plan for quarterly assurance and improvement as per the Professional Standards FQAI. Strengthen collaboration with neighbouring Trusts (e.g. standardisation of locum medical workforce).
Comments:	There is full engagement with the peer network and review as a group process. The Medical Professional Standards team encourages two-way communications and open-door policy to ensure every voice is heard, facilitating a good workplace environment for staff, resource development to complete their job roles with satisfaction. There are active conversations with the RO teams of other Trusts where there is a shared workforce (for example, Northern Lincolnshire and Goole Hospitals NHS Trust, Queen Elizabeth Hospital NHS Trust, and local medical schools). There is a Regional Medical Directors' group that works collaboratively to share practice. The RO or their delegates attend the regional RO network meetings and cascade the information to the Professional standards team, appraisers, and doctors as appropriate. The Trust as a designated body, finalises their annual Board report with commentary on actions identified and present

	this to the Trust Board for approval. The approved annual report and statement of compliance is sent to NHSE.
Action for next year:	Continue to embed QA procedures as per the Professional Standards FQAI and uphold accountability for senior appraisers and divisional leads.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025   .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	914
Total number of appraisals completed	841
Total number of appraisals approved missed	70
Total number of unapproved missed	3
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	217
Total number of late recommendations	1
Total number of positive recommendations	198
Total number of deferrals made	19
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	32
Total number of trained case managers	7
Total number of concerns received by the Responsible Officer[2]	54
Total number of concerns processes completed	48 (MHPS-3)
Longest duration of concerns process of those open on 31 March (working days)	210
Median duration of concerns processes closed (working days)[3]	97
Total number of doctors excluded/suspended during the period	2 (Temporary exclusion)

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[2] Designated bodies' own policies should define a concern. It may be helpful to observe
https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states:
Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.
[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of doctors referred to GMC	1 (3 open)
Total number of appeals against the designated body's professional standards processes made by doctors	2
Total number of these appeals that were upheld	Ongoing
Total number of new doctors joining the organisation	171.75 FTE
Total number of new employment checks completed before commencement of employment	171.75 FTE
Total number claims made to employment tribunals by doctors	2
Total number of these claims that were not upheld[4]	ongoing

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
a. *Revalidation policy to be released by 31st January 2025* – The policy is now available on the Trust intranet.
b. *Replace ASPAT with new QA procedures to be implemented to drive value with people and process, reflect a continuous learning culture and maintain accountability of senior appraisers and divisional leads. The QA framework will include feedback review and impact assessment of the training workshops, appraisers' network meetings, appraisals' compliance, and revalidation evidence* – New QA procedures partially implemented and ongoing. GMC led workshops on GMC Good medical practice, becoming a Reflective practitioner, giving fairer feedback, Professional behaviours and patient safety contribute towards the implementation.
c. *Regular communications with divisions to ensure timely compliance and follow up for an action plan and report* – ongoing.
d. *The Conduct, Capability, Ill health (MHPS) policy draft to be amended to embed Just, Restorative & Learning Culture, including Preliminary Just Culture Assessment* - The amended Policy was presented, ratified and agreed at the JNF and released on the Trust intranet.
e. *Record outcome of 'You said, we did' name change to "Thought Showers" forum functions as an open discussion forum with discussion of future improvements*

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[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

and Trust revalidation policy – The Revalidation policy has been amended accordingly and released.

f. *Clear action plan for quarterly assurance and improvement as per the Professional Standards FQAI* – ongoing.

g. *Strengthen collaboration as the Group structure evolves and with neighbouring Trusts (Governance, training, resources, standardisation of locum medical workforce)* – ongoing work to ensure Group collaboration.

Actions still outstanding

a. *Ensure that the Trust has sufficient trained appraisers to maintain a minimum appraiser: appraisee ratio of 1:7 with continued quarterly monitoring* – a few appraisers stepped down due to retirement or change of job plan.

Current issues

a. Maintaining a healthy appraiser: appraisee ratio of 1:7 as a minimum.

b. Ensuring consistent compliance with mandatory training and timely completion of appraisals remains a priority.

c. Further work required for implementation of Quality assurance framework as per the Professional Standards FQAI and to maintain accountability of Senior appraisers alongside divisional leads for timely completion and quality of appraisals.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

a. Ensure that the Trust has sufficient trained appraisers to maintain a minimum appraiser: appraisee ratio of 1:7 with continued quarterly monitoring – Appraiser training event organised in October 2025 to cover the shortage of appraisers.

b. Continue to embed QA procedures as per the Professional Standards FQAI and uphold accountability for senior appraisers and divisional leads.

c. National Consultant Information Portal to embed for active governance, productivity reflections by surgical teams and individuals.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

This paper provides an update on the Trust's medical appraisal and revalidation function, highlighting key achievements, current challenges, and strategic priorities. The Responsible Officer (RO) function is now fully embedded within the Trust's governance framework, underpinned by a digitally mature infrastructure and a culture of professional accountability. The focus now shifts to sustaining quality, building capacity, and aligning with the Group's long-term workforce strategy.

Organisational Achievements

Governance and Oversight

- The RO function is fully integrated into the Trust's governance structure, with regular reporting to the Board and full compliance with NHS England requirements.

- A clear escalation process ensures timely resolution of exceptions and reinforces engagement and accountability at all levels.

Digital Transformation

- The migration to the SARD platform is complete. This has replaced legacy spreadsheet systems with a robust, real-time database, significantly improving data quality, reporting accuracy, and operational maturity.

Appraiser Development and Quality Assurance

- All new appraisers have undergone structured training and supervised appraisals.

- Senior appraisers lead calibration and peer-learning sessions to ensure consistency in professional judgement.

- Post-appraisal feedback is systematically reviewed and shared through appraiser networks to drive continuous improvement.

- A quality improvement (QI) lens is now embedded in appraisals, particularly for clinicians approaching revalidation.

Professional Development and Culture

- A comprehensive CPD programme supports continuous learning and development.

- Appraisals now incorporate job planning, mandatory training, educational appraisal, and governance reflections—owned and led by the appraisee.

- A culture of transparency, accountability, and learning is actively promoted across clinical divisions.

- Clinicians are empowered to take ownership of their data, governance, and professional reflections through structured appraiser networks.

Key Challenges

Appraiser Capacity

- The Trust continues to experience pressure on appraiser capacity due to retirements and staff turnover.

- Risk is mitigated through a proactive recruitment strategy and exploration of flexible appraisal delivery models tailored to divisional needs.

Compliance and Timeliness

- Ensuring consistent compliance with mandatory training and timely completion of appraisals remains a priority.

- Divisional oversight mechanisms are in place to monitor performance and provide targeted support.

Aspirations/Strategic Priorities

Enhancing Quality and Consistency

- Strengthen feedback mechanisms to improve the quality and impact of appraisals.

- Continue embedding QI principles and standardisation across all appraisal processes to drive productivity and assurance.

Fostering Collaboration and Shared Learning

- Deepen collaboration with neighbouring Trusts to share best practice and address shared workforce challenges.

- Promote cross-organisational learning to support a reflective, resilient, and high-performing medical workforce.

Embedding Inclusivity and Sustainability

- Ensure appraisal and revalidation processes are fair, objective, transparent, and inclusive.

- Align with the evolving Group structure to support a sustainable, valued, and future-ready medical workforce.

Maintaining Regulatory Alignment

- Maintain alignment with GMC guidance, NHS England expectations, and the Equality Act 2010.

- Ensure governance processes continue to support the delivery of safe, high-quality patient care through a well-supported and accountable workforce.

To nurture a culture of collective growth and reflective practice, the team will strategically collaborate across appraiser training, the appraiser pool, network events, and GMC workshops. This integrated approach will foster a shared mindset rooted in compassionate leadership; one that values listening, learning, and leading together. Through intentional interphase reflections between acute and community settings, we aim to mature our practices and support the system-wide journey toward the 'left shift,' ensuring care is increasingly proactive, person-centred, and community-based

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Lincolnshire Community and Hospitals NHS Group

Name:	Professor Karen Dunderdale
Role:	Chief Executive
Signed:	
Date:	

Name of the person completing this form:	Dr Gomathi Margabanthu
Email address:	gmargabanthu@nhs.net

Appendix 1

GMC connect data summary

Recommendations

2024-25 (1/4/24 – 31/3/25):

Recommendations

By type

Showing data for your selected organisation
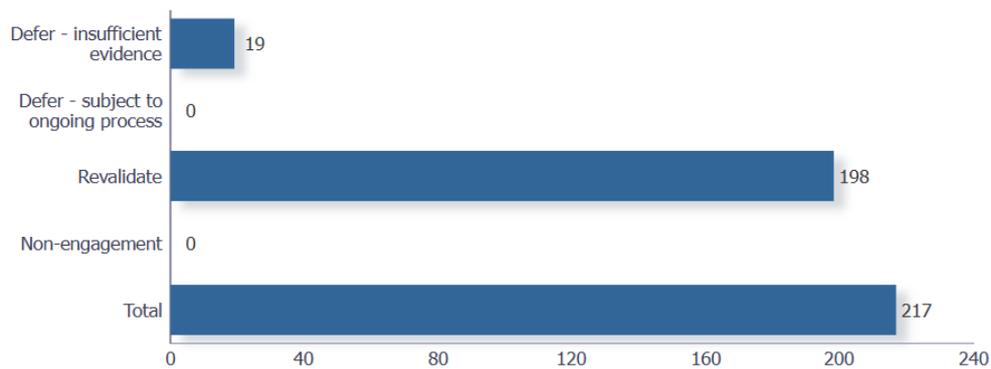
By doctor type

Showing data for your selected organisation
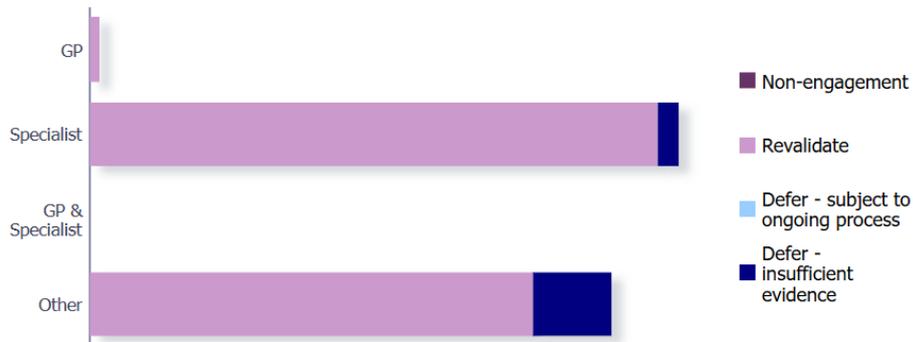
	GP	Specialist	GP & Specialist	Other	Total
Defer - insufficient evidence	0	4	0	15	**19**
Defer - subject to ongoing process	0	0	0	0	**0**
Revalidate	2	110	0	86	**198**
Non-engagement	0	0	0	0	**0**
Total	**2**	**114**	**0**	**101**	**217**

Appendix 2

Deferral – evidence summary

2024-25 (1/4/24 – 31/3/25): Appraisal activity most often refers to being registerd on GMC but outside of the UK or not working so appraisal activity paused.

Additional reasons selected
This shows how many times each additional reason has been selected.

Appraisal Activity	CPD	Colleague Feedback	Compliments & Complaints	Interruption To Practice	Patient Feedback	QIA	Significant Events
17	2	7	1	3	7	4	0

Appraisal Activity	CPD	Colleague Feedback	Compliments & Complaints	Interruption To Practice	Patient Feedback	QIA	Significant Events
85%	10%	35%	5%	15%	35%	20%	0%

Additional reason combinations
This shows has many times each combination of additional reasons has been selected.
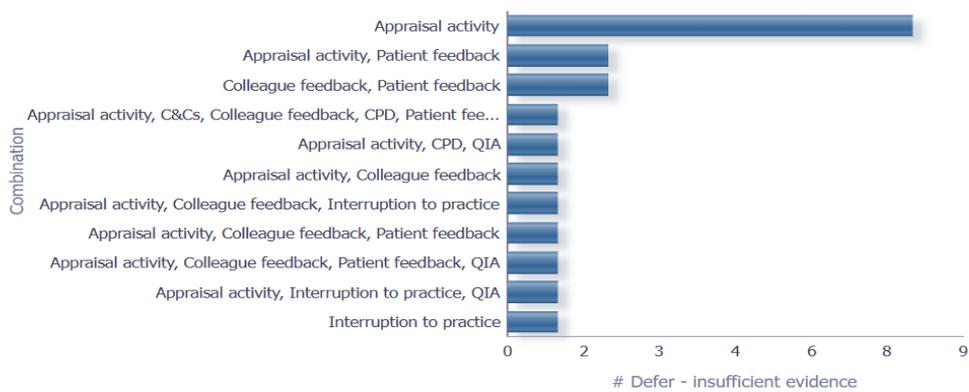
Appendix 3

FTP summary

2024-25 (1/4/24 – 31/3/25):

FTP Summary *(Based on incident location by complaint received year)*
Showing data for your selected organisation

	2021	2022	2023	2024	2025
Enquiries	12	12	18	13	25
Complaints	12	12	17	13	25
Investigations	1	1	1	0	3
Still Open	0	0	0	0	3
Closed without a Hearing	0	1	0	0	0
No Action	0	1	0	0	0
Advice	0	0	0	0	0
Warning	0	0	0	0	0
Undertakings	0	0	0	0	0
Closed at Hearing	1	0	1	0	0
No Action	0	0	0	0	0
Warning	0	0	0	0	0
Undertakings	0	0	0	0	0
Conditions	0	0	1	0	0
Suspension	1	0	0	0	0
Erased	0	0	0	0	0

Appendix 4

AOA Report Summary 2024-25

SARD

United Lincolnshire Hospitals NHS Trust AOA Report (2024/2025)
PDF generated on 31 Jul 2025 at 10:00

		1	1a	2	3
		Number of Prescribed Connections	Completed Appraisal (1)	(Optional) Completed Appraisal (1a)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)
2.1.1	**Consultants** (Permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work.)	401	385	158	16	0
2.1.2	**Staff grade, associate specialist, specialty doctor** (Permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff.)	260	233	92	26	1
2.1.3	**Doctors on Performers Lists** (For NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs.)	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (This is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade.)	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (Temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc)	1	0	0	1	0
2.1.6	Other doctors with a prescribed connection to this designated body (Depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc.)	252	223	104	27	2
Unallocated	**Medics without an AOA medic group** (Medics that have not been allocated an AOA medic group on SARD)	0	0	0	0	0
2.1.7	Total	914	841	354	70	3

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative
All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of:

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	None

Comments:	Medical Director Dr A-L Schokker is the appointed RO with appropriate training, full GMC registration 4371838 and continues in role
Action for next year:	Continue

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Completed – to collaborate with ULTH on accessing training and resources.
Comments:	Continue
Action for next year:	Maintain capacity.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	To maintain accurate records.
Comments:	Electronic appraisal tool renewed and record all licensed medical practitioners with a connection to the designated body, maintained and updated by the RO
Action for next year:	To continue to maintain accurate records

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	To continue with group alignment

Comments:	Continue to work in conjunction with group colleagues
Action for next year	Continue to develop and work in conjunction with group colleagues.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Y
Action from last year:	To align policies and practice within the group model
Comments:	Policies and practice being aligned with the group model
Action for next year:	To continue to develop and work within the group model.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	Locum utilisation is small as we have a high fill rate from internal bank processes. Local induction is completed for locums and recorded within clinical teams. Locum doctors are managed with the same wellbeing offer and support as substantive staff and to dignity at work policy. The MPIT form is used to feedback any relevant clinical governance information to the doctors and direct to their ROs where appropriate.
Comments:	Have continued the above.
Action for next year	To continue

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	All doctors were appraised and revalidated successfully
Comments:	To continue to ensure that all doctors have their GMC annual appraisal and where appropriate revalidation is ensured.
Action for next year:	To continue

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	Any doctor who has not engaged with the annual appraisal process is quickly identified and remedial action agreed. Failure to engage with a remediation plan would result in referral to the GMC. To date there have been no problems identified with engagement of those doctors for whom LCHS is a designated body.
Action for next year:	To continue

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	No outstanding actions
Comments:	Policy in date and compliant
Action for next year:	Annual policy review

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Y

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[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	No outstanding actions
Comments:	4 Appraisers are trained and job planned which is sufficient.
Action for next year:	To continue

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	No outstanding actions
Comments:	The Deputy Medical Director for Professional Standards continues to co-ordinate the formal feedback of appraisals and all appraisers. The local training within the group has been accessed to maintain practice and ensure the correct number of appraisers.
Action for next year:	To continue

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	No outstanding actions

Comments:	Peer quality assurance of appraisals undertaken
Action for next year:	To continue

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	Clear lines of communication with the GMC ELA with the Trust RO.
Action for next year:	To continue

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	Revalidation recommendation dates are identified at the beginning of the quarter prior to the quarter in which the recommendation is due in order to identify any potential problems with making a positive recommendation in a timely manner. Any issues identified can then be discussed with the doctor and a management plan agreed before the recommendation due date.

	All completed within a timely fashion through GMC connect – 100% compliant
Action for next year:	To continue

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	Clinical Directors include doctors attending their service in the local clinical governance arrangements as part of the multi-disciplinary team. Relevant national and local guidance is shared with doctors as is learning from incidents locally and elsewhere in the organisation. Feedback is given from a variety of sources including the Quality Team (incidents), the Medicines Management Team (prescribing data, medication incidents,) and the Corporate Governance team (complaints, patient feedback) . All doctors with a prescribed connection to LCHS complete regular personalised patient feedback activity and 360-degree feedback from work colleagues agreed by LCHS. All other doctors are facilitated in providing the same for their designated body.
Action for next year:	To continue

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	There is regular communication between the Deputy Medical Director and the Responsible Officer, with input from the Clinical Directors/ Divisional Directors/ Clinical Team Leaders and Lead Clinicians across the organisation about conduct and performance issues. There is appropriate and timely support from Human Resources and wellbeing teams as required. The Quality, Medicines Management and Corporate Governance Teams identify significant incidents, complaints and prescribing issues to the Deputy Medical Director and Medical Director/Responsible Officer. Issues raised are discussed with the doctor concerned and management plans agreed as appropriate. There is a system in place for clinical and managerial supervision where appropriate of all doctors. There is a regular ROAG meeting scheduled between MD and HR team.
Action for next year:	To continue

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	No outstanding action
Comments:	Electronic appraisal system used. Governance team provide information on complaints/compliments and incidents. OD team support 360 feedback.

Action for next year:	To continue

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	Doctors are subject to LCHS's Your Performance Matters Policy and Disciplinary policy which has been updated with GMC MHPS updates.
Action for next year:	To continue.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.   Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	The Medical Director and Responsible Officer reports to the Quality and Risk Committee regarding any concerns about doctors in the organisation.

Reports contain details of concerns raised, investigation plans, mitigation of risks and remediation plans if necessary and outcomes. |

	Contemporaneous information is shared with the responsible NED when a MHPS investigation is being instigated.
Action for next year:	Continue

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	Utilisation of the MPIT form to support the appropriate transfer of information about a Doctor's practice to and from the Responsible Officer. The Responsible Officer continues to attend the Responsible officer network meetings when delivered and has close working relationships with both the GMC ELA and PPA regional advisor.
Action for next year:	To continue.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Y
Action from last year:	No outstanding actions

Comments:	LCHS Your Equality and Diversity Matters Policy is followed as per other clinical staff
Action for next year:	Continue

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	No outstanding actions
Comments:	Continue annual reviews and responsive action to information shared by regional team and GC
Action for next year:	To continue

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	No outstanding actions
Comments:	HR team link policies and reviews. Chief AHP undertaking alignment of professional registration monitoring in other health care professional groups. Nursing structure has NMC registration monitoring in place.
Action for next year:	To continue

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	Clear processes are in place and the Responsible Officer/Director for Professional Standards work closely with HR, Locum agencies and doctors
Action for next year:	To continue

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	Continuous improvement and professional development is job planned and reviewed at appraisals.
Action for next year:	Continue

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	EDI and dignity policies are widely advertised and followed. WRES/DES data reviewed and actions taken where appropriate. National and quarterly staff surveys reviewed and benchmarked
Action for next year:	To continue

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	FTSUG has formal and informal meetings with the Responsible Officer. The FTSU report covers concerns involving and raised by medics. Safeguarding whistle blowers policy in place. Exit interviews offered.
Action for next year:	To continue

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y

Action from last year:	No outstanding actions
Comments:	Clinical directors and divisional manager all give supportive informal feedback for both connected and associated nonconnected doctors and act upon 'low level' concerns. ROAG will review concerns and agree actions to support individuals and when investigation is required.
Action for next year:	To continue

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Y
Action from last year:	No outstanding actions
Comments:	There has been a formal review of disciplinary cases and concerns from a EDI perspective.
Action for next year:	To continue

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y

Action from last year:	To work on alignment with group processes.
Comments:	This work continues as the group continues to evolve.
Action for next year:	To continue

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	13
Total number of appraisals completed	13
Total number of appraisals approved missed	0
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	4
Total number of late recommendations	0
Total number of positive recommendations	4
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	13
Total number of trained case managers	9
Total number of concerns received by the Responsible Officer[2]	0
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	0
Median duration of concerns processes closed (working days)[3]	0
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

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[2] Designated bodies' own policies should define a concern. It may be helpful to observe
https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states:
Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.
[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	0
Total number of new employment checks completed before commencement of employment	0
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Continue to work with colleagues across the group to develop group working and alignment of documentation and actions.
Actions still outstanding
No outstanding actions
Current issues
No current issues or risks

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[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Maintain up to date policies following national guidance Maintain appraiser training Participation to continue with peer review, regional meetings and GMC ELA Alignment of electronic portfolios and process with group.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
To nurture a culture of collective growth and reflective practice, the team will strategically collaborate across appraiser training, the appraiser pool, network events and GMC workshops. This integrated approach will foster a shared mindset rooted in compassionate leadership. One that values listening, learning and leading together. Through intentional interphase reflections between acute and community settings, we aim to mature our practices and support the system-wide journey towards the 'left shift', ensuring care is increasingly proactive, person-centred, and community based.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Lincolnshire Community Health Services NHS Trust

Name:	Professor Karen Dunderdale
Role:	Chief Executive
Signed:	
Date:	

Name of the person completing this form:	Dr Anne-Louise Schokker
Email address:	anne-louise.schokker@nhs.net

Workforce Race Equality Standard (WDES) Annual Report 2024-2025

Meeting	Lincolnshire Community and Hospitals Group Board
Date of Meeting	2 September 2025
Item Number	9.4

WRES Annual Report 2024-2025

Accountable Director	Claire Low, Chief People Officer
Presented by	Claire Low, Chief People Officer
Author(s)	Rachel Higgins, EDI Lead (LCHS/Group) Kerry Swift, Deputy Director of People
Recommendations/ Decision Required	*The Board is asked to: -* Approve the publication of *the report* on the Trusts' websites in line with national reporting 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	
1b: Reduce waiting times for our patients	
1c: Improve productivity and deliver financial sustainability	
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	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	
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 committee is asked to note the contents of the Workforce Race Equality Standard (WRES), annual reports for both ULTH and LCHS for 2024-2025. These reports looks back at the achievements from the previous year and show that each Trust has fulfilled its statutory requirements.

In addition, the committee is asked to make a recommendation for Board to approve the report for publication on both Trusts' websites in line with national reporting requirements.

Purpose

The Workforce Race Equality Standard (WRES) agenda has continued to be productive as LCHS and ULHT has entered into a Group model.

The WRES annual report for each organisation focuses on the achievements from the previous year ie 2024-2025. Within both annual reports, it celebrates work achieved and the engagement with staff and staff networks, together with the progress made in continuing with the workforce race agenda with regards to the impact, effectiveness, and responsiveness for both Trusts.

It also details how LCHS and ULTH have continued to follow national requirements and legislative requirements for statutory reporting.

Key Messages

The Workforce Race Equality Standard (WRES) programme has now been collecting data on race inequality for ten years, holding up a mirror to the service and revealing the disparities that exist with ethnically diverse staff compared to their white colleagues.

The WRES annual report focuses on the data and engagement with ethnically diverse staff for both ULTH and LCHS. In addition, to celebrating the work achieved and the engagement with staff and progress made, it highlights any concerns and what actions are planned to address these. The annual report also includes the data from the key indicators and an action plan to improve outcomes. This actions plan has now become a Group three-year action plan to recognise the long-term commitment that is required to improving these metrics and the experience for staff. It also notes the determination to continue with the race agenda with regards to the impact, effectiveness, and responsiveness for both Trusts.

There is a statutory requirement as part of the Trust's contract to publish the WRES annual report and this requires Boards to formally ratify this ahead of publication on the Trusts' websites.

It is important to note that these annual reports have been developed with the staff networks and have also been shared with the Equality, Diversity and Inclusion Group, together with this People Committee.

This annual report informs on the key areas of progress, areas of focus and then key actions that are being taken to address these areas.

The annual report contains the full WRES data at appendix one, a data trends analysis over previous years as appendix two and the action plan for the next three years as appendix three, as a Group action plan.

Further progress against this action plan will be reported on a regular basis into the Equality, Diversity and Inclusion Group and upwards to the People Committee.

As both organisations have moved into the Group Model, both Equality, Diversity and Inclusion teams have come together successfully to ensure the continuation of compliance with the Public Sector Equality Duties and working with our staff across LCHS and ULHT, supporting the coming together of the two organisations' staff networks RE&CH - Race, Ethnicity and Cultural Heritage (RE&CH) and Celebrating our diversity everyday (CODE) as one staff network.

Conclusion/Recommendations

In conclusion, People Committee are asked to note and formally approve the contents of the WRES annual report for both ULHT and LCHS, which looks back at the WRES findings from the previous year and how the Trust is working towards improving the experience of ethnically diverse staff via the joint Group three-year action plan.

Please note that the annual report and supporting appendices have a different look and are less visual than previous years. This is to ensure they met the requirements of the Accessible Information Standard. Work has also been undertaken to ensure that both organisations' reports are in as similar format as possible.

NHS
Lincolnshire Community and Hospitals NHS Group

LCHS Workforce Race Equality Standard Annual Report 2024-2025

Caring and building a
healthier future for all

Authors: EDI Team

Date: June 2025

Contents

Introduction

Welcome to the Lincolnshire Community Health Services NHS Trust, Workforce Race Equality Standard (WRES) 2024-2025 report. This report contains reflections of last year's actions for the Workforce Race Equality Standard (WRES).

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract. To fulfil the Trust's commitments towards staff LCHS complies with the Public Sector Equality Duty, as part of the Equality Act 2010, and the NHS People Promise within the NHS Long Term Workforce Plan. The Trust aspires to create an inclusive culture by embedding a sense of belonging across the organisation.

In the Gov.UK report on Ethnicity Facts and Figures published 13th April 2023, as of June 2022, over 1.3 million people were employed by the NHS:

- Out of NHS staff whose ethnicity was known, 74.3% were white and 25.7% were from ethnic minority groups (not including white minority groups). 68.7% of professionally qualified clinical staff were white and 15.9% were Asian.
- Ethnic minority staff made up 15.0% of people in managerial level positions, and 11.3% of senior managerial level positions.
- Ethnic minority staff made up 49.9% of hospital and community health services (HCHS) doctors.
- Asian staff made up the highest percentage of hospital and community health services (HCHS) doctors working in staff grade, specialty doctor and associate specialist positions.

NHS workforce - GOV.UK Ethnicity facts and figures

Methodology

The National 2024 WRES data report, reflects the state and complexity of race equality in the NHS. It shows significant progress in the number of Very Senior Managers (VSMs) from an ethnic minority, but a fall in the number of executives on trust boards.

There has been a reduction in the number of BME staff experiencing harassment from the public, but an increase in the number experiencing discrimination from a manager at work, which is reflective in the LCHS data.

Nationally, the next steps on the journey of the WRES are to move the NHS on to the stage of advancing race equality by using detailed demographic analysis at organisational level, to encourage local, regional, and national operations to implement bespoke improvement measures. System-wide learning is a key ambition for future implementation of the WRES. Regional data shows striking examples of what can be achieved when there has been a focus on targets.

WRES national key findings:

- Since 2018 the number of BME staff has increased by over 100,000 (with BME representation increasing from 19.1% to 28.6%). An increase in internationally educated nurses (IENs) and international medical graduates (IMGs) is likely to be a significant contributor to this.
- In March 2024, 28.6% of the workforce across NHS trusts came from a BME background (434,077 people). This is an increase of 53,969 (14%) on the previous year.
- The total number of BME staff at very senior manager (VSM) level has increased by 85% since 2018 from 201 to 372 and it is at its highest since the inception of WRES.
- BME board membership has reached its highest level of 16.5% since the WRES was established. However, BME board membership growth has not kept up with the rise in BME staff across the NHS workforce (28.6%).
- At 80% of trusts, white applicants were significantly more likely than BME applicants to be appointed from shortlisting, higher than the 76% last year.

- A lower percentage of BME staff (48.8%) than white staff (59.4%) felt that their trust provides equal opportunities for career progression or promotion.
- With disaggregation, just 42.3% of staff from a black background believed their trust provides equal opportunities for career progression or promotion, with levels below those of other ethnic groups since at least 2015.
- For the second year in a row, White Gypsy or Irish Traveller women (34.1%) and men (42.6%) experienced the highest levels of harassment, bullying or abuse from other staff.
- The percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months was higher for BME staff (24.9%) than for white staff (20.7%). Although disparities between the experiences of BME and white staff persist, harassment, bullying and abuse from staff has followed a largely downward trend since 2018.
- A higher percentage of BME staff (15.5%) than white staff (6.7%) experienced discrimination from other staff – a pattern that has been evident since at least 2015.

The data helps us to understand the trends and patterns of inequality and highlights areas that require improvement. This also illustrates the progress that has been made by the Trust in reducing gaps and inequalities in the workplace. The WRES is an integral part of the NHS Long Term Plan and NHS Long Term Workforce Plan including the People Promise, with ambitions for NHS Trusts to set aspirational targets for BME representation across their leadership team and broader workforce. Progress on the WRES is considered as part of the 'well-led' domain in the Care Quality Commission's (CQC) inspection programme.

The WRES also complements the Workforce Disability Equality Standard (WDES) and both are vital to ensuring that the values of equality, diversity and inclusion lay at the heart of the NHS.

This report sets out key information about the experience of Black Minority Ethnic (BME) staff for the period April 2024 to March 2025 and includes a metrics data report for 2024/25, together with an action plan for 2025 - 2028.

Since starting the WRES in 2016, the Trust has been tracking the trends over time for each of the WRES metrics. For the first time in this report, the data trends are reviewed and analysed from 2020 onwards. Infographics relating to the data trends for each of the metrics are provided in Appendix 2.

Executive summary

The Trust employed 2,308 staff as of 31st March 2025, based on workforce data and feedback from the NHS Staff Survey (detailed in Appendix 1). A WRES action plan 2025/28 (Appendix 2) was developed in partnership with CODE (Celebrating our diversity every day) and the REACH (Race, Ethnicity and Cultural Heritage) Staff network. This will be progressed over the next 12 months to help reduce the barriers that impact the experience of our BME colleagues.

According to the national data, 77% of white people were employed, compared with 69% of people from all other ethnic groups combined. Nationally, in the NHS, around 1.3 million people are employed, 74.3% of the workforce are white and 25.7% are from other ethnic groups combined. In addition, NHS Workforce data indicates that 68.7% of professionally qualified clinical staff were white and 15.9% were Asian. Also, ethnic minority staff made up 15.0% of people in managerial level positions, and 11.3% of senior managerial level positions; Ethnic minority staff made up 49.9% of hospital and community health services (HCHS) doctors. Asian staff made up the highest percentage of HCHS doctors working in staff grade, speciality doctor, and associate specialist positions. (*NHS workforce, 'Ethnicity, facts, figures service' 2022, published April 2023.*)

The WRES metrics are evidence-based, and the Trust is committed to continuing to raise the representation of BME staff across all the organisations, including senior bands. Our local ESR data shows that out of 2,308 members of staff on 31st March 2025, 7.3% (169) of employed LCHS staff are from BME backgrounds, 91.90% white (2121), and 0.8% (18) not stated. Compared to 2024, 7.3% BME backgrounds, white 91.9%, not stated 0.8%.

LCHS WRES Metrics Dashboard 2024-25 Data

Index

- Positive increase ⬆️
- Neutral increase ⬆️
- Negative increase ⬆️
- Neutral ↔️
- Positive decrease ⬇️
- Neutral decrease ⬇️
- Negative decrease ⬇️

Table 1. Index: A difference of 0-5% is Amber, with more than 5% being Green or Red. For probability, a difference of 0 – 0.5 is Amber, with more than 0.5 is Green or Red.

* For 2025 results, indicators 1-4 and 9 are based on Electronic Staff Records (ESR) and local data as of 31 March 2025 for the year 2024-25. Indicators 5-8 are taken from the National Staff Survey (NSS) of 2024.

 ** For national benchmark data, indicators 1-4 and 9 are based on the National WRES Report for 2024 with ESR and local data as of 31 March 2024, indicators 5-8 are based on the NSS results of 2023.

*** For full LCHS data please see Appendix 1.

Metrics (Indicators)	2023 results	2024 results	2025 results	LCHS Progress March 2024-March 2025	National Benchmark (based on 2024 data) **	LCHS data compared with national benchmark
1. ESR % of black and minority ethnic (BME) staff.	5.4%	7.3%	7.3%	↔	28.6%	⬇
2. Relative likelihood of white staff being appointed from shortlisting across all posts.	2.05	2.4	4.8	⬆	1.62	⬆
3. Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	2.36	0.6	3.3	⬆	1.09	⬆
4. Relative likelihood of white staff accessing non-mandatory training and CPD.	1.1	1	0.95	↔	1.06	⬇
5. Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months.	24.6%	30.9%	32.9%	⬆	27.8%	⬆
6. Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months.	24.6%	20.3%	21.3%	⬆	24.9%	⬇
7. Percentage of BME staff believing that trust provides equal opportunities for career progression or promotion.	67.2%	61.3%	61.8%	⬆	48.8%	⬆

8. Percentage of BME staff who experienced discrimination from manager/team leader or other colleagues.	12.3%	13.1%	17.6%	🔼	15.5%	🔼
9. BME Percentage						
• of Board Representation	9.1%	0%	5.6%	🟢⬆	16.5%	🔻
• of non-exec Board	0%	0%	0%	🟡↔	21.2%	🔻
• of the exec Board	16.7%	0%	11.1%	🟢⬆	11.1%	🟡↔
• of the difference between the Board and overall workforce	+3.6%	-7.3%	-1.7%	🟢⬇	12.2%	🟢⬇

Workforce Race Equality Standard 2024-25 Headlines

Key areas of progress:

- Maintaining the highest % of BME staff employed by LCHS, from 2016 (3.5%), when reporting on ethnicity, to 7.3% in the last two years. The ongoing positive direction is confirmed by the data trends from 2020 with 4.4% being the highest increase in 2024, when LCHS joined the national international recruitment programme.

- Increase in the percentage of BME staff who believe that trust provides equal opportunities for career progression or promotion and maintaining this to be well above the national average - LCHS at 61.8% compared to national average of 46.7%.

- Maintaining the equal relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff, as the likelihood is 0.95, with 0.85 of white staff compared to 0.89 of BME staff accessing non–mandatory training and CPD. The data trends confirm that relative likelihood and the equal opportunities to access non-mandatory training are stable (around 0.93 – 1.21) in the last 6 years.

- Decreasing the gap between the BME Trust Board representation and the overall BME workforce.

- Celebrating Black History Month 2024 by delivering a series of webinars where our guest speakers were addressing a range of topics to raise awareness about history and issues faced by people from different backgrounds, including first face to face event.

- Celebrating Race Equality Week 2025 with various activities, including a webinar with the current CODE Chair as a keynote speaker about Microaggressions.

- Celebration of the National Staff Network Day 2024 by participating in online ELT Live. Staff Network leads had the opportunity to speak about their network activities across the group, encouraging staff to be involved with the Chief Executive.

Our key areas of focus:

- To continue to increase BME representation in LCHS, change into career progression by the Triple A Programme (Arising, Ascending and Advancing), developing diverse and inclusive leaders for the NHS.
- To increase completion of National Staff Survey (NSS) by our BME colleagues.
- To continue to promote the 'See Me First' programme.
- To continue to monitor the data for BME staff who are experiencing bullying, harassment and abuse from patients and managers, working with the Group REACH and CODE staff network with regards to the WRES action plan.
- Raise awareness about current opportunities for BME staff in achieving their full potential to maintain the increasing number of BME staff believing that the Trust provides equal opportunities in career progression.

Our commitments

Equality Diversity and Inclusion (EDI) Calendar

The Equality Diversity and Inclusion (EDI) Calendar 2024-2025 provides a selection of key religious and cultural dates, awareness and action days, and some events which reflect the diverse nature of our workforce and local populations. This calendar has been developed as a way to help us celebrate our diverse communities, cultures and faiths. It provides an opportunity to visibly embrace and embed equality, diversity and inclusion into our Trust for patients and colleagues alike, in practical and supportive ways.

This has been developed over the last few years so that Staff Networks and other staff groups can plan campaigns, meetings and events. From 2025, the EDI Calendar is now a Group Model sharing awareness events that are important for both Trusts.

These are some examples from the EDI Calendar:

South Asian Heritage 2024

South Asian Heritage month launched in the House of Commons in July 2019 to commemorate and celebrate South Asian History and culture and heritage to better understand the diverse heritage that continues to link the UK and South Asia. South Asia is made of eight countries: Afghanistan, Bangladesh, Bhutan, India, The Maldives, Nepal, Pakistan, and Sri Lanka.

South Asian Heritage Month Celebrations took place during July and August 2024 for the first time in LCHS, hosted on behalf of the Group. The Celebrating Our Diversity Everyday (CODE) staff network delivered two webinars including the history and cultural heritage of the countries, finished off with a tasting session to enable staff to experience some of the snacks and drinks enjoyed in South Asia. See Me First pledges were collected and badges were also given out.

Anti-Bullying and Harassment Week November 2024

Anti-Bullying Week 2024 was co-ordinated in England, Wales, and Northern Ireland by the Anti-Bullying Alliance. This year it had the theme 'Choose Respect' and took place from Monday 11th to Friday 15th November 2024.

The MAPLE Network and the Freedom to Speak Up Guardians delivered a webinar that focused on a conversation with the Freedom to Speak Up Guardians from LCHS and ULTH, who talked about their Speak Up Journeys.   We took a different approach this year to demonstrate the importance of the freedom to speak up role and shared contact details for all the Freedom to Speak Up Guardians for the Lincolnshire system. This also formed the opening of Disability History month celebrations and was the most attended event of the month.   This was a different approach to previous years. The session was recorded and is available to watch on the staff intranet.

Black History Month 2024

The event began in the USA in the 1920s and was first celebrated in the UK in 1987. It gives everyone the opportunity to share, celebrate and understand the impact of black heritage and culture. People from African and Caribbean backgrounds have been a fundamental part of British history for centuries. However, campaigners believe their contribution to society has often been overlooked or distorted.

Every year in the UK, October is Black History Month, and in 2024 the UK celebrated the themes of 'Reclaiming the Narrative'. ULHT hosted the month with a variety of webinars and a face-to-face day which were well attended for Lincolnshire System.

The conference took place on the 4th of October that was delivered with Macmillan support and focused on Health Inequalities with external and internal speakers from Macmillan, Cancer services, Palliative team, Dr Alice Mpofu-Coles, WO1 R Mukungunugwa, Library services, the Talent Academy, Systemwide Book Group and personal stories from all the system networks. This included a panel discussion with Trust Board, Michelle Bateman, Chief Nurse from Derby. Throughout the month there were online webinars, including one from the Heads of LCHG EDI Team on Allyship.

Race Equality Week 2025

Race Equality Week is celebrated every year (Monday 3rd February 2025 – Sunday 9th February 2025). The theme this year was Every Action Counts. The purpose is to emphasise the importance of taking collective and individual action to tackle the experience of race equality.

This year, LCHS organised a session on Wednesday 5th February 2025, with a session on 'Protected Characteristics, Understanding Macroaggressions and the Importance of being an Ally'. The session was collaborated between the CODE and MAPLE staff networks and was supported by the REACH staff network chairs and the Chief People Officer and was open to staff across the group. The session was powerful and emphasised the fact that all protected characteristics can experience macroaggressions. The initial resources section was recorded, and an unrecorded discussion was held afterwards in a safe space. It was acknowledged that the subject requires further work.

As a part of supporting Race Equality Week, LCHS and ULHT promoted the See Me First Scheme, initiated by Whittington Health NHS Trust, aiming to promote Equality, Diversity, and Inclusivity. LCHS has already pledged to the campaign and the See ME First badge, to show that it is an open, non-judgmental NHS organisation that treats all Black, Asian, and minority ethnic staff and patients, treating them with dignity and respect. LCHS staff make a pledge for the badge, which is supported by senior leaders, and it was also promoted during the CODE network, LCHS bulletin, Facebook, and background for MS Teams. LCHS put on a webinar for both ULHT and LCHS with a key speaker who is a clinician and the Vice-Chair for the CODE staff network - it was well attended.

See Me First

See Me First Campaign started in Whittington Health NHS Trust on 29th October 2020. The creators of this initiative are Beverleigh Senior, Paul Attwal and Delia Mills. LCHS joined in February 2022 and continue to raise awareness for staff to pledge to campaign.

"I promise to acknowledge and celebrate individuality in my interactions with colleagues. I will make an intentional effort to see past my unconscious bias and unlearn what created them in the first place. I promise to respect and accept others no matter their colour or creed. I promise to be teachable and value all that is within person. I pledge to SEE." (REACH Chair)

Cultural Intelligence

Cultural Intelligence (CQ®) goes beyond existing approaches of cultural sensitivity, unconscious bias, and cultural awareness. The programme sets out the skills, abilities, and capabilities that are vital for individuals and organisations in having successful and respectful work with the difference and diversity needed to improve a 'sense of belonging', including within the recruitment process and career progression.

LCHS is continuing to embed the Cultural Intelligence (CQ) programme across the organisation. This year, seven CQ sessions were delivered with a specific focus on international recruitment, aiming to train staff who are involved in or working with internationally recruited staff. Also, implementing the CQ programme was part of the WRES Action Plan to continue to build inclusivity across the Trust.

Freedom to Speak Up Guardian

Here at LCHS, we believe that speaking up about concerns is vital and we want our staff to feel supported at work. To ensure that their concerns are looked into and that staff have access to the support they need, the Trust continues to enhance the initiative and visibility of the FTSUG, and FTSUG champions are working in partnership with staff networks.

Flexible Working

To increase the visibility of the Trust's commitments to the understanding of challenges and experiences of staff with disabilities or long-term conditions, LCHS provides a flexible working policy. Our key purpose is to ensure that our employees have the appropriate support to retain and continue working at LCHS and manage work-life. Therefore, LCHS promote and support flexible

and hybrid working options for staff from the first day of their employment as both opportunities are designed to support our staff to balance their work and personal needs. LCHS also promotes flexible working on all job adverts.

Group Staff Awards 2024

The first joint staff awards as LCHS and ULHT coming together as a group were awarded in November 2024. It is an award, for recognising and celebrating our NHS stars across the Group. The awards are an opportunity for the people of Lincolnshire to recognise the hard work, dedication and care shown by community and hospital staff working across the county, and where they have demonstrated exceptional professionalism and care. There are 15 categories, including the Equality, Diversity and Inclusion Champion of the Year Award. Four staff were shortlisted, across clinical and non-clinical roles in this category. Sara Blackbourn, the Trust Lead Occupational Therapist at ULTH won the category, for initiating the Stronger Together Coaching Forums and welcome hampers to support the team which had several cohorts of internationally educated Allied Health Professionals (AHPs). Sara made herself available and offered to listen and support them in a safe space. The Highly Commended recognition was awarded to the LCHS CODE Staff Network chair for being instrumental in advocating for inclusive culture and diversity across the group and for celebrating South Asian Heritage month for the first time. Also, Trish Tsuro, ULTH Staff Network chair was shortlisted for the Chair's Award at the staff awards.

LCHS staff networks

The staff networks are in a period of transition following the Group model introduction and are at various stages of coming together. All of the staff networks provide an opportunity for staff to find support and share their voices and concerns to improve working practices across the group. The staff networks support the implementation of the Public Sector Equality Duty from the Equality Act (2010) WRES, WDES and EDS.

They support the organisation to prevent and eliminate discrimination, harassment, and victimisation, promoting equality and equal opportunities, as well as fostering good relations by challenging prejudice and promoting understanding between people who share a protected characteristic and those who do not.

Celebrating Our Diversity Everyday (CODE) Staff Network

The CODE Staff Network believes that for every individual to reach their full potential, there must be no fear of discrimination or prejudice and a belief that career opportunities or experience of work is not predetermined by ethnicity, nationality, or colour. The CODE Staff Network's aims are to:

- Encourage LCHS to maintain a safe and positive working environment for BAME staff and the elimination of racial discrimination for employees and patients.
- Support LCHS to develop and maintain a representative workforce with inclusive leadership and to raise the visibility and profile of the contribution that BAME staff members make.
- Maintain and expand the membership of the BAME staff network to provide a forum where BAME staff can share experience and issues affecting their work and professional development.
- Engage with other groups, including other internal and external staff networks, trade unions, employer associations and community groups who share a common agenda or experience of eliminating disadvantage, addressing unmet needs, or increasing participation.
- Offer support and encouragement to other underrepresented or marginalised staff networks and forums.
- Work in partnership with LCHS to ensure compliance with Equality and Human Rights legislation relating to race equality and to develop and implement national policies and strategy.
- Work in accordance with the Workforce Race Equality Standard (WRES) and develop and embed LCHS's WRES Action Plan.

'Celebrating Our Diversity Everyday (CODE) is a network where staff of BME background share experiences and concerns in a safe place. The network allows for like-minded individuals and their allies to discuss ideas and innovate to improve the workplace and culture within the trust to address the inequalities and challenges faced daily. (CODE's network Chair).

CODE highlights:

- The CODE staff network hosted their first South Asian Heritage Month celebrations across the Lincolnshire Community and Hospitals Group incorporating face to face events and webinars with a tasting session with some samples of snacks and tea from the various countries. The webinars included history of the eight countries and a session where a member of the network shared their cultural heritage.
- The CODE chair also collaborated with the MAPLE chair and recorded a presentation on understanding Microaggressions and protected characteristics and this was delivered as part of Race Equality Week.
- Stakeholder and supported ULTH with organising and hosting the Black History Month.
- Supporting international recruitment colleagues and being involved in induction training.
- Supporting REACH in Lincolnshire system family fun-day football for Africa Day.
- CODE Chair shortlisted for Staff Award 2024 in the Equality, Diversity and Inclusion Champion of the Year Award Category.
- The Highly Commended recognition was awarded to the LCHS CODE Staff Network chair for being instrumental in advocating for inclusive culture and diversity across the group and for celebrating South Asian Heritage month for the first time.
- High involvement in completing WRES Action Plan 2024/25.
- Working in partnership with REACH to create a Group Staff Network.

The network is a safe space to talk about any subjects like infection prevention, health and safety updates, health and wellbeing, anxiety, and stress. Also, to share any positive practices, mark equality and diversity celebrations and recognise staff achievements. The Trust Board has supported all staff networks.

Next Steps 2025 - 2026

The Group next steps are to develop a first Group WRES Action Plan and embed the below aims into actions, linked to the equality objectives and the LCHG Strategy with input from the CODE and REACH staff network and from staff across the Group. Appendix 3 contains the Group WRES action plan for 2025-2028.

Key WRES actions 2025 – 2028:

- Launch the Triple A Programme (Arising, Ascending and Advancing), to continue to increase BME representation across the LCHG - change into career progression by developing diverse and inclusive leaders for the NHS.
- Launch Reciprocal Mentoring Programme - overall BME workforce to have opportunity to mentor senior leaders - development opportunities for BME staff.
- Continuing to raise awareness about See Me First scheme across the Group.
- Raise awareness about apprenticeships and the Talent Academy and training among BME staff.
- Start to collect the ethnicity pay gap data to develop next year's Pay Gap Report.
- Continuing to enhance knowledge about reporting bullying and harassment and other supporting procedures for staff - webinar/events during anti-bullying week which will take place from 10th - Friday 14th November 2025. The theme is 'Make Power for good'.
- Implement the Reciprocal Mentoring Programme across the group, starting with the new Group Trust Board.
- Implement the United Against all forms of Discrimination toolkit across LCHS so that it becomes a Group approach.

WRES Actions linked with the LCHG Group Strategy 2025 - 2030:

Strategic Aim 2 – People:
- Better opportunities: Aiming to develop, empower and retain great people by:
  - Enable our people to fulfil their potential through training, development, research and education.

- o Empower our people to continuously improve and innovate
- o Nurture compassionate and diverse leadership.

Conclusion

We will continue to communicate with the CODE and REACH staff networks and the WRES activities to all staff across the group, so we can all be involved in celebrating our achievements. Having a productive inclusive workforce, where staff feel valued and heard is vital and crucial in providing high-quality personalised care for patients. We will continue to implement the LCHG values: compassionate, collaborative and innovative to ensure that staff feedback has been listened to and the WRES actions have been delivered and the sense of belonging has been embedded across the organisation.

Appendix 1

LCHS WRES Workforce Data 2024 – 2025

Appendix 2

LCHS WRES Data Trends 2020 - 2025

Appendix 3

WRES Action Plan 2025-2028

NHS
Lincolnshire Community and Hospitals NHS Group

Appendix 1 – LCHS Workforce Race Equality Standard Report 2024 -2025
Workforce Data Indicators 1 - 9

Caring and building a
healthier future for all

Contents

Indicator 1

Staff in post based on: primary assignments only, no bank staff, no Chair and Non-Executive Directors.

VSM = (Very Senior Manager including Chief Executive, Executive Directors)

* % is the rounded number of the overall LCHS workforce with race data taken from the NHS England Data Collection Framework portal.

** For national benchmark data, indicators 5-8 are based on the National Staff Survey results of 2023 which is the most recent data available for these categories.

Indicator 1

Indicator 1A Clinical workforce

Clinical	White		BME		Not Stated		TOTAL	
WRES Indicator 1	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage
Clinical	**1706**	**91.9%**	**136**	**7.3%**	**15**	**0.8%**	**1857**	**100.00%**
Band 2	85	96.59%	3	3.41%	0	0.00%	88	100.0%
Band 3	378	95.45%	17	4.29%	1	0.25%	396	100.0%
Band 4	100	97.09%	2	1.94%	1	0.97%	103	100.0%
Band 5	338	81.45%	72	17.35%	5	1.20%	415	100.0%
Band 6	377	93.55%	21	5.21%	5	1.24%	403	100.0%
Band 7	319	95.22%	15	4.48%	1	0.30%	335	100.0%
Band 8a	82	94.25%	3	3.45%	2	2.30%	87	100.0%
Band 8b	22	100.00%	0	0.00%	0	0.00%	22	100.0%
Band 8c	3	75.00%	1	25.00%	0	0.00%	4	100.0%
Band 8d	0	0.00%	0	0.00%	0	0.00%	0	100.0%
Band 9	1	50.00%	1	50.00%	0	0.00%	2	100.0%

Very Senior Manager	1	50.00%	1	50.00%	0	0.00%	2	100.0%
Med & Dental Consultants	13	50.00%	13	50.00%	0	0.00%	26	100.00%
Med & Dental Non-Consultants	2	40.00%	2	40.00%	0	0.00%	1	100.0%
Trainee Grade	0	0.00%	1	100.00%	0	0.00%	0	100.0%

Indicator 1B Non-clinical workforce

Non-Clinical	White		BME		Not Stated		TOTAL	
WRES Indicator 1	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage
Non-Clinical	**400**	**4.1%**	**17**	**95.5%**	**2**	**0.5%**	**419**	**100.0%**
Band 1	1	100.0%	0	0.0%	0	0.0%	1	100.0%
Band 2	76	96.2%	3	3.8%	0	0.0%	79	100.0%
Band 3	119	96.0%	5	4.0%	0	0.0%	124	100.0%
Band 4	57	95.0%	3	5.0%	0	0.0%	60	100.0%
Band 5	46	97.9%	1	2.1%	0	0.0%	47	100.0%
Band 6	26	92.9%	1	3.6%	1	3.6%	28	100.0%
Band 7	29	93.5%	2	6.5%	0	0.0%	31	100.0%
Band 8a	16	88.9%	2	11.1%	0	0.0%	18	100.0%
Band 8b	11	100.0%	0	0.0%	0	0.0%	11	100.0%
Band 8c	4	100.0%	0	0.0%	0	0.0%	4	100.0%

Band 8d	3	100.0%	0	0.0%	0	0.0%	3	100.0%
Band 9	4	100.0%	0	0.0%	0	0.0%	4	100.0%
Senior Medical Manager	8	88.9%	0	0.0%	1	11.1%	9	100.00%
Grand Total	**1706**	**91.9%**	**136**	**7.3%**	**15**	**0.8%**	**1857**	**100.00%**

Indicator 2

Relative likelihood of white staff being appointed from shortlisting across all posts, compared to BME staff (Note: this refers to both external and internal posts).

Applicant Status	White	BME	Unknown
Shortlisted	1081	321	16
Appointed	311	19	5
Likelihood	0.28	0.05	0.31

Answer: Relative likelihood of white staff being shortlisted compared to BME staff: 4.8

Indicator 3

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.

	White	BME	Unknown
Number of staff in WF	2121	169	18
No staff entering	15	4	0
Formal disciplinary	0.00	0.02	0.00

Answer: Relative likelihood of BME staff entering formal disciplinary compared to white staff: 3.34

Indicator 4

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff.

	White	BME	Unknown
Number of staff in WF	2121	169	18
No staff accessing NM	1807	151	15
Likelihood of accessing	0.85	0.89	0.83

Answer: Relative likelihood of white staff accessing compared to BME staff: 0.95.

Indicator 5

% of staff who experienced at least one incident of bullying, harassment or abuse in the last 12 months from:

- Patients/service users, their relatives or other members of the public.

Staff	Percentage
White	20.4%
BME	32.9%
BME national benchmark**	27.8%
White responses	1142
BME responses	76

Answer: For BME staff a negative increase of 2.3% in 2024.

Indicator 6

% of staff who experienced at least one incident of bullying, harassment or abuse in the last 12 months from:

- staff

Staff	Percentage
White	18.3%
BME	21.3%
BME national benchmark**	24.9%
White responses	1141
BME responses	75

Answer: For BME staff a negative increase of 1.0%.

Indicator 7

% believing that trust provides equal opportunities for career progression or promotion.

Staff	Percentage
White	63.6%
BME	61.8%
BME national benchmark**	48.8%
White responses	1139
BME responses	76

Answer: For BME staff a positive increase of 0.5%.

Indicator 8

% of staff who experienced discrimination at work from any of the following:

- From manager/team leader or other colleagues

Staff	Percentage
White	5.3%
BME	17.6%
BME National Benchmark**	15.5%
White responses	1134
BME responses	74

Answer: For BME staff a negative increase of 4.5%.

Indicator 9

	BME	Percentage	White	Percentage	Not Declared	Percentage	Total Headcount
Total Board members	1	5.56%	13	72.22%	4	22.22%	18
of which: Voting Board members	1	9.09%	7	63.64%	3	27.27%	11
Non-Voting Board members	0	0.00%	6	85.71%	1	14.29%	7
of which: Exec Board members	1	11.11%	7	77.78%	1	11.11%	9
Non-Executive Board	0	0.00%	6	66.67%	3	33.33%	9
Overall Workforce - by Ethnicity		7.32%		91.90%		0.78%	
Difference (Total Board – Overall workforce)		-2%		-20%		21%	
Difference (Voting membership - Overall Workforce)		2%		-28%		26%	
Difference (Executive membership - Overall Workforce)		4%		-14%		10%	

7.3% of the Trust Workforce is BME, 5.56% of the Board is BME.

Answer: Therefore, 5.56% - 7.32% = - 2 % (rounded up).

** For national benchmark data, indicators 5-8 are based on the National Staff Survey results of 2023.

Appendix 2 – LCHS WRES data trends 2020 - 2025

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Contents

Indicator 1

Percentage of BME staff in each of the AfC Bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce.

	2020	2021	2022	2023	2024	2025
	4.40%	5.10%	6.00%	5.40%	7.30%	7.32%

Indicator Selected	1 ▼
Indicator Definition	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.
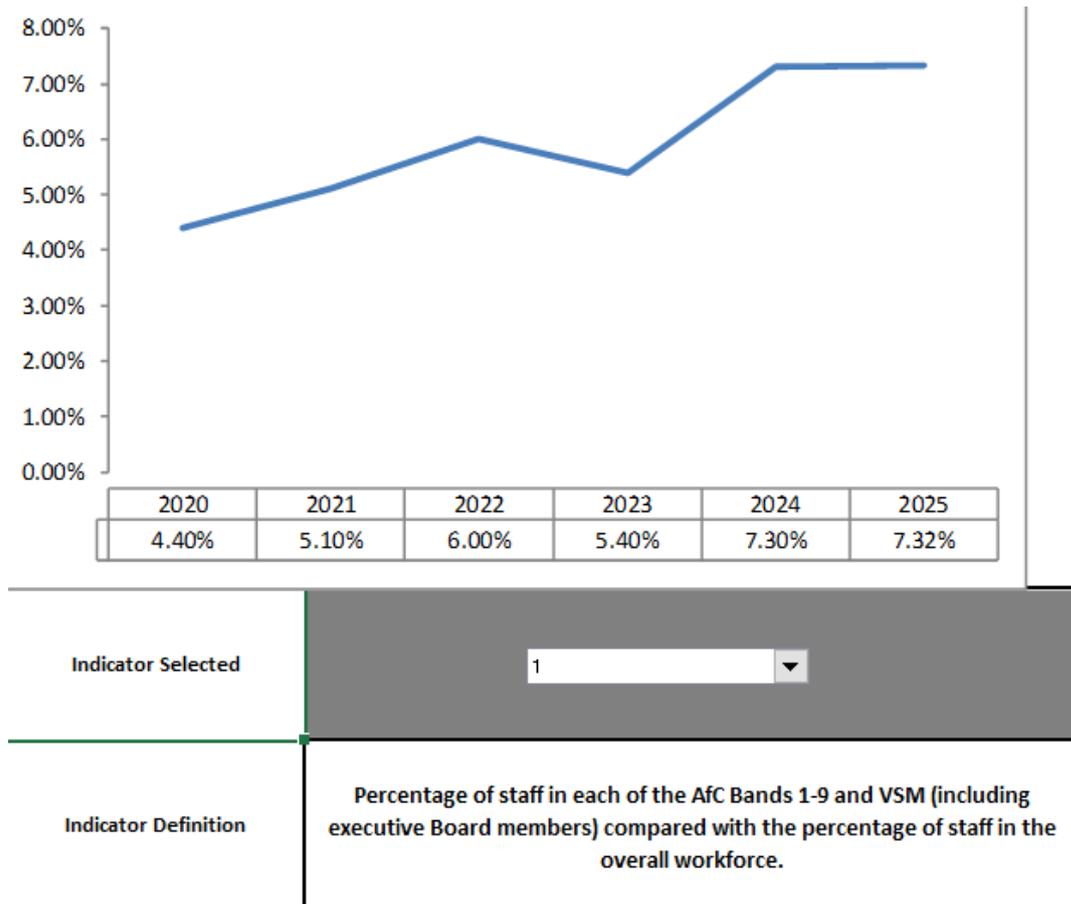
- Overall, a positive increase was observed during the six-year period of 2020 - 2025, from 4.40% to 7.32%. With the highest increase between 2023 and 2024, 5.40% to 7.30%.
- In 2024 and 2025, the percentage remains consistent at 7.30% and 7.32%.

Indicator 2

Relative likelihood of white staff being appointed from shortlisting across all posts, compared to BME staff.

	2020	2021	2022	2023	2024	2025
	1.76	1.58	2.5	2.05	2.4	4.8

Indicator Selected	2 ▼
Indicator Definition	Relative likelihood of staff being appointed from shortlisting across all posts
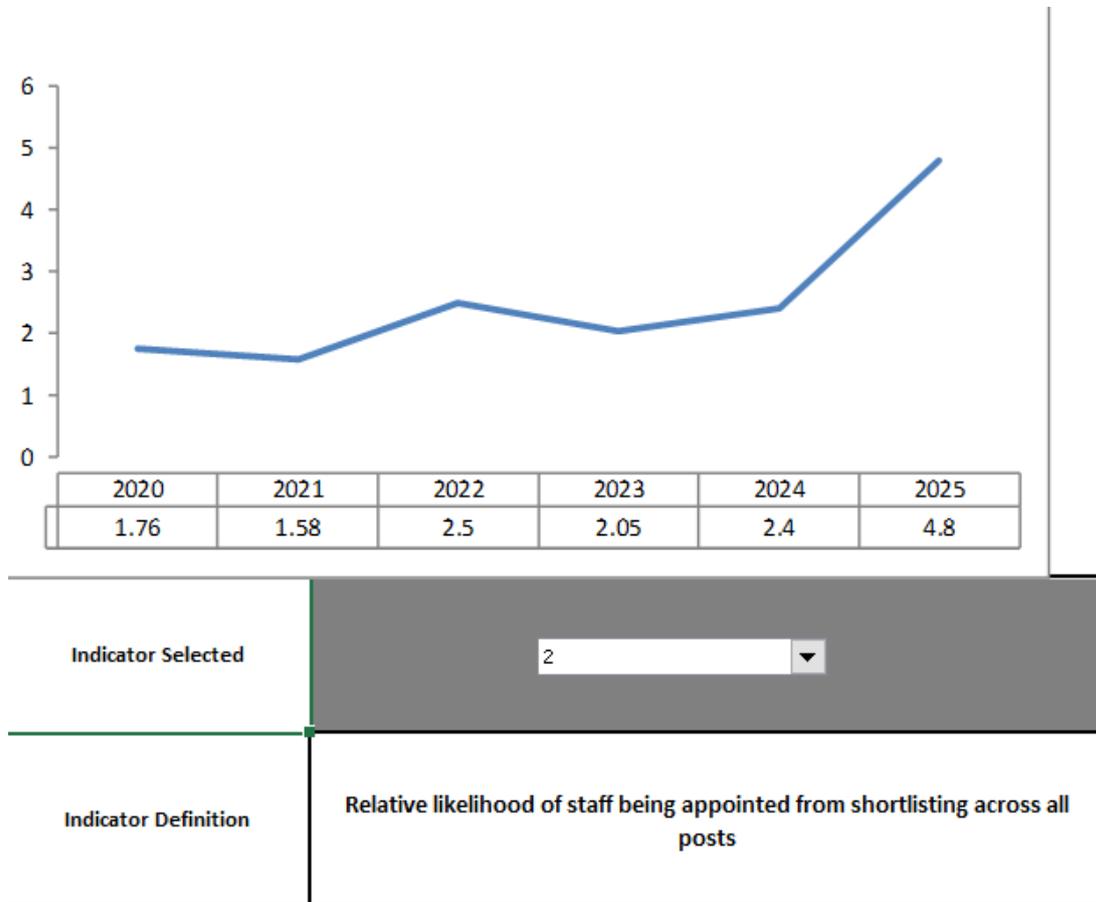
- The relative likelihood of white staff compared to BME staff being appointed from shortlisting across all posts, stayed higher than 1 in the last six years, with 1 representing equal likelihood.
- The chart demonstrates that there has been an increase in the relative probability of white staff being appointed from shortlisting for all posts over the six-year period, except for 2023.
- In 2021, the lowest peak and the closest to equal likelihood was observed at 1.58, while the highest negative peak was recorded in 2025 at 4.8.

Indicator 3

Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

	2020	2021	2022	2023	2024	2025
	0	0	1	2.36	0.60	3.34

Indicator Selected	3 ▼
Indicator Definition	**Relative likelihood of staff entereing the formal disciplinary process, as measured by entry into a formal disiplinary investigation.**
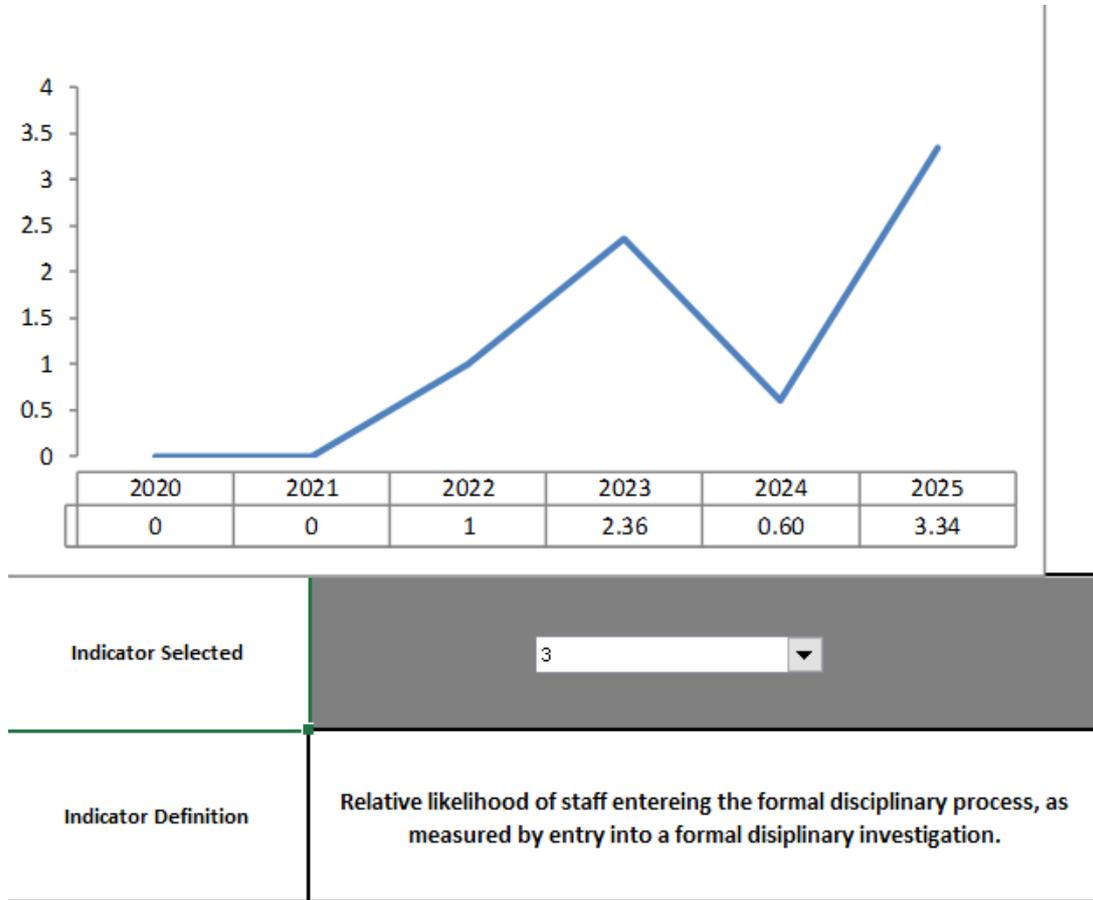
- The formal disciplinary process is more likely to be entered by BME staff than white staff, with the highest rate this year being 3.34 compared to previous years.
- Since 2022, the ethnicity has been recorded, indicating an increase in staff entering the disciplinary procedures, with year 2024 being the closest to the equal likelihood, 1.
- The protected characteristic data was not documented from 2020-2021.

Indicator 4

Relative likelihood of white staff accessing non-mandatory training and CPD, compared to BME staff.

	2020	2021	2022	2023	2024	2025
	0.93	1.07	1.21	1.1	1	0.95

Indicator Selected	4 ▼
Indicator Definition	Relative likelihood of staff accessing non-mandatory training and CPD
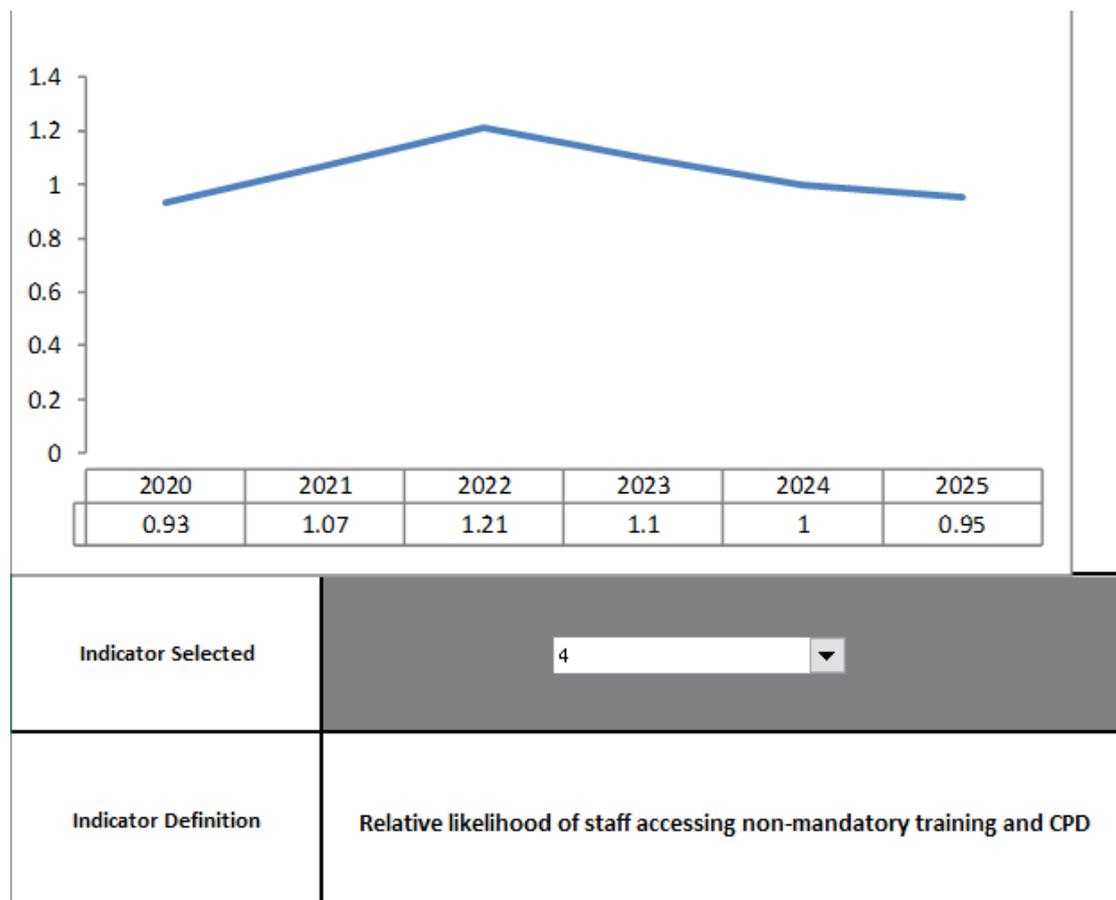
- The relative likelihood of BME staff compared to white staff accessing non-mandatory training and CPD, is close to 1 in the last six years, from, 0.93 to 1.21 in 2021, with 1 representing equal likelihood.
- The chart shows LCHS is maintaining equal likelihood of staff accessing non-mandatory training and CPD.

Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

	2020	2021	2022	2023	2024	2025
White	25.44%	25.45%	20.07%	18.97%	19.39%	20.40%
BME	27.50%	31.25%	32.00%	24.62%	30.55%	32.89%

Indicator Selected	5 ▼
Indicator Definition	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
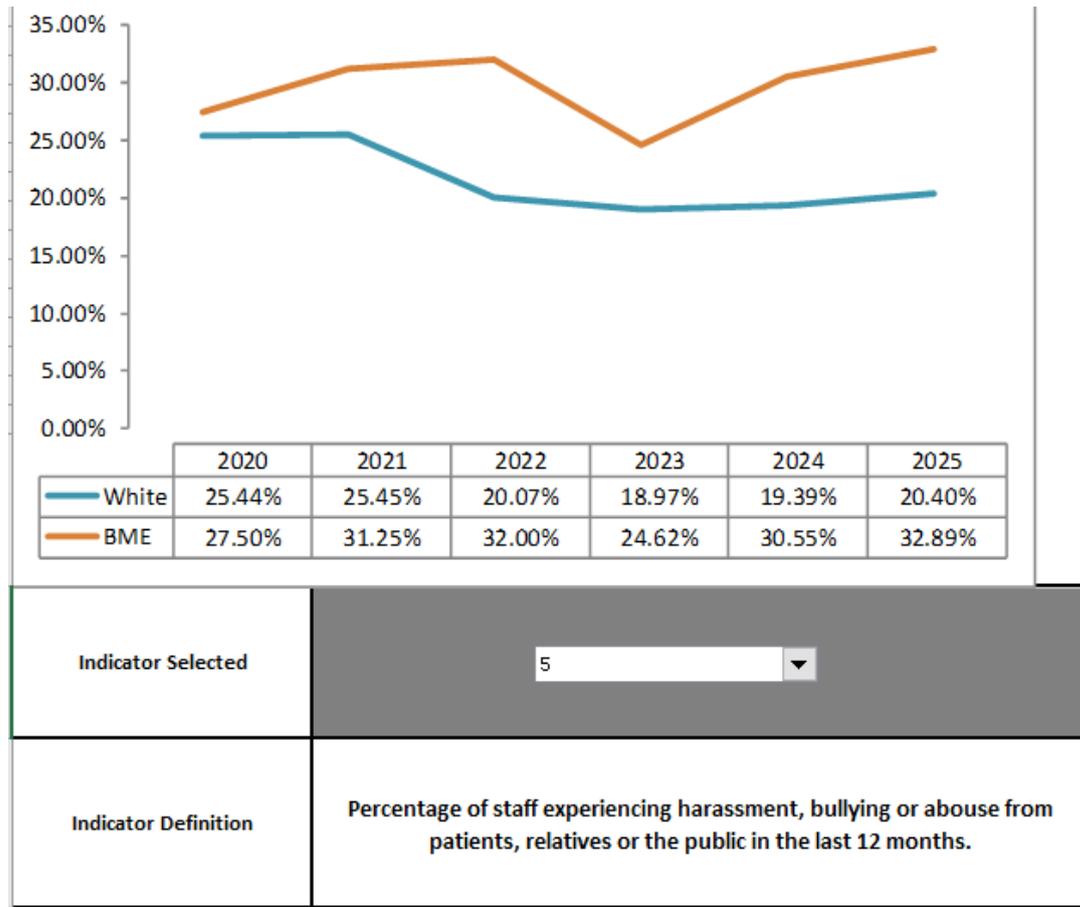
- During the six years, the results have been inconsistent, with 2022 and 2025 being the highest peak with 32.0% and 32.89% respectively for BME staff, with 2023 being the lowest for BME staff at 24.62%.
- The chart indicates a negative rise for BME staff in the last three years, from 24.62% in 2023 to 32.89% in 2025.

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

	2020	2021	2022	2023	2024	2025
White	20.05%	19.41%	18.30%	15.88%	17.54%	18.32%
BME	20.00%	27.66%	29.41%	24.62%	20.30%	21.33%
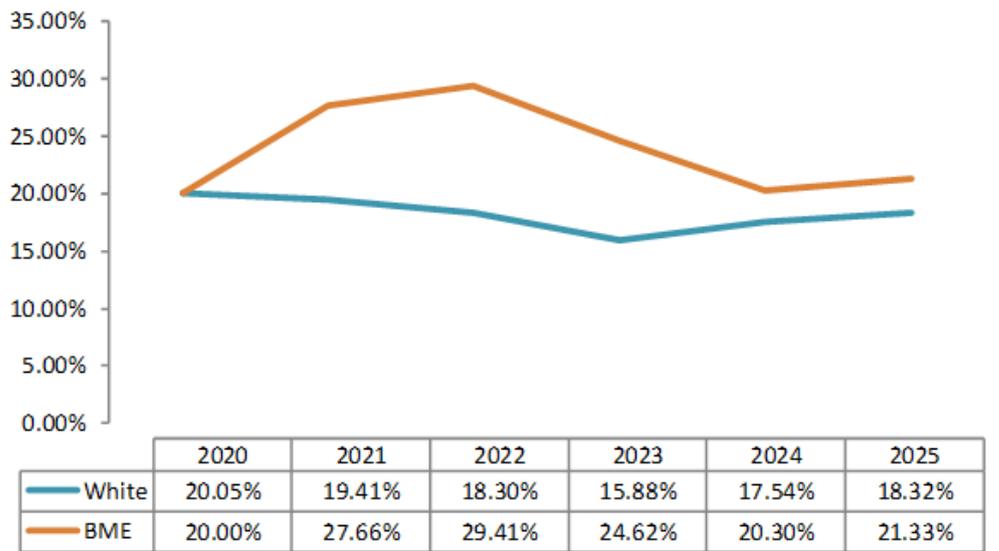
Indicator Selected	6 ▼
Indicator Definition	Percentage of staff experiencing harassment, bullying or abouse from staff in the last 12 months.

- The chart demonstrates a slight increase since last year, from 20.30% to 21.33% for BME staff. However, overall the percentage has declined from 29.41% in 2022, which marked the highest rate in the past six years.

Indicator 7

Percentage believing that the Trust provides equal opportunities for career progression or promotion.

	2022	2023	2024	2025
White	86.65%	68.55%	68.56%	63.56%
BME	55.77%	67.19%	61.29%	61.84%

Indicator Selected	7 ▼
Indicator Definition	Percentage believing that the Trust provides equal opportunities for career progression or promotion
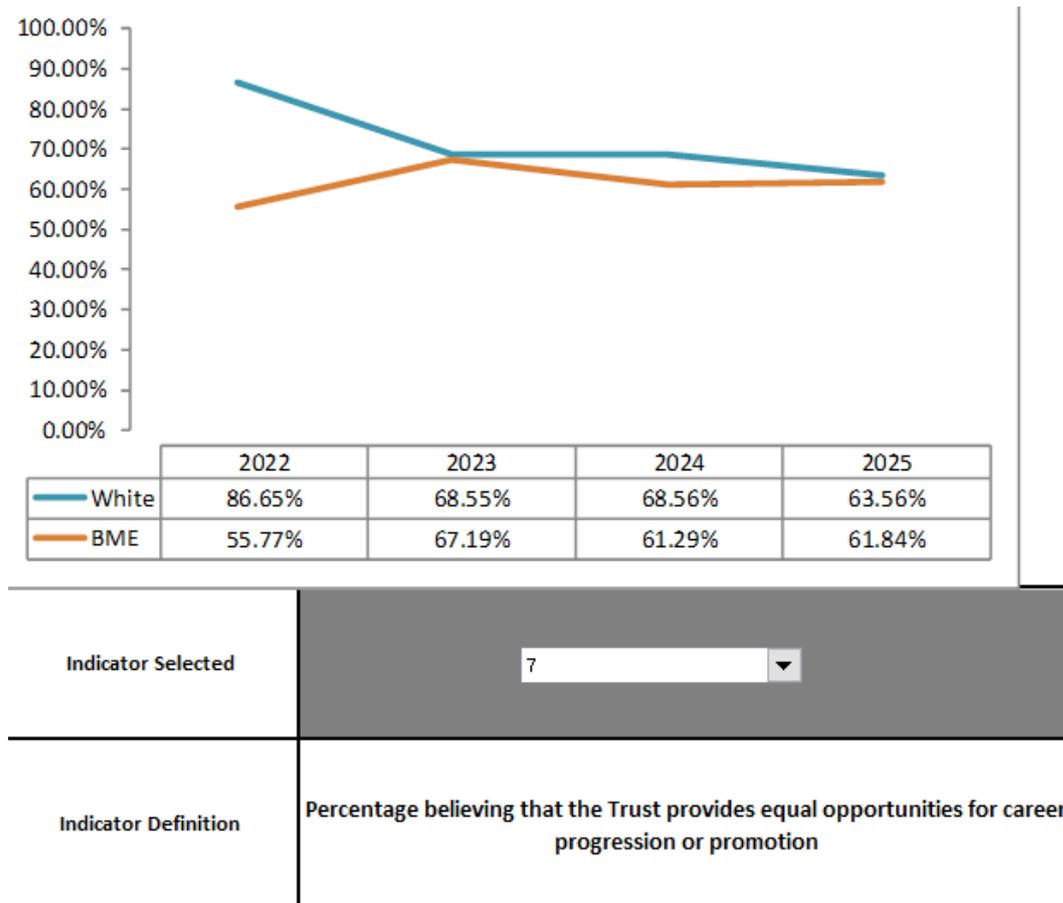
- The chart shows that the percentage of BME staff believing that the Trust provides equal opportunities for career progression or promotion remains above 55.77%, the lowest rate during the four-year period.

- With the highest percentage of 67.19% in 2023 and with 61.29% and 61.84% in 2024 and 2025, respectively, which shows this percentage has remained consistent.

Indicator 8

Percentage of staff personally experiencing discrimination at work from manager/team leader or other colleagues.

	2020	2021	2022	2023	2024	2025
White	4.09%	5.16%	6.24%	5.08%	5.89%	5.29%
BME	7.50%	16.33%	21.15%	12.31%	13.11%	17.57%

Indicator Selected	8 ▼
Indicator Definition	Percentage of staff personally experiencing discrimination at work from Manager/team leader or other colleagues
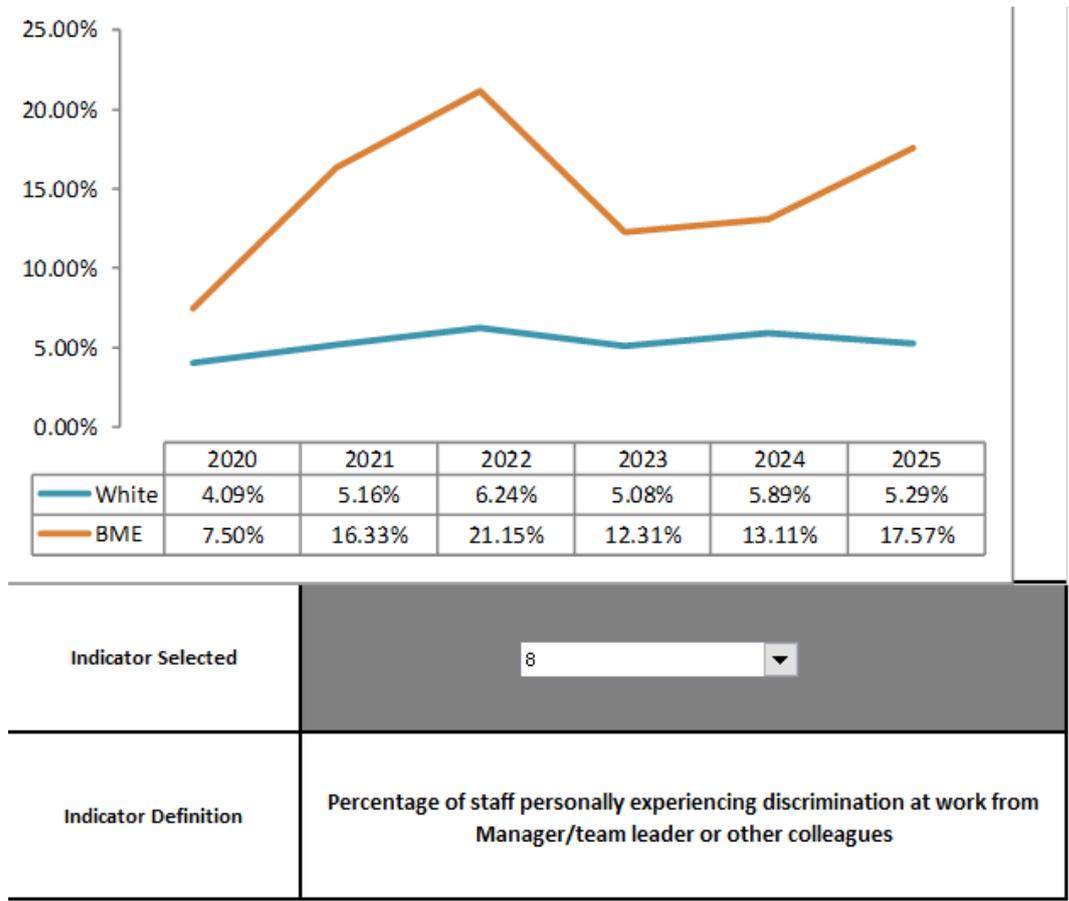
- Across the last six years, there have been a variety of outcomes for BME (although this has remained largely consistent for white staff), with the highest peak being in 2022 at 21.15% and the lowest being in 2020 at 7.50%.

- The highest positive decline occurred between 2022 and 2023, decreasing from 21.15% to 12.31%, followed by a negative increase in the last three years, reaching 17.57% in 2025.

Indicator 9

Trust Board Representation Indicator.

2020	2021	2022	2023	2024	2025
All Board members identify as white	All Board members identify as white	All Board members identify as white	One Board member identified as BME	All Board members identify as white	One Board member identified as BME

Indicator Selected	9 ▼
Indicator Definition	**Trust Board Representation Indicator**

- In the last year, there has been a rise in the number of BME Trust Board representation, from none to 5.6%, in 2025.
- Also, in 2023, 9.1% of the Trust Board representation identified as BME.

ULTH Workforce Race Equality Standard Annual Report 2024-2025

Caring and building a
healthier future for all

Authors: EDI Team

Date: June 2025

Authors: EDI Team

Contents

Introduction

Welcome to the United Lincolnshire Teaching Hospital (ULTH) Workforce Race Equality Standard (WRES) 2024-2025 report. This report contains reflections of the last year's actions for the Workforce Race Equality Standard (WRES).

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract. To fulfil the Trust's commitments towards staff ULTH complies with the Public Sector Equality Duty, as part of the Equality Act 2010, and the NHS People Promise within the NHS Long Term Workforce Plan. The Trust aspires to create an inclusive culture by embedding a sense of belonging across the organisation.

In the Gov.UK report on Ethnicity Facts and Figures published 13th April 2023, as of June 2022, over 1.3 million people were employed by the NHS:

- Out of NHS staff whose ethnicity was known, 74.3% were white and 25.7% were from ethnic minority groups (not including white minority groups) 68.7% of professionally qualified clinical staff were white and 15.9% were Asian.
- Ethnic minority staff made up 15.0% of people in managerial level positions, and 11.3% of senior managerial level positions.
- Ethnic minority staff made up 49.9% of hospital and community health services (HCHS) doctors.
- Asian staff made up the highest percentage of hospital and community health services (HCHS) doctors working in staff grade, specialty doctor and associate specialist positions.

NHS workforce - GOV.UK Ethnicity facts and figures

Methodology

The national 2024 WRES data report, reflects the state and complexity of race equality in the NHS. It shows significant progress in the number of Very Senior Managers (VSMs) from an ethnic minority, but a fall in the number of executives on trust boards.

There has been a reduction in the number of BME staff experiencing harassment from the public, but an increase in the number experiencing discrimination from a manager at work, which is reflective in the ULTH data.

Nationally, the next steps on the journey of the WRES are to move the NHS on to the stage of advancing race equality by using detailed demographic analysis at organisational level, to encourage local, regional, and national operations to implement bespoke improvement measures. System-wide learning is a key ambition for future implementation of the WRES. Regional data shows striking examples of what can be achieved when there has been a focus on targets.

WRES National Key Findings:

- Since 2018 the number of BME staff has increased by over 100,000 (with BME representation increasing from 19.1% to 28.6%). An increase in internationally educated nurses (IENs) and international medical graduates (IMGs) is likely to be a significant contributor to this.
- In March 2024, 28.6% of the workforce across NHS trusts came from a BME background (434,077 people). This is an increase of 53,969 (14%) on the previous year.
- The total number of BME staff at very senior manager (VSM) level has increased by 85% since 2018 from 201 to 372 and it is at its highest since the inception of WRES.
- BME board membership has reached its highest level of 16.5% since the WRES was established. However, BME board membership growth has not kept up with the rise in BME staff across the NHS workforce (28.6%).
- At 80% of trusts, white applicants were significantly more likely than BME applicants to be appointed from shortlisting, higher than the 76% last year.

- A lower percentage of BME staff (48.8%) than white staff (59.4%) felt that their trust provides equal opportunities for career progression or promotion.
- With disaggregation, just 42.3% of staff from a black background believed their trust provides equal opportunities for career progression or promotion, with levels below those of other ethnic groups since at least 2015.
- For the second year in a row, White Gypsy or Irish Traveller women (34.1%) and men (42.6%) experienced the highest levels of harassment, bullying or abuse from other staff.
- The percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months was higher for BME staff (24.9%) than for white staff (20.7%). Although disparities between the experiences of BME and white staff persist, harassment, bullying and abuse from staff has followed a largely downward trend since 2018.
- A higher percentage of BME staff (15.5%) than white staff (6.7%) experienced discrimination from other staff – a pattern that has been evident since at least 2015.

The data helps us to understand the trends and patterns of inequality and highlights areas that require improvement. This also illustrates the progress that has been made by the Trust in reducing gaps and inequalities in the workplace. The WRES is an integral part of the NHS Long Term Plan and NHS Long Term Workforce Plan including the People Promise, with ambitions for NHS Trusts to set aspirational targets for BME representation across their leadership team and broader workforce. Progress on the WRES is considered as part of the 'well-led' domain in the Care Quality Commission's (CQC) inspection programme.

The WRES also complements the Workforce Disability Equality Standard (WDES) and both are vital to ensuring that the values of equality, diversity and inclusion lay at the heart of the NHS.

This report sets out key information about the experience of Black Minority Ethnic (BME) staff for the period April 2024 to March 2025 and includes a metrics data report for 2024/25, together with an action plan for 2025 - 2028.

Since starting the WRES in 2016, the Trust has been tracking the trends over time for each of the WRES metrics. In this report, the data trends are reviewed and analysed from 2019 onwards. Infographics relating to the data trends for each of the metrics are provided in Appendix 2.

Executive summary

The Trust employed 10,372 staff, as of 31*st* March 2025, based on workforce data and feedback from the NHS Staff Survey (detailed in Appendix 1). A WRES action plan 2025/28 (Appendix 3) was developed in partnership with CODE (Celebrating our diversity everyday) and REACH (Race, Ethnicity and Cultural Heritage) Staff network. This will be progressed over the next 12 months to help reduce the barriers that impact the experience of our BME colleagues.

According to the national data, 77% of white people were employed, compared with 69% of people from all other ethnic groups combined. Nationally, in the NHS, around 1.3 million people are employed, 74.3% of the workforce are white and 25.7% are from other ethnic groups combined. In addition, NHS Workforce data indicates 68.7% of professionally qualified clinical staff were white and 15.9% were Asian. Also, ethnic minority staff made up 15.0% of people in managerial level positions, and 11.3% of senior managerial level positions; Ethnic minority staff made up 49.9% of hospital and community health services (HCHS) doctors. Asian staff made up the highest percentage of HCHS doctors working in staff grade, specialty doctor, and associate specialist positions. (*NHS workforce, 'Ethnicity, facts, figures service' 2022, published April 2023).*

The WRES metrics are evidence-based, and the Trust is committed to continuing to raise the representation of BME staff across all the organisations including senior bands. Our local ESR data shows that out of 10,372 members of staff on 31*st* March 2025, 27.5% (2848) of employed ULTH staff are from BME backgrounds, 71.20% white, 1.3% not stated. Compared to 2024, 24.6% BME backgrounds, white 73.8%, not stated 1.6%.

ULTH WRES Metrics Dashboard 2024-25 Data

Index

- Positive increase
- Neutral increase
- Negative increase
- Neutral
- Positive decrease
- Neutral decrease
- Negative decrease

Table 1. Index: A difference of 0-5% is Amber, with more than 5% being Green or Red. For probability a difference of 0 – 0.5 is Amber, with more than 0.5 is Green or Red.

* For 2025 results, indicators 1-4 and 9 are based on Electronic Staff Records (ESR) and local data as of 31 March 2025 for the year 2024-25. Indicators 5-8 are taken from the National Staff Survey (NSS) of 2024.

** For national benchmark data, indicators 1-4 and 9 are based on the National WRES Report for 2024 with ESR and local data as of 31 March 2024, indicators 5-8 are based on the NSS results of 2023.

*** For full ULHT data please see Appendix 1.

Metrics (Indicators)	2023 results	2024 results	2025 results	ULTH Progress March 2024-March 2025	National Benchmark (based on 2024 data) **	ULTH data compared with national benchmark
1. ESR % of black and minority ethnic (BME) staff.	20.6%	24.6%	27.5%	⬆	28.6%	⬇
2. Relative likelihood of white staff being appointed from shortlisting across all posts.	1.60	1.64	1.72	⬆	1.62	↔
3. Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	0.82	1.00	0.48	⬇	1.09	⬇ (green)
4. Relative likelihood of white staff accessing non-mandatory training and CPD.	0.84	0.74	0.98	↔	1.06	⬇
5. Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months.	27.4%	21.7%	24.5%	⬆	27.8%	⬇
6. Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months.	31.8%	23.1%	24.3%	⬆	24.9%	⬇
7. Percentage of BME staff believing that trust provides equal opportunities for career progression or promotion.	47.4%	51.6%	52.8%	⬆	48.8%	⬆

8. Percentage of BME staff who experienced discrimination from manager/team leader or other colleagues.	18.6%	17.2%	18.40%	⬆️	15.5%	⬇️
9. BME Percentage						
• of Board Representation	0%	6.7%	5.6%	⬇️	16.5%	⬇️
• of non-exec Board	0%	0%	0%	↔️	21.2%	⬇️
• of the exec Board	0%	14.3%	11.1%	⬇️	11.1%	↔️
• of the difference between the Board and overall workforce	-20.6%	-17.9%	-21.9%	⬇️	12.2%	⬇️

Workforce Race Equality Standard 2024-25 Headlines

Key areas of progress:

- Increasing % of BME staff employed by ULTH, from 26.4% when to 27.5% in the last year. The ongoing positive direction is confirmed by the data trends from 2016 with 10.9% with the highest increase between 2021 and 2025, with an average increase of 3% per year.

- Increase in the % of BME staff who believe that the trust provides equal opportunities for career progression or promotion and maintaining this to be well above the national average - ULTH at 52.8%, national average at 46.7%.

- Decreasing the likelihood of BME staff entering the disciplinary process.

- Increasing the equal relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff, as the likelihood is 0.98, with 0.52 of white staff compared to 0.53 of BME staff accessing non–mandatory training and CPD. The data trends demonstrate a positive increase of equal likelihood of BME staff attending non-mandatory training through the years as in 2016 the likelihood was 1.73

- Celebrating Black History Month 2024 by delivering a series of webinars where our guest speakers were addressing a range of topics to raise awareness about history and issues faced by people from different backgrounds, including the first face to face event.

- Celebrating Race Equality Week 2025 with various activities including a webinar with the current CODE Chair as a keynote speaker about Microaggressions.

- Celebration of the National Staff Network Day 2024 by participating in online ELT Live. Staff Network leads had the opportunity to speak about their network activities across group encouraging staff to be involved with the Chief Executive.

Our key areas of focus:

On the 1st April 2024, ULTH and LCHS entered into a Group model. A decision was taken to produce a Group WRES Action Plan with key areas of focus:

- To continue to increase BME representation across leadership roles across the LCHG by implementing the Triple A programme (Arising, Ascending and Advancing), developing diverse and inclusive leaders for NHS.

- To increase completion of National Staff Survey (NSS) by our BME colleagues.

- To continue to promote the 'See Me First' programme.

- To continue to monitor the data for BME staff who are experiencing bullying, harassment and abuse from patients and managers, working with the Group REACH and CODE staff network with regards to the WRES action plan.

- Raise awareness about current opportunities for BME staff in achieving their full potential to maintain the increasing number of BME staff believing that Trust provides equal opportunities in a career progression.

Our Commitments

Equality Diversity and Inclusion (EDI) Calendar

The Equality Diversity and Inclusion (EDI) Calendar 2024-2025 provides a selection of key religious and cultural dates, awareness and action days, and some events which reflect the diverse nature of our workforce and local populations. This calendar has been developed as a way to help us celebrate our diverse communities, cultures and faiths. It provides an opportunity to visibly embrace and embed equality, diversity and inclusion into our Trust for patients and colleagues alike, in practical and supportive ways.

This has been developed over the last few years so that Staff Networks and other staff groups can plan campaigns, meetings and events. From 2025, the EDI Calendar is now a Group Model sharing awareness events that are important for both Trusts.

These are some examples from the EDI Calendar:

South Asian Heritage Month

South Asian Heritage month launched in the House of Commons in July 2019 and to commemorate and celebrate South Asian History and culture and heritage to better understand the diverse heritage that continues to link the UK and South Asia. South Asia is made of eight countries: Afghanistan, Bangladesh, Bhutan, India, The Maldives, Nepal, Pakistan, and Sri Lanka.

South Asian Heritage Month Celebrations took place during July and August 2024 for the first time in LCHS hosted on behalf of the Group. The Celebrating Our Diversity Everyday (CODE) staff network delivered two webinars including the history and cultural heritage of the countries, finished off with a tasting session to enable staff to experience some of the snacks and drinks enjoyed in South Asia. See Me First pledges were collected and badges were also given out.

Black History Month 2024

The event began in the USA in the 1920s and was first celebrated in the UK in 1987. It gives everyone the opportunity to share, celebrate and understand the impact of black heritage and culture. People from African and Caribbean backgrounds have been a fundamental part of British history for centuries. However, campaigners believe their contribution to society has often been overlooked or distorted.

Every year in the UK, October is Black History Month, and in 2024 the UK celebrated the themes of 'Reclaiming the Narrative'. ULHT hosted the month with a variety of webinars and a face-to-face day which were well attended for Lincolnshire System.

The conference took place on the 4th of October that was delivered with Macmillan support and focused on Health Inequalities with external and internal speakers from Macmillan, Cancer services, Palliative team, Dr Alice Mpofu-Coles, WO1 R Mukungunugwa, Library services, the Talent Academy, Systemwide Book Group and personal stories from all the system networks. This included a panel discussion with Trust Board, Michelle Bateman, Chief Nurse from Derby. Throughout the month there was online webinars including one from Heads of LCHG EDI Team on Allyship.

Anti-Bullying and Harassment Week November 2024

Anti-Bullying Week 2024 was co-ordinated in England, Wales, and Northern Ireland by the Anti-Bullying Alliance. This year it had the theme 'Choose Respect' and took place from Monday 11th to Friday 15th November 2024.

The MAPLE Network and the Freedom to Speak Up Guardians delivered a webinar that focused on a conversation with the Freedom to Speak Up Guardians from LCHS and ULTH, who talked about their Speak Up Journeys.   We took a different approach this year to demonstrate the importance of the freedom to speak up role and shared contact details for all the Freedom to Speak Up Guardians for the Lincolnshire system. This also formed the opening of Disability History month celebrations and was the most attended event of the month.   This was a different approach to previous years. The session was recorded and is available to watch on the staff intranet.

Race Equality Week 2025

Race Equality Week is celebrated every year (Monday 3rd February 2025 – Sunday 9th February 2025). The theme this year was Every Action Counts. The purpose is to emphasise the importance of taking collective and individual action to tackle experience of race equality.

This year ULHT has attended LCHS session on Wednesday 5th February 2025, with a session on 'Protected Characteristics, Understanding Macroaggressions and the Importance of being an Ally'. The session was collaborated between the CODE and MAPLE staff network and was supported by the REACH staff network chairs and the Chief People Officer and was open to staff across the group. The session was powerful and emphasised the fact that all protected characteristics can experience macroaggressions. The initial resources section was recording and an unrecorded discussion was held afterwards in a safe space. It was acknowledged that the subject requires further work.

As a part of supporting Race Equality Week, LCHS and ULHT promoted the See Me First Scheme, initiated by Whittington Health NHS Trust aiming to promote Equality, Diversity, and Inclusivity. LCHS has already pledged to the campaign and the See ME First badge, to show that it is an open, non-judgemental NHS organisation that treats all Black, Asian, and minority ethnic staff and patients, treating them with dignity and respect. LCHS staff make a pledge for the badge, which is supported by senior leaders, and it was also promoted during the CODE network, LCHS bulletin, Facebook, and background for MS Teams. LCHS put on a webinar for both ULHT and LCHS with a key speaker who is a clinician and the Vice-Chair for the CODE staff network, it was well attended.

United against Discrimination

In our National Staff Survey (NSS) results from 2021 and 2022 it showed a rising trend for racism and LGBTQ+ abuse from patients. In order to tackle this, we have developed a practical tool to help us make a positive difference in stopping and reducing the impact of these incidents. The new flowcharts were developed with a wide group of colleagues in the United against Discrimination Working Group - including representatives from Staff Side, Patient Experience, Divisions, Medical, Nursing and

Family Health representatives, Staff Networks, HR, Freedom to Speak Up, Security Management and Safeguarding. Alongside this, advice from the Trust's solicitors was also sought, for extra assurance.

The flowcharts are based on British Medical Association guidance originally, however, have been adapted so they can be applied to all staff who work across our Trust. The flowcharts apply to all forms and types of discrimination and are not limited to racism and LGBTQ+ abuse (where the data gives the greatest cause for concern), but also: sexism and sexual harassment, religious discrimination or abuse, abuse towards disabled colleagues, and age-related discrimination.

United against discrimination posters have been designed to be displayed in all areas for patients and now developed for staff to report anonymously. The posters are designed with a QR code so can be scanned and reported to a new reporting system called "SafetyQUBE" for Bullying and Harassment.

Race Equality Matters Trailblazer

ULHT was confirmed as successful in achieving Race Equality Matters Trailblazer status at the Race Equality Matters Leaders Event on the 8th of February 2024. This follows two years of race equality and wider anti-discrimination work, with the support and engagement of the REACH network, See Me First and other staff networks and allies across the Trust, based around the Trust's Anti-Racism strategy. This is a great acknowledgement of intentions while we work towards silver, gold and platinum status because there is still a lot of work to be done.

See Me First

See Me First Campaign started in Whittington Health NHS Trust on 29th October 2020. The creators of this initiative are Beverleigh Senior, Paul Attwal and Delia Mills. ULTH joined in February 2023 and continue to raise awareness for staff to pledge to campaign.

"I promise to acknowledge and celebrate individuality in my interactions with colleagues. I will make an intentional effort to see past my unconscious bias and unlearn what created them in the first place. I promise to respect and accept others no matter their colour or creed. I promise to be teachable and value all that is within person. I pledge to SEE." (REACH Chair)

Just Culture

As part of the launch of our desired culture of civility and respect in September 2023, we continue to develop and implement a 'Just Culture' approach to how we will respond to adverse incidents or potential breaches of conduct.

A Just Culture is built upon the foundations of civility and psychological safety and it focuses on a learning, restorative and just approach to incident management. By focusing on learning and understanding, rather than blame or judgement when incidents occur, we can improve the care we provide to patients and improve our staff experience.

In order to foster a Just Culture, it is crucial that we encourage all colleagues to feel comfortable and empowered to speak up when incidents, errors or mistakes occur. Without all colleagues feeling safe and valued to speak up freely, we can't learn from each other or prioritise the safety and improvement of patient care.

The Just Culture briefing session aims to provide all colleagues with an understanding of the core principles, background and implementation of our Just Culture as well as empower them to use a Just Culture approach in practice.

Cultural Intelligence

Cultural Intelligence (CQ®) goes beyond existing approaches of cultural sensitivity, unconscious bias, and cultural awareness. The programme sets out the skills, abilities, and capabilities that are vital for individuals and organisations in having successful and respectful work with the difference and diversity needed to improve a 'sense of belonging', including within the recruitment process and career progression.

ULTH is continuing to embed the Cultural Intelligence (CQ) programme across the organisation. This year, seven CQ sessions were delivered with a specific focus on international recruitment, aiming to train staff who are involved in or working with

internationally recruited staff. Also, implementing the CQ programme was part of the WRES Action Plan to continue to build inclusivity across the Trust.

Dream and Apply follow-up sessions

The session includes a recap of what was covered and then some ideas to explore how we can develop and use our Cultural Intelligence skills to lead more inclusively going forward.
The aims are:
- Recap the Cultural Values
- Recap your CQ Capabilities
- Explore how to apply CQ to a situation
- Look at how we dare to dream and design with cultural intelligence

LCHG will continue to embed this through the Group Leadership Programme going forward.

Flexible Working

To increase the visibility of the Trust's commitments to the understanding of challenges and experiences of staff with disabilities or long-term conditions, ULTH provides a flexible working policy. Our key purpose is to ensure that our employees have the appropriate support to retain and continue working at ULTH and manage work-life. Therefore, ULTH promote and support flexible and hybrid working options for staff from the first day of their employment as both opportunities are designed to support our staff to balance their work and personal needs. ULTH also promotes flexible working on all job adverts.

Freedom to Speak Up Guardian

Here at ULTH, we believe that speaking up about concerns is vital and we want our staff to feel supported at work. To ensure that their concerns are looked into and that staff have access to the support they need, the Trust continues to enhance the initiative and visibility of the FTSUG, and FTSUG champions are working in partnership with staff networks.

Group Staff Awards 2024

The first joint staff awards as LCHS and ULTH coming together as a group were awarded in November 2024. It is an award, for recognising and celebrating our NHS stars across the Group. The awards are an opportunity for the people of Lincolnshire to recognise the hard work, dedication and care shown by community and hospital staff working across the county, and where they have demonstrated exceptional professionalism and care. There are 15 categories, including the Equality, Diversity and Inclusion Champion of the Year Award. Four staff were shortlisted, across clinical and non-clinical roles in this category. Sara Blackbourn, the Trust Lead Occupational Therapist at ULTH won the category, for initiating the Stronger Together Coaching Forums and welcome hampers to support the team which had several cohorts of internationally educated Allied Health Professionals (AHPs). Sara made herself available and offered to listen and support them in a safe space. The Highly Commended recognition was awarded to the LCHS CODE Staff Network chair for being instrumental in advocating for inclusive culture and diversity across the group and for celebrating South Asian Heritage month for the first time. Trish Tsuro, Staff Network chair was shortlisted for the Chair's Award at the staff awards.

ULTH staff networks

The staff networks are in a period of transition following the Group model introduction and are at various stages of coming together. All of the staff networks provide an opportunity for staff to find support and share their voices and concerns to improve working practices across the group. The staff networks support the implementation of the Public Sector Equality Duty from the Equality Act (2010) WRES, WDES and EDS.

They support the organisation to prevent and eliminate discrimination, harassment, and victimisation, promoting equality and equal opportunities, as well as fostering good relations by challenging prejudice and promoting understanding between people who share a protected characteristic and those who do not.

Race, Ethnicity, and Cultural Heritage (REACH)

REACH staff network is one of our longest established networks and continues to provide professional support and expertise by experience and guidance in relation to race equality matters, alongside peer support to all colleagues and particularly to the internationally educated staff joining the Trust.

The REACH Staff Network's aims are to:

- Encourage ULTH to maintain a safe and positive working environment for BAME staff and the elimination of racial discrimination for employees and patients.

- Support ULTH to develop and maintain a representative workforce with inclusive leadership and to raise the visibility and profile of the contribution that BAME staff members make.

- Maintain and expand the membership of the BAME staff network to provide a forum where BAME staff can share experience and issues affecting their work and professional development.

- Engage with other groups, including other internal and external staff networks, trade unions, employer associations and community groups who share a common agenda or experience of eliminating disadvantage, addressing unmet needs, or increasing participation.

- Offer support and encouragement to other underrepresented or marginalised staff networks and forums.

- Work in partnership with ULTH to ensure compliance with Equality and Human Rights legislation relating to race equality and to develop and implement national policies and strategy.

- Work in accordance with the Workforce Race Equality Standard (WRES) and develop and embed ULTH's WRES Action Plan.

- Support collaborative working with the international recruitment team and recruitment as part of substantive roles were seeing responses in surveys to show that the 'you said, we did' changes were working.

REACH's highlights:

- Led Black History Month for Lincolnshire system and included a variety of sessions including: a conference delivered with Macmillan focused on Health Inequalities supported by external and internal speakers from Macmillan, Cancer services, Palliative team, Dr Alice Mpofu-Coles, WO1 R Mukungunugwa, Library services, the Talent Academy, Systemwide Book Group and personal stories from all the system networks. This included a panel discussion with Trust Board, Michelle Bateman, Chief Nurse from Derby. Throughout the month there was online webinars including one from Heads of LCHG EDI Team on Allyship.
- The Leanne Pero Foundation was a national support group for BME women to raise awareness about the differences in cancer experiences and to address how people were feeling. The REACH network was able to fund online sessions and through this group it was found that the patient wig voucher does not offer ethnic hair as an option. This has now been addressed and it is now possible to obtain funding to get ethnic wigs improving working practices and creating more inclusivity.
- The Equality Diversity and Inclusion calendar is being used across the group and the catering staff are incorporating awareness days into their menus such as Windrush, Shrove Tuesday and Fat Tuesday sharing donuts.
- A Diwali competition was held where the wards came together and celebrated Diwali with food.
- Led Lincolnshire system family fun-day football for Africa Day.
- REACH chairs supported delivery of a recorded presentation by the CODE chair at LCHS and the MAPLE chair on understanding microaggressions and protected characteristics and this was delivered as part of Race Equality Week. The session was informative and gave a wider perspective on microaggressions for all protected characteristics.
- Collaborative working with the international recruitment team and recruitment as part of substantive roles were seeing responses in surveys to show that the 'you said, we did' changes were working.
- Collaborative working with Chaplaincy, Charity, EDI Team and REACH Staff Network to give out at the start of Ramadan packs for staff.

- Continued work through our United Discrimination campaign.
- Trish Tsuro, Staff Network chair shortlisted for Chair's Award at Staff awards.

Next Steps 2025 - 2026

The Group next steps are to develop a first Group WRES Action Plan and embed the below aims into actions, linked to the equality objectives and the LCHG Strategy with input from the CODE and REACH staff network and from staff across the Group. Appendix 3 contains the Group WRES action plan for 2025-2028.

Key WRES actions 2025 – 2028:

- Launch the Triple A Programme (Arising, Ascending and Advancing), to continue to increase BME representation across the LCHG - change into career progression by developing diverse and inclusive leaders for the NHS.
- Launch Reciprocal mentoring programme - overall BME workforce to have opportunity to mentor senior leaders - development opportunities for BME staff.
- Continuing to raise awareness about See Me First scheme across the Group.
- Raise awareness about apprenticeships and the Talent Academy and training among BME staff.
- Start to collect the ethnicity pay gap data to develop next year's Pay Gap Report.
- Continuing to enhance knowledge about reporting bullying and harassment and other supporting procedures for staff - webinar/events during anti-bullying week which will take place from 10th - Friday 14th November 2025. The theme is 'Make Power for good'.
- Implement the Reciprocal Mentoring Programme across the group, starting with the new Group Trust Board.
- Continuing to raise awareness about the United Against all forms of Discrimination toolkit across ULTH and implementing it across the Group.

WRES Actions linked with the LCHG Group Strategy 2025 - 2030:

Strategic Aim 2 – People:

- Better opportunities: Aiming to develop, empower and retain great people by:
  - o Enable our people to fulfil their potential through training, development, research and education.
  - o Empower our people to continuously improve and innovate
  - o Nurture compassionate and diverse leadership.

Conclusion

We will continue to communicate with the CODE and REACH staff networks and the WRES activities to all staff across the group, so we can all be involved in celebrating our achievements. Having a productive inclusive workforce, where staff feel valued and heard is vital and crucial in providing high-quality personalised care for patients. We will continue to implement the LCHG values: compassionate, collaborative and innovative to ensure that staff feedback has been listened to and the WRES actions have been delivered and the sense of belonging has been embedded across the organisation.

Appendix 1:

ULTH WRES Workforce Data 2024 – 2025

Appendix 2:

ULTH WRES Data Trend 2016 - 2025

Appendix 3:

WRES Action Plan 2025-2028

Appendix 1 – ULTH Workforce Race Equality Standards Report 2024 -2025, Workforce Data Indicators 1 - 9

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Indicator 1

Staff in post based on: primary assignments only, no bank staff, no Chair and Non-Executive Directors

VSM = (Very Senior Manager including Chief Executive, Executive Directors)

*% is the exact number of the overall ULTH workforce with a race, data taken from the NHS England.

** For national benchmark data, indicators 5-8 are based on the National Staff Survey results of 2023.

Indicator 1A Clinical workforce

Clinical	White		BME		Not Stated		TOTAL	
WRES Indicator 1	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage
Clinical	4158	70.1%	1717	28.9%	59	1.00%	5934	100.00%
Under Band 1	3	60.00%	2	40.00%	0	0.00%	5	100.00%
Band 1	0	0.00%	0	0.00%	0	0.00%	0	100.00%
Band 2	185	81.14%	39	17.11%	4	1.75%	228	100.0%
Band 3	1048	79.88%	255	19.44%	9	0.69%	1312	100.0%
Band 4	224	90.69%	20	8.10%	3	1.21%	247	100.0%
Band 5	938	45.40%	1109	53.68%	19	0.92%	2066	100.0%
Band 6	891	79.34%	216	19.23%	16	1.42%	1123	100.0%
Band 7	551	93.23%	37	6.26%	3	0.51%	591	100.0%
Band 8a	232	87.55%	30	11.32%	3	1.13%	265	100.0%
Band 8b	49	89.09%	5	9.09%	1	1.82%	55	100.0%

Band 8c	18	81.82%	3	13.64%	1	4.55%	22	100.0%
Band 8d	10	100.00%	0	0.00%	0	0.00%	10	100.0%
Band 9	8	100.00%	0	0.00%	0	0.00%	8	100.0%
Very Senior Manager	1	50.00%	1	50.00%	0	0.00%	2	100.0%
Med & Dental Consultants	119	28.95%	278	67.64%	14	3.41%	411	100.00%
Med & Dental Non-Consultants	19	7.09%	234	87.31%	15	5.60%	268	100.0%
Trainee Grade	95	18.06%	422	80.23%	9	1.71%	526	100.0%

Indicator 1B Non-clinical workforce

Non-Clinical	White		BME		Not Stated		TOTAL	
WRES Indicator 1	**Headcount**	**Percentage**	**Headcount**	**Percentage**	**Headcount**	**Percentage**	**Headcount**	**Percentage**
Non-Clinical	**2997**	**92.7%**	**197**	**6.1%**	**39**	**1.2%**	**3233**	**100.0%**
Band 1	32	84.2%	0	0.0%	6	15.8%	38	100.0%
Band 2	1327	92.3%	97	6.8%	13	0.9%	1437	100.0%
Band 3	630	92.9%	44	6.5%	4	0.6%	678	100.0%
Band 4	339	91.9%	21	5.7%	9	2.4%	369	100.0%
Band 5	208	94.5%	9	4.1%	3	1.4%	220	100.0%
Band 6	157	91.8%	12	7.0%	2	1.2%	171	100.0%
Band 7	134	95.0%	6	4.3%	1	0.7%	141	100.0%
Band 8a	76	100.0%	0	0.0%	0	0.0%	76	100.0%
Band 8b	46	93.9%	3	6.1%	0	0.0%	49	100.0%
Band 8c	13	86.7%	2	13.3%	0	0.0%	15	100.0%

Band 8d	8	88.9%	1	11.1%	0	0.0%	9	100.0%
Band 9	19	90.5%	2	9.5%	0	0.0%	21	100.0%
Senior Medical Manager	8	88.9%	0	0.0%	1	11.1%	9	100.00%
Grand Total	**7388**	**71.23%**	**2848**	**27.46%**	**136**	**1.31%**	**10372**	**100.00%**

Indicator 2

Relative likelihood of white staff being appointed from shortlisting across all posts, compared to BME staff (Note: this refers to both external and internal posts).

Applicant Status	White	BME	Unknown
Shortlisted	4010	2821	579
Appointed	1357	556	437
Likelihood	0.33	0.19	0.75

Answer: Relative likelihood of white staff being shortlisted compared to BME staff: 1.71.

Indicator 3

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.

	White	BME	Unknown
Number of staff in WF	7388	2848	136
No staff entering	97	18	1
Likelihood	0.13	0.00	0.00

Answer: Relative likelihood of BME staff entering formal disciplinary compared to white staff: 0.48.

Indicator 4

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff.

	White	BME	Unknown
Number of staff in WF	7388	2848	136
No staff accessing NM	3843	1511	68
Likelihood of accessing	0.52	0.53	0.50

Answer: Relative likelihood of white staff accessing compared to BME staff: 0.98.

Indicator 5

% of staff who experienced at least one incident of bullying, harassment or abuse in the last 12 months from:

- Patients/service users, their relatives or other members of the public.

Staff	Percentage
White	20.7%
BME	24.5%
BME national benchmark**	27.8%
White responses	2860
BME responses	642

Answer: For BME staff a negative increase of 2.8% in 2024.

Indicator 6

% of staff who experienced at least one incident of bullying, harassment or abuse in the last 12 months from:

- staff

Staff	Percentage
White	24.60%
BME	24.3%
BME national benchmark**	24.9%
White responses	2854
BME responses	641

Answer: For BME staff a negative increase of 1.2%.

Indicator 7

% believing that trust provides equal opportunities for career progression or promotion.

Staff	Percentage
White	57.1%
BME	52.8%
BME national benchmark**	48.8%
White responses	2852
BME responses	631

Answer: For BME staff a positive increase of 1.2%.

Indicator 8

% of staff who experienced discrimination at work from any of the following:

- From manager/team leader or other colleagues

Staff	Percentage
White	8.1%
BME	18.4%
BME National Benchmark**	15.5%
White responses	2832
BME responses	631

Answer: For BME staff a negative increase of 1.2%.

Indicator 9

	BME	Percentage	White	Percentage	Not Declared	Percentage	Total Headcount
Total Board members	1	5.56%	13	72.22%	4	22.22%	18
of which: Voting Board members	1	9.09%	7	63.64%	3	27.27%	11
Non-Voting Board members	0	0.00%	6	85.71%	1	14.29%	7
of which: Exec Board members	1	11.11%	7	77.78%	1	11.11%	9
Non-Executive Board	0	0.00%	6	66.67%	3	33.33%	9
Overall Workforce - by Ethnicity		27.46%		71.23%		1.31%	
Difference (Total Board – Overall workforce)		-22%		1%		21%	
Difference (Voting membership - Overall Workforce)		18%		-8%		26%	
Difference (Executive membership - Overall Workforce)		-16%		7%		10%	

27.46% of the Trust Workforce is BME, 5.56% of the Board is BME.

Answer: Therefore, 5.56% - 27.46% = - 22%*

** For national benchmark data, indicators 5-8 are based on the National Staff Survey results of 2023.

Appendix 2 – ULTH WRES Data Trends 2016 - 2025

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Indicator 1

Percentage of BME staff in each of the AfC Bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce.

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
	10.90%	11.34%	11.78%	11.56%	12.10%	13.30%	16.76%	20.60%	24.60%	27.46%

Indicator Selected	1 ▼
Indicator Definition	**Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.**

- A positive data-trend observed, over the 10-years period, with an increased percentage every year, from 10.90% in 2016 and reaching a high at 27.46% in 2025.

Indicator 2

Relative likelihood of white staff being appointed from shortlisting compared to BME staff across all posts.
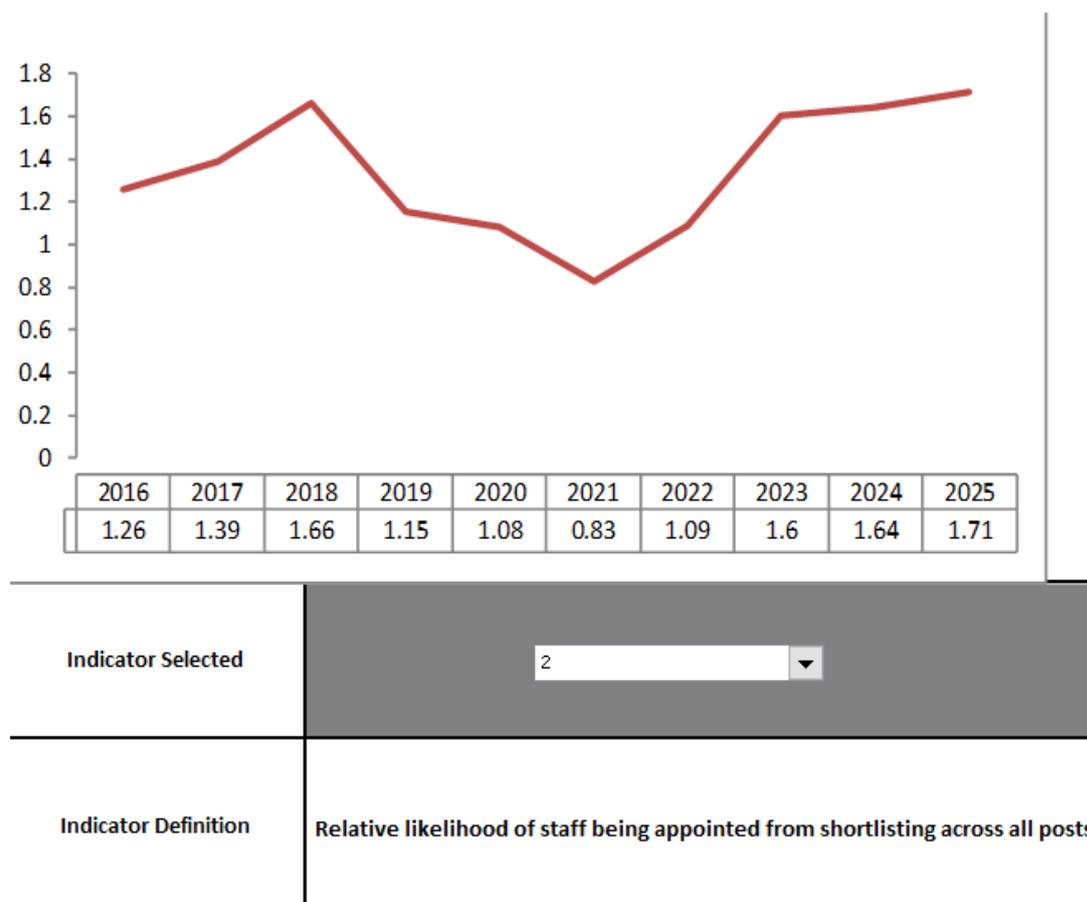
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
	1.26	1.39	1.66	1.15	1.08	0.83	1.09	1.6	1.64	1.71

Indicator Selected	2 ▼
Indicator Definition	Relative likelihood of staff being appointed from shortlisting across all posts

- The relative likelihood of white staff compared to BME staff being appointed from shortlisting across all posts, stayed higher than 1 in the 10-years period, except for 2021.

- Between 2019 and 2022, the closest to equal likelihood was observed, with 1 representing equal likelihood.

- The chart also demonstrates that there has been a negative increase in the relative probability of white staff being appointed from shortlisting from 2022 to 2025, reaching 1.71 in 2025.

Indicator 3

Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
	1.92	1.87	1.65	1.25	1.37	1.55	1.13	0.82	1.00	0.48

Indicator Selected	3 ▼
Indicator Definition	**Relative likelihood of staff entereing the formal disciplinary process, as measured by entry into a formal disiplinary investigation.**
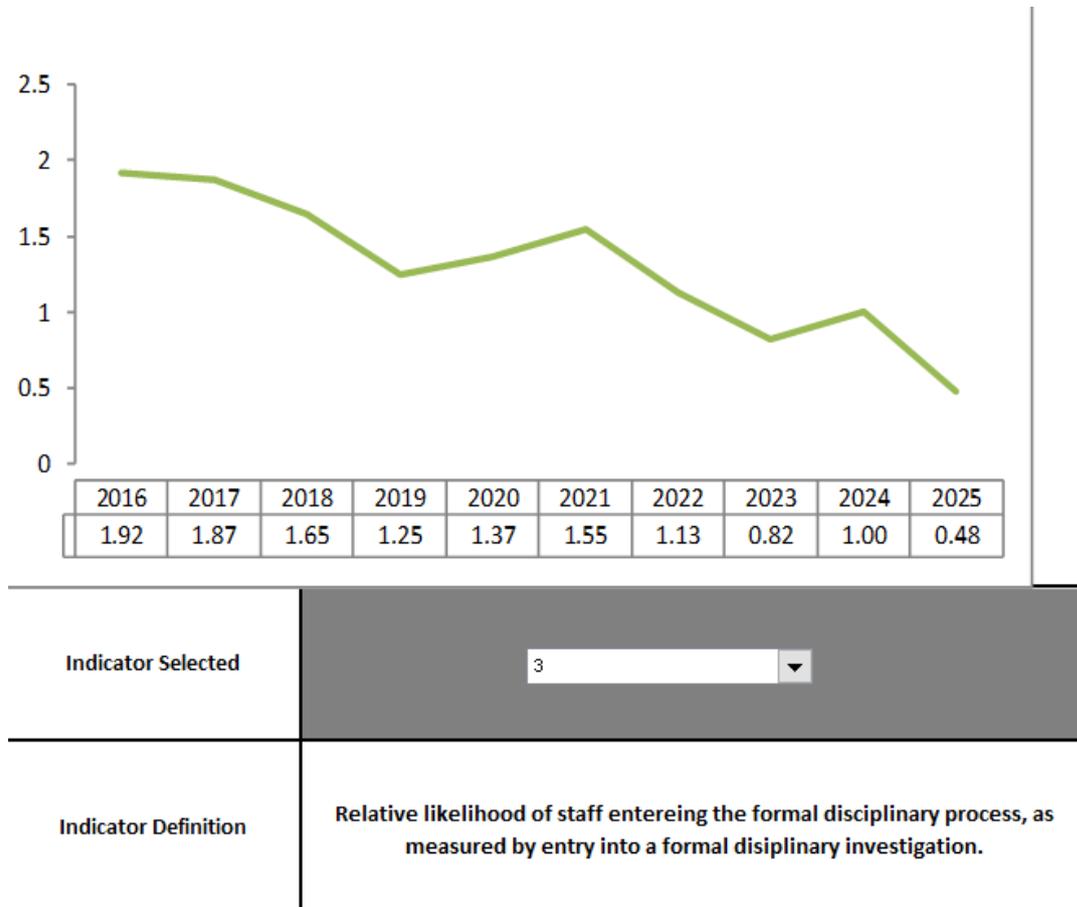
- According to the recent data, the chart indicates that the formal disciplinary process is more likely to be entered by white staff than BME staff, with the rate this year being 0.48, which is a positive opposite outcome when compared to the previous years.

- With 1 representing equal likelihood, the outcomes fluctuate during the 10-years period, with the highest rate in 2016, at 1.92 and the closet to 1 in 2024 with 1. Overall, this shows a positive decreasing trend.

Indicator 4

Relative likelihood of white staff accessing non-mandatory training and CPD, compared to BME staff.

2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
1.73	1.87	1.36	1.27	1.27	1.28	0.85	0.84	0.74	0.98
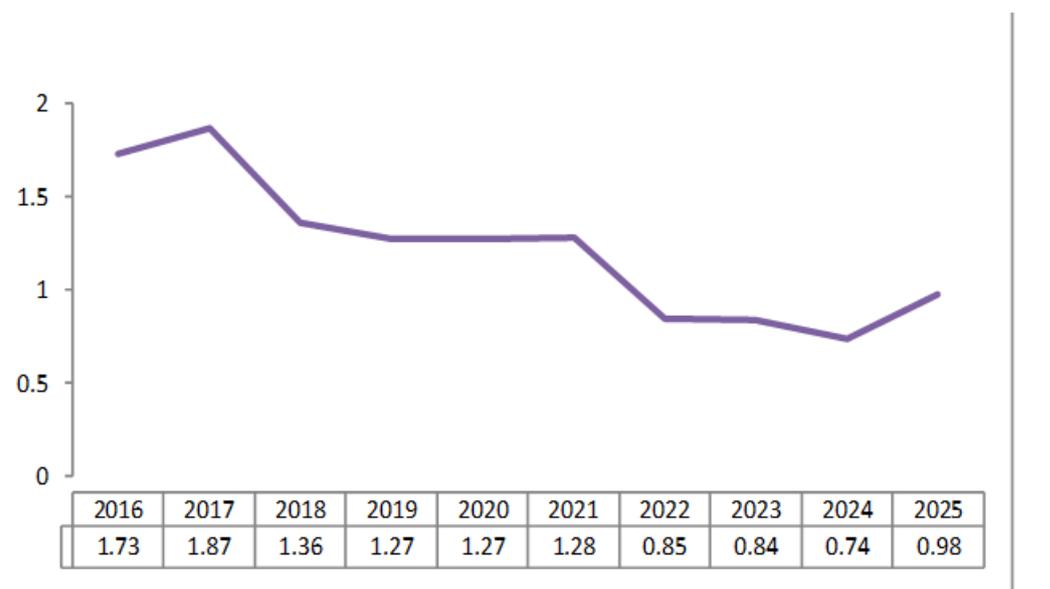
Indicator Selected	4 ▼
Indicator Definition	**Relative likelihood of staff accessing non-mandatory training and CPD**

- The relative likelihood of white staff compared to BME staff accessing non-mandatory training and CPD, is close to 1 from 2018, between, 0.74 to 1.36, with 1 representing equal likelihood.

- The chart shows maintaining equal likelihood of staff accessing non-mandatory training and CPD and an overall positive trend during the 10-years period.

Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
White	24.80%	26.57%	28.60%	29.60%	29.30%	27.60%	26.50%	25.60%	23.20%	20.70%
BME	17.65%	27.78%	26.30%	30.30%	29.10%	28.20%	25.30%	27.40%	21.70%	24.50%

Indicator Selected	5
Indicator Definition	Percentage of staff experiencing harassment, bullying or abouse from patients, relatives or the public in the last 12 months.
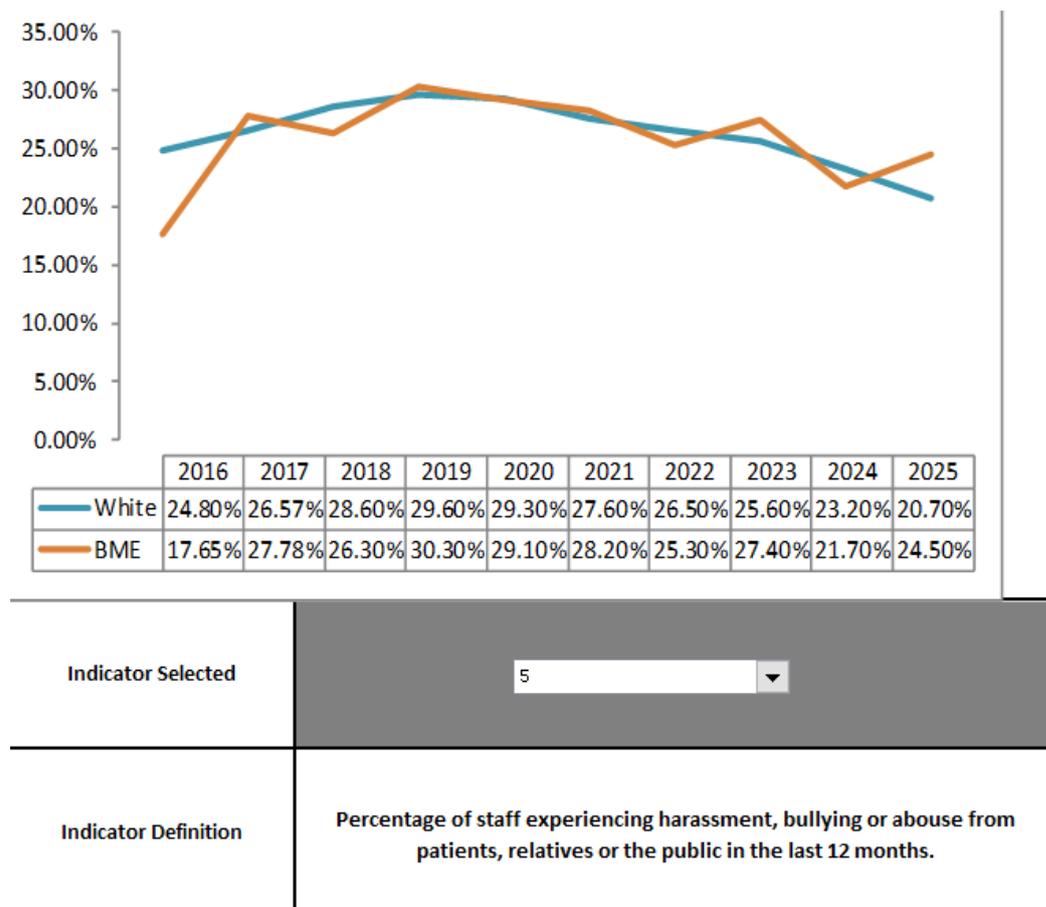
- Across the 10 years, there have been a variety of outcomes, with the lowest peak being in 2016 at 17.65% and the highest in 2019 at 30.30%.

- Despite a positive decline in 2019, from 30.30% to 25.30% in 2022, the following years indicates a fluctuation, with an increase to 24.50% in the last year for BME staff.

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
White	26.42%	24.39%	27.12%	32.30%	30.90%	31.20%	30.60%	26.90%	25.50%	24.60%
BME	47.06%	31.11%	32.46%	37.40%	37.90%	36.90%	32.30%	31.80%	23.10%	24.30%
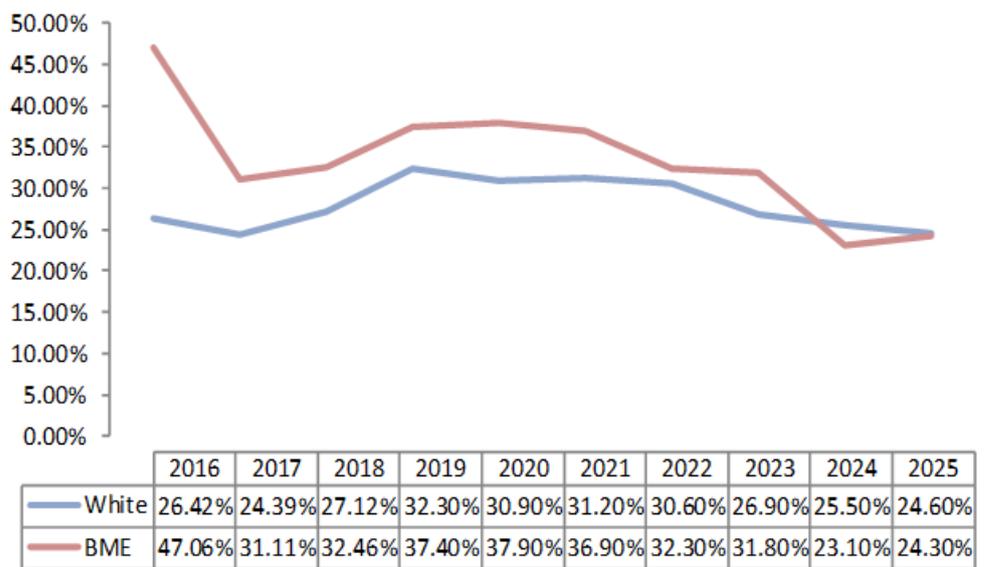
Indicator Selected	6 ▼
Indicator Definition	Percentage of staff experiencing harassment, bullying or abouse from staff in the last 12 months.

- During the 10 years, the results have been inconsistent, with 2016 being the highest percentage, 47.06%, with 2024 being the lowest with 23.10%.

- Despite a slight rise in the last year, from 23.10% to 24.30%, overall the chart indicates a positive trend for BME staff over the 10-years period.

Indicator 7

Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion.

	2022	2023	2024	2025
White	52.00%	56.50%	56.40%	57.10%
BME	42.40%	47.40%	51.60%	52.80%
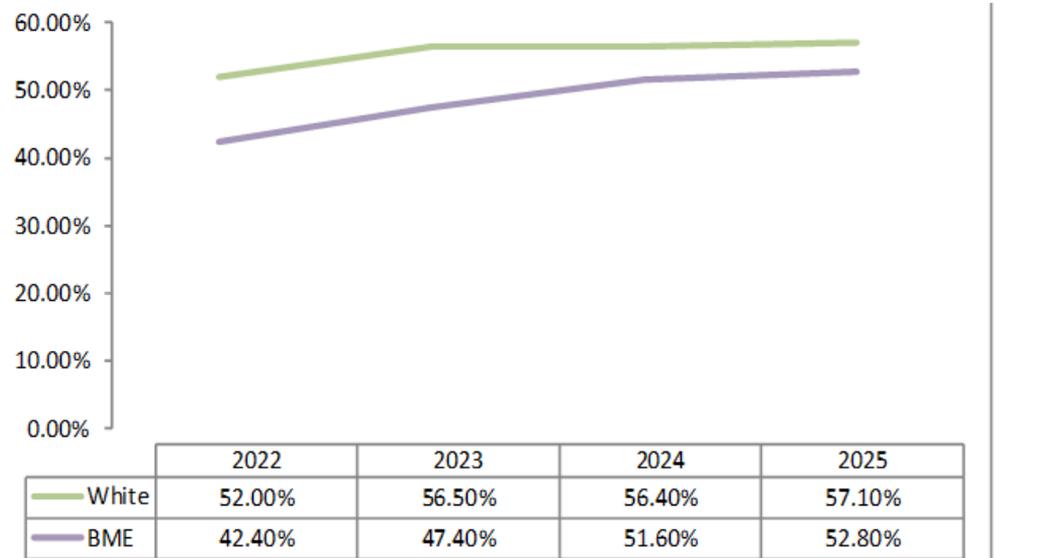
Indicator Selected	7 ▼
Indicator Definition	Percentage believing that the Trust provides equal opportunities for career progression or promotion

- The chart shows that the percentage of BME staff believing that the Trust provides equal opportunities for career progression or promotion remained above 42.40%, the lowest rate in 2022.
- The overall outcome demonstrates a continued positive trend over the four-year period, reaching 52.80% in 2025.

Indicator 8

Percentage of staff personally experiencing discrimination at work from manager/team leader or other colleagues.

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
White	4.47%	5.67%	6.71%	8.50%	6.80%	7.30%	8.00%	7.40%	8.30%	8.10%
BME	11.76%	14.55%	16.17%	19.10%	19.70%	19.50%	21.30%	18.60%	17.20%	18.40%
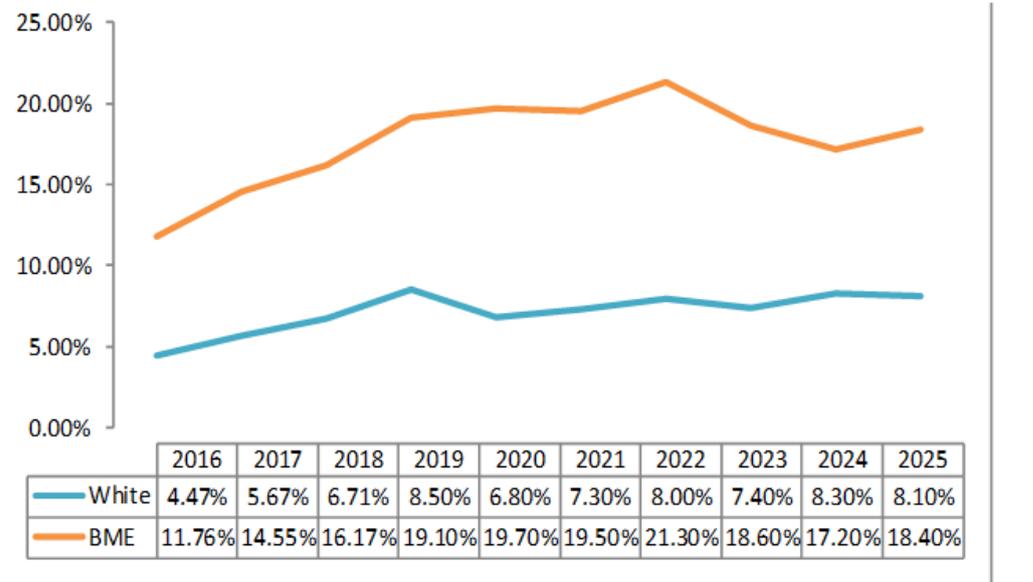
Indicator Selected	8 ▼
Indicator Definition	Percentage of staff personally experiencing discrimination at work from Manager/team leader or other colleagues

- Across the 10 years-period, there have been a variety of outcomes, with the highest peak being in 2022 at 21.30% and the lowest being in 2016 at 11.76%.

- The highest positive decline for BME staff occurred between 2022 and 2023, dropping from 21.30% to 18.60%, followed by a decline in 2024 and a rise in the following year, reaching 18.40% in 2025.

Indicator 9

Trust Board Representation Indicator.

2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
All Board members identify as white	All Board members identify as white	One Board member identified as BME	All Board members identify as white	All Board members identify as white	All Board members identify as white	All Board members identify as white	All Board members identify as white	One Board member identified as BME	One Board member identified as BME

Indicator Selected	9 ▼
Indicator Definition	**Trust Board Representation Indicator**

- In the last two years, there has been a rise in the number of BME Trust Board representatives, from none to6.7% in 2024 and 5.6%, in 2025.
- Also, in 2018, one Trust Board member identified as BME.

Metric
Indicator 1: Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce.
Indicator 2: Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants.

Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.

Indicator 4: Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff.

Indicator 5: Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

| Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months |
| Indicator 7: Percentage of staff believing that the trust provides equal opportunities in a career progression. |
| Indicator 8: In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleagues? |

Indicator 9: Percentage difference between the organisation's board voting membership and its overall workforce.

Objective
To increase number of representation of staff from the BME community across all bands at the Trust. **Community across all bands.** **Acute across B7 and above**.
Develop actions to influence and support recruitment for BME staff. **Community across all bands.** **Acute across B7 and above.**

| To continue to monitor the data for BME staff entering the formal disciplinary process. |
| Promote CPD opportunities for BME staff. (Triple A programme). |
| Promote and encourage healthy conversations and where to get support. |

Promote and encourage healthy conversations and where to get support.

BME staff to share experiences and give examples around the opportunities they received.

Promote and encourage healthy conversations and where to get support.

Maintaining the partnership working between The Trust Board, Board Sponsor and CODE/Reach staff network.

Why
To increase the visibility of diverse representation across all bands at LCHG.
To increase inclusivity and support within the Trust.

a) To ensure that BME staff who are entering into the disciplinary process are treated fairly and equally. b)To improve the work related experience for BME staff members.
a) To ensure that everyone has fair access to career development. b) To increase opportunities for BME staff in achieving their full potential.
a) To decrease the number of challenging experiences for staff in the workplace. b) Creating a healthy, inclusive and compassionate culture of belonging. c) To implement necessary support for staff to reassure them that they are listened to and valued.

a) To decrease the number of inappropriate experiences for staff in the workplace.   b) Creating a healthy, inclusive and compassionate culture of belonging.   c) To guide staff to the necessary support and create a culture where staff are listened to and valued.
a) To ensure that everyone has fair access to career development.   b) To increase opportunities for BME staff in achieving their full potential.
a) To decrease the number of inappropriate experiences for staff in the workplace.   b) Creating a healthy, inclusive and compassionate culture of belonging.   c) To sign post support for staff to reassure them that they are listened to and valued.

a) To ensure BME staff feel valued and their voice is heard by senior leaders and the Trust Board.

b) To increase the visibility of diverse representation across LCHG and increase allyship and to provide opportunity to share experiences.

Action(s)
a) Launch the triple 'A' programme . b) Plan Race Equality Week 5th Feb - 11th 2026. This is a UK-wide campaign focused on addressing barriers to race equality in the workplace. It is an annual event to raise awareness and encourage anti-racist activities, including engaging senior leaders and sharing activities throughout the week. c) Promote celebrations days/week i.e Africa Day/South Asian Heritage week (to review EDI Calendar with the Staff Network)
a) Increase social media presence (twitter/facebook/podcast) to showcase inclusivity and opportunities within the group across the bandings. b) Develop a user-friendly guide to apply for jobs at LCHG, available on the public website. C) To embed inclusive recruitment toolkit.

a) Continue to monitor data and progress of disciplinary process.
b) Work with OD team to embed CQ into leadership programmes at LCHG.
c) EDI elements to support Leadership Programme provided within the LCHG, emphasis on cultural competency, dealing with different cultures, anti-racist practices, allyship, and compassionate leadership.

Launch the triple 'A' programme

Network to acknowledge that NSS data from 2024.
Webinar/events during anti-bullying week which will take place from 10th - Friday 14th November 2025. The theme is 'Make Power for good'.
Continue to promote "United Against Discrimination" approach.

Network to acknowledge the NSS data from 2024
Discuss next steps.
Continue to promote "United Against Discrimination" approach and LCHG Values.

CODE/Reach Staff network to share lived experiences to promote this further in podcasts/social media platforms.

CODE/Reach Staff network to plan promotion of The International Day for the Elimination of Racial Discrimination which is on the 21st March 2026.
Race equality

a) Reach/CODE staff network to be involved in stakeholder panels.
b) Launch recipricol mentoring programme - overall BME workforce to have opportunity to mentor senior leaders - development opportunities for BME staff.

Timescales
Apr-26
Apr-26

Apr-26

Apr-2026

Apr-2026

Mar-2026

Apr-2026

Mar-2026

Mar-26

Lead(s)
EDI Team
EDI Team Recruitment Team

EDI Team
OD Team
HR Team

EDI Team
Nursing Leadership Team
All Leaders

EDI Team
All Leaders
CODE/REACH Staff Network

EDI Team
All Leaders
CODE/REACH Staff Network

CODE/REACH Staff Network

CODE/REACH Staff Network

CODE/Reach Staff Network
Trust Board
EDI team

Workforce Disability Equality Standard (WDES) Annual Report 2024-2025

Meeting	Lincolnshire Community and Hospitals Group Board
Date of Meeting	2 September 2025
Item Number	9.5

WDES annual report (2024/2025)

Accountable Director	Claire Low, Chief People Officer
Presented by	Claire Low, Chief People Officer
Author(s)	Rachel Higgins, EDI Lead (LCHS/Group) Kerry Swift, Deputy Director of People
Recommendations/ Decision Required	The Board are asked to approve the publication of the report on the Trusts' websites in line with national reporting 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	
1b: Reduce waiting times for our patients	
1c: Improve productivity and deliver financial sustainability	
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	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	
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 committee is asked to note the contents of the Workforce Disability Equality Standard (WDES), annual reports for both ULTH and LCHS 2024-2025. These reports look back at the achievements from the previous year and show that each Trust has fulfilled its statutory requirements.

Purpose

The Workforce Disability Equality Standard (WDES) agenda has continued to be productive as LCHS and ULHT has entered into a Group model.

The WDES annual report for each organisation focuses on the achievements from the previous year ie 2024-2025. Within both annual reports, it celebrates work achieved and the engagement with staff and staff networks, together with the progress made in continuing with the workforce disability agenda with regards to the impact, effectiveness, and responsiveness for both Trusts.

It also details how LCHS and ULTH have continued to follow national requirements and legislative requirements for statutory reporting.

Key Messages

The Workforce Disability Equality Standard (WDES) programme has now been collecting data on disability inequality for four years, holding up a mirror to the service and revealing the disparities that exist with disability or long-term conditions compared to colleagues without a disability or a long-term condition.

The WDES annual report focuses on the data and engagement with disabled staff or staff with long term conditions for both ULTH and LCHS. In addition, to celebrating the work achieved and the engagement with staff and progress made, it highlights any concerns and what actions are planned to address these. The annual report also includes the data from the key indicators and an action plan to improve outcomes. This action plan has now become a Group three-year action plan to recognise the long-term commitment that is required to improving these metrics and the experience for staff. It also notes the determination to continue with the disability agenda with regards to the impact, effectiveness, and responsiveness for both Trusts.

There is a statutory requirement as part of the Trust's contract to publish the WDES annual report and this requires Boards to formally ratify this ahead of publication on the Trusts' websites.

It is important to note that these annual reports have been developed with the staff networks and have also been shared with the Equality, Diversity and Inclusion Group, together with this People Committee.

This annual report informs on the key areas of progress, areas of focus and then key actions that are being taken to address these areas.

The annual report contains the full WDES data at appendix one, a data trends analysis over previous years as appendix two and the action plan for the next three years as appendix three, as a Group action plan.

Further progress against this action plan will be reported on a regular basis into the Equality, Diversity and Inclusion Group and upwards to the People Committee.

As both organisations have moved into the Group Model, both Equality, Diversity and Inclusion teams have come together successfully to ensure the continuation of compliance with the Public Sector Equality Duties and working with our staff across LCHS and ULHT, supporting the coming together of the two organisations' Mental and Physical Lived Experience staff network's (MAPLE) as one staff network.

Conclusion/Recommendations

In conclusion, People Committee are asked to note and formally approve the contents of the WDES annual report for both ULHT and LCHS, which looks back at the WDES findings from the previous year and how the Trust is working towards improving the experience of disabled staff via the joint Group three-year action plan.

Please note that the annual report and supporting appendices have a different look and are less visual than previous years. This is to ensure they met the requirements of the Accessible Information Standard. Work has also been undertaken to ensure that both organisations' reports are in as similar format as possible.

LCHS Workforce Disability Equality Standard Annual Report - 2024-2025

Caring and building a
healthier future for all

Authors: EDI Team

Date: June 2025

Authors: EDI Team

Date: June 2025

Contents

Introduction

Welcome to the Lincolnshire Community Hospital Services NHS Trust, Workforce Disability Equality Standard (WDES) 2024-2025 report. This report contains reflections of last year's actions for the Workforce Disability Equality Standard (WDES).

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS organisations use the metrics data to develop and publish an action plan, building on high impact actions shared in the first ever NHS Equality, Diversity and Inclusion improvement plan. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality to create the cultures of belonging and trust that will improve retention, recruit from the widest possible talent pool and provide sustainable careers. To fulfil the Trust's commitments towards staff, LCHS complies with the Public Sector Equality Duty, as part of the Equality Act 2010, and the NHS People Promise as part of the NHS Long Term Workforce Plan. The Trust aspires to create an inclusive culture by embedding a sense of belonging across the organisation. From the 1st April 2024, LCHS entered into a Group Model with United Lincolnshire Teaching Hospital (ULTH).

To improve the experience of staff with long-term conditions and disabilities, working or seeking employment in the NHS, LCHS adopted the Workforce Disability Equality Standard (WDES). It was introduced in 2019 and commissioned by the NHS Equality and Diversity Council, the WDES is mandated through the NHS Standard Contract. It consists of 10 metrics, based on workforce data and staff feedback from the NHS Staff Survey, which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The data help us understand the trends and patterns of inequality and highlight areas that require improvement. This also illustrates the progress that has been made by the Trust in reducing gaps and inequalities in the workplace.

Methodology

The WDES remains the only example in the UK where employers are mandated to report and publish annual data on the workplace and career experiences of disabled staff. The ambition is to increase the representation of disabled people in the NHS workforce and see the disparities between disabled and non-disabled staff reduce year on year; supported by an inclusive culture through the realisation of the vision set out in the People Promise. As well as delivering high quality healthcare for millions, the NHS also provides employment for more than a million people in some of the most valued, varied and skilled roles in the country.

We have recently witnessed two landmark moments in the 75-year history of the NHS. The publishing of the NHS Long Term Workforce Plan is the first time the government has asked the NHS to produce a comprehensive workforce plan; a once-in-a-generation opportunity to put staffing on a sustainable footing and improve patient care. Meanwhile the NHS Equality, Diversity and Inclusion (EDI) Improvement Plan recognises that the NHS is more diverse than it has ever been. The plan sets out six high impact actions, to ensure our staff work in an environment where they feel they belong, can safely raise concerns and provide the best possible care to our patients.

As NHS Staff Survey data shows, 1 in 4 members of our NHS workforce has lived experience of a disability or long-term condition. If we are to achieve the ambitions set out in the NHS Long Term Workforce Plan – to improve training and retention and deliver new ways of working – we must also do so through a disability-inclusive lens. The NHS EDI Improvement Plan sets out actions and interventions that NHS organisations can adopt as they work to build workplaces that enable our staff to thrive.

The vast lived experience of disability within the NHS workforce is captured in this 2024-25 report on the Workforce Disability Equality Standard (WDES), which remains the UK's only mandated standard on the working lives of disabled staff. The WDES metrics data continues to help us keep our minds targeted on where we can prioritise actions to improve current performance. Thanks to a maturing body of evidence, the WDES offers a rich and thought-provoking exploration of how the NHS, as an employer, can best care for and protect colleagues across the broad spectrum of disability.

It is particularly good to note that there has been a further improvement in the WDES metric on workforce representation. The proportion of staff whose disability status is 'unknown' has reduced to its lowest recorded level. This is a measurement of the work that trusts have delivered to reduce barriers and create inclusive workplaces; with more staff feeling confident to share information about their disabilities.

Also welcome is the further improvements in the representation of disabled people on boards, which brings greater diversity in lived experiences into senior decision-making and benefits both the workforce and our patients.

LCHS remains committed to reducing the disparities that disabled staff experience and to improving the talent pipeline for disabled NHS staff.

WDES National Key Findings:

The 2024 Workforce Disability Equality Standard (WDES) key findings in England show that disabled staff continue to experience challenges, particularly in perceptions of equal opportunities for progression and feeling valued. While improvements are noted in some areas like recruitment outcomes and reasonable adjustments, disparities persist, particularly for certain demographic groups. Here's a more detailed breakdown of the key findings:

- In March 2024, 5.7% of the workforce across NHS trusts declared a disability through the Electronic Staff Record (ESR) (86,312 people), which was an increase of 0.8% on 2023. 14.3% of staff did not declare whether they have a disability. 6.5% of board members declared that they have a disability or not.
- The likelihood of non-disabled candidates being appointed from shortlisting compared to disabled candidates was close to equity (0.98). Specifically, 19.5% of non-disabled candidates were appointed from shortlisting compared with 19.8% of disabled candidates.
- Disabled staff were more than twice as likely (2.04) to enter the formal capability process (on performance grounds) compared to their non-disabled colleagues, although this was an improvement from 2.17 in 2023.

- 25.05% of respondents from NHS trusts indicated they were disabled.
- 74.5% of disabled staff reported that their employer has made reasonable adjustment(s) to enable them to carry out their work, an increase from 2022 (73.0%).
- 30.0% of disabled staff reported experiencing harassment, bulling or abuse by patients, family, service users or the public, 14.6% from managers and 15.4% from other colleagues, lower than in previous years but higher than the experience of non-disabled staff.
- Fewer disabled staff (52.2%) than non-disabled staff (58.1%) felt that their trust provides equal opportunities for career progression or promotion.
- More disabled staff (26.6%) said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties, compared with 18.5% of non-disabled staff.
- Fewer disabled staff (36.9%) than non-disabled staff (47.8%) were satisfied with the extent to which their organisation values their work.

The WDES also complements the Workforce Race Equality Standard (WRES) and both are vital to ensuring that the values of equality, diversity and inclusion lie at the heart of the NHS.

This report sets out key information about the experience of staff with disability and long term conditions for the period April 2024 to March 2025 and includes a metrics data report for 2024-25, together with an action plan for 2025-28.

Further, since the inception of the WDES in 2019, the Trust has been tracking the trends over time for each of the WDES metrics. For the first time in this report, the data trends are reviewed and analysed. Infographics relating to the data trends for each of the metrics are provided in Appendix 2. An LCHG action plan is contained at appendix 3.

Executive summary

The Trust employed 2308 staff as of 31 March 2025 of which 207 disclosed their disability or long-term condition on the Electronic System Record (ESR). Based on workforce data as of 31 March 2025 and feedback from the NHS Staff Survey 2024 (detailed in Appendix 1), a WDES action plan 2025-28 (contained in Appendix 3) has been developed in partnership with the Group Mental and Physical Lived Experience (MAPLE) Staff Network. The action plan will be implemented and progressed over the next 12 months to help reduce the barriers that impact the experience of our staff with disability and long-term conditions.

The Census 2021, states that across both England and Wales, the proportion of disabled people is 17.8% (10.4 million) and it has decreased by 1.7 percentage points from 2011 when it was 19.5% (10.0 million). According to the 2021 Census, 26.6% population in Lincolnshire declared to have long-term physical or mental health. Nationally in the NHS, there is still a significant under-reporting of the number of NHS staff who declare themselves to be disabled. However, currently over 72,000 employees have declared a disability in ESR, compared with just 35,000 in 2015.

As the WDES metrics are evidence-based, the Trust is committed to continuing to raise awareness about the importance of declaring disability across the organisation to help to understand the experiences of staff with disability or long-term conditions (LTC). Our local NHS Electronic Staff Record (ESR) indicates that 9.0% of staff employed staff have declared a disability, 207 out of 2308.

LCHS WDES Metrics Dashboard 2024-2025 Data

Index

- Positive increase 🟢⬆
- Neutral increase 🟡⬆
- Negative increase 🔴⬆
- Neutral ↔
- Positive decrease 🟢⬇
- Neutral decrease 🟡⬇
- Negative decrease 🔴⬇

Table 1. Index: A difference of 0-5% is Amber, with more than 5% being Green or Red. For probability a difference of 0 – 0.5 is Amber, with more than 0.5 being Green or Red.

*For 2025 results, indicators 1-3 and 10 are based on Electronic Staff Records (ESR) and local data as of 31 March 2025 for the year 2024-25. Indicators 4-9 are taken from the National Staff Survey (NSS) of 2024. ** For national benchmark data, indicators 1-3 and 10 are based on the national WDES report for 2024 with ESR as of 31 March 2024. Indicators 4-9 are based on the NSS results of 2023 (which is the latest benchmark data available). *** For full LCHS data please see Appendix 1.

Metrics (Indicators)	2023 Results	2024 Results	2025 Results	LCHS Progress March 2024-March 2025	National Benchmark (based on ESR 2024 and NSS 2023)**	LCHS data compared with national benchmark
1. Percentage of disabled staff in LCHS (excluding bank)	9.6%	9.8%	9.0%	⬇	5.7%	⬆
2. Relative likelihood of non-disabled staff being appointed from shortlisting across all posts (as a ratio)	1.23	1.13	0.77	⬇	0.98	⬇
3. Relative likelihood of disabled staff entering the formal capability process (as a ratio)	0.6	3.21	5.56	🔺	2.04	🔺
4a) % of disabled staff who experienced at least one incident of bullying, harassment, or abuse from:						
• Patients/service users	27.6%	25.4%	30.0%	⬆	30.0%	↔
• Managers	15.8%	11.4%	13.3%	⬆	14.6%	⬇
• Other colleagues.	20.1%	21.2%	22.9%	⬆	23.8%	⬇
4b) % of disabled staff saying they, or a colleague, reported their last incident of bullying, harassment, or abuse.	57.1%	51.2%	52.3%	⬆	52.5%	⬇

Metrics (Indicators)	2023 Results	2024 Results	2025 Result	LCHS Progress March 2024-March 2025	National Benchmark (based on ESR and NSS 2023)**	LCHS data compared with national benchmark
5. % of disabled staff who believe that their organisation provides equal opportunities for career progression or promotion.	61.3%	62.7%	60.0%	⬇️ (yellow down)	52.2%	⬆️ (green up)
6. % of disabled staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	25.1%	21.7%	23.3%	⬆️ (yellow up)	26.6%	⬇️ (yellow down)
7. % of disabled staff are satisfied with the extent to which their organisation values their work.	46.8%	45.1%	42.0%	⬇️ (yellow down)	36.9%	⬆️ (green up)
8. % of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work.	75.7%	77.9%	78.0%	↔️ (yellow sideways)	74.5%	⬆️ (yellow up)
9. National Staff Survey engagement score for disabled staff (out of 10)	6.9	6.8	6.7	↔️ (yellow sideways)	6.5	↔️ (yellow sideways)
10. Percentage of: • Total Board declaration	11.11%	11.11%	16.67%	⬆️ (green up)	6.5%	⬆️ (green up)
• Exec declaration	0.0%	0.0%	11.11%	⬆️ (yellow up)	6.2%	⬆️ (green up)
• Non-exec declaration	16.67%	16.67%	22.22%	⬆️ (green up)	6.8%	⬆️ (green up)

Workforce Disability Equality Standard 2024-25 Headlines

Key areas of progress

- Maintaining the number of staff disclosing disability or long-term conditions (LTC) on ESR to 9.0% - higher than national average, the national benchmark is 5.7%. The ongoing positive direction is confirmed by the data trends from 2019 with 5.40% being the highest increase between 2022 and 2024, with a slight decrease between 2024 and 2025, of 0.8% to 9%.
- The relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts has positively decreased from 1.13 in 2024 to 0.77, so it is more likely to be appointed for disabled staff compared with non-disabled.
- % of disabled staff saying they, or a colleague, reported their last incident of bullying, harassment, or abuse positively increased from 51.2% to 52.3%.
- Maintaining above the national average % of staff with long-term conditions and illness saying the Trust has made adequate adjustment(s) to enable them to carry out their work, 78.0% in 2025 which is the highest since year 2022, where the highest decrease was to 69.0%, but with a stable increase since then.

- Hosting Disability History Month 2024 with inspiring programme for the Lincolnshire system. Various sessions on a range of topics were delivered including: The Diary of a Freedom to Speak Up Leader; Paul White, CEO Hidden Disabilities Sunflower Scheme; Being a Member of the Older Workforce support Session; Reasonable Adjustment considerations; Workplace Thriving with Neurodiversity, Past, Present and Potential; Access to Work support session; Carer Burnout delivered by 'The Recovery College' and Living with a Long-Term Condition Lived Experience Journeys including staff lived experience journeys.

- Blue Monday Brew Monday drop-in support session to bring the MAPLE and IMPACT staff networks together as one network across the Lincolnshire Community and Hospitals Group.

- Celebration of the National Staff Network Day 2024 by participating in online ELT Live. Staff Network leads had the opportunity to speak about their network activities across group encouraging staff to be involved with the Chief Executive.

Our key areas of focus as LCHG

On the 1st April 2025, LCHS and ULTH became part of a Group Model. A decision was taken to produce a Group WDES action plan with key areas of focus:

- Ongoing work on increasing staff disclosing their disability or long-term conditions, particularly for staff at senior levels.
- Raising awareness about staff's lived experience with visible and hidden disability.
- To decrease % of disabled staff and non-disabled staff experiencing harassment, bullying, or abuse from patients as negative increase in previous year.
- To decrease the number of staff experiencing bullying and harassment from managers and other colleagues as the number of staff experiencing bullying or harassment is increasing.
- Raise awareness of the reporting procedures when experiencing or witnessing bullying and harassment and available support.
- Ongoing monitoring and reviewing of capability process data to assess factors and reasons for increasing numbers of disabled staff entering the process.
- Career opportunities include leadership opportunities for staff with disability and long-term conditions.
- Raise staff and line managers' awareness about reasonable adjustment processes to support their needs, including the Health Passport across the Group Model.

Our commitments

The Equality Diversity and Inclusion (EDI) Calendar 2024-2025

The Equality Diversity and Inclusion (EDI) Calendar 2024-2025 provides a selection of key religious and cultural dates, awareness and action days, and some events which reflect the diverse nature of our workforce and local populations. This calendar has been developed as a way to help us celebrate our diverse communities, cultures and faiths. It provides an opportunity to visibly embrace and embed equality, diversity and inclusion into our Trust for patients and colleagues alike, in practical and supportive ways.

This has been developed over the last few years so that Staff Networks and other staff groups can plan campaigns, meetings and events. From 2025, the EDI Calendar is now a Group Model sharing awareness events that are important for both Trusts.

These are some examples from the EDI Calendar.

Anti-Bullying and Harassment Week November 2024

Anti-Bullying Week 2024 was co-ordinated in England, Wales, and Northern Ireland by the Anti-Bullying Alliance. This year it had the theme 'Choose Respect' and took place from Monday 11th to Friday 15th November 2024.

The MAPLE Network and the Freedom to Speak Up Guardians delivered a webinar that focused on a conversation with the Freedom to Speak Up Guardians from LCHS and ULTH, who talked about their Speak Up Journeys.   We took a different approach this year to demonstrate the importance of the freedom to speak up role and shared contact details for all the Freedom to Speak Up Guardians for the Lincolnshire system. This also formed the opening of Disability History month celebrations and was the most attended event of the month.   This was a different approach to previous years. The session was recorded and is available to watch on the staff intranet.

Carers Rights Day November 2024

Carers Rights Day was on Thursday 21st November 2023 and this year's theme was 'recognising your rights'.   We celebrated during the Disability History month programme on Friday 29th November by participating in a workshop hosted by Lincolnshire Recovery College on Carer Burnout.

We recognised that there was some crossover between staff with caring responsibilities who sometimes have long term health conditions and disabilities. We held a MAPLE session talking about support available with workplace health challenges, particularly as an older member of the workforce and shared resources about the Carer's resources that were available.

Disability History Month 2024

Thursday 14th November 2024 – 20th December 2024

MAPLE has led on the Disability History Month Programme 2024 on behalf of the three Lincolnshire Trusts. The theme was Disability, Employment and Livelihood. There were nine sessions delivered during November and December 2024. All webinars were held virtually this year and addressed several disability related topics and reached over 80 staff across the Lincolnshire System. The events were supported by system partners and members of the MAPLE network. The topics covered incorporated other awareness days that happened during the month too, including Carer's Rights Day, Anti-Bullying and Harassment Week, Trans Remembrance Day and an intersectional approach was taken to incorporate these events into the programme. The sessions delivered were:

- The Diary of a Freedom to Speak Up Leader acknowledging Anti-bullying and Harassment week, the theme this year was 'Choose Respect'.
- Hidden Disabilities Sunflower Scheme, by Paul White, CEO Hidden Disabilities Sunflower Scheme. The scheme continues to be promoted throughout the Trust.
- Understanding UK Trans Health – to acknowledge Trans Remembrance Day.

- MAPLE – Being a Member of the Older Workforce Support Session, Reasonable Adjustment considerations.
- Workplace Thriving with Neurodiversity, Past, Present and Potential.
- Access to Work Support Session.
- Carer Burnout 'The Recovery College'. In support of Carer's Rights Day.
- Living with a Long Term Condition Lived Experience Journeys.
- Closure and Reflections of the month session.

Race Equality Week

Race Equality Week is celebrated every year between Monday 3rd February 2025 – Sunday 9th February 2025. The theme this year was Every Action Counts. The purpose is to emphasise the importance of taking collective and individual action to tackle experience of race equality.

This year Race Equality week was celebrated at LCHS on Wednesday 5th February 2025, with a session on 'Protected Characteristics, Understanding Macroaggressions and the Importance of being an Ally'. The session was collaborated between the CODE and MAPLE staff network and was supported by the REACH staff network chairs and the Chief People Officer and was open to staff across the group. The session was powerful and emphasised the fact that all protected characteristics can experience macroaggressions. The initial resources section was recorded and an unrecorded discussion was held afterwards in a safe space. It was acknowledged that the subject requires further work.

Hidden Disability Scheme

The Chief Executive Officer delivered a webinar to MAPLE members all about the importance of the Hidden Disabilities Sunflower Scheme. We have now also renewed the Hidden Disabilities Sunflower Scheme as one membership for LCHG. MAPLE continues to promote the hidden disability sunflower scheme through communications platforms. We also promote the

importance of declaring disability and long term conditions on the NHS Electronic System Record. LCHS extended the Hidden Disability Scheme membership aiming to encourage inclusivity, acceptance, and understanding of hidden disability across the Trust and to encourage colleagues to disclose their disability or long-term conditions on the NHS Electronic System Record. We have also promoted and distributed white sunflower supporter badges to staff to raise awareness about allyship.

Reasonable Adjustments

The WDES data analysis indicates that the Trust slightly increased our commitment to providing reasonable adjustments for staff with disability and long-term conditions, 78.0% from 77.9% and that we are maintain the increasing % from 2021. To make sure that the support is provided we are aiming to maintain a positive increase of implementing reasonable adjustments and to achieve this the Trust is committed to supporting staff with a range of reasonable adjustments and raising their awareness about available support. In previous years we had a reasonable adjustments form that was replaced by the Health Adjustments Passport in July 2023.

Health Adjustments Passport

This health passport was reviewed by MAPLE staff network and was formally launched by LCHS in July 2023 and continues to be used. It is designed for individuals working within LCHS with a disability, long-term health condition, mental health issue, learning disability or difficulty which has a substantial impact on their work or work environment. It allows individuals to easily record information about their condition, any reasonable adjustments they may need or have in place and any difficulties they face.

The passport helps to ensure there is a clear record and can be used with current or new line managers to explain what is needed in the workplace to help them carry out their role. This is a live document that should be reviewed annually or where there is a change in personal circumstances. This is a confidential document that will only be shared with the employee, line manager and human resources.

Carer's Passport

LCHS introduced the Carer's Passport as part of the NHS People Plan to support working carers and continues to be promoted. The carer's passport acts as a live document and is a communication tool that can be reviewed and updated at any time when circumstances change. The main aim of this document is to enhance communication and support for working carer's in managing work-life with caring responsibilities. The Carer's Passport is a document to be completed between the LCHS staff carer and their line manager and is available in word or pdf formats.

Flexible Working

To increase the visibility of the Trust's commitments to the understanding of challenges and experiences of staff with disabilities or long-term conditions, LCHS provides a flexible working policy. Our key purpose is to ensure that our employees have the appropriate support to retain and continue working at LCHS and manage work-life. Therefore, LCHS implemented flexible and hybrid working options for staff from the first day of their employment as both opportunities are designed to support our staff to balance their work and personal needs. LCHS also promotes flexible working on all job adverts.

Disability Confident Employer Scheme

This year LCHS applied and successfully renewed in April 2024 the Level 2 Disability Confident for the next 3 years. The Trust is committed to continuing to achieve Disability Confident Scheme goals by supporting our employers and candidates with disabilities and LTCs in fulfilling their potential, talents, and aspirations. Through Disability Confident, we are challenging attitudes towards disability, increasing understanding of the challenges, removing barriers and inequalities aiming to bring people with disabilities and long-term health conditions to our organisation, and being the best place to work.

Freedom to Speak Up Guardian

Here at LCHS, we believe that speaking up about concerns is vital and we want our staff to feel supported at work. To ensure that their concerns are looked into, and that staff have access to the support they need. The Trust continues to enhance the initiative and visibility of the FTSUG, and FTSUG champions and partnership working with staff networks.

Cultural Intelligence

Cultural Intelligence (CQ®) goes beyond existing approaches of cultural sensitivity, unconscious bias, and cultural awareness. The programme sets out the skills, abilities, and capabilities that are vital for individuals and organisations in having successful and respectful work with the difference and diversity needed to improve a 'sense of belonging', including within the recruitment process and career progression.

LCHG will continue to embed this through the Group Leadership Programme going forward.

Group Staff Awards 2024

The first joint staff awards as LCHS and ULHT coming together as a group were awarded in November 2024. It is an award, for recognising and celebrating our NHS stars across the Group. The awards are an opportunity for the people of Lincolnshire to recognise the hard work, dedication and care shown by community and hospital staff working across the county, and where they have demonstrated exceptional professionalism and care. There are 15 categories, including the Equality, Diversity and Inclusion Champion of the Year Award. Four staff were shortlisted, across clinical and non-clinical roles in this category. Sara Blackbourn, the Trust Lead Occupational Therapist at ULTH won the category, for initiating the Stronger Together Coaching Forums and welcome hampers to support the team which had several cohorts of internationally educated Allied Health Professionals (AHPs). Sara made herself available and offered to listen and support them in a safe space. The Highly

Commended recognition was awarded to the LCHS CODE Staff Network chair for being instrumental in advocating for inclusive culture and diversity across the group and for celebrating South Asian Heritage month for the first time.

LCHS Staff Networks

The staff networks are in a period of transition following the Group model introduction and are at various stages of coming together. All the staff networks provide an opportunity for staff to find support and share their voices and concerns to improve LCHG working practices. The staff networks support the implementation of the Public Sector Equality Duty from the Equality Act (2010), WRES, WDES and EDS.

They support LCHS to prevent and eliminate discrimination, harassment, and victimisation, promoting equality and equal opportunities, as well as fostering good relations by challenging prejudice and promoting understanding between people who share a protected characteristic and those who do not.

LCHS is committed to continuing the partnership working with the networks and forums aiming to raise awareness about the importance of the networks. To fulfil the commitments, the networks are staff led with an appointed leadership team with adequate support and resources, for example LCHG has agreed to support the networks with additional resources including an honorarium and release time to undertake this role.

Mental and Physical Lived Experience (MAPLE)

The Mental and Physical Lived Experience (MAPLE) staff network provides a safe, inclusive, and diverse environment that encourages authenticity, respect and equality for all. Over the last year MAPLE has come together across the Lincolnshire Community Hospitals Group as one network incorporating MAPLE (with Impact) Café's. It is open to all LCHG staff who have a disability or long-term condition, have carers' responsibilities, or who are interested in health and well-being at work and want to drive forward disability equality as an employer. The network is a catalyst to empower, encourage and promote equitable

opportunities for staff with disabilities. It is a great place for our colleagues to share their experiences and find new friends and support.

MAPLE's Progress highlights

- In January 2025 it worked in partnership with the MAPLE group at ULTH and IMPACT to become one single network.
- MAPLE has led on the Disability History Month programme for the Lincolnshire system in 2024 delivering various sessions on a range of topics including: The Diary of a Freedom to Speak Up Leader; Paul White, CEO Hidden Disabilities Sunflower Scheme; Being a Member of the Older Workforce support Session; Reasonable Adjustment considerations; Workplace Thriving with Neurodiversity, Past, Present and Potential; Access to Work support session; Carer Burnout delivered by 'The Recovery College' and Living with a Long-Term Condition Lived Experience Journeys including staff lived experience journeys.
- Throughout the year MAPLE have held various sessions aligned to the WDES Action Plan including a visit from the Apprentice Centre to discuss barriers and challenges to career progression for disabled staff. The Freedom to Speak Up guardian also joined that session to provide reassurance that any freedom to speak up issues would be escalated and dealt with appropriately.
- Blue Monday Brew Monday drop-in support session to bring the MAPLE and IMPACT staff networks together as one network across the Lincolnshire Community and Hospitals Group.
- Celebration of the National Staff Network Day 2024 by participating in online ELT Live. Staff Network leads had the opportunity to speak about their network activities across group encouraging staff to be involved with the Chief Executive.
- Raising the MAPLE network's profile among leaders and new staff has continued including:
  - Attendance at Induction Marketplace.
  - Members of the MAPLE Leadership Circle participated in an EDI Sounds Podcast to raise the profile of the MAPLE staff network that was circulated on Blue Monday.
  - Anti-Bullying and Harassment Week was celebrated with a session delivered by the Freedom to Speak Up Guardians who talked about their roles as Freedom to Speak up Guardians.

- The National Staff Survey results and Workforce Disability Equality Standards action plan have aligned with the actions MAPLE group has taken.

In summary, the MAPLE group has been working in collaboration across the organisation and regionally and has been working towards widening the reach of our network to bring in new members. Going forward we are looking forward to more visibility and influence with the possibilities of social gatherings and continuing to work as allies with other staff networks across the Group.

Next Steps 2025 - 2026

The Group next steps are to develop a first Group WDES Action Plan and embed the below aims into actions, linked to the equality objectives and the LCHG Strategy with input from the MAPLE staff network and from staff across the Group.

Key WDES actions for 2025- 2028:
- Raising awareness of the importance of the 'disability and long-term condition disclosure' on ESR among staff in senior positions.
- Continuing to raise awareness about staff's lived experiences with a visible and hidden disability and promoting Hidden Disability Sunflower and Disability Confident schemes.
- Raise awareness about apprenticeship and the Talent Academy and training among staff with disability and LTC.
- Raise staff and line managers' awareness about the Health Passport across LCHS and implement across the Group.
- Start to collect the disability pay gap data to develop next year's Pay Gap Report.
- Continuing to enhance knowledge about reporting bullying and harassment and other supporting procedures for staff.
- Implement the Reciprocal Mentoring Programme across the group, starting with the new Group Trust Board.
- Continuing to raise awareness about the United Against all forms of Discrimination toolkit across ULTH and implementing it across the Group.

WDES Actions linked with the LCHG Group Strategy 2025 - 2030:

Strategic Aim 2 – People:

- Better opportunities: Aiming to develop, empower and retain great people by:
  - o Enable our people to fulfil their potential through training, development, research and education.
  - o Empower our people to continuously improve and innovate.
  - o Nurture compassionate and diverse leadership.

Conclusion

We will continue to communicate the MAPLE staff network and the WDES activities to all staff across the group, so we can all be involved in celebrating our achievements. Having a productive inclusive workforce, where staff feel valued and heard is vital and crucial in providing high-quality personalised care for patients. We will continue to implement the LCHG values: compassionate, innovative and collaborative to ensure that staff feedback has been listened to and the WDES actions have been delivered and a sense of belonging has been embedded across the organisation.

Appendix 1

LCHS Workforce WDES Data 2024 – 2025

Appendix 2

LCHS WDES Data Trends 2019 - 2025

Appendix 3

WDES Action Plan 2025 - 2028

Workforce Disability Equality Standards Report - 2024 -2025 Appendix 1 – LCHS Workforce Data Indicators 1 - 10

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Indicator 1

Staff in post based on: primary assignments only, no bank staff, no Chair/Non-Executive Directors

VSM = (Very Senior Manager including Chief Executive, Executive Directors)

% is the rounded number of the overall LCHS workforce with disability, data taken from the NHS England Data Collection Framework portal.

Indicator 1A Clinical Workforce

Clinical	Disability (NO)		Disability (YES)		Not Declared		TOTAL	
WDES Metric 1	**Headcount**	**Percentage**	**Headcount**	**Percentage**	**Headcount**	**Percentage**	**Headcount**	**Percentage**
Clinical	**1648**	**88.7%**	**144**	**7.8%**	**65**	**3.5%**	**1857**	**100%**
Band 2	75	85.23%	8	9.09%	5	5.68%	88	100.0%
Band 3	342	86.36%	30	7.58%	24	6.06%	396	100.0%
Band 4	93	90.29%	5	4.85%	5	4.85%	103	100.0%
Band 5	372	89.64%	31	7.47%	12	2.89%	415	100.0%
Band 6	363	90.07%	33	8.19%	7	1.74%	403	100.0%
Band 7	303	90.45%	26	7.76%	6	1.79%	335	100.0%
Band 8a	73	83.91%	9	10.34%	5	5.75%	87	100.0%
Band 8b	20	90.91%	2	9.09%	0	0.00%	22	100.0%
Band 8c	3	75.00%	0	0.00%	1	25.00%	4	100.0%
Band 8d	0	0.00%	0	0.00%	0	0.00%	0	100.0%
Band 9	2	100.00%	0	0.00%	0	0.00%	2	100.0%
VSM- Very Senior Manager	2	100.00%	0	0.00%	0	0.00%	2	100.0%

Med & Dental Consultants	25	96.15%	1	3.85%	0	0.00%	26	100.0%
Med & Dental Non-Consultants	5	100.00%	0	0.00%	0	0.00%	5	100.0%
Trainee Grade	1	100.00%	0	0.00%	0	0.00%	1	100.0%

Indicator 1B Non-clinical Workforce

Non-Clinical	Disability (NO)		Disability (YES)		Not declared		Total	
WDES Metric 1	**Headcount**	**Percentage**	**Headcount**	**Percentage**	**Headcount**	**Percentage**	**Headcount**	**Percentage**
Non-Clinical	**337**	**80.4%**	**62**	**14.8%**	**20**	**48%**	**419**	**100%**
Band 1	1	100.00%	0	0.00%	0	0.00%	1	100.00%
Band 2	55	69.6%	21	26.6%	3	3.8%	79	100.0%
Band 3	101	81.5%	17	13.7%	6	4.8%	124	100.0%
Band 4	53	88.3%	6	10.0%	1	1.7%	60	100.0%
Band 5	37	78.7%	6	12.8%	4	8.5%	47	100.0%
Band 6	22	78.6%	4	14.3%	2	7.1%	28	100.0%
Band 7	28	90.3%	3	9.7%	0	0.0%	31	100.0%
Band 8a	16	88.9%	1	5.6%	1	5.6%	18	100.0%
Band 8b	8	80.0%	2	20.0%	0	0.0%	10	100.0%
Band 8c	5	100.0%	0	0.0%	0	0.0%	5	100.0%
Band 8d	2	66.7%	1	33.3%	0	0.0%	3	100.0%

Band 9	3	75.0%	1	25.0%	0	0.0%	4	100.0%
Senior Medical Manager	6	66.7%	0	0.0%	3	33.3%	9	100.0%
Grand Total	**207**	**8.97%**	**2016**	**87.35%**	**85**	**3.68%**	**2308**	**100%**

Indicator 2

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.

Note:

i) This refers to both external and internal posts.

ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.

Applicant Status	Disabled	Non-Disabled	Not Stated/ Undisclosed
Shortlisted	147	1245	26
Appointed	43	284	8
Likelihood	0.29	0.22	0.30

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts is 0.77.

Indicator 3

Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Note:

i)   This metric will be based on data from a two-year rolling average of the current year and the previous year.

ii)   This metric applies to capability on the grounds of performance and not ill health.

	Disabled	Non-Disabled	Unknown
Average number of staff entering the formal capability process over the last 2 years. (i.e. Total divided by 2.)	2	3.5	0.5
Of these, how many are on the grounds of ill health only?	0	0	0

The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff is 5.56.

Indicator 4

Indicator 4a

% of staff who experienced at least one incident of bullying, harassment or abuse from:

- Patients/service users, their relatives or other members of the public

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	30.0%
Staff without Long term conditions and illness	16.9%
National benchmark for staff with LTC&I	30.0%
National benchmark for staff without LTC&I	23.3%
Responses with LTC&I	377
Responses without LTC&I	831

For staff with LTC&I a negative increase, of 4.6% from 25.4%.

Metric 4a (continued)

% of staff who experienced at least one incident of bullying, harassment or abuse from:

- Managers

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	13.3%
Staff without Long term conditions and illness	7.3%
National benchmark for staff with LTC&I	14.6%
National benchmark for staff without LTC&I	8.2%
Responses with LTC&I	376
Responses without LTC&I	823

For staff with LTC&I a negative decrease of 1.9% from 11.4 % to 13.3% in 2024.

Metric 4a (continued)

% of staff who experienced at least one incident of bullying, harassment or abuse from:

- Other colleagues

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	22.9%
Staff without Long term conditions and illness	11.0%
National benchmark for staff with LTC&I	23.8%
National benchmark for staff without LTC&I	15.4%
Responses with LTC&I	375
Responses without LTC&I	812

For staff with LTC&I a negative increase of 1.7% from 21.2% to 22.9% in 2024.

Indicator 4b

% of staff saying they, or a colleague, reported their last incident of bullying, harassment, or abuse.

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	52.3%
Staff without Long term conditions and illness	61.2%
National benchmark for staff with LTC&I	52.5%
National benchmark for staff without LTC&I	51.4%
Responses with LTC&I	151
Responses without LTC&I	183

For staff with LTC&I a positive increase of 1.1% in 2024.

Indicator 5

% of staff who believe that their organisation provides equal opportunities for career progression or promotion.

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	60.0%
Staff without Long term conditions and illness	65.1%
National benchmark for staff with LTC&I	52.2%
National benchmark for staff without LTC&I	58.1%
Responses with LTC&I	377
Responses without LTC&I	828

For staff with LTC&I a negative increase of 2.7% in 2024.

Indicator 6

% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	23.3%
Staff without Long term conditions and illness	15.7%
National benchmark for staff with LTC&I	26.6%
National benchmark for staff without LTC&I	18.5%
Responses with LTC&I	253
Responses without LTC&I	337

For staff with LTC&I a negative increase of 1.6% in 2024.

Indicator 7

% of staff satisfied with the extent to which their organisation values their work.

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	42%
Staff without Long term conditions and illness	52.2%
National benchmark for staff with LTC&I	36.9%
National benchmark for staff without LTC&I	47.8%
Responses with LTC&I	379
Responses without LTC&I	833

For staff with LTC&I a negative decrease of 3.1% in 2024.

Indicator 8

% of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work.

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	78.0%
National benchmark for staff with LTC&I	74.5%
Responses with LTC&I	233

For staff with LTC&I a positive increase of 0.1% in 2024.

Indicator 9

Indicator 9a

The NSS staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

Staff	Score
Organisational average	7.0
Staff with Long term conditions and illness (LTC&I)	6.7
Staff without Long term conditions and illness	7.2
National benchmark for staff with LTC&I	6.5
National benchmark for staff without LTC&I	7.0
Responses with LTC&I	379
Responses without LTC&I	833

For staff with LTC&I a slight decrease of 0.1 in 2024.

Indicator 9b

b) Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard? (yes) or (no) Yes

Please provide at least one practical example of current action being taken in the relevant section of your WDES annual report.

MAPLE (Mental and Physical Lived Experience) Staff Network and IMPACT (Long- term conditions support group

We also have done other activities:

- National Staff Survey (promoted by MAPLE/IMPACT)

- Trust Board sponsor for MAPLE Network

- Webinars with Question and Answers during Disability History Month 2024

- MAPLE involvement in the WDES Action Plan

- Reasonable Adjustment and Flexible Working webinars during Disability History Month 2024/Carers Week 2024/Carers Rights Day 2024

Indicator 10

Indicator outcome:

Disability representation across the Trust Board: 16.67%

9% of the Trust Workforce is disabled, 16.67% of the Voting Board is disabled

Therefore, 16.67% - 9% = +7.6 % (8 %*)

*% is the rounded number of the overall LCHS workforce with disability, data taken from the NHS England Data Collection Framework portal.

	Disabled	Percentage	No Disabled	Percentage	Not Declared	Percentage	Total Headcount
Total Board members	3	16.67%	8	44.44%	7	38.89%	18
of which: Voting Board members	2	18.18%	4	36.36%	5	45.45%	11
Non-Voting Board members	1	14.29%	4	57.14%	2	28.57%	7
of which: Exec Board members	1	11.11%	5	55.56%	3	33.33%	9
Non-Executive Board	2	22.22%	3	33.33%	4	44.44%	9
Overall Workforce by Disability		9%		87.35%		3.5%	
Difference % (Total Board – Overall workforce)		8%		-43%		35%	
Difference % (Voting membership - Overall Workforce)		9%		-51%		42%	
Difference% (Executive membership - Overall workforce)		2%		-32%		30%	

Appendix 2 – LCHS WDES data trends - 2019 - 2025

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Indicator 1

Percentage of the overall LCHS workforce with a disability, data taken from the NHS England Data Collection Framework portal.

Staff in post based on: primary assignments only, no bank staff,
no Chair/Non- Executive Directors.

	2019	2020	2021	2022	2023	2024	2025
	5.40%	7.50%	6.20%	5.80%	9.60%	9.80%	9.00%

Metric Selected	1 ▼
Metric Definition	Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce.

- The percentage declined slightly from 9.8% in 2024 to 9.0% in 2025.
- Overall, a positive trend was observed during the seven-year period of 2019 - 2025, from 5.40% to 9.0%. With the highest increase between 2022 and 2023 5.8% to 9.6%.

Indicator 2

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.
Note:
i) This refers to both external and internal posts.
ii) If the organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.

	2020	2021	2022	2023	2024	2025
	0.97	1.52	1.26	1.23	1.13	0.77

Metric Selected	2 ▼
Metric Definition	**Relative likelihood of staff being appointed from shortlisting across all posts**

- The relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts, is close to 1 in the last six years, from, 0.77 to 1.52 in 2021, with 1 representing equal likelihood.
- In 2025, the likelihood for staff with disability and long-term conditions is 0.77, indicating that it is more likely for staff with LTC and disability to appointed compared with staff without LTC. This has seen a positive decrease overall.

Indicator 3

Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Note:

    i)   This metric will be based on data from a two-year rolling average of the current year and the previous year.

    ii)   This metric applies to capability on the grounds of performance and not ill health.

	2020	2021	2022	2023	2024	2025
	0	0	0	0.6	3.21	5.56

Metric Selected	3 ▼
Metric Definition	**Relative likelihood of staff entering the formal capability procedure.**

- The formal capability process is more likely to be entered by disabled staff than non-disabled staff, with the highest rate this year being 5.56 compared to previous years.
- It should be noted that protected characteristic data was not captured prior to 2022.
- Since 2023, the disability/LTC has been recorded, indicating a significant increase in staff entering the LTC/disability into the capability procedures.

Indicator 4

Indicator 4a

% of staff who experienced at least one incident of bullying, harassment or abuse from:

- Patients/service users, their relatives or other members of the public

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	27.20%	32.69%	35.94%	31%	28%	25.43%	29.97%
Non-disabled Staff	21.80%	23.45%	22.34%	16%	16%	17.53%	16.85%

Metric Selected	4a (i) – Abuse from patients and ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients/service users, their relatives or other members of the public**

- Throughout the past seven years, there have been varying outcomes, with the highest peak being in 2021 at 35.94% and the lowest being in 2024, 25.43%.
- The chart shows a stable positive decrease among staff who experienced bullying, harassment or abuse from patients/service users, their relatives or other members of the public between 2020 – 2024 with a negative increase this year, with 29.97%.

Metric 4a (continued)

% of staff who experienced at least one incident of bullying, harassment or abuse from:

- Managers

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	17.60%	14.01%	12.81%	14.63%	16%	11.39%	13.30%
Non-disabled Staff	10.30%	8.57%	7.48%	7.85%	6%	6.69%	7.29%
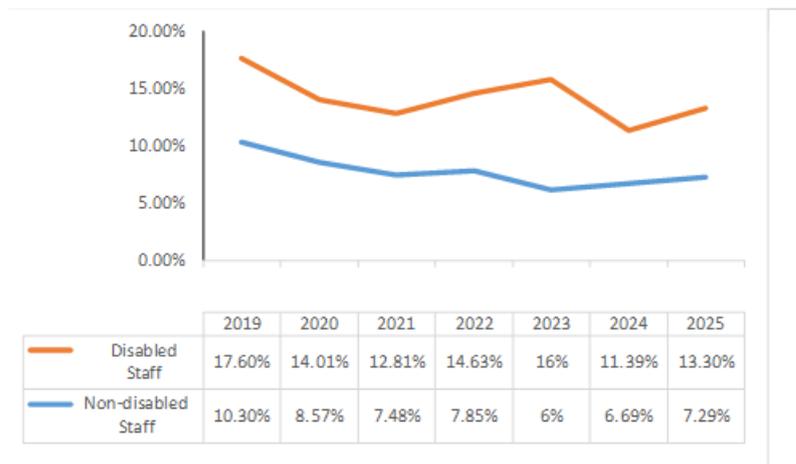
Metric Selected	4a (ii) - Abuse from managers ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers.**

- During the seven years, the results have been inconsistent, with 2019 and 2023 being the highest peak with 17.6% and 16% respectively, while 2024 being the lowest with 11.39%.
- Despite the fact, of the variation over the 7 years period, overall, the chart shows a positive decrease, from 17.6% in 2019 to 13.30% in 2025.

Metric 4a (continued)

% of staff who experienced at least one incident of bullying, harassment or abuse from:

- Other colleagues

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	21.50%	22%	21.86%	19.45%	20%	21.17%	22.93%
Non-disabled Staff	13.80%	12.22%	13.66%	11.46%	8%	10.85%	10.96%

Metric Selected	4a (iii) - Abuse from other collea ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled other staff experiencing harassment, bullying or abuse from other Staff**

- The percentage of staff who experienced bullying, harassment, or abuse from colleagues increased steadily between 2022 and 2025, with 19.45% in 2022 and 22.93% in 2025.

Indicator4 b

% of staff saying they, or a colleague, reported their last incident of bullying, harassment, or abuse.

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	56.80%	62.39%	66.12%	54.41%	57.14%	51.20%	52.32%
Non-disabled Staff	55.60%	52.83%	54.63%	53.26%	51.45%	62.37%	61.20%

Metric Selected	4b ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it**

- Throughout the past seven years, there have been varying outcomes, with the highest peak being in 2021 at 66.12% and the lowest being in 2024, 51.420%.
- There has been a positive development in staff reporting their latest incident of bullying, harassment, or abuse, in the last year, with 1.12% increase between year 2024 and 2025.

Indicator 5

% of staff who believe that their organisation provides equal opportunities for career progression or promotion.

	2022	2023	2024	2025
Disabled Staff	61%	61.34%	62.70%	59.95%
Non-disabled Staff	71%	70.53%	70.00%	65.10%

Metric Selected	5 ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.**

- The chart shows the highest decline in 2025 to 59.95%, which is the lowest in the four years, where in previous years there was a stable postive increase from 61.0% to 62.7%, over the previous three years period.

Indicator 6

% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	30.10%	35.06%	25%	30.70%	25.12%	21.70%	23.32%
Non-disabled Staff	22.30%	26.15%	26%	17.94%	19.69%	17.10%	15.73%

Metric Selected	6
Metric Definition	**Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**

- The results have varied over the last seven years, with the highest peak being in 2020 with 35.06% and the lowest being in 2024, 21.70%.
- Despite the fact that chart shows the negative increase in the last year, to 23.32%, overall the chart indicates a positive decrease over the seven years period.

Indicator 7

% of staff satisfied with the extent to which their organisation values their work.

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	51.60%	43.30%	49.48%	41.57%	46.82%	45.07%	41.95%
Non-disabled Staff	55.60%	54.76%	59.43%	57.73%	54.96%	54.13%	52.22%

Metric Selected	7 ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work**

- The chart shows a negative decrease among staff who are satisfied with the extent to which their organisation values their work when comparing 2019 and 2025, 51.60% and 41.95%, respectively.
- With the highest drop in 2022, and this years, which are the lowest for the seven years period.

Indicator 8

% of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work.

	2019	2020	2021	2022	2023	2024	2025
	74.50%	77.60%	84.40%	69.00%	75.68%	77.88%	78.03%

Metric Selected	8 ▼
Metric Definition	**Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work**

- Despite a high negative decrease in 2022, the number dropped to 69.0%, and then has increased to 75.68% and seen a steady increase since then of staff reporting that their employer has made adequate adjustments.
- Overall, this has seen a positive increase among staff saying their employer has made adequate adjustment(s) to enable them to carry out their work, over the seven years period, from 74.50%in 2019 and 78.03% in 2025.

Indicator 9

The NSS staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	7.1	6.9	7.15	6.77	6.85	6.83	6.66
Non-disabled Staff	7.4	7.48	7.62	7.46	7.35	7.3	7.2

Metric Selected	9a
Metric Definition	**Staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.**

- Over the course of seven years, disabled staff have maintained a staff engagement score around 6.66 to 7.1, (within the 0.5 variation), with the lowest engagement score this year.

Indicator 10

- Disability representation across the Trust Board.

2019	2020	2021	2022	2023	2024	2025
1 Board members identified as having a disability/LTC	1 Board members identified as having a disability /LTC	1 Board members identified as having a disability/ LTC	1 Board members identified as having a disability/LTC	2 Board members identified as having a disability /LTC	1 Board members identified as having a disability / LTC	3 Board members identified as having a disability/LTC

Metric Selected	10 ▼
Metric Definition	**Percentage difference between the organisation's Board voting membership and its overall workforce representation.**

- In the past seven years, there has been a rise in the number of Trust Board representations who declared their disability or long-term condition, from 11.1% to 16.7%, in 2019 to 2025.

ULTH Workforce Disability Equality Standard Annual Report - 2024-2025

Caring and building a
healthier future for all

Authors: EDI Team

Date: June 2025

Contents

Introduction

Welcome to the United Lincolnshire Teaching Hospital (ULTH), Workforce Disability Equality Standard (WDES) 2024-2025 report. This report contains reflection of last year's actions for the Workforce Disability Equality Standard (WDES).

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS organisations use the metrics data to develop and publish an action plan, building on high impact actions shared in the first ever NHS Equality, Diversity and Inclusion (EDI) improvement plan. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality to create the cultures of belonging and trust that will improve retention, recruit from the widest possible talent pool and provide sustainable careers. To fulfil the Trust's commitments towards staff, ULTH complies with the Public Sector Equality Duty, as part of the Equality Act 2010, and the NHS People Promise as part of the NHS Long Term Workforce Plan. The Trust aspires to create an inclusive culture by embedding a sense of belonging across the organisation. From the 1st April 2024, ULTH entered into a Group Model with Lincolnshire Community Hospital Services. (LCHS).

To improve the experience of staff with long-term conditions and disabilities, working or seeking employment in the NHS, LCHS adopted the Workforce Disability Equality Standard (WDES). It was introduced in 2019 and commissioned by the NHS Equality and Diversity Council, the WDES is mandated through the NHS Standard Contract. It consists of 10 metrics, based on workforce data and staff feedback from the NHS Staff Survey, which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The data help us understand the trends and patterns of inequality and highlight areas that require improvement. This also illustrates the progress that has been made by the Trust in reducing gaps and inequalities in the workplace.

Methodology

The WDES remains the only example in the UK where employers are mandated to report and publish annual data on the workplace and career experiences of disabled staff. The ambition is to increase the representation of disabled people in the NHS workforce and see the disparities between disabled and non-disabled staff reduce year on year; supported by an inclusive culture through the realisation of the vision set out in the People Promise. As well as delivering high quality healthcare for millions, the NHS also provides employment for more than a million people in some of the most valued, varied and skilled roles in the country.

We have recently witnessed two landmark moments in the 75-year history of the NHS. The publishing of the NHS Long Term Workforce Plan is the first time the government has asked the NHS to produce a comprehensive workforce plan; a once-in-a-generation opportunity to put staffing on a sustainable footing and improve patient care. Meanwhile the NHS Equality, Diversity and Inclusion (EDI) Improvement Plan recognises that the NHS is more diverse than it has ever been. The plan sets out six high impact actions, to ensure our staff work in an environment where they feel they belong, can safely raise concerns and provide the best possible care to our patients.

As NHS Staff Survey data shows, 1 in 4 members of our NHS workforce has lived experience of a disability or long-term condition. If we are to achieve the ambitions set out in the NHS Long Term Workforce Plan – to improve training and retention and deliver new ways of working – we must also do so through a disability-inclusive lens. The NHS EDI Improvement Plan sets out actions and interventions that NHS organisations can adopt as they work to build workplaces that enable our staff to thrive.

The vast lived experience of disability within the NHS workforce is captured in this 2024-25 report on the Workforce Disability Equality Standard (WDES), which remains the UK's only mandated standard on the working lives of disabled staff. The WDES metrics data continues to help us keep our minds targeted on where we can prioritise actions to improve current performance. Thanks to a maturing body of evidence, the WDES offers a rich and thought-provoking exploration of how the NHS, as an employer, can best care for and protect colleagues across the broad spectrum of disability.

It is particularly good to note that there has been a further improvement in the WDES metric on workforce representation. The proportion of staff whose disability status is 'unknown' has reduced to its lowest recorded level. This is a measurement of the work that trusts have delivered to reduce barriers and create inclusive workplaces; with more staff feeling confident to share information about their disabilities.

Also welcome is the further improvements in the representation of disabled people on boards, which brings greater diversity in lived experiences into senior decision-making and benefits both the workforce and our patients.

ULTH remains committed to reducing the disparities that disabled staff experience and to improving the talent pipeline for disabled NHS staff.

WDES National Key Findings:

The 2024 Workforce Disability Equality Standard (WDES) key findings in England show that disabled staff continue to experience challenges, particularly in perceptions of equal opportunities for progression and feeling valued. While improvements are noted in some areas like recruitment outcomes and reasonable adjustments, disparities persist, particularly for certain demographic groups. Here's a more detailed breakdown of the key findings:

- In March 2024, 5.7% of the workforce across NHS trusts declared a disability through the Electronic Staff Record (ESR) (86,312 people), which was an increase of 0.8% on 2023. 14.3% of staff did not declare whether they have a disability. 6.5% of board members declared that they have a disability or not.
- The likelihood of non-disabled candidates being appointed from shortlisting compared to disabled candidates was close to equity (0.98). Specifically, 19.5% of non-disabled candidates were appointed from shortlisting compared with 19.8% of disabled candidates.
- Disabled staff were more than twice as likely (2.04) to enter the formal capability process (on performance grounds) compared to their non-disabled colleagues, although this was an improvement from 2.17 in 2023.

- 25.05% of respondents from NHS trusts indicated they were disabled.
- 74.5% of disabled staff reported that their employer has made reasonable adjustment(s) to enable them to carry out their work, an increase from 2022 (73.0%).
- 30.0% of disabled staff reported experiencing harassment, bulling or abuse by patients, family, service users or the public, 14.6% from managers and 15.4% from other colleagues, lower than in previous years, but higher than the experience of non-disabled staff.
- Fewer disabled staff (52.2%) than non-disabled staff (58.1%) felt that their trust provides equal opportunities for career progression or promotion.
- More disabled staff (26.6%) said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties, compared with 18.5% of non-disabled staff.
- Fewer disabled staff (36.9%) than non-disabled staff (47.8%) were satisfied with the extent to which their organisation values their work.

The WRES also complements the Workforce Disability Equality Standard (WDES) and both are vital to ensuring that the values of equality, diversity and inclusion lie at the heart of the NHS.

This report sets out key information about the experience of Black Minority Ethnic (BME) staff for the period April 2024 to March 2025 and includes a metrics data report for 2024/25, together with an action plan for 2025-28.

Further, since the inception of the WDES in 2019, the Trust has been tracking the trends over time for each of the WDES metrics. In this report, the data trends are reviewed and analysed. Infographics relating to the data trends for each of the metrics are provided in Appendix 2. An LCHG action plan is contained at appendix 3.

Executive summary

The Trust employed 10,372 staff as of 31 March 2025 of which 667 disclosed their disability or long-term condition on the Electronic System Record (ESR). Based on workforce data as of 31 March 2025 and feedback from the NHS Staff Survey 2024 (detailed in Appendix 1), a WDES action plan 2025-28 (contained in Appendix 3) has been developed in partnership with the Group Mental and Physical Lived Experience (MAPLE) Staff Network. The action plan will be implemented and progressed over the next 12 months to help reduce the barriers that impact the experience of our staff with disability and long-term conditions.

The Census 2021, states that across both England and Wales, the proportion of disabled people is 17.8% (10.4 million) and it has decreased by 1.7 percentage points from 2011 when it was 19.5% (10.0 million). According to the 2021 Census, 26.6% population in Lincolnshire declared to have long-term physical or mental health. Nationally in the NHS, there is still a significant under-reporting of the number of NHS staff who declare themselves to be disabled. However, currently over 72,000 employees have declared a disability in ESR, compared with just 35,000 in 2015.

As the WDES metrics are evidence-based, the Trust is committed to continuing to raise awareness about the importance of declaring disability across the organisation to help to understand the experiences of staff with disability or long-term conditions (LTC). Our local NHS Electronic Staff Record (ESR) indicates that 6.4% of staff employed staff have declared a disability, 667 out of 10,372.

ULTH WDES Metrics Dashboard 2024-2025 Data

Index

- Positive increase
- Neutral increase
- Negative increase
- Neutral
- Positive decrease
- Neutral decrease
- Negative decrease

Table 1. Index: A difference of 0-5% is Amber, with more than 5% being Green or Red. For probability a difference of 0 – 0.5 is Amber, with more than 0.5 being Green or Red.

*For 2025 results, indicators 1-3 and 10 are based on Electronic Staff Records (ESR) and local data as of 31 March 2025 for the year 2024-25. Indicators 4-9 are taken from the National Staff Survey (NSS) of 2024. ** For national benchmark data, indicators 1-3 and 10 are based on the national WDES report for 2023 with ESR as of 31 March 2024. Indicators 4-9 are based on the NSS results of 2023 (which is the latest benchmark data available). *** For full ULTH data please see Appendix 1.

Metrics (Indicators)	2023 Results	2024 Results	2025 Results	ULTH Progress March 2024-March 2025	National Benchmark (based on ESR 2024 and NSS 2023)**	ULTH data compared with national benchmark
1.Percentage of disabled staff in ULTH (excluding bank)	4.2%	5.0%	6.4%	↑ (yellow up)	5.7%	↑ (yellow up)
2. Relative likelihood of non-disabled staff being appointed from shortlisting across all posts (as a ratio)	1.16	1.33	1.16	↓ (yellow down)	0.98	↑ (yellow up)
3. Relative likelihood of disabled staff entering the formal capability process (as a ratio)	0	0	1.71	↑ (red up)	2.04	↓ (yellow down)
4a) % of disabled staff who experienced at least one incident of bullying, harassment, or abuse from:						
• Patients/service users	32.0%	28.2%	28.4%	↑ (yellow up)	30.0%	↓ (yellow down)
• Managers	18.9%	16.8%	15.7%	↓ (yellow down)	14.6%	↑ (yellow up)
• Other colleagues.	28.8%	25.5%	29.3%	↑ (yellow up)	23.8%	↑ (red up)
4b) % of disabled staff saying they, or a colleague, reported their last incident of bullying, harassment, or abuse.	50.4%	50.3%	49.2%	↓ (yellow down)	52.5%	↓ (yellow down)
5. % of disabled staff who believe that their						

Metrics (Indicators)	2023 Results	2024 Results	2025 Results	ULTH Progress March 2024-March 2025	National Benchmark (based on ESR 2024 and NSS 2023)**	ULTH data compared with national benchmark
organisation provides equal opportunities for career progression or promotion.	48.4%	50.7%	52.6%	⬆	52.2%	⬆
6. % of disabled staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	30.4%	29.3%	27.2%	⬇	26.6%	⬆
7. % of disabled staff are satisfied with the extent to which their organisation values their work.	31.9%	33.4%	35.5%	⬆	36.9%	⬇
8. % of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work.	71.5%	70.6%	72.7%	⬆	74.5%	⬇
9. National Staff Survey engagement score for disabled staff (out of 10)	6.2	6.1	6.2	⬌	6.5	⬌
10. Percentage of:						
• Total Board declaration	0%	13.13%	11.11%	⬇	6.5%	⬆
• Exec declaration	0%	14.29%	11.11%	⬇	6.2%	⬆
• Non-exec declaration	0%	12.5%	11.11%	⬇	6.8%	⬆

Workforce Disability Equality Standard 2024-25 Headlines

Key areas of progress

- Increasing number of staff disclosing disability or long-term conditions (LTC) on ESR to 6.4% from 5.0% and maintaining higher than national average - the national benchmark is 5.7%. Also, the data trend from 2019 confirms our positive increase among staff disclosing their disability and long term condition on ESR, from 2.90% in 2019.
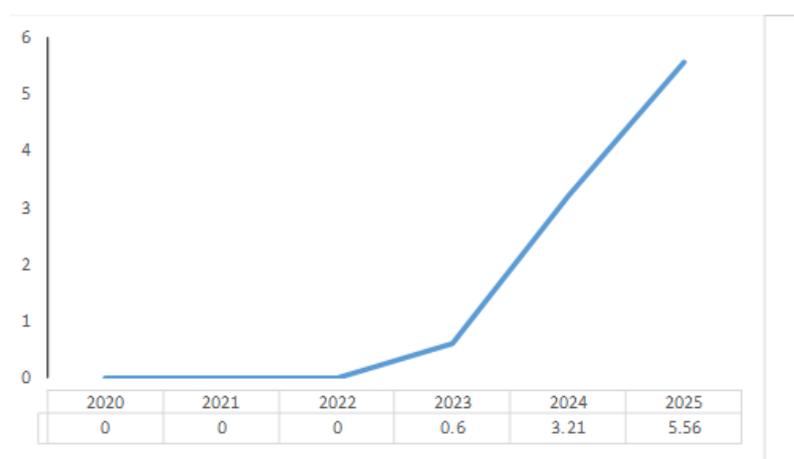
- The relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts has positively decreased from 1.33 in 2024 to 1.16.

- Maintain reduction in % of disabled staff saying they experienced, incident of bullying, harassment, or abuse from managers with positively decreased from 16.8% to 15.7%.

- Increasing % of staff with long-term conditions and illness saying the Trust has made adequate adjustment(s) to enable them to carry out their work, from 70.6% to 72.7%. That is a steady positive increase for most of the period from 2019 (64.90%) to 2025, with an exceptional decrease in 2022 of 4.2% and with an increase since then.

- Supporting LCHS with Disability History Month 2024 with inspiring programme for the Lincolnshire system. Various sessions on a range of topics were delivered including: The Diary of a Freedom to Speak Up Leader; Paul White, CEO Hidden Disabilities Sunflower Scheme; Being a Member of the Older Workforce support Session; Reasonable Adjustment considerations; Workplace Thriving with Neurodiversity, Past, Present and Potential; Access to Work support session; Carer Burnout delivered by 'The Recovery College' and Living with a Long-Term Condition Lived Experience Journeys including staff lived experience journeys.

- Blue Monday Brew Monday drop-in support session to bring the MAPLE and IMPACT staff networks together as one network across the Lincolnshire Community and Hospitals Group.

- Celebration of the National Staff Network Day 2024 by participating in online ELT Live. Staff Network leads had the opportunity to speak about their network activities across group encouraging staff to be involved with Chief Executive.

Our key areas of focus as LCHG

On the 1st April 2025, LCHS and ULTH became part of a Group Model. A decision was taken to produce a Group WDES Action Plan with key areas of focus:

- Ongoing work on increasing staff disclosing their disability or long-term conditions, particularly for staff at senior levels.

- Raising awareness about staff's lived experience with visible and hidden disability.

- To decrease % of disabled staff and non-disabled staff experiencing harassment, bullying, or abuse from patients as negative increase in previous year.

- To decrease the number of staff experiencing bullying and harassment from other colleagues as the number of staff experiencing bullying or harassment has increased.

- Raise awareness of the reporting procedures when experiencing or witnessing bullying and harassment and available support.

- Ongoing monitoring and reviewing of capability process data to assess factors and reasons for increasing numbers of disabled staff entering the process.

- Career opportunities include leadership opportunities for staff with disability and long-term conditions.

- Raise staff and line managers' awareness about reasonable adjustment processes to support their needs, including reviewing implementation the Health Passport across the Group Model.

Our commitments

The Equality Diversity and Inclusion (EDI) Calendar 2024-2025

The Equality Diversity and Inclusion (EDI) Calendar 2024-2025 provides a selection of key religious and cultural dates, awareness and action days, and some events which reflect the diverse nature of our workforce and local populations. This calendar has been developed as a way to help us celebrate our diverse communities, cultures and faiths. It provides an opportunity to visibly embrace and embed equality, diversity and inclusion into our Trust for patients and colleagues alike, in practical and supportive ways.

This has been developed over the last few years so that Staff Networks and other staff groups can plan campaigns, meetings and events. From 2025, the EDI Calendar is now a Group Model sharing awareness events that are important for both Trusts.

These are some examples from the EDI Calendar.

Anti-Bullying and Harassment Week November 2024

Anti-Bullying Week 2024 was co-ordinated in England, Wales, and Northern Ireland by the Anti-Bullying Alliance. This year it had the theme 'Choose Respect' and took place from Monday 11th to Friday 15th November 2024.

The MAPLE Network and the Freedom to Speak Up Guardians delivered a webinar that focused on a conversation with the Freedom to Speak Up Guardians from LCHS and ULTH, who talked about their Speak Up Journeys.   We took a different approach this year to demonstrate the importance of the freedom to speak up role and shared contact details for all the Freedom to Speak Up Guardians for the Lincolnshire system. This also formed the opening of Disability History month celebrations and

was the most attended event of the month. This was a different approach to previous years. The session was recorded and is available to watch on the staff intranet.

Carers Rights Day November 2024

Carers Rights Day was on Thursday 21st November 2024 and this year's theme was 'recognising your rights'. We celebrated during the Disability History month programme on Friday 29th November by participating in a workshop hosted by Lincolnshire Recovery College on Carer Burnout.

We recognised that there was some crossover between staff with caring responsibilities who sometimes have long term health conditions and disabilities. We held a MAPLE session talking about support available with workplace health challenges, particularly as an older member of the workforce and shared resources about the Carer's resources that were available.

Disability History Month 2024

Thursday 14th November 2024 – 20th December 2024

LCHS MAPLE has led on the Disability History Month Programme 2024 on behalf of the three Lincolnshire Trusts. The theme was Disability, Employment and Livelihood. There were nine sessions delivered during November and December 2024. All webinars were held virtually this year and addressed several disability related topics and reached over 80 staff across the Lincolnshire System and included staff from ULHT. The events were supported by system partners and members of the MAPLE network. The topics covered incorporated other awareness days that happened during the month too including Carer's Rights Day, Anti-Bullying and Harassment Week, Trans Remembrance Day and an intersectional approach was taken to incorporate these events into the programme. The sessions delivered were:

- The Diary of a Freedom to Speak Up Leader acknowledging Anti-bullying and Harassment week the theme this year was 'Choose Respect'.

- Hidden Disabilities Sunflower Scheme, by Paul White, CEO Hidden Disabilities Sunflower Scheme. The scheme continues to be promoted throughout the Trust.
- Understanding UK Trans Health – to acknowledge Trans Remembrance Day.
- MAPLE – Being a Member of the Older Workforce Support Session, Reasonable Adjustment considerations.
- Workplace Thriving with Neurodiversity, Past, Present and Potential.
- Access to Work Support Session.
- Carer Burnout 'The Recovery College'. In support of Carer's Rights Day.
- Living with a Long Term Condition Lived Experience Journeys.
- Closure and Reflections of the month session.

Race Equality Week

Race Equality Week is celebrated every year between Monday 3rd February 2025 – Sunday 9th February 2025. The theme this year was Every Action Counts. The purpose is to emphasise the importance of taking collective and individual action to tackle experience of race equality.

This year ULHT has attended LCHS session on Wednesday 5th February 2025, with a session on 'Protected Characteristics, Understanding Macroaggressions and the Importance of being an Ally'. The session was collaborated between the CODE and MAPLE staff network and was supported by the REACH staff network chairs and the Chief People Officer and was open to staff across the group. The session was powerful and emphasised the fact that all protected characteristics can experience macroaggressions. The initial resources section was recording and an unrecorded discussion was held afterwards in a safe space. It was acknowledged that the subject requires further work.

Hidden Disability Scheme

The Chief Executive Officer delivered a webinar to MAPLE members all about the importance of the Hidden Disabilities Sunflower Scheme. We have now also renewed the Hidden Disabilities Sunflower Scheme as one membership for LCHG. MAPLE continues to promote the hidden disability sunflower scheme through communications platforms. We also promote the importance of declaring disability and long term conditions on the NHS Electronic System Record. ULTH extended the Hidden Disability Scheme membership aiming to encourage inclusivity, acceptance, and understanding of hidden disability across the Trust and to encourage colleagues to disclose their disability or long-term conditions on the NHS Electronic System Record. We have also promoted and distributed white sunflower supporter badges to staff to raise awareness about allyship.

Reasonable Adjustments

The WDES data analysis indicates that we increased our commitment to providing reasonable adjustments for staff with disability and long-term conditions, 70.6% from 72.7%. To make sure that the support is provided we are aiming to maintain a positive increase of implementing reasonable adjustments and to achieve this the Trust is committed to supporting staff with a range of reasonable adjustments and raising their awareness about available support.

Flexible Working

To increase the visibility of the Trust's commitments to the understanding of challenges and experiences of staff with disabilities or long-term conditions, ULTH provides a flexible working policy. Our key purpose is to ensure that our employees have the appropriate support to retain and continue working at ULTH and manage work-life. Therefore, ULTH implemented flexible and hybrid working options for staff from the first day of their employment as both opportunities are designed to support our staff to balance their work and personal needs. ULTH also now promotes flexible working on all job adverts.

Disability Confident Employer Scheme

This year ULTH applied and successfully renewed in April 2024 the Level 2 Disability Confident Employer for the next 3 years. The Trust is committed to continuing to achieve Disability Confident Scheme goals by supporting our employers and candidates with disabilities and LTCs in fulfilling their potential, talents, and aspirations. Through Disability Confident, we are challenging attitudes towards disability, increasing understanding of the challenges, removing barriers and inequalities aiming to bring people with disabilities and long-term health conditions to our organisation, and being the best place to work.

Freedom to Speak Up Guardian

Here at ULTH, we believe that speaking up about concerns is vital and we want our staff to feel supported at work. To ensure that their concerns are looked into, and that staff have access to the support they need. The Trust continues to enhance the initiative and visibility of the FTSUG, and FTSUG champions and partnership working with staff networks.

United against Discrimination

In our National Staff Survey (NSS) results from 2021 and 2022 showed a rising trend for racism and LGBTQ+ abuse from patients. In order to tackle this, we have developed a practical tool to help us make a positive difference in stopping and reducing the impact of these incidents. The new flowcharts were developed with a wide group of colleagues in the United against Discrimination Working Group - including representatives from Staffside, Patient Experience, Divisions, Medical, Nursing and Family Health representatives, Staff Networks, HR, Freedom to Speak Up, Security Management and Safeguarding. Alongside this, advice from the Trust's solicitors was also sought, for extra assurance.

The flowcharts are based on British Medical Association guidance originally, but have been adapted so they can be applied to all staff who work across our Trust. The flowcharts apply to all forms and types of discrimination and are not limited to racism

and LGBTQ+ abuse (where the data gives the greatest cause for concern), but also: sexism and sexual harassment, religious discrimination or abuse, abuse towards disabled colleagues, and age-related discrimination.

United against discrimination posters have been designed to be displayed in all areas for patients and are now developed for staff to report anonymously. The posters are designed with a QR code so can be scanned and reported to a new reporting system called "SafetyQUBE" for Bullying and Harassment.

Cultural Intelligence

Cultural Intelligence (CQ®) goes beyond existing approaches of cultural sensitivity, unconscious bias, and cultural awareness. The programme sets out the skills, abilities, and capabilities that are vital for individuals and organisations in having successful and respectful work with the difference and diversity needed to improve a 'sense of belonging', including within the recruitment process and career progression.

Dream and Apply follow-up CQ sessions

The session includes a recap of what was covered and then some ideas to explore how we can develop and use our Cultural Intelligence skills to lead more inclusively going forward.
The aims are:
- Recap the Cultural Values
- Recap your CQ Capabilities
- Explore how to apply CQ to a situation
- Look at how we dare to dream and design with cultural intelligence

LCHG will continue to embed this through the Group Leadership Programme going forward.

Group Staff Awards 2024

The first joint staff awards as LCHS and ULHT coming together as a group were awarded in November 2024. It is an award, for recognising and celebrating our NHS stars across the Group. The awards are an opportunity for the people of Lincolnshire to recognise the hard work, dedication and care shown by community and hospital staff working across the county, and where they have demonstrated exceptional professionalism and care. There are 15 categories, including the Equality, Diversity and Inclusion Champion of the Year Award. Four staff were shortlisted, across clinical and non-clinical roles in this category. Sara Blackbourn, the Trust Lead Occupational Therapist at ULTH won the category, for initiating the Stronger Together Coaching Forums and welcome hampers to support the team which had several cohorts of internationally educated Allied Health Professionals (AHPs). Sara made herself available and offered to listen and support them in a safe space. The Highly Commended recognition was awarded to the LCHS CODE Staff Network chair for being instrumental in advocating for inclusive culture and diversity across the group and for celebrating South Asian Heritage month for the first time.

ULTH staff networks

The staff networks are in a period of transition following the Group model introduction and are at various stages of coming together. All of the staff networks provide an opportunity for staff to find support and share their voices and concerns to improve working practices across the group. The staff networks support the implementation of the Public Sector Equality Duty from the Equality Act (2010), WRES, WDES and EDS.

They support the organisation to prevent and eliminate discrimination, harassment, and victimisation, promoting equality and equal opportunities, as well as fostering good relations by challenging prejudice and promoting understanding between people who share a protected characteristic and those who do not.

Mental and Physical Lived Experience (MAPLE)

MAPLE is the staff inclusion network for colleagues with Mental And Physical Lived Experience. Our aim is to create a safe place to discuss our disabilities and long-term conditions in order to improve our experiences and working lives. We are a growing network and welcome allies and advocates as well as anyone who has lived experience of a visible or non-visible disability, long-term health condition, and/or mental health condition, whether formally diagnosed, self-identified or through caring responsibilities.

MAPLE meets regularly as a group on Teams to share updates and to hear your feedback and experiences to influence our priorities. Going forward MAPLE has started to partnership working with LCHS MAPLE and LCHS Impact Forum and coming together in April 2025 as one LCHG MAPLE Staff Network.

MAPLE's Progress highlights

- Continuing to grow the staff network.
- Continue to raise awareness of hidden disabilities through the Sunflower Scheme and had three Sunflower roadshows across the summer at different sites.
- Partnership working with other staff networks like Womens' Staff Network, for example the working from home focus group and webinars such as Menopause, Endometriosis and Cancer.
- They have implemented a regular programme of Ask Me Anything sessions to enable colleagues to learn more about common conditions other colleagues live with, and MAPLE network members have frequently contributed to the EDI Sounds podcast, sharing their stories and lived experience.
- Attended various webinars throughout Disability History Month that LCHS hosted on a range of topics including: The Diary of a Freedom to Speak Up Leader; Paul White, CEO Hidden Disabilities Sunflower Scheme; Being a Member of the Older Workforce support Session; Reasonable Adjustment considerations; Workplace Thriving with Neurodiversity, Past,

Present and Potential; Access to Work support session; Carer Burnout, Hidden disabilities and Living with a Long Term Condition Lived Experience Journeys.

- Continue to be a stakeholder of any Group work regarding the national staff survey results and Workforce Disability Equality Standards action plans.

In summary, the MAPLE group has been working in collaboration across the organisation and regionally and has been working towards widening the reach of the network to bring in new members. Going forward they are looking forward to more visibility and influence with the possibilities of social gatherings and continuing to work as allies with other staff networks.

Next Steps 2025 - 2026

The Group's next steps are to develop a first Group WDES Action Plan and embed the below aims into actions, linked to the equality objectives and the LCHG Strategy, with input from the MAPLE staff network and from staff across the Group.

Key WDES actions for 2025- 2028:

- Raising awareness of the importance of the 'disability and long-term condition disclosure' on ESR among staff in senior positions.
- Continuing to raise awareness about staff's lived experiences with a visible and hidden disability and promoting Hidden Disability Sunflower and Disability Confident schemes.
- Raise awareness about apprenticeships and the Talent Academy and training among staff with disability and LTC.
- Raise staff and line managers' awareness about the Health Passport across ULTH and implement across the Group.
- Start to collect the disability pay gap data to develop next year's Pay Gap Report.
- Continuing to enhance knowledge about reporting bullying and harassment and other supporting procedures for staff.
- Implement the Reciprocal Mentoring Programme across the group, starting with the new Group Trust Board.
- Continuing to raise awareness about the United Against all forms of Discrimination toolkit across ULTH and implementing it across the Group.

WDES Actions linked with the LCHG Group Strategy 2025 - 2030:

Strategic Aim 2 – People:
- Better opportunities: Aiming to develop, empower and retain great people by:
  - Enable our people to fulfil their potential through training, development, research and education.
  - Empower our people to continuously improve and innovate
  - Nurture compassionate and diverse leadership.

Conclusion

We will continue to communicate the MAPLE staff network and the WDES activities to all staff across the group, so we can all be involved in celebrating our achievements. Having a productive inclusive workforce, where staff feel valued and heard is vital and crucial in providing high-quality personalised care for patients. We will continue to implement the LCHG values: compassionate, innovative and collaborative to ensure that staff feedback has been listened to and the WDES actions have been delivered and a sense of belonging has been embedded across the organisation.

Appendix 1

ULTH Workforce WDES Data 2024 – 2025

Appendix 2

ULTH WDES Data Trends 2019 – 2025

Appendix 3

ULTH Action Plan 2025 - 2028

Workforce Disability Equality Standards Report - 2024 -2025 Appendix 1 – ULTH Workforce Data Indicators 1 - 10

Contents

Indicator 1

Indicator 1A Clinical Workforce

Staff in post based on primary assignments only, no bank staff, no Chair/Non- Executive Directors
VSM = (Very Senior Manager including Chief Executive, Executive Directors)

*% is the rounded number of the overall ULTH workforce with disability, data taken from the NHS England Data Collection Framework portal.

Clinical	Disability (NO)		Disability (YES)		Not Declared		TOTAL	
WDES Metric 1	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage
Clinical	**5301**	**89.3%**	**370**	**6.2%**	**263**	**4.4%**	**5934**	**100%**
Under Band 1	3	60.00%	2	40.00%	0	0.00%	5	100.0%
Band 1	0	0.00%	0	0.00%	0	0.00%	0	100.0%
Band 2	197	86.40%	13	5.70%	18	7.89%	228	100.0%
Band 3	1171	89.25%	82	6.25%	59	4.50%	1312	100.0%
Band 4	220	89.07%	23	9.31%	4	1.62%	247	100.0%
Band 5	1859	89.98%	123	5.95%	84	4.07%	2066	100.0%
Band 6	998	88.87%	70	6.23%	55	4.90%	1123	100.0%
Band 7	530	89.68%	40	6.77%	21	3.55%	591	100.0%
Band 8a	234	88.30%	15	5.66%	16	6.04%	265	100.0%
Band 8b	51	92.73%	0	0.00%	4	7.27%	55	100.0%
Band 8c	20	90.91%	1	4.55%	1	4.55%	22	100.0%
Band 8d	8	80.00%	1	10.00%	1	10.00%	10	100.0%
Band 9	8	100.00%	0	0.00%	0	0.00%	8	100.0%

Clinical	Disability (NO)		Disability (YES)		Not Declared		TOTAL	
WDES Metric 1	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage
VSM- Very Senior Manager	2	100.00%	0	0.00%	0	0.00%	2	100.0%
Med & Dental Consultants	367	89.29%	7	1.70%	37	9.00%	411	100.0%
Med & Dental Non-Consultants	248	92.54%	3	1.12%	17	6.34%	268	100.0%
Trainee Grade	498	94.68%	17	3.23%	11	2.09%	526	100.0%

Indicator 1B Non-clinical workforce

Non-Clinical	Disability (NO)		Disability (YES)		Not Declared		Total	
WDES Metric 1	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage	Headcount	Percentage
Non-Clinical	**2717**	**84.0%**	**270**	**8.4%**	**246**	**7.6%**	**3233**	**100%**
Band 1	16	42.1%	4	10.5%	18	47.4%	38	100.0%
Band 2	1193	83.0%	115	8.0%	129	9.0%	1437	100.0%
Band 3	566	83.5%	73	10.8%	39	5.8%	678	100.0%
Band 4	321	87.0%	19	5.1%	29	7.9%	369	100.0%
Band 5	191	86.8%	21	9.5%	8	3.6%	220	100.0%
Band 6	148	86.5%	16	9.4%	7	4.1%	171	100.0%
Band 7	128	90.8%	9	6.4%	4	2.8%	141	100.0%
Band 8a	65	85.5%	8	10.5%	3	3.9%	76	100.0%
Band 8b	44	89.8%	2	4.1%	3	6.1%	49	100.0%
Band 8c	14	93.3%	0	0.0%	1	6.7%	15	100.0%
Band 8d	7	77.8%	1	11.1%	1	11.1%	9	100.0%
Band 9	18	85.7%	2	9.5%	1	4.8%	21	100.0%

Senior Medical Manager	6	66.7%	0	0.0%	3	33.3%	9	100.0%
Grand Total	**9131**	**88.04%**	**667**	**6.43%**	**574**	**5.53%**	**10372**	**100%**

Indicator 2

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.
Note:
i) This refers to both external and internal posts.
ii) If the organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.

Applicant Status	Disabled	Non-Disabled	Not Stated/ Undisclosed
Shortlisted	597	6209	604
Appointed	145	1753	452
Likelihood	0.24	0.28	0.74

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts is 1.16.

Indicator 3

Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Note:

    i)   This metric will be based on data from a two-year rolling average of the current year and the previous year.

    ii)   This metric applies to capability on the grounds of performance and not ill health.

	Disabled	Non-Disabled	Unknown
Average number of staff entering the formal capability process over the last 2 years. (i.e. Total divided by 2.)	2	21.5	4
Of these, how many are on the grounds of ill health only?	1	13.5	3

The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff is 1.71.

Indicator 4

Indicator 4a

% of staff who experienced at least one incident of bullying, harassment or abuse from:

- Patients/service users, their relatives or other members of the public

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	28.4%
Staff without Long term conditions and illness	18.8%
National benchmark for staff with LTC&I	30.0%
National benchmark for staff without LTC&I	23.3%
Responses with LTC&I	926
Responses without LTC&I	2554

For staff with LTC&I a negative increase, of 0.2% from 28.2%.

Metric 4a (continued)

% of staff who experienced at least one incident of bullying, harassment or abuse from:

- Managers

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	15.7%
Staff without Long term conditions and illness	8.6%
National benchmark for staff with LTC&I	14.6%
National benchmark for staff without LTC&I	8.2%
Responses with LTC&I	909
Responses without LTC&I	2520

For staff with LTC&I a positive decrease of, 1.1% from 16.8% to 15.7% in 2024.

Metric 4a (continued)

% of staff who experienced at least one incident of bullying, harassment or abuse from:
- Other colleagues

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	29.3%
Staff without Long term conditions and illness	17.3%
National benchmark for staff with LTC&I	23.8%
National benchmark for staff without LTC&I	15.4%
Responses with LTC&I	910
Responses without LTC&I	2525

For staff with LTC&I a negative increase of 3.8% from 25.5% to 29.3% in 2024.

Indicator 4b

% of staff saying they, or a colleague, reported their last incident of bullying, harassment, or abuse.

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	49.2%
Staff without Long term conditions and illness	51.5%
National benchmark for staff with LTC&I	52.5%
National benchmark for staff without LTC&I	51.4%
Responses with LTC&I	394
Responses without LTC&I	682

For staff with LTC&I a negative decrease of 1.1% in 2024.

Indicator 5

% of staff who believe that their organisation provides equal opportunities for career progression or promotion.

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	52.6%
Staff without Long term conditions and illness	57.5%
National benchmark for staff with LTC&I	52.2%
National benchmark for staff without LTC&I	58.1%
Responses with LTC&I	922
Responses without LTC&I	2538

For staff with LTC&I a positive increase of 1.9% in 2024.

Indicator 6

% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	27.2%
Staff without Long term conditions and illness	19.8%
National benchmark for staff with LTC&I	26.6%
National benchmark for staff without LTC&I	18.5%
Responses with LTC&I	618
Responses without LTC&I	1135

For staff with LTC&I a positive decrease of 2.1% in 2024.

Indicator 7

% of staff satisfied with the extent to which their organisation values their work.

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	35.5%
Staff without Long term conditions and illness	46.8%
National benchmark for staff with LTC&I	36.9%
National benchmark for staff without LTC&I	47.8%
Responses with LTC&I	926
Responses without LTC&I	2561

For staff with LTC&I a positive increase of 2.1% in 2024.

Indicator 8

% of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work.

Staff	Percentage
Staff with Long term conditions and illness (LTC&I)	72.7%
National benchmark for staff with LTC&I	74.5%
Responses with LTC&I	565

For staff with LTC&I a positive increase of 2.1% in 2024.

Indicator 9

Indicator 9a

The national staff survey staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

Staff	Score
Organisational average	6.6
Staff with Long term conditions and illness (LTC&I)	6.2
Staff without Long term conditions and illness	6.7
National benchmark for staff with LTC&I	6.5
National benchmark for staff without LTC&I	7.0
Responses with LTC&I	930
Responses without LTC&I	2568

For staff with LTC&I a slight decrease of 0.1 in 2024.

Indicator 9b

b) Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard? (yes) or (no) Yes
Please provide at least one practical example of current action being taken in the relevant section of your WDES annual report.
MAPLE (Mental and Physical Lived Experience) Staff Network and IMPACT (Long- term conditions support group

We also have done other activities:

- National Staff Survey (promoted by MAPLE/IMPACT)
- Trust Board sponsor for MAPLE Network
- Webinars with Question and Answers during Disability History Month 2024
- MAPLE involvement in the WDES Action Plan
- Reasonable Adjustment and Flexible Working webinars during Disability History Month 2024/Carers Week 2024/Carers Rights Day 2024

Indicator 10

Indicator outcome:

Disability representation across the Trust Board: 11.11%

6.43% of the Trust Workforce is Disabled, 11.11% of the Board is Disabled

Therefore, 11.11% - 6.43% = 4.68 % (5 %*)

*% is the rounded number of the overall ULTH workforce with disability, data taken from the NHS England Data Collection Framework portal.

	Disabled	Percentage	Not Disabled	Percentage	Not Declared	Percentage	Total Headcount
Total Board members	2	11.11%	9	50.00%	7	38.89%	18
of which: Voting Board members	1	9.09%	5	45.45%	5	45.45%	11
Non-Voting Board members	1	14.29%	4	57.14%	2	28.57%	7
of which: Exec Board members	1	11.11%	5	55.56%	3	33.33%	9
Non-Executive Board	1	11.11%	3	44.44%	4	44.44%	9
Overall Workforce by Disability		6.43%		88.04%		5.53%	
Difference % (Total Board – Overall workforce)		5%		-38%		33%	
Difference % (Voting membership - Overall Workforce)		3%		-43%		40%	
Difference% (Executive membership - Overall workforce)		5%		-32%		28%	

Appendix 2 - ULHT WDES
data trends - 2019 - 2025

Contents

Indicator 1

Percentage of the overall ULTH workforce with a disability, data taken from the NHS England Data Collection Framework portal.

Staff in post based on: primary assignments only, no bank staff,
no Chair/Non- Executive Directors.

	2019	2020	2021	2022	2023	2024	2025
	2.90%	3.20%	3.30%	3.58%	4.22%	5.02%	6.43%

Metric Selected	1 ▼
Metric Definition	**Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce.**

- A positive trend is observed during the seven years period of 2019 – 2025, from 2.90% to 6.43%.

Indicator 2

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.

Note:

i) This refers to both external and internal posts.

ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.

	2019	2020	2021	2022	2023	2024	2025
	1.29	1.16	0.95	0.94	1.16	1.33	1.16

Metric Selected	2 ▼
Metric Definition	**Relative likelihood of staff being appointed from shortlisting across all posts**

- Over the last seven years, there has been a fairly stable relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff, ranging from 0.94 to 1.33, with 1 representing equal likelihood.

Indicator 3

Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Note:

i)   This metric will be based on data from a two-year rolling average of the current year and the previous year.

ii)   This metric applies to capability on the grounds of performance and not ill health.

	2019	2020	2021	2022	2023	2024	2025
	1.93	18.24	26.45	9.41	2.85	0	1.71
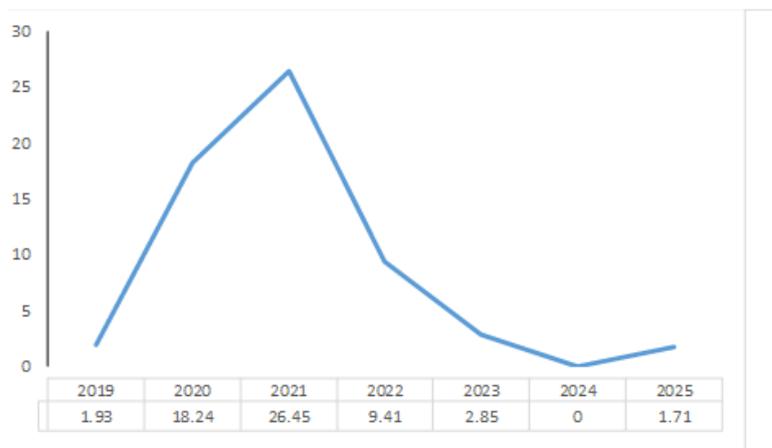
Metric Selected	3 ▼
Metric Definition	**Relative likelihood of staff entering the formal capability procedure.**

- The relative likelihood of disabled staff entering the formal capability process was highest in 2021, and the positive decrease has remained stable since then, with a negative decrease in 2024 due to the non-registration of protected characteristics for that year.
- In 2025, the probability of disabled staff entering the formal capability process is 1.71, with 1 representing the same probability.

Indicator 4

Indicator 4a

% of staff who experienced at least one incident of bullying, harassment or abuse from:

- Patients/service users, their relatives or other members of the public

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	36.60%	33.60%	35.80%	34%	32%	28.20%	28.40%
Non-disabled Staff	27.40%	28.10%	25.70%	24%	24%	21.00%	18.80%

Metric Selected	4a (i) - Abuse from patients and ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients/service users, their relatives or other members of the public**

- The rate of staff experiencing bullying, harassment, or abuse from patients/service users, their relatives, or other members of the public decreased steadily between 2019 and 2025, with a minor increase in 2021. With 36.60% in 2019 and 28.20% in 2025.

Metric 4a (continued)

% of staff who experienced at least one incident of bullying, harassment or abuse from:

- Managers

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	28.10%	24.30%	26.60%	22.20%	19%	16.80%	15.70%
Non-disabled Staff	17.00%	15.60%	16.30%	14.70%	12%	10.60%	8.60%
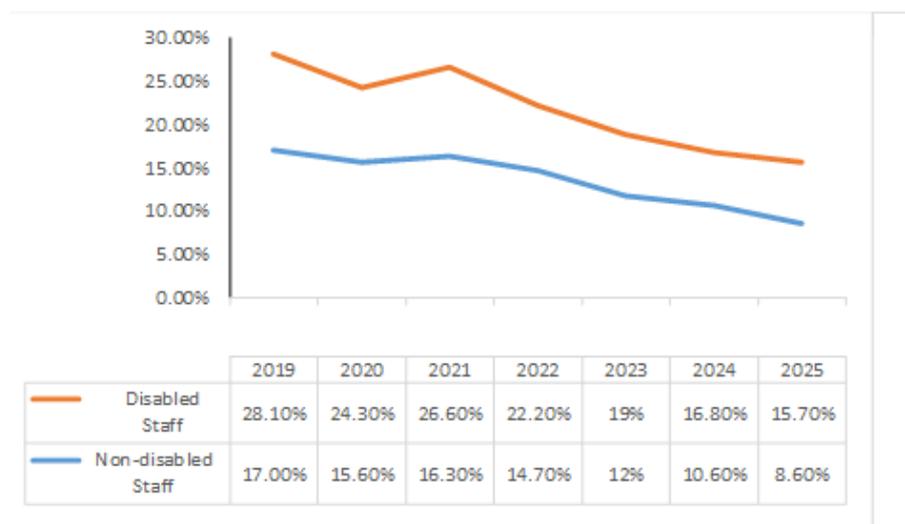
Metric Selected	4a (ii) - Abuse from managers ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers.**

- Between 2019 and 2025, there has been a steady decrease in staff who experienced bullying, harassment, or abuse from managers, with 28.10% in 2019 and 15.70% in 2025.

Metric 4a (continued)

% of staff who experienced at least one incident of bullying, harassment or abuse from:

- Other colleagues

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	33.80%	32%	30.30%	32.40%	29%	25.50%	29.30%
Non-disabled Staff	21.40%	21.30%	20.90%	20.20%	20%	18.10%	17.30%
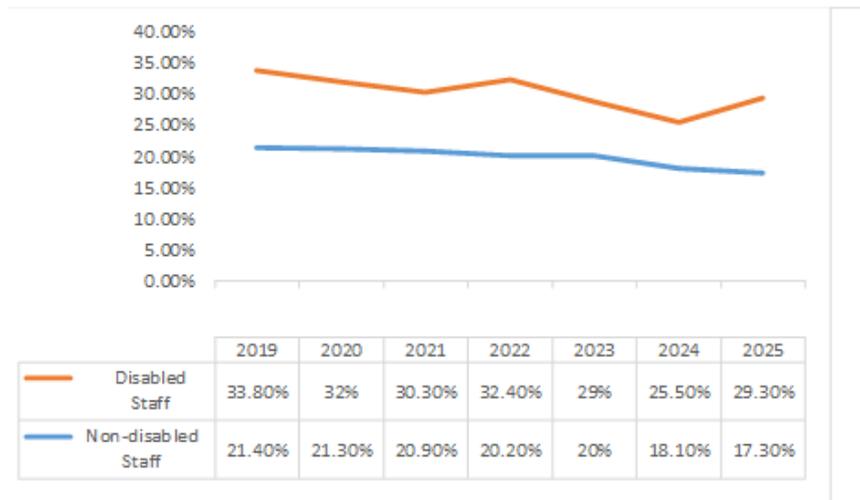
Metric Selected	4a (iii) - Abuse from other colle ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled other staff experiencing harassment, bullying or abuse from other Staff**

- The percentage of staff who experienced bullying, harassment, or abuse from other colleagues decreased steadily between 2019 and 2024, with 33.80% in 2019 and 25.50% in 2024.
- In 2025, there was a negative change in the number of staff who experienced bullying, harassment, or abuse from other colleagues, with 29.30% experiencing it.

Indicator 4b

% of staff saying they, or a colleague, reported their last incident of bullying, harassment, or abuse.

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	41.70%	47.70%	43.60%	46.20%	50.40%	50.30%	49.20%
Non-disabled Staff	42.30%	42.90%	46.00%	44.60%	42.00%	46.10%	51.50%

Metric Selected	4b
Metric Definition	**Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it**

- There has been a positive development in staff reporting their latest incident of bullying, harassment, or abuse, compared to 2019 and 2025, with 41.70% and 49.20%, respectively.
- The results have varied over the last seven years, with the highest peak being in 2023 with 50.40% and the lowest being in 2019, 41.40%.

Indicator 5

% of staff who believe that their organisation provides equal opportunities for career progression or promotion.

	2022	2023	2024	2025
Disabled Staff	46%	48.40%	50.70%	52.60%
Non-disabled Staff	52%	57.00%	57.20%	57.50%

Metric Selected	5 ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.**

- There has been a positive increase among staff saying they believe that their organisation provides equal opportunities for career progression or promotion, compared between years 2020 and 2025, with 46.0% and 52.60%, respectively.

Indicator 6

% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	37.10%	32.80%	40%	32.90%	30.40%	29.30%	27.20%
Non-disabled Staff	27.10%	25.40%	29%	26.40%	22.20%	22.20%	19.80%

Metric Selected	6 ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**

- There has been a stable positive decrease among staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties, between 2019 – 2025, with 37.10% in 2019 and 27.20% in 2025.

Indicator 7

% of staff satisfied with the extent to which their organisation values their work.

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	28.20%	29.30%	28.50%	23.90%	31.90%	33.40%	35.50%
Non-disabled Staff	38.40%	40.50%	38.70%	33.90%	39.80%	45.20%	46.80%

Metric Selected	7 ▼
Metric Definition	**Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work**

- There has been a positive increase among staff who are satisfied with the extent to which their organisation values their work when comparing 2019 and 2025,with 28.20% and 35.50%, respectively.
- The chart shows the highest decrease in 2022, with a negative decrease of 23.9%, which is the lowest for the seven years. Despite the fact, the most positive increase was after 2022, with a 4.6% increase in 2023.

Indicator 8

% of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work.

Year	2019	2020	2021	2022	2023	2024	2025
Series1	64.90%	66.10%	71.20%	67.00%	71.50%	70.60%	72.70%

Metric Selected	8 ▼
Metric Definition	**Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work**

- Despite a high negative decrease in 2022, the number decreased to 67.0%, and then a steady approximate 70% of staff reported that their employer has made adequate adjustments since then.
- Overall there has been a positive increase among staff saying their employer has made adequate adjustment(s) to enable them to carry out their work, over the seven years period, 64.80% in 2019 compared with 72.70% in 2025.

Indicator 9

The national staff survey staff engagement score for disabled staff, compared to non-disabled staff.

	2019	2020	2021	2022	2023	2024	2025
Disabled Staff	6.1	6.2	6.1	6	6.2	6.1	6.2
Non-disabled Staff	6.2	6.6	6.5	6.4	6.5	6.6	6.7

Metric Selected	9a
Metric Definition	**Staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.**

- Over the course of seven years, disabled staff have maintained the staff engagement score around 6.1 to 6.2.

Indicator 10

- Disability representation across the Trust Board.

2019	2020	2021	2022	2023	2024	2025
No representation	No representation	No representation	No representation	No representation	2 Board members identified as having a disability / LTC	2 Board members identified as having a disability / LTC

Metric Selected	10 ▼
Metric Definition	**Percentage difference between the organisation's Board voting membership and its overall workforce representation.**

- In the past seven years, there has been a rise in the number of Trust Board representatives who declared their disability or long-term condition, from 0% in 2019 to 11.11% in 2025.

Metric
1. Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.
2. Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

3. Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

4a. Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:
i. Patients/Service users, their relatives or other members of the public
ii. Managers
iii. Other colleagues

4b. Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

5. Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

6. Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

7. Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

8. Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

9a) The staff engagement score for disabled staff, compared to non-disabled staff.
9b) Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? (Yes) or (No)

10. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:
• By voting membership of the Board.
• By Executive membership of the Board.
WDES Metrics

Objective
To maintain the increase of representation of staff with disability and long-term conditions across all bands in Group.
Promoting LCHG as a inclusive workplace.

Civility and Respect approach and to maintain a low relative likelihood of disabled staff entering the capability process.

Continue implementing the culture of civility and respect, Just Culture and implement across all of LCHG United Against any form of discrimination

Continuing enhancing knowledge about bullying and harassment procedures among patients and staff.

Enabling great development and fulfilling careers.

Making LCHG the best place to work by embedding flexible working approaches and looking after staff health and wellbeing.

Continuing to raise awareness about the importance of recognition of staff and their achievements.

Lookng after staff health and wellbeing.

Engaging with our people.

a) Maintaining the partnership working between The Trust Board, Board Sponsors and MAPLE staff network.
b)To increase the representation of staff with disability and LTCs across the Trust.

Why
To be an inclusive employer with visible representation of staff with disability and long-term conditions across all bands at LCHG.
To be an inclusive employer supporting the Disability confident scheme.

To treat fairly and equally staff who are entering into the capability process.

a) To maintain a decreasing number of staff experiencing bullying and harassment from patients.
b) To create an inclusive and compassionate culture to prevent the increase of bullying and harassment incidents at our workplace.

To implement necessary support for staff to reassure them that they are listened to and valued.

To develop an inclusive talent approach.

a) To ensure that staff with LTCs are adequately supported with reasonable adjustments and that their voice is heard.

b) Enable flexibility by default approach.

To ensure that staff including those with disability or LTCs feel valued members of LCHG.

a) To maintain the increasing number of staff with disabilities and LTCs having a reasonable adjustment and adequate support.
b) Raising awareness of the importance of the 'disability disclosure' on ESR among colleagues across all bands at LCHS.

To ensure everyone feels they have a voice, control and influence.

a) To ensure staff with LTCs and disabilities feel valued and their voice is heard by senior leaders and the Trust Board.
b) To increase the visibility of diverse representation across LCHG.

Action(s)
a) Raising awareness of the importance of the 'disability and long-term condition disclosure' on ESR among staff in senior positions. b) Implementation and promotion of the Hidden Disability Scheme. c) Celebrate Disability History month and review the EDI Calendar.
a) continue to work with recruitment team regarding inclusivity. b) Embed inclusvie recruitment toolkit.

a) Continuing monitoring of the progress of disabled and non-disabled staff entering the formal capability process.
b) Raise the profile of MAPLE Staff Network as 'a safe space' and the networks' involvement in supporting staff with disability and long-term conditions

a) Continuing implementing system-wide Allyship toolkit and raising awareness across LCHG.
b) Review and design the allyship approach for staff with disability and long term-conditions.
c) Implementing Recipricol Mentoring programme.

LCHG to continue to raise awareness of bullying and harassment policy, and procedures, including how to report this and the available support.

a) Work with the recruitment team across LCHG as how can be more inclusive.
b) Raise awareness about apprenticeships and the Talent Academy and training among staff with disability and LTC.
c) Partnership working with senior leaders to promote career progression among their teams to enable staff with disability and long-term conditions to grow.

a) Implement 'health passport' across LCHG.
b) Continuing to increase awareness about reasonable adjustment and flexible working procedures.
c) Raise awareness about sickness absence and disability leave procedures among staff and line managers.

a) Ongoing partnership working with staff networks and wider colleagues with disabilities and LTCs to understand what would need to be different for them to feel valued by the organisation.
b) To promote the values and aims of LCHG

a) Continue increasing awareness about reasonable adjustment procedures.
b) Implementing the 'Health passport' across LCHG.
c) Continuing to raise awareness about flexible working and hybrid approaches.

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a) Ongoing promotion of the NSS and NQPS, in particular, encouraging staff with LTCs to participate.
b) Raise a profile of MAPLE Staff Network/Board sponsor and the network's involvement in the EDI agenda and calendar.
c) Celebrate national celebrations of the equality, diversity, and inclusion agenda /calendar.

a) Ongoing Trust Board members' participation in celebrating Disability History Month and in other EDI events.
b) Raise a profile of MAPLE Network Board Sponsor.
c) Raising awareness of the importance of the 'disability and long-term condition disclosure' on ESR among staff in senior positions.

Timescales
April – 26

April - 26

Apr-26

Apr-26

April - 26

April – 26

Apr-26

April - 26

April – 26

April – 26

April– 26

Lead(s)
EDI Team Maple Staff Network
EDI Team Recruitment Team

EDI Team
Maple Staff Network

EDI Team
Maple Staff Network

EDI Team
HR Team
All Leaders

EDI Team
Recruitment Team
All Leaders

EDI Team
HR Team
All Leaders

EDI Team
Maple Staff Network

EDI Team
HR Team
Maple Staff Network
All Leaders

EDI Team
Maple Staff Network

EDI Team
Maple Staff Network
Exec Board Sponsors

Integration Committee Upward Report

NHS

Lincolnshire Community and Hospitals NHS Group

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*2 September 2025*
Item Number	*10.1*

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

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

Purpose

This report summarises the assurances received, and key decisions made by the 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 pressures in respect of space with a number of new requests having been received. It was noted that there was some concern about changes being undertaken without consideration of the impact on space with work being undertaken to ensure awareness of space forming part of the change process.

The Committee noted the capital programmes of work that continued to progress, particularly Pilgrim ED, phase 1b however delayed were noted in the programme which introduced risk, this was being managed.

Work continued in respect of the planning for capital works related to the maternity environments at both Pilgrim and Lincoln with plans being devised which would support bids being made should national investment become available.

The Committee noted the progress on electronic menus which were due to commence rollout on 1 August. It was anticipated that this would not only improve patient experience but would also ensure appropriate volumes of meals were produced for the wards.

Scotter Ward Remedial Work
The Committee received the report noting that historical issues had been identified in respect of the structure at John Coupland Hospital. Appropriate monitoring measures were in place, and it was noted that a re-survey had recently been undertaken.

Work was now underway to address the areas of concern and act in accordance with the recommendations.

Fragile Service Risk Review -TB
The Committee received the report noting that fragile services were being identified in coordination with the Quality Committee, with service redesign being received by the Integration Committee.

The Committee noted that there would be a pipeline of reports received that would support service redesign, where viable.

The Committee noted the TB service redesign and the impact that this had seen in reducing wating lists and improving the backlog and the ambition to move to a multiple MDT approach. Through the review of the service, it was noted that lessons had been learnt which could be applied to other reviews.

Redesign of Children's Speech and Language Service
The Committee received the report noting that there was recognition by the System that the service had not been invested in by the ICB and LCC and following an Ofsted and CQC inspection action was required.

The Committee noted that action for the Group to manage the waiting list with the service redesign being in line with the left-shift approach. This would see a move from clinic bases to family hubs and integration with the local authority hubs, improved access.

The timeframe for delivery was January 2026, with the Committee requesting a further report in line with the timescale to consider benefits realisation.

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 that meetings were being held on a monthly basis and that the 4 workstreams being considered by the group.

The clinical care groups were engagement in the group on the left shift work and the prioritisation of work, utilising population health data to inform the work being undertaken.

There was recognition of the opportunities being identified from the publication of the 10-year plan for Primary Care Networks (PCNs) which would support the Group in progressing areas of work.

TOM Group Upward Report
The Committee received the report noting the workstreams in respect of the large services, transfer of teams and functions, contract transfers and contracts with other providers.

There was recognition that there had been a shift in the focus of the work from the workforce elements to the large service changes due to the national direction of travel for ICBs.

The Group was undertaking appropriate due diligence where required to support the changes and ensure delivery. There was also recognition of the alignment of the PCNAs as a legal entity which would support engagement.

End of Life Due Diligence
The Committee received the report noting that appropriate due diligence had been undertaken and development of the service would continue, with appropriate clinical engagement in place in respect of the pathway work.

Assurance in respect of Objective 3c – Enhance our digital, research and innovation capability

EPR Update inc. BadgerNet
The Committee received the Electronic Patient Record (EPR) update noting that the Programme Director was now in post and the first meeting had been held with the supplier and an initiation stage meeting with Subject Matter Experts (SMEs) had been held in order to develop a detailed plan.

There was recognition of the challenges, including resource and accommodation which were being addressed. Resource was being supported through recruitment and partnership working with other providers.

The Committee was pleased to note that BadgerNet for maternity was now live across ULTH with lessons learned to be reviewed alongside benefits realisation. Whist some challenges were noted these had been resolved through training and the roll out of additional equipment.

EDMS Accelerated Programme Plan

The Committee received the report noting that the Electronic Document Management System (EDMS) business case had been signed off with a view to a 3-year implementation. Following discussions, it had been determined that it would be possible to accelerate the programme of work, delivering in 12 months through the purchase of additional scanners. Whilst there was a capital cost implication, there was recognition that this would provide transformation capacity more quickly and positively impact the bottom line by circa £2.9m.

The Committee supported the accelerated programme, noting the additional costs that were associated with this.

Discharge Upward – OPTICA

The Committee received the report noting that the pilot was now live on the Lincoln site with Pilgrim due to go live in October. There was recognition that the staggering of the go live would allow for audits to be completed to confirm appropriate use of the system which would interface with the EPR in future.

The data from the system would also be available to the Local Authority, further supporting discharge, and allowing granular level reporting and sight of areas of pressure. It was noted that the community module was due to come online post the winter period.

Research and Innovation Group Upward Report

The Committee received the report noting that the first meeting regarding research champions had been held to consider how this may development, particularly within innovation.

Work was underway to develop a new 5-year strategy, that would be developed in line with the 10-year health plan, utilising task and finish group forums to bring stakeholders together to support the work.

The Committee noted the trial recruitment position, with the recognition that this could be improved, and also recognised the need to expand research and innovation wider than medics, which was underway.

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 upward report noting the continued progress of the group and recognised that the large transformation programmes were now coming online, which would be monitored for delivery by the Committee.

There was recognition of the impact that would be had as a result of the industrial action being taken by Resident Doctors in respect of transformation programmes of work.

Booking Centre Update

The Committee received an update in respect of the work being undertaken by PWC into the booking centre recognising the level of opportunity presented through the undertaking of the work.

The Committee noted the intention to ensure that this was done with staff, rather than to, in order to support delivery and achievement however acknowledged challenges in respect of available space to site the booking centre.

Work was progressing positively, and consideration was being given to existing and future digital solutions to ensure compatibility.

Intermediate Care Improvements (Newton)

The Committee received the report noting that the work had commenced for a diagnostic period which would be followed by the issuing of recommendations. There was recognition of the opportunities that could be achieved through the work being undertaken with regular updates to be offered to the Committee.

Assurance in respect of other areas

Board Assurance Framework 2025/26

The Committee received the Board Assurance Framework noting the updates provided and during the course of the meeting confirmed that the assurance ratings would remain as presented.

Committee Performance Dashboard

The Committee received the report with **assurance** noting the continued development of the RACH reporting system.

There was recognition of the work being undertaken in respect of transitional care with the Committee noting that despite this being red rated, this was a planned approach to reduce the transitional care beds.

Front door standards were being brought online, in line with the new national metrics and the Committee was pleased to note that the reports being received provided assurance against the areas detailed.

10-year Health Plan Summary

The Committee received the summary (**appended**) of the 10-year health plan recognising the move nationally to the NHS App by 2028 which would support the population in accessing bookings, video consultations, long term records and medicines management.

There was recognition of the work undertaken to summarise, and produce a gap analysis, against the Groups position, in order to respond to and identify any current gaps.

The Committee noted the focus required in the digital space to ensure that the Group developed appropriately with the creation of an Innovation Task Force to extract the ambition from clinical and administrative leaders, to develop a deliverable plan.

There was recognition of the need to develop the next steps, as a result of the gap analysis having been produced, however it was noted that this would support strategy development.

Risk Report
The Committee received the report noting the realignment of risks from the Quality Committee, with the recognition that a number of risks were now sat with the Integration Committee as a result. The Committee noted the risks presented and would continue to consider those relevant to the Committee, as well as confirming any reassigned risks were relevant to be received.

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 patient experience at the Urgent Treatment Centres in respect of the periods of seasonal demand.

Attendance Summary for rolling 12-month period

Voting Members	A	S	O	N	D	J	F	M	A	M	J	J
Rebecca Brown, Non-Executive Director (Chair)				X	X	X	X	X	X	X	A	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	X	X
Jim Connolly, Non-Executive Director								X	X	X	X	A
Daren Fradgley, Group Chief Integration Officer				X	X	X	X	X	X	X	X	X
Mike Parkhill, Group Chief Estates and Facilities Officer				X	X	X	X	X	D	X	X	X
Caroline Landon, Group Chief Operating Officer				A	X	D	D	D	X	X	D	X
Claire Low, Group Chief People Officer				A						X	X	A
Paul Antunes-Goncalves, Group Chief Finance Officer				A								

Colin Farquharson, Group Chief Medical Officer				A	A	X	X	X	X	A	X	A
Nerea Odongo, Group Chief Nurse				A	D	A	D	X	D	X	D	X
Kathryn Helley, Group Chief Clinical Governance Officer				A	X	X	X	X	X	X	X	D

X in attendance
A apologies given
D deputy attended

Integration Committee Upward Report

Lincolnshire Community and Hospitals NHS Group

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*2 September 2025*
Item Number	*10.1*

Integration Committee Upward Report of the meeting held on 22 August 2025

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

Purpose

This report summarises the assurances received, and key decisions made by the 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 that the Space Group had met for the first time in July and approved a number of relocations.

Underutilisation of open space continued to be an area of concern with 53% of booked rooms not being utilised appropriately. A review of policies was being undertaken in order to improve the use of space. Underutilisation within NHS Property Services (NHSPS) was also noted with support in place from NHSPS to gather evidence on space use.

The Committee noted a number of capital projects underway, including the development of the central production units, design work for the urgent treatment centres and John Coupland Hospital and Skegness as well as the Scotter Ward works at John Coupland Hospital.

Maternity service projects remained underway with the identification of further funding required to progress the designs to RIBA stage 4a. Delays in the Pilgrim Emergency Department build were noted which was causing delay in the occupation of some rooms.

The introduction of the electronic meal ordering system was noted with mobilisation and roll out plans being developed with the contractor, it was noted that efficiency savings would be achieved following the roll out.

The Committee noted the ambition in driving forward capital spend and transformation work noting that there was some risk associated with this however mitigations were in place, particularly around personnel resource.

Fragile Service Risk Review -Lymphoedema
The Committee received the report noting that the service was commissioned by the ICB however there had been no change to the commissioning specification since 2012. This has resulted in the current service being recognised as fragile due to the differences in demand and capacity.

There was recognition that the delivery of the service contributed to the NHS Outcomes Framework (NOF) due to the wait times and actions were in place to improve delivery and impact on the NOF score for the Group.

The Committee was supportive of the work being undertaken to transform the service, within the current resource. A deep dive was being undertaken and would be presented to the Committee at a future date, along with the transformation plan.

Optica Update
The Committee received the report noting that the pilot was in place across a number of wards which was offering a richness of data to support conversations across the system and with partners in respect of discharge.

Whilst the Committee noted the delay in the second phase of the project there reassurance provided that this would be addressed, due to the pace at which the first phase had been delivered. At this time the Committee noted no escalations were being made, , however oversight would be maintained.

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 that the meeting had not taken place due to staffing constraints.

It was noted that work continued to progress with significant activity being undertaken, including ongoing conversations with the Primary Care Network (PCN) and Primary Care Network Alliance (PCNA). There was recognition of the impact that the change management process for the ICB will have on the programmes of work however mitigations would be put in place where required.

TOM Group Upward Report
The Committee received the verbal update noting that some processes had slowed due to the progress required from the ICB prior to service transfers taking place to the Group.

Where required the Group was undertaking due diligence and ensuring assurance was in place prior to any transfer of services, including where required legal assurances and advice.

Health Inequalities Action Plan
The Committee received the report with **assurance** noting that work was on track to deliver from a data perspective, with further data triangulation undertaken and national benchmarking demonstrated.

The Committee noted that an internal audit would be undertaken that would provide further assurance on the progress being made in respect of health inequalities, in addition to the feedback due to be received from the recent NHS Providers Well-Led review.

Strategic Neighbourhood Board Terms of Reference
The Committee received the report noting the national direction in relation to Integrated Neighbourhood Teams, noting that the Group would ensure the establishment of the Neighbourhood Board, coordinating from a system perspective.

The Committee noted the proposal and would review the terms of reference for the Board, once established, noting the ambition to drive this forward for Lincolnshire.

Assurance in respect of Objective 3c – Enhance our digital, research and innovation capability

Digital Planning and Delivery Update
The Committee received the report with **assurance** noting the progress in respect of the delivery plan, and the focus on the Electronic Patient Record (EPR) which had progressed to implementation. Milestones for delivery were being identified with documentation being developed to continue progress whilst understanding the structure of the programme.

The Electronic Document Management System (EDMS) was moving at pace and was ahead of schedule. Spaces had been identified for the scanners and costs were being determined. It was noted that there had been some challenges in job descriptions being matched but was being addressed to support appropriate resource.

Digital Oversight Group Upward Report
The Committee received the upward report noting the review of digital literacy that had been undertaken, that had identified areas of support required for staff and enabled staff to receive support.

Work was continuing to develop the IT infrastructure, including network access control and Wi-Fi and the data centre being in place at Lincoln which would reduce the risk of outages.

Progress of the Windows 11 roll out was noted and those areas of challenge were being addressed.

EPR Programme Plan
The Committee noted the initiation stage of the EPR programme with implementation due to commence on 15 September. Work was developing in respect of training and knowledge transfer and system design and build. There was recognition of the need to ensure processes were optimised to support both roll out and continuation of the use of the EPR.

Shared Care Record
The Committee received the report noting that there would be a novation of the contract to the Group, further detail would be offered to the Committee to ensure clarity and oversight of the position.

EPR Approval Letters
The Committee received the EPR approval letters (**appended**) noting that a number of conditions were associated with the approval and relevant action had been taken.

Assurance in respect of Objective 3d – Drive forward our improvement and efficiency agenda including sustainability and Green Plan

Green Plan
The Committee received the Green Plans for LCHS and ULTH noting the requirement to achieve a carbon footprint reduction of 80% by 2030 and full net zero by 2040.

The plans were underpinned by a number of strategic themes to support delivery, and the Group had established a network of Green Champions to support the ambition.

The Committee requested that the underpinning plans be received, including associated timescales, to maintain oversight of the delivery. The Committee recommended the plans for both organisations to the Board for approval.

Assurance in respect of other areas

Board Assurance Framework 2025/26

The Committee received the Board Assurance Framework noting the updates provided and during the course of the meeting confirmed that the assurance ratings would remain as presented. There was recognition of the progress being made by the Committee and a request that the BAF be reviewed and update to clearly identify controls, assurances and mitigations to support review and movement in the assurance ratings.

Committee Performance Dashboard

The Committee received the report with **assurance** noting the ongoing work in respect of the development of the new format of the report. The Committee noted the format that would be presented, allowing for the drill down into areas of concern, supported by appropriate narratives and trajectories.

Risk Report

The Committee received the report noting the risks presented and reflected the on the need for further risks to be considered, in respect of delivery of transformation programmes of work. This will be presented to the committee in September.

LCHS Data Quality Update

The Committee received the report for information.

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	S	O	N	D	J	F	M	A	M	J	J	A
Rebecca Brown, Non-Executive Director (Chair)			X	X	X	X	X	X	X	A	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	X	X	X
Jim Connolly, Non-Executive Director							X	X	X	X	A	X
Daren Fradgley, Group Chief Integration Officer			X	X	X	X	X	X	X	X	X	X

			1	2	3	4	5	6	7	8	9	10
Mike Parkhill, Group Chief Estates and Facilities Officer			X	X	X	X	X	D	X	X	X	X
Caroline Landon, Group Chief Operating Officer			A	X	D	D	D	X	X	D	X	X
Claire Low, Group Chief People Officer			A						X	X	A	X
Paul Antunes-Goncalves, Group Chief Finance Officer			A									
Colin Farquharson, Group Chief Medical Officer			A	A	X	X	X	X	A	X	A	D
Nerea Odongo, Group Chief Nurse			A	D	A	D	X	D	X	D	X	A
Kathryn Helley, Group Chief Clinical Governance Officer			A	X	X	X	X	X	X	X	D	X

X in attendance
A apologies given
D deputy attended

10 Year Plan – LCHG View and Gaps

Meeting	Lincolnshire and Community Hospitals Group Board
Date of Meeting	2nd September 2025
Item Number	10.2

10 Year Plan - LCHG View and Gaps

Accountable Director	Daren Fradgley, Group D/CEO and CIO
Presented by	Daren Fradgley, Group D/CEO and CIO
Author(s)	Sameeedha Rich-Mahadkar, Group Director Strategy, Improvement and Redesign Esme Burrough- Strategic Business Partner, Gareth Hart – Strategic Business Partner - Planning, Rebecca Maxwell – Strategy Manager Sally Robinson, Head of Best Practise, Strategy
Recommendations/ Decision Required	Trust Board are asked to note key implications of the 10 year plan and next steps. • *The 10-Year Health Plan aims to bring about radical changes to NHS financial management, accountability, and care delivery.* • *While the plan is expected to define national care models and set out how neighbourhood health will be organised, it is also considered more aspirational than detailed. We need to continue delivery through our alliance work and deploy integrated neighbourhood teams and co create integrated neighbourhood working with all our key partners.* • ***Financial Management****: The plan includes measures to restore financial discipline, such as removing deficit support funding and requiring organisations to carve out 3% of their budgets for service transformation.* • ***Care Delivery****: The plan aims to shift investment from hospitals to community care over a decade, with a target to have most outpatient care to be delivered outside of hospitals by 2035. Our ambitions outlined in the "left shift" transformation programme are aligned to this, we need to work with our partners to redesign pathways to enable care being delivered closer to patients taking into account digital inclusion alongside.* • ***Digital****: The plan aims to create the most digitally accessible health system in the world, where patients have*

a 'doctor in their pocket' to provide 24/7 advice and guidance and staff are liberated from the NHS' archaic systems. LCHG ambitions around EPR and intents set out in our digital strategy are key.

- *Emergency Care: The plan intends to move away from block contracts for urgent and emergency care, making a portion of funding dependent on delivering safety and quality metrics, we need to work with the system partners to understand the implications for future funding mechanisms on delivery.*

- *Neighbourhood Health: The plan is expected to detail how each area will organise the provision of neighbourhood health, potentially including selecting lead providers.*

- *An end to bureaucratic planning process with a much simpler set of requirements – a strategic commissioning plan for ICBs and a neighbourhood health plan for local partners at single or upper tier level. We will also see the abolition of Integrated Care Partnerships.*

- *Summary: The plan's success in Lincolnshire will be determined, in part, by a shift in the mental models used by all partners and leaders within the system. Changing behaviours, adapting the current delivery methods to meet the 10-year plan goals is essential but only combining this with high standards of BAU - delivery is key.*

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

This paper provides an update to Trust Board following the publishing of the national 10 year health plan.

Appendix 1 provides an overview and general timeline of the 10 year plan.

Appendix 2- summarises key gaps within our LCHG strategy vs. the 10 year plan

In order to achieve the ambitions set in the LCHG strategy and the 10 year plan, we will:
- empower the organisation to deliver change through collective accountability and devolved responsibility across all areas in the organisation.
- create the firm foundations for the delivery of the 10-year plan across the Group by ensuring typical BAU processes and practices are delivered to the highest possible standards. Do the simple things exceptionally well.
- ensure that the newly published Oversight Framework is utilised to anchor and drive delivery against the Groups plan.

Next steps, include:
- assessing our capability against the five 'big bets' which include transformative technologies that should drive the new model of care by aligning research, investment and innovation. we need to strengthen our approach to ai to drive patient power and productivity; uptake of wearables in preventative, chronic and post acute treatment; and uptake of genomics and predictive analytics to embed personalised care.
- showcasing our achievements and ambitions for becoming an accelerated IHO site, and LCHG strategy and innovation task force is being set up.
- Assessing what this means for each of our care groups and ensure it links with their care group annual plan- the golden thread of how our LCHG strategy translates into the care group's delivery plan.

We will reinvent the NHS through 3 radical shifts:

2 New Contracts
with roll-out beginning next year, to encourage **GPs** to work over larger geographies and **lead new neighbourhood providers**

Neighbourhood Health Centres **OPEN**
Establish an NHC in every community, beginning with places where healthy life expectancy is lowest - **a 'one stop shop'** for patient care and the place from which multidisciplinary teams operate. **NHCs will be open at least 12 hours a day and 6 days a week**

Dentistry
improve access to NHS dentistry, improve children's oral health and **increase the number of NHS dentists working in the system by making the dental contract more attractive** and introducing tie-ins for those trained in the NHS

Mental Health
Invest up to £120 million to develop more dedicated mental health emergency departments, to ensure **patients get fast, same day access** to specialist support in an appropriate setting

From hospital to community

2026

Shift Spending Patterns
Over the course of this plan, the share of expenditure on hospital care will fall, **with proportionally greater investment in out-of-hospital care.** This is not just a long-term ambition. We will also deliver this shift in investment over the next 3 to 4 years as local areas build and expand their neighbourhood health services

Pharmacy
increase the role of community pharmacy in the **management of long-term conditions** and link them to the **single patient record**

Delivery
Deliver more urgent care in the community, in people's homes or through NHCs, **to end hospital outpatients as we know it by 2035**
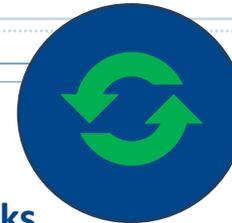
18 Weeks
Restore the NHS constitutional standard of **92% of patients beginning elective treatment within 18 weeks**

Expand
expand same day emergency care services and co-located urgent treatment centres. support patients to book into the most appropriate urgent care service for them, via 111 or the **NHS App** before attending, by 2028

2028

NHS App
End the 8am scramble by training thousands more GPs and building online advice into the NHS App. People who need one will be able to get a **same day GP appointment**

Through the NHS App, **allow patients to book appointments,** communicate with professionals, receive advice, **draft or view their care plan and self-refer to local tests and services**

2027

Active Participants
support people to be active participants in their own care by ensuring **95% of people** with complex needs will have an **agreed care plan by 2027**

2028-2035

Personal Health Budgets
double the number of people offered a personal health budget (PHB) by **2028 to 2029**, offer **one million people a PHB by 2030**, and ensure it is a universal offer **for all who would benefit by 2035**

AI
free up hospitals to prioritise safe deployment of AI and harness new technology to bring the very best of cutting-edge care to all patients. **All hospitals will be fully AI-enabled within the lifetime of this plan**

From analogue to digital

My NHS GP
'From bricks to clicks'

My NHS GP
My Health Record
MY Choices
MY Specialist
MY Consult
MY Medicines
MY Vaccines
MY Care
MY Companion
My Carer

For the first time ever in the NHS, give patients real control over a single, secure and authoritative account of their data – **a single patient record** to enable more co-ordinated, personalised and predictive care

2028
Transform the NHS App into a world-leading tool for patient access, empowerment and care planning. **By 2028, the app will be a full front door to the entire NHS**

NHS App

Enabling **instant advice for non-urgent care**, and help finding the most appropriate service first time, through **My NHS GP**

MY Choice
Choose preferred provider, **delivers the best outcomes**, has the best feedback or is simply closer to home

MY Care
manage a long-term condition through My Care

MY Health
upload health data through My Health

MY Consult
Hold consultations through the app with **My Consult**

MY Specialist
Book directly into tests where clinically appropriate through **My Specialist**.

MY Medicines
Manage their medicines through My Medicines and **book vaccines** through **My Vaccines**

MY Children
manage their children's healthcare through **My Children**

MY Carer
Co-ordinate the care of a loved one or relative through My Carer

MY Companion
get extra care support through My Companion

Introduce single sign on for staff, and scale the use of technology like **AI scribes** to liberate staff from their current burden of bureaucracy and administration, freeing up time to care and to focus on the patient

Use **continuous monitoring** to help make proactive management of patients the new normal, allowing clinicians to reach out at the first signs of deterioration to **prevent an emergency admission to hospital**

build 'HealthStore' to enable patients to access approved digital tools to manage or treat their conditions, **enabling innovative businesses to work more collaboratively with the NHS** and regulators

allow patients to leave feedback on the care they have received - compiled and communicated back to providers, clinical teams and professionals in easy-to-action formats

From sickness to prevention

In a world first - introduce **mandatory health food sales reporting** for all large companies in the food sector.

Power to make the healthy choice

Our overall goal is to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, and to raise the **healthiest generation of children ever**.

This will **boost our health**, but also ensure the **future sustainability** of the NHS and **support economic growth**

We will achieve our goals by harnessing a huge cross-societal energy on prevention. We will work with businesses, employers, investors, local authorities and mayors to create a **healthier country together.**

Alcohol

Tackle harmful alcohol consumption by introducing new standards for alcohol labelling.
We will support further growth in the no- and low-alcohol market.

End the obesity epidemic

We will restrict junk food advertising targeted at children, ban the sale of high-caffeine energy drinks to under 16-year-olds, reform the soft drinks industry levy to drive reformulation

Increase uptake of human papillomavirus (HPV) vaccinations among young people who have left school, to support our aim to **eliminate cervical cancer by 2040**. We will fully roll out lung cancer screening for those with a history of smoking

Weight Loss Medication

Harness recent breakthroughs in **weight loss medication** and expand access through the NHS - negotiate new partnerships with industry to provide access to new treatments on a **'pay for impact on health outcomes' basis**

Tobacco and Vapes

Deliver on our world-leading Tobacco and Vapes Bill, which will mean that children **turning 16 this year (or younger) can never legally be sold tobacco.** The number of 11 to 15-year-olds who regularly vape has doubled[footnote 9] in the last 5 years, and to crack down on this unacceptable trend, we will also **halt the advertising and sponsorship of vapes and other nicotine products**

New Health Reward Scheme

Encourage citizens to play their part, including through **a new health reward scheme** to incentivise healthier choices. We will also work with the **Great Run Company** to set up a campaign to motivate millions to move more on a regular basis

Mental Health

Expand mental health support teams in schools and colleges and provide additional support for children and young people's mental health through **Young Futures Hubs**

Food Education

Restore the value of Healthy Start from the 2026 to 2027 financial year, expand free school meals so that all children with a parent in receipt of Universal Credit are eligible, and **update school food standards** to ensure all schools provide healthy, nutritious food

Help people find and stay in work. establish Health and Growth Accelerators models

Genomic testing

Create a new genomics population health service, accessible to all, by the end of the decade.

We will implement universal newborn genomic testing and population-based polygenic risk scoring alongside other emerging diagnostic tools, enabling early identification and intervention for individuals at high risk of developing common diseases

New Operating Model

Lincolnshire

Department of Health & Social Care

NHS England

Combine NHS England, the headquarters of the NHS, with the Department of Health and Social Care (DHSC), **reducing central headcount by 50%**

NHS Lincolnshire Integrated Care Board

Make ICBs the strategic commissioners of local healthcare services. We will build ICB capability and **close commissioning support units**

Introduce a **system of earned autonomy** and where local services consistently underperform, step in with a new failure regime. Our **priority will be to address underperformance in areas with the worst health outcomes**.

NHS Foundation Trust

By **2035**, our ambition is that **every NHS provider should be an FT** with freedoms including the ability to retain surpluses and reinvest them and borrowing for capital investment. FTs will use these freedoms and flexibilities to improve population health, not just increase activity

Create a new opportunity for the **very best NHS FTs to hold the whole health budget** for a defined local population as an integrated health organisation (IHO).

Our intention is to designate a small **number of these IHOs in 2026,** with a view to them becoming operational in 2027. Over time they will become the norm

2026-2027

NHS Lincolnshire Partnership NHS Foundation Trust

Set **higher standards for leaders** - with pay tied to performance, and good work rewarded

Work in closer **partnership with local government** and other local public services. We will streamline how local government and the NHS work together and make **ICBs coterminous with strategic authorities** by the end of the plan wherever feasibly possible

Introduce a new **patient choice charter**, starting in the areas of highest health need. This will ensure the NHS is receptive and reactive to patient preference, voice and choice

Trial new **patient power payments**, which are an innovative **new funding flow** in which patients are contacted after care and given a say on whether the full payment for the costs of their care should be released to the provider

Continue to make use of **private sector capacity** to treat NHS patients where it is available and we will enter discussions with private providers to **expand NHS provision in the most disadvantaged areas**

Quality

Care Quality Commission

Reform CQC towards **a more data-led regulatory model**. When concerns are identified, CQC will rapidly assemble inspection teams of highly qualified staff to assess service quality in greater detail

Change the time limit for the Care Quality Commission (CQC) to bring legal action against a provider and **review how to improve patients' experience of clinical negligence claims**

Reform the National Quality Board (NQB) with all other bodies, including royal colleges, feeding into it.

We will task it with developing **a new quality strategy**, as well as the development of modern service frameworks. **Early priorities will include cardiovascular disease, mental health, frailty and dementia**.

Reform the complaints process and improve response times to patient safety incidents and complaints

NHS App

Allow patients to search and choose providers based on quality data on the NHS App, including **length of wait**, **patient ratings and clinical outcomes**.

The app will also show data on clinical teams and clinicians

Use **patient reported outcome measures and patient reported experience measures** to help patients when choosing their provider on the NHS App

Publish **easy-to-understand league tables**, starting this summer, that rank providers against key quality indicators

Set up a **national independent investigation into maternity and neonatal services**. We will also establish a national maternity and neonatal taskforce, **chaired by the Secretary of State for Health and Social Care**, to inform a **new national maternity and neonatal action plan**, **co-produced with bereaved families**

Give all **providers new flexibilities to make additional financial payments** to clinical teams that have consistently high clinical outcomes and excellent patient feedback or are significantly improving care

Make sure persistent **poor-quality care results** in the **decommissioning or contract termination** of services or providers, no matter:
the setting
whether the provider is in the NHS or independent sector
whether they are a GP practice or an individual NHS trust

Our 5 big bets

AI to drive productivity supporting patient choice and liberating staff

Wearables to make care 'real time' and become standard in preventative, chronic and post-acute treatment

Data to deliver impact, flowing seamlessly and securely to enable earlier diagnosis and better health research

Genomics and predictive analysis for pre-emptive, personalised care starting at birth

Robotics to support precision, transforming patient care from surgery to rehabilitation

Timeline

2025

Maternity Outcomes Signals System

Wave 1 – New Foundation Trusts

AI Scribe Procurement framework

2026

Integrated Health Organisations

NHSE Central headcount reduced by 50%

2027

NHS App Complete SPR accessible

NHS App

Expand same day emergency care services and co-located urgent treatment centres

Funding changed into Neighbourhoods

2028

AI supported teledermatology hubs

Patient reported experience measures

2029

Personal Health Budgets for 1m people

Genomic Service accessible to all

2030

Few commitments discussed between 2030 and 2035

AI integrated into most clinical pathways

ALL NHS providers to be Foundation Trusts

2035

Appendix

Short, medium and long term plan

Short Term Plan by 2028

Subject	Description	Deadline/target date
Quality transparency (league tables)	Publish easy-to-understand NHS provider "league tables" of key quality indicators, allowing patients to compare services	Summer 2025
Neighbourhood health centres funding	Prepare a business case to use public-private partnerships (PPPs) for new Neighbourhood Health Centres, ahead of a final decision at the autumn Budget	Autumn 2025
Productivity improvement target	Achieve 2% year-on-year productivity gains in the NHS for each of the next three years (annual target)	2025-2028
Clinical trials efficiency	Cut clinical trial setup times. By March 2026, the average setup time for clinical trials will be reduced to 150 days.	March 2026
NHS Workforce Standards	Introduce new minimum employment standards (covering working conditions) across the NHS. These standards will take effect in April 2026, with performance against them published quarterly at employer level.	April 2026
Introduce first neighbourhood health contracts	Roll out will begin "next year" of new neighbourhood primary care contracts – a "single neighbourhood provider" and "multi neighbourhood provider".	2026
Integrated Health Organisations launch	Begin establishing Integrated Health Organisations – leading NHS providers that hold whole-population health budgets. A small number of top-performing foundation trusts will be designated in 2026, with the first IHOs becoming operational by 2027.	2026-2027
NHS dental workforce reforms	Expand and strengthen NHS dentistry. Newly qualified dentists will be required to work at least three years in the NHS (to repay public training investment), and an initiative beginning in 2026-27 will upskill dental professionals (e.g. allowing dental nurses to apply fluoride varnish) to improve children's oral health.	2026-2027
"Year of care" payment model	Pilot new payment models to incentivise preventive care. Starting in the 2026–27 financial year, the NHS will test "year of care" bundled payments, aligning funding with year-long patient outcomes rather than per-episode tariffs.	2026-2027
Personal care plans for complex needs	Ensure nearly all patients with complex conditions have proactive care plans. By 2027, 95% of people with complex needs should have a co-created personal care plan (up from ~20% currently).	By 2027
Integrated Health Organisations operational	By 2027, the first Integrated Health Organisations (designated in 2026) will be fully operational, managing care and budgets for their local populations.	By 2027
Single national formulary (medicines)	Streamline medicine management by adopting one national drug formulary. The NHS will move to a single national formulary (SNF) for medicines within the next two years.	By 2027
Urgent care digital booking	Enable digital urgent-care appointments. By 2028, patients will be able to book into the most appropriate urgent care service (e.g. urgent treatment centre or same-day emergency care) via NHS 111 or the NHS App before attending.	By 2028
NHS App as "front door"	Transform the NHS App into a one-stop gateway for care. By 2028, the app will serve as a full "front door" to the entire NHS, enabling symptom advice, provider choice, test booking, virtual consultations, medication management, and more.	By 2028

Medium Term Plan by 2030

Subject	Description	Deadline/target date
Unified digital patient records	Establish a single, integrated digital health record accessible to patients and clinicians. A new law will mandate all providers to use a unified patient record, and from 2028 patients and professionals will be able to access this record via the NHS App.	From 2028
Specialty training posts expansion	Address doctor training bottlenecks. Over the next three years, create 1,000 new specialty training posts in undersubscribed specialties (targeting areas of greatest need).	By 2028
Nursing apprenticeships expansion	Grow the nursing workforce through apprenticeships. Over the next three years, create 2,000 new nurse apprenticeship places, prioritising regions with the greatest staffing needs.	By 2028
Personal health budgets – double uptake	Empower more patients with personal health budgets (PHBs). Currently ~180,000 people have PHBs; the plan aims to at least double this number by April 2029.	By April 2029
Neighbourhood health centres	Establish local "one-stop shop" health hubs across England. 250–300 Neighbourhood Health Centres are planned, with 50 centres up and running by 2029 (open at least 12 hours/day, 6 days/week, staffed by GPs, nurses, mental health workers, etc.)	By 2029 (50 hubs)
Personal health budgets – one million offer	Scale up personal health budgets significantly. By 2030, offer one million people an NHS personal health budget to tailor their care (covering therapies, equipment, support services, etc.).	By 2030
NHS financial balance (surplus)	Restore NHS financial health. By 2030, the majority of NHS providers should be operating in surplus (ending the era of routine deficits) as part of moving the whole NHS back into financial balance.	By 2030

Ref: Health Service Journal

Long Term Plan by 2035

Subject	Description	Deadline/target date
Personal health budgets - universal access	Make personal health budgets a standard option. By 2035, personal health budgets should be a universal offer for everyone eligible – meaning any patient who could benefit will have access to one.	By 2035
All NHS providers to gain foundation trust status	Extend autonomy and flexibility to all hospitals. By 2035, every NHS provider trust is expected to achieve foundation trust status (up from ~50% today), granting them greater financial and operational freedoms (e.g. retaining surpluses, borrowing for capital investment).	By 2035
Outpatient care shift to community	Radically reduce hospital outpatient visits. By 2035, the majority of outpatient care will take place outside hospitals, delivered instead in community settings (e.g. via neighbourhood health centres and virtual tools). The plan's aim is to "end hospital outpatients as we know it" by this date.	By 2035
AI-enabled hospitals	Modernise hospital care with technology. By 2035, all hospitals will be fully AI-enabled, deploying artificial intelligence for diagnostics, administrative tasks (e.g. AI medical scribes) and clinical decision support to improve efficiency and patient care.	By 2035
Wearable health tech	Make wearable devices a routine part of care. By 2035, wearable health technologies (for monitoring and managing conditions) will be standard in preventive, chronic, and post-acute care, with all NHS patients having access to these as part of normal treatment.	By 2035
Workforce recruitment (domestic vs international)	Increase domestic health workforce self-sufficiency. The NHS will reduce reliance on overseas recruitment – by 2035, less than 10% of new NHS staff should be internationally recruited, focusing recruitment on local UK-trained professionals.	By 2035
Integrated care boards and local authorities	Align health system geography with local government. By the end of the plan (2035), aim to have ICBs coterminous with upper-tier local authority boundaries wherever feasible, to streamline collaboration between the NHS and local government.	By 2035
Cervical cancer elimination	End cervical cancer as a public health threat. Through HPV vaccination and screening, the ultimate goal is to eliminate cervical cancer by 2040.	By 2040

Ref: Health Service Journal

10 Year Health Plan –
How our LCHG Strategy meets it and gaps

Authors :

Sameedha Rich-Mahadkar, Group Director Strategy, Improvement & Redesign;

Esme Borroughs- Strategic Business partner LCHS, Sally Robinson, Head of Strategy & Best practise

17 July 2025-v1

Caring and building a
healthier future for all

What does the plan intent to deliver by 2028/29?

While this is a plan for the next 10 years, NHSE ambition is that much of what is in the plan will be delivered more quickly than this.

HOSPITAL TO COMMUNITY

- **Same-day digital and telephone GP appointments will be available and calls to GPs will be answered more quickly – ending the 8am scramble.**

- **A GP led Neighbourhood Health Service** with teams organised around groups with most need.

- **Neighbourhood Health Centres in every community; increased pharmacy services and more NHS dentists.**

- **Redesigning outpatient and diagnostic services**.

- **Redesigning urgent and emergency care,** allowing people to book into UEC services before attending via the NHS App or NHS 111.

- People with complex needs will have the offer of a **care plan by 2027** and the **number of people offered a personal health budget will have doubled.**

- **Patient-initiated follow-up will be a standard approach.**

ANALOGUE TO DIGITAL

- **The NHS App** will be the front door to the NHS, making it simpler to manage medicines and prescriptions, check vaccine status and manage the health of your children.

- **'HealthStore' to access approved health apps:** Enabling innovative SMEs to work more collaboratively with the NHS and regulators.

- **A Single Patient Record** will mean patient information will flow safely, securely and seamlessly between care providers.

- **Digital liberation for staff** with the scale of proven technology to boost clinical productivity.

SICKNESS TO PREVENTION

- **Health Coach will be launched** to help people take greater control of their health, including smoking and vaping habits later this year.

- **New weight loss treatments and incentive schemes to help reduce obesity.**

- **The Tobacco and Vapes Bill will be passed, creating the first smoke-free generation.**

- **Women will be able to carry out cervical screening at home using self-sample kits from 2026.**

Five 'big bets' – transformative technologies that will drive our new model of care by aligning research, investment and innovation

Data to deliver impact

Allowing data to flow seamlessly and securely to deliver better care, and supporting UK companies to apply their skills to solving health problems.

Wearables to make care 'real-time,'

By 2035 wearables will be standard in preventative, chronic and post-acute treatment, with data connected to the NHS App and integrated with SPR. We will make remote monitoring standard for cardiovascular disease (by 2028).

AI to drive patient power and productivity

New regulatory frameworks for AI and software as a medical device by 2026 and significant investments in AI infrastructure.
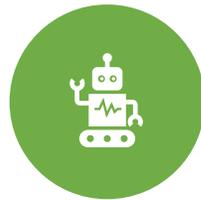
Robotics to support precision

to transform care and service delivery and automate operational processes in and out of hospitals. We will introduce national registries for robotic surgery data and developing telesurgery networks (from 2029).

Genomics and predictive analytics for pre-emptive, personalised care starting at birth

Build on expertise of the NHS Genomic Medicine Service to develop a unified genomic record, integrating patient genomic data with clinical data in near real-time.

LCHG Strategic Alignment to 10 year plan

🟣 **Patient Pillar** 🔵 **People Pillar** 🟢 **Population Pillar**

Hospital to Community
Department of Health & Social Care

2 New Contracts 🟣🟢
encouraging GPs to work over larger geographies and lead new neighbourhood providers

Shift Spending Patterns 🟣🟢
with proportionally greater investment in out-of-hospital care

**Establish an NHC in every community,** 🟣🔵🟢 beginning with places where healthy life expectancy is lowest - a 'one stop shop'

Pharmacy 🟣🟢
increase the role of community pharmacy in the management of long-term conditions and link them to the single patient record

Outpatients 🟣🟣🔵🟢
Deliver more urgent care in the community, in people's homes or through NHCs, to end hospital outpatients as we know it by 2035

18 Weeks 🟣🟢
Restore the NHS constitutional standard of 92% of patients beginning elective treatment within 18 weeks

Expand same day emergency care 🔵🔵
services and co-located urgent treatment centres

All hospitals fully AI 🟣🔵🟢
enabled within the lifetime of this plan

Analogue to Digital
Department of Health & Social Care

Introduce single sign on for staff
scale the use of technology like **AI scribes** to liberate staff from their current burden of bureaucracy and administration, freeing up time to care and to focus on the patient 🔵🔵

Trusted Assistants 🔵🟢
Make AI every nurse's and doctor's trusted assistant, saving them time and supporting them in decision making. Over the next 3 years we will overhaul education and training curricula to future-proof the NHS workforce

NHS App 🟣🔵🟢

Sickness to Prevention
Department of Health & Social Care

HPV Vaccinations
Increase uptake of human papillomavirus (HPV) vaccinations among young people who have left school, to support our aim to **eliminate cervical cancer by 2040**. We will fully roll out lung cancer screening for those with a history of smoking 🟣🟢

Add personalisation and Networks + groups

Operating Model
Department of Health & Social Care

Integrated Health Organisations (IHO)
Our intention is to designate a small **number of these IHOs in 2026,** with a view to them becoming operational in 2027. Over time they will become the norm 🔵🔵🟢

Foundation Trust Status 🟣🟣🟢

Set higher standards for leaders - with pay tied to performance, and good work rewarded 🔵

Introduce a new patient choice charter, starting in the areas of highest health need. This will ensure the NHS is receptive and reactive to patient preference, voice and choice 🟣🟢

Continue to make use of private sector capacity to treat NHS patients where it is available and we will enter discussions with private providers to expand NHS provision in the most disadvantaged areas 🟣🟢

Quality
Department of Health & Social Care

CareQualityCommission 🟣🔵🟢

Persistent poor-quality care results in the decommissioning or contract termination of services or providers, no matter:
the setting
whether the provider is in the NHS or independent sector
whether they are a GP practice or an individual NHS trust 🔵🟢🟢

NHS App 🟣🔵🟢

Allow patients to search and choose providers based on quality data on the NHS App, including length of wait, patient ratings and clinical outcomes. The app will also show data on clinical teams and clinicians

Workforce
Department of Health & Social Care

Recruitment - Reduce 🔵🟢
international recruitment to less than 10% by 2035 and towards its own communities
Over the next 3 years, create 1,000 new specialty training posts, increase the number of nurse consultants, particularly in neighbourhood settings and create 2,000 more nursing apprenticeships over the next 3 years,

Ensure every single member of NHS staff has their own personalised career coaching and development plan 🔵

Reduce sickness absence rates from 5.1% to the lowest recorded national average level (approximately 4.1%), 🔵

Develop advanced practice models for nurses and other professionals, 🔵

Accelerate delivery of the recommendations in General Sir Gordon Messenger's review of health and care leadership and establish a new college of executive and clinical leadership to define and drive excellence 🔵

Big 5 Bets
Department of Health & Social Care

We have identified 5 transformative technologies: **data, AI, genomics, wearables and robotics** - personalise care, improve outcomes, increase productivity and boost economic growth. 🟣🔵🟢

Expand NICE's technology appraisal process to cover devices, diagnostics and digital products. NICE will also be given a new role to identify which outdated technologies and therapies can be removed from the NHS to free up resources for investment in more effective ones 🟣🔵🟢

Establish new global institutes ambition to help the UK lead the world on science and innovation and speed up clinical trial recruitment. March 2026, clinical trials set-up time will fall to 150 days 🟣🔵🟢

Expand the role life sciences and technology companies can play in service delivery. We will streamline procurement of technology, and we will move to a single national formulary (SNF) for medicines within the next 2 years 🟣🔵🟢

Finance
Department of Health & Social Care

Urgently resolve the NHS's productivity crisis. For the next 3 years we have set the NHS a target to deliver a 2% year-on-year productivity gain 🟣🔵

Introduce multi-year budgets and require NHS organisations to reserve at **least 3% of annual spend for** one-time investments in service transformation, to help translate innovations into practice more rapidly 🟢🟣

Deconstruct block contracts
Payment for poor-quality care will be withheld, and high-quality care will attract a bonus. In addition, we will introduce new incentives for the best NHS leaders, clinicians and teams 🟣🔵

Restore financial discipline by ending the practice of providing additional funding to cover deficits. 🟣🔵

Break the old, short-term cycle of financial planning, all to prepare robust and realistic 5-year plans, demonstrating how financial sustainability will be secured over the medium term 🔵

To embed better incentives, we will introduce new arrangements for senior managers' pay. 🔵

Key emerging gaps vs. LCHG strategy

	Change:	Impact:	Delivery method	LCHG Strategy (elements)	Gap
1 Care closer to home	• Care delivered as locally as possible: digital, at home, or in neighbourhoods. • The share of expenditure on hospital care will fall, with proportionally greater investment in out of hospital care	• Reduces hospital demand; requires rebalancing budgets toward community and hospitals will only focus on high quality care that needs to be in hospitals. • Strategic move away from acute-centric model	• Shift investment from hospitals to tech-enabled community care • Reconfigure estates, workforce flexibility and structural redesign of trust remits	Left shift ambition with population health data. Alliance created to transform and services out of hospital closer to people's home. Integrated neighbourhood teams, GP led neighbourhood health service High intensity user programme/planned/unplanned care programmes focussed on reducing hospital demand.	Greater understanding of digital enabled care to enable left shift Better oversight of space opportunity available within wider community buildings to transform Capitated budgets/personal health budgets understanding and implications on services Updated staff standards to reflect social partnership forum reforms

	Change:	Impact:	Delivery method	LCHG Strategy (elements)	Gap
2 Elective reform	• End outpatient care "as we know it" by 2035 – through redesign of outpatient pathways, patient-initiated follow-up and shifting services to the community. • Operational levers such as surgical hubs, robotics, and AI to reduce demand	• Most outpatient care will be digital or community-based. • Reduces unnecessary follow-ups, frees hospital slots. • Hospitals must adopt AI and digital automation across clinical and operational services.	• Invest in digital tools, retrain staff, update pathways, clinician training and patient education. • Scale up and spread Advice and guidance and digital enabling technology/tools	Ambition to move all outpatients in outside hospital settings & redesign outpatients and diagnostics elements Productivity & planned care programme focussed reducing unnecessary follow ups.	Understanding of AI and digital automation at scale for our services Scale patient initiated follow up as a standard approach (by 2026); embedding 'advice and guidance' in many more specialities (over the next 10 years)

Key emerging gaps vs. LCHG strategy

	Change:	Impact:	Delivery method	LCHG Strategy	Gap
3 **Urgent and Emergency Care**	• New UEC models prioritising care at home/community, expansion of same-day emergency care and digital tools to support better triage, flow and discharge • Invest up to £120 million in Mental Health EDs co-located (or very close to) 50% of existing type 1 A&E units	• Hospital EDs must shift from admission-default to flow-optimised urgent care. • Reduces ED visits and acute admissions. Increased use of alternative care pathways • Improve mental health management away from ED	• Reallocate funding; ensure ambulance/111 integration; strengthen data analytics. • Split emergency and urgent care, invest in triage tech and discharge planning. • Redesign UEC pathways	• Redesigning UEC- Front door streaming pilot • SDEC assessment areas • Combined urgent care service within the community (UCR,HV,Virtual wards, SPA, CAS, EMAS, LIVES)	• Pre admission discharge planning • Group wide seasonal planning • Group bed plan • Using tech/AI to aid with discharge planning • enabling patients to self-book into A&E (via the NHS App or 111) before attending, enabling clinical triage in advance and redirection if appropriate (by 2028
4 **Financial Reform**	• NHS payment system shift to reward same-day and out-of-hospital care. • Patient Reported Experience Measures (PREMs) will influence provider funding through 'Patient Power Payments'. • Block contract changes to only pay providers for care commissioned. • Shift to outcome-linked payments and surplus goals by 2030	• Reduces reliance on inpatient care. • Pressures hospitals to reform operations. • Aligns hospital funding with patient experience. Redesign pathways	• Introduce new financial models (e.g. Year-of-Care, PREMs-linked) and realign funding structures • Evolution of analytical tools to support ICBs to carry out utilisation reviews	• Ambition to move all outpatients in outside hospital settings • Embed population health analytics in all service redesign	• Understanding of outcome linked payments and surplus goals by 2030 (need a long term financial model for the group) • Understanding of PREMs

Key emerging gaps vs. LCHG strategy

	Change:	Impact:	Delivery method	LCHG Strategy	Gap
5 Infrastructure	• Estates reform: Trusts to retain 100% of land sale proceeds for reinvestment. • Consider new Public-Private Partnership (PPP) models for health infrastructure. • New FTs to focus on the total resources available to them.	• Unlocks capital for modernisation. May unlock funding for modern facilities. • Hospitals must become financially self-sufficient and capital-strategic	• Support trusts in disposal strategy and reinvestment planning. • Rigorous business case development and governance safeguards. • Align financial governance and productivity benchmarks to support autonomy.	• Clear intent on left shift and ambition to utilise community estates alongside the development of a health campus ambition • Development of a wholly owned subsidiary model • Establishment of neighbourhood health centres to host GPs, nurses, physios, mental health workers, etc, open 12 hours/day, 6 days/week	• Estates strategy • Multi year business capital business case plan aligned to estates strategy

				LCHG Strategy	Gap
6 Research and Innovation	• Hospitals to make research a business-as-usual activity, not a "'nice to have'." • AI to drive patient power and productivity: support patient choice, wearables, sustainable future for the NHS, interpret genomic data & precision care. • Innovator passport' by 2026.	• Research must become a core hospital function. • Spread of robotic surgery, genomics, smart diagnostics expected system-wide. • Improve outcomes, empower patients to make decisions and enhance effectiveness of care	• Allocate time, roles, and funding for clinical. • Technology diffusion plans, equity-focused investment, workforce tech training. • Deploying AI tools – including decision support tools and admin-reduction tools	• LCHG digital strategy, EPR, EDM, strengthen network, data centres, device infrastructure, consolidate platforms • Build LCHG AI academy • R&I strategy	• R&I strategy lined to robotics/genetics • Improve the research environment, speeding up clinical trial set-up times to <150 days (by March 2026), publishing monthly scorecards on site level trial performance. • Invest in innovative medicines • AI strategy and tools (for decision support and admin reduction) • high-tech upgrades; digital records, AI triage, remote 'doctor in your pocket • NHS app synergies • New platforms for proactive & planned care

Key emerging gaps vs. LCHG strategy

		Change:	Impact:	Delivery method	LCHG Strategy	Gap
7	Performance	• New Productivity Index against providers can be assessed. • From financial year 2026 to 2027, all NHS organisations to deliver operational plans that are fully compliant with the NHS planning guidance.	• Providers with high productivity gain will have more operational and financial freedom. • Need to fully reset plans to align with the 10-yr plan which will be operationalised in the delivery plan	• Operationalise a new plan and understand / map out what is needed to achieve the objectives in the planning guidance. • Define and track internal productivity metrics, expand high value care pathways and workforce redesign	• LCHG productivity and improvement plan brings together key elements	• Estates strategy • Multi year business capital business case plan aligned to estates strategy • Impact of new performance measures and league tables • The 10 Year Workforce Plan will set out training, education and retention of the workforce and the general shape of the workforce that will deliver our new models of care.

					LCHG Strategy	Gap
8	Regulation (Linked to oversight framework)	• Placed in segment ratings (1-5) on a quarterly basis. Measured against metrics under 5 domains. • Dashboards published for the public. Various degrees of support offered depending on segment (Provider Improvement Programme for segment 5)	• Provide rigour, transparency and framework of monitoring performance, productivity safety and oversight. • Designed to "push" for financial rebalance.	• Priority validation and reporting on key metrics in the domains. • Work with region and ICB to set local improvement plans for low performing trusts.	• Left shift ambition on key specialities • Clear CIP plan • Ambition to move all outpatients in outside hospital settings	• Understanding of outcome linked payments and surplus goals by 2030 (need a long term financial model for the group) • Understanding of PREMs • R&I strategy lined to robotics/genetics • AI strategy and tools (for decision support and admin reduction) • Build sustainability in our financial model carving out 3% of our budgets for service transformation. • Map our FT journey

Key emerging gaps vs. LCHG strategy

Quality

- **Power to the patient through transparency, voice and choice:** publish easy-to-understand league tables, ranking providers against key quality indicators. Improve response times to patient safety incidents and complaints by expanding use of AI tools to support faster collection of complaints data. Pilot rapid response teams in 2026/27 to act quickly and decisively for those who have concerns about the care they are receiving. We will set up a national investigation into NHS maternity and neonatal services to provide accountability for impacted families and drive urgent improvements to care and safety.

- **Clearer accountability and stronger incentives for high quality of care:** revitalise the National Quality Board (NQB) in 25/26 and task it with developing a new quality strategy, overseeing quality measurement. All providers will be given flexibilities to make additional financial payments to clinical teams that have consistently high clinical outcomes and excellent patient feedback or are significantly improving care, under a new framework.

- **Streamlining regulation to focus on quality of care:** Moving CQC's operations to an intelligence-led model and giving it expansive new access to data. CQC will provide verbal feedback at the end of inspections, with written feedback within 2 days outlining any significant concerns. A reformed DHSC will also incorporate the functions of Healthwatch England to put patient voice at the heart. We will introduce new tools on NHS.uk and through the My Choices tool in the NHS App to make it easier for patients to access and interpret quality measures. The new Maternity Outcomes Signal System (MOSS) system for maternity will be in place across trusts from November and will use near-real time data to indicate higher than expected rates of stillbirth, neonatal death and brain injury. And we will establish a national AI-led warning system building on the capabilities in the Federated Data Platform (FDP) to analyse data to identify where quality issues are emerging in parts of the NHS.

Gaps

- Use of AI tools for faster collection of complaints data
- Review mechanisms to offer additional financial payments to clinical teams having consistent high clinical outcomes
- Impact of new Maternity Outcomes Signal System (MOSS) system
- Federated Data Platform (FDP) to analyse data to identify where quality issues are emerging

Key changes for services

Cancer

Top lines:

The three shifts will enable rapid progress on the prevention, diagnosis and treatment of cancer:
- Hospital to community will make it easier to access cancer screening, diagnostic and treatment services in patients' local areas, with more choice for people on how and where they access these services.
- Analogue to digital will ensure the NHS is able to harness the power of technological innovation to improve the prevention, diagnosis and treatment of all cancers.
- Sickness to prevention will enable the NHS to identify those who are at greatest risk of developing cancer earlier and make it easier for everyone to access screening services.

Key policies:
- **We will eliminate cervical cancer by 2040:** women and girls will all be able to access the HPV vaccine and cervical screening will be more accessible through the use of self-sampling kits.
- **Cancer screening will be available to book and histories of cancer screenings will be logged on the NHS App**, meaning both patients and healthcare professionals can review a patient's full medical history.
- **Those most as risk will be provided with lung cancer screening** to detect more cases of cancer at an earlier stage
- **Genomic testing for inherited causes of cancers will be expanded from next year.**
- **The MHRA will prioritise the review of personalised cancer vaccines, with 10,000 cancer vaccines to be provided in the next 5 years.**
- DHSC has set up the **Children and Young People Cancer Taskforce** to look at how cancer in children and young people can be prevented and diagnosed more effectively.
- **Access to 24/7 advice on the NHS App** will provide patients with reassurance when facing the difficulties of living with cancer. The single patient record will also mean patients do not have to retell their story, whether they are receiving care in hospital, the community or at home.
- **The MyHealth tool through the NHS App will being bring all health data in one place, enabling remote monitoring.**

Diabetes

Top lines:

The plan aims to reduce the prevalence of Type 2 diabetes and enhance the care of patients living with diabetes through the delivery of the three shifts:
- Hospital to community will enable those living with diabetes to manage their care in the best way for them through the Neighbourhood Health Service.
- Analogue to digital will make it easier for those living with diabetes to access tailored advice and manage their appointments at a time that suits them.
- Sickness to prevention will make it easier for people to access diabetes screening and support people to make healthier choices to prevent them from developing Type 2 diabetes.

Key policies:
- **By 2028 patients will be able to book appointments, manage their medication and prescriptions and view their single-patient record through the NHS App** so they can become better advocates for themselves. **Patients will also be able to access tailored advice through the NHS App on how to manage their diabetes.**
- **The single patient record will mean clinicians will be able to see a patient's full medical information and history**, helping them to make informed diagnoses against co-morbidities and advise patients of their individual risk factor.
- **We will identify at risk patients earlier by taking an evidence based approach to new and emerging genomic technologies.**
- **By 2035, all patients will have access to wearables,** which will enable patients and their carers to better manage their care by having access to their health data such as blood pressure and glucose levels.
- **The MyHealth tool will enable remote monitoring** for those who wish the share their data with their care team.
- **The Neighbourhood Health Service will give those living with diabetes more choice and control of their care.** By 2027 95% of people with complex needs, including long-term conditions, will have an agreed care plan.
- **More people will be able to access Personal Health Budgets**.
- **By 2028 the Diagnosis Connect service will support better self-care.** In partnership with the Richmond Group this service will bring together the NHS and the voluntary sector to help people with new diagnoses manage their care.
- **Neighbourhood Health Centres will open-up diabetes screening**, making it easier to access.
- **The plan will reverse the obesity epidemic to safeguard people from developing Type 2 diabetes in the future** by restricting junk food adverts targeted at children on TV and online, schools will provide healthier school meals, healthy food reporting for the food sector will be introduced and patients will be able to access new weight loss medicines and treatments to help reduce obesity.

Cardiovascular Disease (CVD)

Top lines:

The three shifts will support our ambition to tackle the biggest killers, reducing the number of people dying early from heart disease and stroke and make it easier for those living with CVD to manage their care.

- Hospital to community will create neighbourhood health teams who are better equipped to pre-emptively identify those at risk of CVD, and better support those already diagnosed in managing their care, closer to where patients live and work.
- Analogue to digital will make it easier for patients with CVD to manage their care, remote monitoring will enable pre-emptive care, and the NHS App will support patients to book appointments, view test results and access 24/7 support and guidance.
- Sickness to prevention shift will target overweight and obesity, a key risk factor of CVD.

Key policies:

- **The plan will reduce premature mortality associated with CVD through the introduction of a National Service Framework for CVD** to identify the best evidenced interventions and the most effective treatments.
- **We will test new delivery models for secondary prevention of cardiovascular disease and diabetes through the Neighbourhood Health Service.**
- **We will increase the role of community pharmacy in the management of long-term conditions and link them to the Single Patient Record.**
- **We will work with clinical experts to explore how genomic testing for pharmacogenomic profiles can be integrated into the NHS over-40s Health Check. Over time, we will make this a universal offer.**
- **We will begin integrating genomic insights into cardiovascular disease prevention and care through a trial with NHS and Our Future Health, and will expand genomic testing for inherited causes of major diseases to allow earlier detection and intervention.**
- **The plan will reverse the obesity epidemic and reduce the risk of people developing CVD in the future** by restricting junk food adverts targeted at children on TV and online, schools will provide healthier school meals, the Soft Drinks Industry Levy and review sugar content thresholds will be uplifted, healthy food reporting for the food sector will be introduced and patients will be able to access new weight loss medicines and treatments to help reduce obesity.
- **The single patient record will enable healthcare providers to access previous consultations and diagnoses** to join the dots on symptoms which may be associated with their treatment or co-morbidities.
- **Remote monitoring for cardiovascular disease, using wearables and similar devices integrated into the NHS App, will be a standard part of NHS care by 2028. The MyHealth tool will bring blood pressure, glucose levels and heart rate into one place, with real-time monitoring.**
- **The My Carer tool will give family, friends and carers access to the NHS App.**

Children's Health

The Plan will raise our healthiest generation of children ever through delivery of the three shifts:

- Hospital to community will mean parents and children will have better access to care and treatment in their local areas, meaning less time taken out of school to make appointments and fewer hospital visits which can be daunting for children.
- Analogue to digital will see delivery of My Children function on the NHS App. This will enable parents to have access to their child/children's complete medical history, retiring the "red book". It will also enable parents to book appointments for their children and be signposted through AI to advice for urgent and non-urgent medical questions.
- Sickness to prevention will see a greater emphasis on ensuring children develop and maintain healthy habits throughout their childhood and into adulthood. Children turning 16 this year or younger, will never legally be sold tobacco, and we intend to strengthen the existing ban on smoking in public places to reduce the harms of passive smoking to children.
- All children will see less junk food advertising and will be given healthy nutritious food in schools.

Key policies:

- **My Children will replace the "red book", providing support and advice.**
- **We will improve access to dental care for children** by making better use of the workforce by upskilling professionals.
- **Increased GP access and opening hours** will enable parents to get rapid advice on urgent issues and prevention when they need it.
- **Children turning 16 this year or younger, will never legally be sold tobacco**, and the ban on smoking in public places will be strengthened.
- **Junk food marketing aimed at children will be restricted,** the sale of high-caffeine energy drinks to under-16s will be banned and school food standards legislation will be updated to ensure all schools provide healthy nutritious food. From September 2026, free school meals will be expanded to all households in receipt of Universal Credit.
- **The Health Start scheme will be restored from 2026/27, to tackle child poverty.** Pregnant women and children aged 1 to 4 years will receive £4.65 per week, and children under 1 £9.30 every week.
- **We will continue the roll out of Mental Health Support Teams in schools for full coverage by 2029/30.**
- **New Young Futures Hubs will ensure there is no "wrong front door" for people seeking help,** these will have embedded mental health support for young people.
- **We will launch an independent review to better understand prevalence, demand, referral rates and diagnosis of mental health and neurodevelopmental conditions in both children and adults.**
- **We will prioritise evaluating digital therapies which could support children and adolescents on mental health waiting lists.**

Men's Health

The Plan will lay the foundations to deliver the upcoming Men's Health Strategy due later this year through the three shifts:
- The shift from hospital to community will support men to access health care in ways that are convenient to them and in their local area.
- The shift from analogue to digital will put the power in men's hands to manage their care and treatment, including better access to mental health support including digitised therapies .
- The shift from sickness to prevention will support us to tackle the biggest killers, including too many lives lost to suicide.
- In April this year, we launched a call for evidence for the first Men's Health Strategy.

Key policies:
- **We will redistribute resources to areas of greatest need, to ensure that funding reflects the community it serves. We know men are at greater risk of CVD and our plan will tackle the biggest killers, reducing the number of people dying early from heart disease and stroke.**
- **A Neighbourhood Health Centre in every community will make access simpler and mean men can seek support from different health services in the same visit.**
- **The NHS App will provide 24/7 guidance and advice to patients and the HealthStore will enable men to download approved health apps.** We will increase access to digitised therapies and enable men to access support without having to seek support through their GP.
- **The Plan will introduce neighbourhood models of mental health care integrated with wider local services**, to ensure the right support is delivered to the right person at the right time.

MSK

Top lines:
The Plan will support people with MSK to better manage their condition and access services and support through the three shifts:
- The shift from hospital to community will enable people with MSK to access a range of additional services to support management of their condition and treatment closer to home.
- The shift from analogue to digital will mean people with MSK will have access to their medical history, can book and manage their appointments and medication and their unpaid carers will have access to the information they need to support their loved one.
- The shift from sickness to prevention including through tackling the risk factors for MSK conditions such as obesity, physical inactivity and smoking, will help to shorten the amount of time people spend in ill-health by preventing illnesses before they happen, as well as support earlier identification and management of MSK conditions.

Key policies:
- **By 2028/29, neighbourhood health teams will be organised around the needs of their patients.**
- **By 2030, 1 million patients with long-term conditions will be offered Personal Health Budgets**, these will enable people, including those with MSK, to use NHS resources and determine care that best suits their needs.
- **The NHS App will provide access to advice, guidance, self-care support and** appointment management. Patients will be able to self-refer to MSK services where clinically appropriate through My Specialist on the NHS App.
- **The Single Patient Record** will mean patients no longer need to repeat their story and My Consult will allow patients to connect remotely to a clinician, making appointments more accessible.
- **My Care will provide a one-stop** shop for patients to manage their care, My Medicines will enable patients to manage their prescriptions and remind them when to take their tablets, My Health will enable patients to monitor their symptoms and bring all their data into one place and My Carer will support those providing care to people with MSK.

Dementia

Top lines:

The plan will aim to prevent people developing dementia and support the care of those currently living with the disease:

- The shift from hospital to community will make it easier for dementia patients and their carers to navigate care services by bringing different professionals together in the Neighbourhood Health Centres.
- The shift from analogue to digital will put the power and data in patient and carer hands. The NHS App will become a "doctor in their pocket" giving them 24/7 access to all elements of their care, from virtual and in-person appointments, advice and guidance on symptoms, and prescription management.
- The shift from sickness to prevention will reduce the number of people at risk of developing dementia by supporting people to live healthier lives for longer and targeting the biggest causes of ill health.

Key policies:

- **By 2028, we will create a smoke free generation through the Tobacco and Vapes Bill.** This will reduce the number of people developing dementia, as we know smoking is a major risk factor.
- **The My Carer tool will give family, friends and carers access to the NHS App.** This will ensure decisions are agreed and taken by those who best know the patient, who may not be able to make those decisions independently, whilst making it easier for unpaid carers to manage their care and access professionals whenever they need them.

Social Care

Top lines:

- **The 10 Year Health Plan sets out how we will shift towards a Neighbourhood Health Service, bringing care into the places people live.** Social care professionals will be an important part of neighbourhood teams, working alongside the NHS to help people stay independent for longer and playing an enhanced role in rehabilitation and recovery.
- **Over the next three years, we will roll out the neighbourhood health approach to the groups most failed by the current system, improving people's quality of life and easing pressures on both hospitals and the adult social care system**. Those groups will include people with frailty, people living in care homes, people nearing the end of the life, people with severe and enduring mental illness, and disabled people. Neighbourhood health will mean more proactive, joined-up health and social care services - designed around people's lives, not around the system. It also means putting unpaid carers at the heart of our plan.
- **We will also work with social care organisations to enable care professionals to carry out more healthcare activities**, such as blood pressure checks, to help people receive more proactive and timely care.
- **Neighbourhood health providers will work closely with local government, the voluntary sector and social care providers to tailor services to local needs**, with neighbourhood health plans developed jointly by the NHS and local government.
- **The Plan also sets out how we will drive a shift to digitally enabled care,** through digital care records, remote monitoring, and innovative use of AI.
- Social care will, for some people, be a key part of neighbourhood health services. But the adult social care system is under significant pressure and in need of reform. The independent commission, led by Baroness Casey, will build national consensus on how to create a National Care Service.
- **Over time, the Neighbourhood Health Service and the National Care Service will work hand-in-hand with each other** to help people stay well and live independently.

2025 – 2028 ULTH/LCHS
Green Plans

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2 September 2025*
Item Number	*10.3*

2025 – 2028 ULTH/LCHS Green Plans

Accountable Director	*Mike Parkhill, Group Chief Estates & Facilities Officer*
Presented by	*Mike Parkhill, Group Chief Estates & Facilities Officer*
Author(s)	*Claire Hall, Group Head of Sustainability and Net zero*
Recommendations/ Decision Required	The Board is requested to approve the Refreshed Green Plans for LCHS and ULTH and note the progress with communications and engagement on the sustainability agenda following National Net Zero Week.

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

4b Successful delivery of the Acute Services Review	
4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	
5c Tackle system priorities and service transformation in partnership with our population and communities	√
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	

Executive Summary

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

The 2022 Green Plans for LCHS and ULTH have been reviewed and engagement with key stakeholders undertaken to enable to the Group to produce refreshed Green Plans for 2025 to 2028.

The key themes within the Green Plans are:

*   Workforce and System Leadership
*   Sustainable Models of Care
*   Digital Transformation
*   Travel and Transport
*   Estates and Facilities
*   Food and Nutrition
*   Medicines
*   Supply chain and Procurement
*   Adaptation

The Group is required to produce Green Plans for both ULTH and LCHS. The approach taken to draft the plans is to ensure there is consistency but that each reflect any unique aspects, areas of focus and opportunities for both organisations.

Purpose

The Purpose of the paper is to provide update and assurance on the progress within the sustainability agenda. And to present the Refreshed Green Plans for LCHS and ULTH for approval by the committee to be presented to Board in September.

Background

In early February 2025 NHS England published "refreshed" green plan guidance for systems and trusts. The guidance builds on the learnings of a three-year cycle of action and commitment by healthcare organisations and their suppliers to deliver a net zero NHS.

Key dates

2020	The NHS is the world's first healthcare system to commit to net zero.
2021	The green plan "ask" becomes a duty under the Health and Care Act 2022.
April 2022	A minimum 10% net zero and social value weighting is included in all NHS procurements.
April 2023	For all new contracts above £5 million per annum, the NHS requires suppliers to publish a Carbon Reduction Plan in alignment with PPN 06/21.
31st July 2025	NHS systems and trusts are expected to have draft refreshed green plans for the next three-year cycle ready for the Board approval process
31st October 2025	Board approved plans should be shared with NHS England and be published on organisation websites.
From April 2027	NHS supplier obligations increase with all suppliers required to publish a Carbon Reduction Plan for all Scope 1, 2, and 3 emissions.
From April 2028	New requirements for the carbon foot printing of individual products supplied to the NHS will be introduced.
From 2030	In order to qualify for NHS contracts, suppliers must be able to demonstrate progress to net zero through published reports and continued GHG emissions reporting.
2028 to 2032	Interim 80% reduction target for the NHS Carbon Footprint.
2036 to 2039	Interim 80% reduction target for the NHS Carbon Footprint Plus.
2040	Net zero target year for the emissions the NHS controls directly (NHS Carbon Footprint).

Green plan refresh

The latest guidance recommends NHS organisations take a collaborative approach to refresh their green plans in alignment with updated priorities. The approach should include:
- a review of green plan progress to date,
- stakeholder engagement on priorities, particularly clinical and staff groups,
- reference to national targets and interim 80% emissions reduction goals,
- definition of SMART actions and KPIs for each area of focus,
- governance processes to measure and report on progress, and
- mechanisms to ensure legal compliance where required.

The Refreshed Green Plans for ULTH and LCHS have been developed in collaboration with the leads and key stakeholders for the theme areas. Feedback has also been sought from System Leaders and the Group's Green Champions.

Areas of focus

NHS green plans are structured around areas of focus drawn from contributions by NHS staff and external expertise. The refresh guidance considers progress to date in prioritising actions for the next cycle in each area of focus. Here are some of the key refresh priorities.

Workforce and system leadership
- Appointment of a designated board-level net zero lead is recommended along with upskilling and specialist training for staff delivering on green plan actions.

Net zero clinical transformation / Digital transformation
- Green plans should support commitment to preventative, out-of-hospital, and digitally enabled care where clinically appropriate and focus actions on carbon-intensive clinical areas such as critical care, emergency care, and mental health.

Medicines
- 25% of NHS emissions are from medicines, with a significant proportion originating from anaesthetic gases (2%) and inhalers (3%).
- Guidance for decommissioning desflurane, an anaesthetic with high global warming potential, is available, and mitigation guidance to reduce nitrous oxide emissions will soon be published.
- Green plans should support patients and primary care providers to reduce inhaler waste and other impacts.

Travel and transport
- Specific time-bound goals are set out in the NHS Net zero travel and transport strategy towards the target of a fully decarbonised fleet by 2035.
- Green plans should include a sustainable travel plan by 2026 underpinned by a clear understanding of employee commuting patterns and including a shift to zero-emissions vehicles in all lease and purchase agreements.

Estates and facilities
- Employee and expert engagement has identified many opportunities for reducing energy consumption and emissions while lowering costs across the NHS estate.
- Key priorities include electrification and heating system upgrades, aligning estate decarbonisation plans with local priorities, and compliance with the NHS Net Zero Building Standard.

Supply chain and procurement
- A strong priority for green plans this cycle is action to tackle supply chain emissions, estimated to be 62% of total NHS emissions.
- Required actions of suppliers are detailed in the NHS net zero supplier roadmap, with monitoring and reporting obligations steadily increasing over the next three to five year period.

Food and nutrition
- Priorities in this focus area include delivery of healthy and sustainable food and control of waste through monitoring and reporting against reduction targets.

Adaptation
- Continuity planning and emergency preparedness must be part of green plans to ensure organisational resilience in adverse weather and other climate emergencies.
- It was recommended by the key stakeholders that the cost of undertaking an Adaptation Risk Assessment for each organisation is explored.

Developing the LCHG's Green Plans

The Refreshed Green Plans have been developed using the national template provided by NHS England for LCHS and ULTH – Appendix 1 and 2.

Working with theme key stakeholders position statements and actions plans have been developed.

Timeline for Refreshed Green Plans

Board approved Refreshed Green Plans are required for both ULTH and LCHS. These are expected to be presented to NHSE by 31st October 2025. The timeline for the Group is as follows:
- Integration Committee to receive the Green Plans for in August 2025.
- Trust Board to receive the Refreshed Green Plans for approval in September 2025.

Next Steps for Monitoring Delivery Against the Green Plans

There are national reporting criteria via the NHS Greener Dashboard. This questionnaire is a self-assessment return inputted quarterly. Sustainability is also reported in each Trust's Premises Assurance Model (PAM).

In addition delivery is considered under the CQC Well- Led pillar against the following criteria [Environmental sustainability – sustainable development - Care Quality Commission](#)

The key metrics NHS Greener is asking for Trust's to record are shown below.

NHS

Focus area	Metric
Workforce	Named board-level lead for green plan delivery
Medicines	Emissions (tCO$_2$e) and volume (litres) of nitrous oxide by trust
	Emissions (tCO$_2$e) and volume (litres) of nitrous oxide and oxygen (gas and air) by trust
	Average inhaler emissions per 1,000 patients
	Mean emissions of Short-acting beta-2 agonists (SABAs) inhalers prescribed
	% of non-SABA inhalers that are MDIs
Travel and transport	% of owned and leased fleet that is ultra-low emission vehicle (ULEV) or zero-emission vehicle (ZEV)
	Total fleet emissions
	Does the organisation offer only ZEVs in its salary sacrifice scheme
	Does the organisation operate sustainable travel-related schemes for staff (for example, salary sacrifice cycle-to-work)
Estates and facilities	Emissions from fossil-fuel-led heating sources
	Number of oil-led heating systems
	% of gross internal area covered by LED lighting
	% of sites with a heat decarbonisation plan
Supply chain and procurement	Inclusion of Carbon Reduction Plan and Net Zero Commitment requirements in all relevant procurements
	Inclusion of requirements for a minimum 10% net zero and social value weighting in procurements, including defined KPIs
Food and nutrition	Weight (tonnes) of food waste, with further break down by spoilage, production, unserved and plate waste
Adaptation	Number of overheating occurrences triggering a risk assessment (in line with trust's "heatwave" plan)
	Number of flood occurrences triggering a risk assessment

The LCHG Green Group will be formed from September and will meet with each Green Plan theme key stakeholders to agree an action plan for monitoring progress and delivery. These plans will be shared with Integration Committee members.

The Group's Head of Sustainability is currently developing a dashboard to present a visual update of carbon reducing schemes and projects within the Group. This will also be presented to Integration Committee.

National Net Zero Week (5th-11th July 2025)

For National Net Zero-week communications about The Network of Green Champions was shared. With several champion profiles featured across social media. This generated applications for new champions to join the network and suggestions for projects to improve the Group's Carbon Footprint.

Green Competition
Individual teams within the Group have been invited to create their own projects that deliver on cutting carbon, improving patient care and staff experience, reducing the costs of care delivery and making healthcare more sustainable.

Healthcare workers can directly influence, implement and measure changes in your daily practice, showing tangible benefits to net zero carbon, cost and care. The Group

is empowering teams to contribute to sustainable models of care. Two prizes of £1000 are on offer, one for ULTH and one for LCHS. The closing date for entries is 31st August 2025.

Recommendations

The Committee is asked to:

- Note the content of this paper and approve the Refreshed Green Plans to go forward for Board approval.
- Note the timeline for the production and approval of the Refreshed Green Plans.
- Note updates on System Green Plans
- Note updates on the sustainability project examples given.

Our Green LCHS Plan

As a large organisations in our region, Lincolnshire Community Hospitals NHS Trust (LCHS) has both the responsibility and the opportunity to help build healthier lives, stronger communities, and a more sustainable future.

Our Green LCHS Plan offers our sustainability and carbon reduction strategy, putting environmental responsibility at the heart of everything we do. While we've made strong progress, we know we must go further and faster to meet our ambitions.

This strategy is our roadmap for real, long-term change, one that evolves continuously to support our patients, our communities, and our workforce. It guides how we design and deliver services now and, in the future, embedding sustainability across all aspects of our care.

But we can't do it alone. Success will only come through shared commitment and action. By working together, with compassion, collaboration, and innovation, we can make a lasting difference.

Read the Green LCHS Plan and join us in making it happen.

Professor Karen Dunderdale

Group Chief Executive
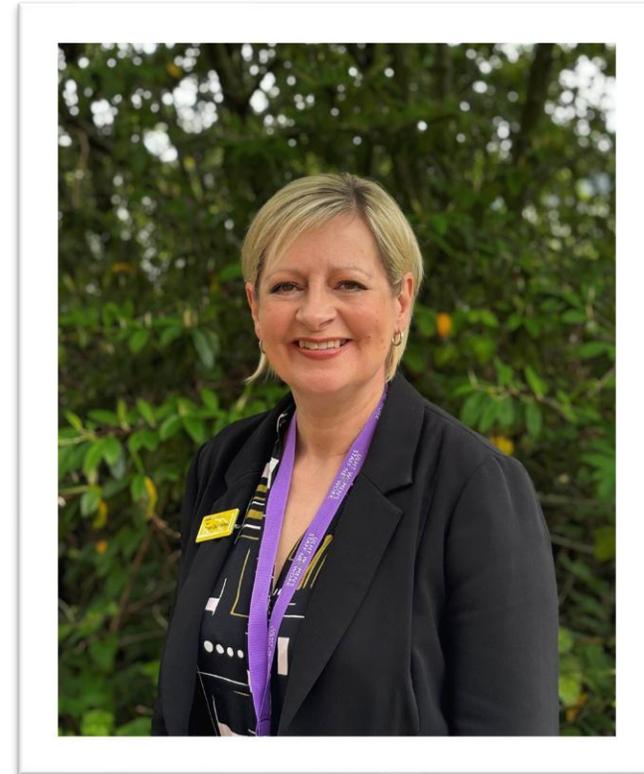
Our achievements

2022 – Our **Green Plan** to achieve net zero was published

2025 – Our Network of **Green Champions** was launched. We were awarded with £23million for Energy Improvements at Pilgrim Hospital and our Green Plan receives a refresh

Net Zero 2040

Championing Net Zero

As a cornerstone of the UK's commitment to health and wellbeing, the NHS has a responsibility not only to care for patients but also to protect the environment in which we all live. The impacts of climate change are already being felt in the health and care system—from increasing respiratory conditions linked to air pollution, to the risks posed by heatwaves and extreme weather events. Addressing these challenges is no longer optional; it is essential.

This Green Plan outlines our vision, objectives and commitment to delivering high-quality healthcare in a way that is environmentally sustainable and resilient for the future. It represents a bold step toward reducing our carbon footprint, improving the sustainability of our operations, and embedding environmental responsibility into every aspect of our service delivery.

Our approach is grounded in the understanding that what is good for the planet is also good for health. By reducing waste, investing in clean energy, promoting active travel, and improving air quality, we can create healthier environments for patients, staff, and our wider communities.

Achieving the goals in this plan will require innovation, collaboration, and determination. It will mean transforming how we think, work, and lead. But the rewards, healthier people, a healthier planet, and a sustainable NHS are well worth the effort.

Together, we can lead the way toward a greener, healthier future.

Claire Hall

Group Head of Sustainability and Net Zero
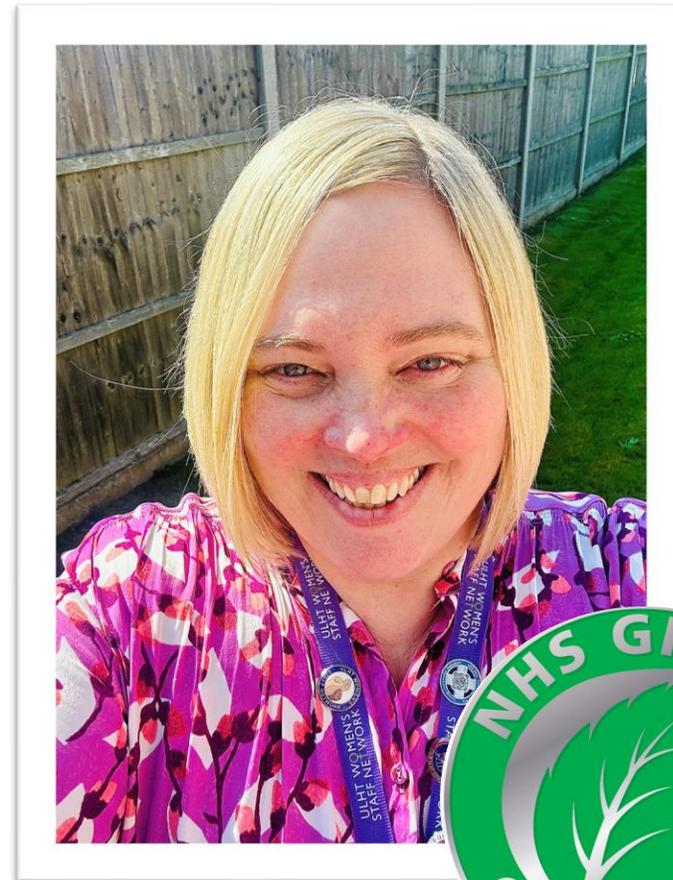
Introduction

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

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

LCHS has a significant economic, social and environmental impact. We spend over £146.2million per year, we employ around 2,000 people. LCHS operates as a Group with United Lincolnshire Teaching Hospitals NHS Trust. Our Green agenda is managed as a group function. Our key activity figures below show the number of clinical attendances to the Trust in 2024/25.

LCHS Activity	Figure
Community - Appointments	265,867
Community - Visits	549,982
Community Hospitals - Admissions	2,035
Urgent Care - UTC Attendances	174,476
Virtual Ward - Admissions	3,465

As a result of our activity, we consume resources, generate substantial waste materials and are responsible for significant carbon emissions. In addition to these elements the travel and transport to deliver the materials we need and to move staff, patients and visitors impacts on local air quality. In line with the NHS Long Term Plan and as an "Anchor Institution" in Lincolnshire we are committed to embedding sustainability across our own organisation and with partners, leading by example in our sector and improving the health and wellbeing of the communities we serve. Everyone has a part to play in delivering this plan and by working together, we will achieve more and deliver truly sustainable healthcare.

LCHS has a central role to play in reducing health inequalities and helping the NHS to reach net zero. This refreshed Green Plan serves as the central document for LCHS's sustainability agenda and provides the rationale for sustainability at the Trust. Through this Green Plan, LCHS will work with staff, patients and partners to take sustainable development and climate action as part of the Trust's commitment to offer the highest quality care to the Lincolnshire community.

The Trust has established a Sustainability Group that will meet regularly and manage the delivery of Green Plan activities by multiple teams. The Green Plan will be reviewed annually and updated where necessary to ensure continual improvement.

LCHS has also established a network of Green Champions coming together to support the Green Plan actions and raise the profile of the sustainability agenda.

Cornerstone Targets

The National key targets are:

Net Core Carbon Footprint:

Reduced 80% by 2030

Net Zero Carbon by 2040

Carbon Footprint PLUS:

Net Zero Carbon by 2045

Clean Air Hospital

Baseline Assessment 2025

Reduce Use of Resources:

Reduce single use plastics

Zero waste to landfill

100% renewable energy

Carbon Reduction

The diagram shows the elements that make up the NHS carbon emissions – *The Carbon Footprint*

The NHS's Core Carbon Footprint is shown by the green arrow, it includes carbon emissions that are directly produced through the use of building energy, water, waste processes, anaesthetics, inhalers and business travel.

The NHS Footprint PLUS is shown by the blue arrow and includes the other emissions associated with products and services that we purchase.

In line with the NHS commitment to become the world's first Net Zero Carbon National Health Service, LCHS is committed to these targets
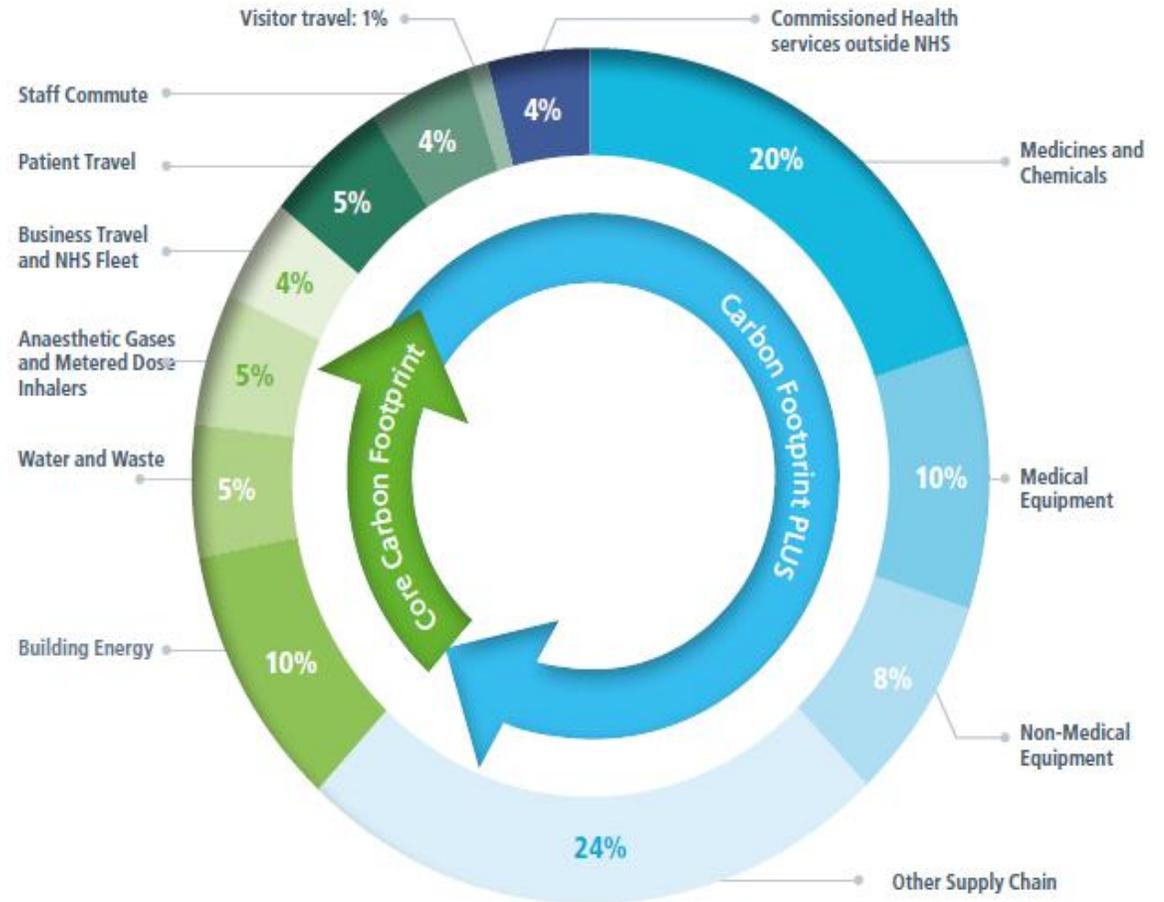
The Challenge Ahead: Carbon Footprint Plus Emissions

Assessing and decarbonising NHS supply chain emissions is a complex undertaking.

The NHS is working step by step to both reduce emissions and the robustness of emission measurement and reporting.

During 2022/23, the central Greener NHS team carried out a nation-wide carbon foot printing assessment of NHS 2019/20 footprint plus emissions. LCHS's Carbon footprint was not identified in this process.

Our Aim: To collate the data to allow us to benchmark LCHS's Carbon Footprint.

1 tonne of CO2 is equal to...

A 500m³ hot air balloon

Net Zero Supply Chain Roadmap

Close

Use HM Treasury Green Book Guidance to assess impacts from capital spend

Adopt PPN 06-20 10% SV included in all Tenders

Adopt PPN 06-21 suppliers to publish a Carbon Reduction Plan for contracts over £5m

APRIL 2022

APRIL 2023

New builds & major refurbishments compliant with NZ hospital building standard

PPN 06-21 - suppliers to publish a carbon reduction plan (CRP) for all contracts

All suppliers to report emissions and publish a CRP aligned to NHS footprint plus 2024 Net Zero target

APRIL 2024

Net Zero Supply Chain

All suppliers required to demonstrate progress against NZ targets via progress and carbon emissions reports

APRIL 2027

MARCH 2045

APRIL 2030

Climate Change is a health emergency

"*Unabated it will disrupt care and affect patients and the public at every stage of our lives. With poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer, our efforts must be accelerated.*"

Sir Simon Stevens, NHS Chief Executive

In office 1st April 2014 to 31st July 2021

Our Vision" Caring and building a healthier future for all".

We recognise our role in influencing the wider health and wellbeing of our populations, and along with our system partners have committed to focusing on building healthier, safe and more resilient communities, promoting local skills and employment, decarbonising and safeguarding our world and supporting growth of responsible local/regional business.

Our new Green Plans for 2025 will be key enablers to the delivery of some of our priority anchor responsibilities and ambitions and we will work with our local communities and partners to deliver even greater local benefits (e.g. through procurement, supply chains, partnership working, community outreach). We will strengthen our relationship with the University of Lincoln to enhance local employment opportunities through the development of a joint strategy with a focus on educating and developing the workforce for the future.

Becoming environmentally sustainable is a growing priority due to the link between environment and health.

We will reduce our carbon footprint and be on track to meet the NHS net zero target by 2040. This Green Plan will be a key enabler on our journey towards net zero in 2040.

Our Green Champions and transformation framework will help to ensure that we consider the sustainability impact of everything we do, from recycling our waste, choosing how we travel to and from work, through to how we reduce environmental impact from the medicines and single use equipment we use and how we spend our money with suppliers who mirror our sustainability and social value ambitions.

Vision: Caring and building a healthier future for all

PATIENTS	PEOPLE	POPULATION
Better Care	*Better Opportunities*	*Better Health*

AIMS	Provide timely, high quality, affordable care in the right place	Develop, empower and retain great people	Improve population health

OBJECTIVES	1a Improve patient safety, patient experience and deliver clinically effective care	2a Enable our people to fulfil their potential through training, development, research and education	3a Transform clinical pathways and rationalise our estates, investing more in community care and reducing reliance on acute services
	1b Reduce waiting times for our patients	2b Empower our people to continuously improve and innovate	3b Move from prescription to prevention, through a population health management and health inequalities approach
	1c Improve productivity and deliver financial sustainability	2c Nurture compassionate and diverse leadership	3c Enhance our digital and research and innovation capability
	1d Provide modern, clean and fit for purpose care settings	2d Recognise our people through thanks and celebration	3d Drive forward our improvement, efficiency and sustainability agenda including our Green Plan

Workforce and Leadership Commitment

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

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

The NHS is the biggest employer in Europe and the world's largest employer of highly skilled professionals. The Trust's Green Plan needs to be embedded within its culture, with the recognition that people are at the core of the NHS. The Trust will empower staff to deliver this Green Plan at all levels of the organisation.

Workforce and Leadership

⌖ What do we want to achieve?	⚑ How can we achieve it?	🔍 How will we measure it?
• Deliver, monitor and report on sustainability progress.	• Report performance quarterly to the Sustainability Group and Integration Committee plus via the trust annual accounts.	• Number of policies and business cases including a sustainability impact assessment.
• Senior staff, stakeholders and are engaged in, and accountable for, delivering our Green Plan.	• Play an active role as an Anchor Institution in Lincolnshire, creating opportunities for local communities to become more sustainable.	• No of staff that have undertaken sustainability training including sustainability induction for new staff.
• Strategies, policies, procedures, business cases and processes always have a meaningful sustainability impact assessment.	• Incorporate the Green Plan into the Trust Strategy	• Number of apprentices, work placements and volunteers employed.
• Staff are supported and empowered to improve sustainability at work and home.	• Establish an active Network of Green Champions to support embedding the sustainability agenda as a 'green thread' across the organisation	• Carry out annual sustainability surveys to measure staff awareness levels.
• A sustainable workforce, succession planning, recruitment and retention.	• Workforce plans	• Number of apprentices, work placements and volunteers employed.
• Responsible anchor institution showing sustainability leadership and a positive impact for our communities.		
• Encourage staff to actively participate in the Greener NHS community and other forums such as the Greener AHP Hub, Centre for Sustainable Healthcare and related workspaces on the Future NHS platform.		

Our Aim: To have 50% of business cases supported by a sustainability impact assessment by March 2026

Sustainable Models of Care

Sustainable models of NHS healthcare delivery are important for several key reasons:

- The NHS is one of the largest public sector contributors to carbon emissions in the UK. Hospitals, transport, pharmaceuticals, and medical devices all consume significant energy and resources. Reducing the environmental footprint helps tackle climate change and promotes planetary health.

- Environmental degradation contributes to health problems such as respiratory diseases, cardiovascular conditions, and mental health issues. Greener healthcare reduces air pollution, waste, and chemical exposure, which directly improves public health outcomes.

- Sustainable practices can reduce long-term operational costs. For example, energy-efficient buildings, digital systems that reduce paper waste, and local sourcing of supplies can save money, which can then be reinvested into patient care.

- Sustainable models make the NHS more resilient to climate-related disruptions, such as heatwaves or supply chain breakdowns. They also ensure that the NHS can continue to deliver care in the face of environmental challenges.

- LCHG has committed to supporting the NHS becoming the world's first net-zero health service by 2045. Green models support this goal and demonstrate leadership in public sector responsibility and climate action.

- Patients and the public increasingly value environmental responsibility. A sustainable NHS aligns with societal values and can enhance public trust and engagement in health initiatives.

By approaching our green ambitions as a Group, LCHG can support the delivery of sustainable models of care through the consolidation of estates & facilities, streamlined logistics and transport, joint procurement chains, digital integration and a combined culture of unity as we look to reduce our environmental impact, deliver both the LCHG and NHS ambitions, and support our productivity and efficiency agenda - all whilst still improving patient care.

Sustainable healthcare delivery not only protects the environment but also enhances patient care, reduces costs, supports public health, and prepares the NHS for future challenges.

Sustainable models of care

What do we want to achieve?	How can we achieve it?	How will we measure it?
• Deliver the best quality of care while being mindful of its social, environmental and financial impact and take a whole systems approach to the way it is delivered.	• Through implementation of our Clinical Strategy, including care closer to home, left shift of services and virtual wards. • Facilitate virtual and telephone patients consultations in line with sustainable care pathways.	• Changes in travel data for patients. • Reduction in onsite outpatient follow ups.
• Build on current efforts Getting it Right First Time (GiRFT), National Safety Improvement Programme to reduce health inequalities and improve early intervention, linking this work to potential emissions reductions.	• Work with the Best Practice Manager and Care Groups to ensure GIRFT Greener Pathway Guidance is implemented	• Monitor practice under for example the Greener Bladder Cancer Care Pathway.
• Use the Embedding Public Health into Clinical Services Programme's toolkit and Sustainability in Quality Improvement (SusQI) Framework to ensure the best possible health outcomes with minimum financial and environmental costs, while adding positive social value at every opportunity.	• Management and monitoring of Sustainability Impact Assessments as part of our project methodology	• Develop a carbon footprint trackers for our clinical services
• Continue to collaborate with Lincolnshire system colleagues on the population's health.	• Through the Health Inequalities Group Action Plan	• Improved Patient outcomes/access to services
• Delivery against the objectives detailed in the Group Strategy 2025-2030 (add internet link)	• Care Groups delivery plans	

Our Aim: To develop a carbon calculator to measure the impact of changes to service delivery

Digital Transformation

LCHS is already a relatively digitally mature organisation, with a Digital Maturity Assessment score of 2.5 (2024) and a Healthcare Information and Management Systems Society score of 4 (2023). An established cloud hosted Electronic Patient Record has been in place since 2006, and a recent tender exercise has focused on usability and functionality to deliver significant benefits to the Trust. Many of which focus on operational efficiency, reduced travel, and supporting patients in their communities.

As we continue to optimise the use of technology and better equip patients and services with the skills and capability to provide and receive alternative and sustainable care provision, it is essential that this is meets the LCHS Green Plan.

Key priorities in Digital focus on:

• Optimising the use of the Electronic Patient Record

• Enhancing Community Connectivity

• Reducing power consumption of devices

• Creating operational efficiencies

• Utilising cloud technology responsibly

Digital Transformation

🎯 What do we want to achieve?	🚩 How can we achieve it?	🔍 How will we measure it?
• Build on current practice of engaging staff and care groups in digital care channels, meaning fewer patient journeys.	• Targeted Digital inclusion sessions in the community and update of digital clinical networks to upskill staff and patients in using technology	• Number of online services available to reduce travel for staff and patients • Number of engagement sessions held in the community with increased update in online services
• Implementation of an optimised Electronic patient record will support delivering care in the community, improving resource utilisation and support remote care delivery.	• 5G connectivity in laptops, with remote working over VPN, with staff no longer required to return to base to complete digital records	• Full impact assessment caried out against implementation plan, alongside benefits realisation of EPR
• Reducing power consumption of devices	• Adopt energy –efficient hardware • Optimise power settings • Promote low-power networking equipment	• Successful implementation of power policies with reduced power usage of devices • Better value for money on devices based on benchmarking data available nationally
• Creating operational efficiencies	• Reduce physical infrastructure by virtualising servers and decrease hardware requirements • Implement remote work policies to where possible reduce travel-related emissions and energy demand for office spaces	• Cloud booking utilisation for estate • Server migration and server running cost monitoring
• Patient engagement portal to support digital communications with the patient and clinical service to reduce travel and increase access.	• Part of Electronic Patient Record functionality (patient portal) to increase digital material shared with patients and reduce printing, postage and emissions of paper material	• Successful implementation of patient portal • Monitor number of electronic communications • Decreased printing and postage costs
• Continue to explore options for even greater re-use and recycling of digital equipment that no longer meets Trust requirements, increasing re-use over recycling where possible	• Re-procure a secure digital recycling partner, this will present an opportunity to maximise re-use and recycling of digital assets, while maintaining the required levels of secure compliant asset disposal.	• Include metrics that evidence the re-use and recycling to support us to improve sustainability of assets in new contracts

Travel and Transport

The Trust is committed to developing a Green Travel Plan, outlining the aims and objectives related to reducing congestion, single occupancy travel, and CO_2 emissions whilst promoting alternative transport. It will explore how to promote active travel to staff and visitors. In addition, the Trust will produce site-specific plans to focus on the individual challenges of each hospital and their locality concerns, particularly related to the difficulty experienced for the geographical nature of the county.

Commuting, Visitor/Patient Travel

The Trust has implemented a car sharing app to promote the reduction in single occupancy transport.

There has also been a subsidised bus scheme linked to a salary sacrifice process implemented for travel to Lincoln County Hospital - further discussions are underway with providers at the other sites into the possibility of mirroring this scheme.

For alternative travel, the Trust offers a salary sacrifice cycle to work scheme. This is supported by cycle storage at all main sites including lockers and showering facilities. Staff have benefited from free bike maintenance and the Trust has actively promoted cycle events. The Trust is currently undertaking a full review of cycling provisions with the view to modernising both the public and staff facilities.

Public transport to the sites remains vital to the Trust's employees and communities, helping to reduce health inequalities. The Trust is currently engaging with local councils on improving bus provisions to the sites including accessibility requirements such as safe routes and crossings for wheelchair users.

During 2025 we will undertake a travel survey conducted to ascertain requirements of both staff and public for accessing the site. There will be supporting analysis conducted such as Shape Atlas to ascertain from a Dutch model of cycling what the potential provision and location of the population could access the Trust's sites by cycle.

Travel and Transport

LCHS Fleet Vehicles

LCHS operates a combined fleet of 118 vehicles. These are a mix of salary deduction lease cars for essential car users, service pool cars for business use and commercial vehicles that are used for support services e.g. Electronic Assistive Technology Service(EATS).

The Group has a legal duty (Health & Care Act 2022) to meet the NHS Net Zero Travel & Transport (NZTT) targets that relate to the introduction of sustainable travel strategies and the introduction of zero emissions vehicles into Trust operated fleet. By 2027 all new vehicles owned or leased by the NHS must be zero emission and by 2035 all vehicles owned by the NHS must be zero emission (excluding ambulances).

Group vehicle replacement strategies are being developed to meet these targets.

In addition to these 118 vehicles, LCHS offers salary sacrifice lease vehicles that are externally managed by 'NHS Fleet Solutions'. The NZTT targets state that all vehicles offered through these schemes must be zero emissions by 2026.

Employees who use their own privately owned vehicles for business purposes are referred to as the 'Grey Fleet'. These employees are reimbursed through the electronic expenses system, and this Payroll managed system holds the travel and vehicle data for this element of the LCHS vehicle fleet.

Travel and Transport

⊚ What do we want to achieve?	⚑ How can we achieve it?	🔍 How will we measure it?
• Conduct a Trust wide staff and patient/ visitor travel survey	• Working with our Communications, Organisation Development, Staff and Public Representatives, the Travel Team will conduct a survey for all possible users to collect and analyse current methods of travel but also consider barriers to alternative travel.	• This will be measured through a full analysis of collected data and will form part of the overall Travel Plan.
• Publish a Trust Local Travel Plan	• Consider feedback from the travel survey to form the basis of a long-term strategic plan for travel each of the sites • Work with supporting organisation to ensure the first experience of the NHS (travel to site) is supported for all ages and abilities	• Clear KPIs will be established with ongoing review processes to measure the effectiveness of the plan • Work with partners and services to ensure experience of attending the sites is suitable and sufficient for all
• Review and improve cycling facilities on all sites	• Conduct a cycle facility review, explore funding, sponsorship or collaboration opportunities to create new bespoke cycle hubs	• Implement modern cycle provisions which are easily accessed, clean, modern and are designed in such a way to remove barriers to cycling to work
• The Trust has a legal duty (Health & Care Act 2022) to meet the NHS Net Zero Travel & Transport (NZTT) strategy targets (this applies to both emissions that the Trust can control and also influence)	• Vehicle replacement programme and budget planning to introduce zero emission vehicles into the Trust's fleet • Bid for external funding and grants to facilitate the development of EV charging infrastructure on Trust sites and the introduction of EV vehicles • Review the 'grey fleet' and lease car policies (salary deduction and salary sacrifice) to influence and incentivise the introduction of zero emission vehicles • Tender documents for equipment and services should influence and incentivise a reduction in emissions as a result of travel & transport	• By 2027 all new vehicles owned or leased by the NHS will be zero emission • By 2025 all vehicles owned by the NHS will be zero emission (excluding ambulances) • Monitor the Trust's fleet profile in relation to vehicle numbers, miles travelled and projected CO2 output • Procurement Teams to consider when evaluating tender responses • Annual NHSE Green Fleet Data collection
• Remove or minimise the requirement for (and impact of) Travel & Transport	• Key stakeholders to consider the impact of travel and transport when making strategic decisions relating to service provision e.g. the centralisation of a service may either increase or reduce travel & transport requirements • Monitor Trust vehicle usage with service leads and potentially reduce vehicle numbers • Implement digital solutions remove or minimise travel and transport requirements	• Monitor the expenses system relating to staff travel claims to identify trends • Monitor the Trust's service vehicle fleet in relation to vehicle numbers, miles travelled and projected CO2 emissions

Estates and Facilities

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

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

The Built Environment (our Buildings) of the NHS influences both the quality of care and environmental impact.

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

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

The LCHS Estate comprises of four freehold properties and the rest of the estate used for service delivery is either leased from private landlords or NHS Property Services in the case Johnson Hospital, Spalding, Skegness Hospital, Louth County Hospital and John Coupland Hospital, Gainsborough as well as several Health Clinics. We work closely with these third parties to maximise the efficiency of estate and to minimise the carbon emissions created.

Estates and Facilities is further sub-divided into

- Energy and Emissions

- Water Efficiencies

- Capital Projects

- Waste and Recycling

- Biodiversity and Green Space

Estates and Facilities – Energy and Emissions

⊙ What do we want to achieve?	⚐ How can we achieve it?	🔍 How will we measure it?
• Review the strategy for energy efficient lighting across freehold properties. And to work with NHS Property Services to maximise implementation in areas occupied under lease.	• Targeted replacement schemes and evolutionary maintenance replacements.	• Building coverage by percentage.
• Explore opportunities for on-site Solar Photovoltaic electricity generation.	• Explore Trust funded and external investment opportunities.	• Annual kWh generation.
• Enhance automated building management systems in freehold properties.	• Develop and modify Building Management Systems with investment into modern emissions focussed equipment and operational strategies.	• Feedback from recorded data streams, including energy usage and Carbon Dioxide emissions.
• Expand heating zone segregation as appropriate within freehold properties.	• Subdivision of heating system distribution, with localised variable valves.	• Heating demand profiling against degree data and more consistent internal temperatures.
• Sub-metering with automated monitoring and targeting within freehold properties.	• Phased roll out of energy metering equipment.	• Increased data availability.
• Improved air quality.	• Air Quality Audit, Plant NOx/particulate monitoring, with targeting of hot spot areas.	• Comparisons against benchmarks.
• Continuously review the sources of heat generation to maximise low carbon usage.	• Installation of low carbon heating solutions in place of traditional heating boilers.	• Annual kWh generation from Heat pump, biomass and other low carbon solutions
• Climate Change Adaptation.	• Review processes and systems to widen operation parameters.	• Minimise periods of site stress during extreme weather events.

Estates and Facilities – Water Efficiencies

🎯 What do we want to achieve?	🚩 How can we achieve it?	🔍 How will we measure it?
• Efficient use of water around the Trust.	• Incorporate appropriate water saving and efficient end use devices where appropriate.	• Comparative water usage on an individual basis.
• Monitoring and targeting of water usage across the Trust.	• Strategic installation of sub-metering across the network.	• Collating and reporting consumption against developed trends.
• Promote awareness for appropriate use of water among staff and other consumers.	• Awareness campaigns for water usage and encouragement to report leaks, regardless of severity.	• Identify changes in water demand linked to campaign success.
• Early identification of water loss.	• Utilisation of technologies to detect adverse water demand changes and actively detect leaks in high-risk locations.	• Key performance indicators for detection and resolution of system leaks.
• Explore options for alternative water sources.	• Review opportunities for rainwater harvesting and reuse of grey water on individual location basis.	• Annual quantity of alternative water consumed.

Capital Projects

The Built Environment of the NHS influences both the quality of care and environmental impact. The Trust's design and construction of buildings will play a key role in the collective ability to achieve net zero carbon emissions. The Trust uses the NHS Net Zero Building Standard as a guide for significant construction works.

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

In terms of all Trust construction or refurbishment there are fundamental principles that are adhered to within all conceptual planning.

BREEAM which stands for Building Research Establishment Environmental Assessment Method, is a globally recognized green building certification system used to assess the sustainability performance of buildings and infrastructure. It evaluates various aspects of a building's design, construction, and operation, aiming to reduce environmental impact and improve overall performance. All buildings, construction builds, refurbishments are rated and certified on a scale of "Pass", "Good", "Very Good", "Excellent" and "Outstanding. BREEAM assesses buildings across various stages of their lifecycle, including design, construction, operation, and refurbishment.

By integrating BREEAM principles, projects can reduce life cycle costs, improve asset value, enhance user experience, and demonstrate a commitment to sustainability. BREEAM supports the achievement of various sustainability goals, such as reducing carbon emissions, improving whole-life performance, and enhancing circularity and resilience, this supports the Trust's green plan. BREEAM certification of excellence will ensure and improve the sustainability performance of the build environment through the project and building lifecycle.

The Principal Supply Chain Partner's (PSCP) must be identifying their own Net Carbon Zero (NCZ) policy, this policy must support the Strategic approach for the Trust's green plan and NCZ. This can be supported in many ways, but two fundamental principles are Modern Methods of Construction (MMC) and BREEAM achievements. The MMC must deliver upon offsite manufacturing, design for manufacture and assembly, technological advancements and pre-fabrication.

Modern Methods of Construction (MMC) refer to a range of techniques that aim to improve construction processes, often involving off-site manufacturing and prefabrication, leading to faster, more efficient, and potentially more sustainable building practices. These methods include modular construction, panelised systems, 3D printing, and hybrid approaches that combine elements of different techniques

Estates and Facilities – Capital Projects

What do we want to achieve?	How can we achieve it?	How will we measure it?
• To deliver our Capital Programme in line with Trust Net carbon zero initiative and guidance.	• We design and build with an ambition to achieve BREEAM excellence	• Post project evaluation and review throughout the design stages that we achieve the BREEAM classification
• To support a carbon neutral design	• Work with designers through all design stages collaboratively with Trust colleagues to discuss alternative methods of Mechanical Electrical and Plumbing services.	• Safety Group discussion and other collaborative meetings as well as Post project evaluation.
• Market leading energy efficient technology	• Through design and collaborative working, provide competent and updated energy efficiencies through modern technology.	• Through design and project initiation documentation, ensuring scope of works includes detailed outcomes and expectations.
• Digital systems aligned with Building Management Systems	• To benchmark and collaborate with other Trusts to seek proactive methods for robust technology services which support effective project delivery and longer terms Trust governance.	• Through compliance and governance processes, audits and data collation
• Innovative design methodology	• To ensure designs are modern, ambitious and innovative. Collaboration with key stakeholders to ensure design meets the brief.	• Through post project evaluation and review from design concept to initiation.
• Heating Ventilation and Air Conditioning systems	• Using robust design and modernisation, to improve HVAC systems across the sites ensuring efficiency methods and savings are captured and presented positively.	• In collaboration with teams to ensure HVAC design achieves expectations.
• Modern Methods of Construction	• Using a range of techniques that aim to improve construction processes, including (but not limited to); off-site manufacturing, panelised systems, prefabrication, achieving faster production and utilising more sustainable products.	• Through design and post project review, aligning with BS standards and other guidance where appropriate.

Estates and Facilities – Waste and Recycling

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

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

The Trust has a legal duty under The Environmental Protection Act (EPA) 1990 to ensure all waste generated through its activities are responsibly managed and a safe system of work is in place for the segregation, collection, storage, handling and transportation of waste from point of production to point its final disposal.

Our aim: to maximise the amount of waste that is recycled

Estates and Facilities – Waste and Recycling

⌖ What do we want to achieve?	⚑ How can we achieve it?	🔍 How will we measure it?
• Better segregation of waste across the Trust	• Development of training sessions to include mandatory and waste awareness days. Development of a waste strategy for the Trust. Continued review also of the groups waste policy in line with any new waste regulations.	• Pre acceptance audits conducted across the Trust to gauge levels of compliance. Change in tonnage rates of waste streams to determine that measures are working, e.g. reduction in high temperature treatment as an example.
• Reduce waste costs by the correct waste going into the right waste stream	• Education of all staff. Reusables sharps system.	• From reports from our waste collection companies and reduced costs
• Zero land fill being carried out by our waste contractors in relation to the Groups waste streams	• Produce waste contracts that detail the requirement of zero land fill. Clear instruction on the sustainability and green plan section of the contract specification.	• Waste Manager to conduct audits of the contractor's premises to ensure compliance. • Reporting will be part of the contracts for general waste streams. • Data provided to inform Estates Return Information Collection return.
• Better working together with Infection Prevention and Control colleagues to reduce Health Care Waste streams for example reduce where we can Orange to Tiger stripe waste in clinical areas.	• Review of Health Care waste and the environment its being produced by working with the Infection Prevention and Control.	• Reduced costs and compliance in external audits such as the Integrated Care Board and NHS England
• Improved waste recycling and compliance to any new waste regulations.	• Work in conjunction with our waste contractors to achieve recycling options. This will need to include better education for staff and visitors	• External and internal audits. • Reduced waste costs across the Trust
• Improved general waste and recycling contract for the Trust to detail the different waste streams (including estates waste) under one contract opposed to different contracts.	• Working together with colleagues from across the group along with purchasing on the development of a clear specification on the different waste streams.	• Improved compliance measured from internal and external auditing
• Re use of equipment etc. rather than disposal of it.	• Any fit for purpose equipment to be stored and then reused as opposed to ordering new.	• Reduced new purchase orders being raised and reduce waste costs

Biodiversity and Green Space

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

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

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

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

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

We will work with our landlords to maximise access to green spaces for our staff, patients and visitors.

Estates and Facilities – Biodiversity and Green Space

🎯 What do we want to achieve?	🚩 How can we achieve it?	🔍 How will we measure it?
• Maintain and improve our green spaces and biodiversity on-site.	• Develop a biodiversity and green space strategy that encompass the challenges and opportunities across our Estate.	• NHS Sustainability Assessment Tool score for green space and biodiversity section.
• Help improve the physical and mental wellbeing of staff, patients and the wider community through access to green space, biodiversity and interactions with nature.	• Produce a biodiversity and green space action plan that details actions and those responsible for maintaining our green spaces.	• Habitat and biodiversity site surveys.
• Help to mitigate climate change and biodiversity loss through our biodiversity strategy.	• Ensure tight integration of biodiversity and green space plan with capital projects policy to underpin the approach for major new works and refurbishments.	• Achievement of Biodiversity Net Gain standards
• Increase access to green space for staff, patients and visitors	• Work with staff, local community organisations and strategic partners to enable increased access to green space and nature both on-site and traveling to and from site.	• Assessment of staff and patient use of and interaction with greenspace via staff surveys.

Food and Nutrition

Food illustrates the links between climate change and public health. The NHS Long Term Plan commits us to promoting plant-forward diets and reducing unhealthy options like sugary drinks on NHS premises, accepting that plant forward items need to be navigated with care, as some are now classified as ultra processed foods.
The Trust only provides diet drinks in vending machines. Not only will these actions help prevent obesity and non-communicable disease, but they will also play a role in reducing greenhouse gas emissions and environmental impact.

Catering for our patients at LCHS Hospitals is currently provided by a third party. Our priority during the period of this Green Plan is to work with them to ensure our model of delivery is the best solution for our patients.

There is no action plan for LCHS in this theme.

Mike – should we add an action plan?

Medicines

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

Methoxyflurane (Penthrox™) pen-inhalers can be used to treat moderate to severe pain associated with trauma in the Accident and Emergency department. Methoxyflurane can be self-administered under medical supervision, in a similar fashion to nitrous oxide. It has a lower global warming potential (GWP) than nitrous oxide and switching to methoxyflurane would lessen emissions at point-of-use. However, this comes at a cost, as methoxyflurane is delivered in non-reusable 3ml inhaler pens, creating additional non-recyclable waste.

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

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

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

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

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

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

Medicines

🎯 What do we want to achieve?	🚩 How can we achieve it?	🔍 How will we measure it?
• Reduction of environmental impact of medicines prescribed by LCHS (carbon footprint and ecotoxicology).	• Establish Nitrous Oxide waste minimisation programme and review of volatile anaesthetic gas emission reduction options. • Explore alternative treatments for pain relief.	• Monthly consumption of all anaesthetic gases by type.
• Reduction in Pharmaceutical waste	• Working with wards and departments to make reductions in waste produced through changes to clinical process such as Intravenous Paracetamol to tablets, use of patients own medication supply and inventory management systems.	• Reduction in costs of medicines and waste generated
• Reduce use of single use plastics in medicines distribution.	• Educate staff/patients on sustainable medicines use and disposal	• Reduction in waste

Supply Chain and Procurement

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

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

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

Procurement and Climate Action

Supply chain emissions represent a huge portion of LCHS's overall carbon footprint.

Net zero supplier roadmap

- **From April 2022**: All NHS procurements include a minimum 10% net zero and social value weighting. The Net zero and social value guidance for NHS procurement teams helps to unlock health-specific outcomes (building on PPN 06/20). Net Zero and Social Value will be applied via the Evergreen assessment for NHS England Medicines tenders.
- **From April 2023**: for all new contracts above £5 million per annum, the NHS requires suppliers to publish a Carbon Reduction Plan for their UK Scope 1 and 2 emissions and a subset of scope 3 emissions as a minimum (aligning with PPN 06/21). The Carbon reduction plan and net zero commitment requirements for the procurement of NHS goods, services and works guidance outlines what is required from suppliers and how it should be implemented.
- **From April 2024**: The NHS has proportionately extended the Carbon Reduction Plan requirements to cover all new procurements.
- **From April 2027**: All suppliers will be required to publicly report targets, emissions and publish a Carbon Reduction Plan for global emissions aligned to the NHS net zero target, for all of their Scope 1, 2 and 3 emissions.
- **From April 2028**: New requirements will be introduced overseeing the provision of carbon footprinting for individual products supplied to the NHS. The NHS will work with suppliers and regulators to determine the scope and methodology.

Supply Chain and Procurement

🎯 What do we want to achieve?	🚩 How can we achieve it?	🔍 How will we measure it?
• Meet national legal and regulatory requirements such as NHS Standard Contract and Net Zero Procurement Roadmap.	• Include sustainability criteria in procurement, tender evaluations, framework design and selection, and product selection, in line with PPNs	• Assess the use of Evergreen system to support trust green plan objectives.
• Implementation of an Inventory Management System (IMS) Trust-wide	• Roll-out of the IMS	• Reduction in stock waste
• Work with local SMEs and Business Groups to support the requirements of them to fulfil Evergreen Supply Chain requirements and evidence their Carbon Reduction Plans	• Workshops with local business groups	• Number of local business attendees • % of contracts awarded to suppliers with a carbon reduction plan (CRP).
• Ensuring social value compliance in procurement	• Tenders include minimum 10% Social Value criteria and assessment	• Social Value trackers
• Re-use of materials and items where appropriate	• Replace single use products with reusable alternatives where there is a viable, more sustainable option e.g. re-usable sharps bins • • Promote a culture of reuse and refurbishment of items	• Track the positive carbon and other environmental impacts from procurement initiatives e.g. introduction of reusable materials

Adaptation

Climate change will make extreme weather, such as heatwaves, droughts and flooding, more prevalent. Sea-level rise and increased risk of Vector Borne Diseases, such as Lyme Disease, may also impact Lincolnshire's communities.

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

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

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

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

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

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

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

Adaptation

🎯 What do we want to achieve?	🏳 How can we achieve it?	🔍 How will we measure it?
• Ensure our whole organisation is prepared to deal with the effects of climate change, particularly extreme weather events such as heat waves and flooding, and continues to invest in adaptation and mitigation measures.	• Nominate an adaptation lead and incorporate adaptation into our sustainability governance structure, corporate risk register and reporting processes.	• BREEAM Building Standard or other sustainable buildings methodology scores.
• Ensure our infrastructure, services, procurement, local communities and colleagues are prepared for the impacts of climate change.	• Work with Lincolnshire system partners and other stakeholders to create and approve a Climate Change Adaptation Plan (CCAP)	• Review and Approve the recommendations within the Lincolnshire Climate Change Adaptation Plan
• Understanding our risks	• Develop a Climate Change Risk Assessment (CCRA) Adaptation plan to mitigate risk to continuity and resilience of services	• The overall risk rating in our climate change risk assessment.
• Emergency preparedness	• Ensure that our emergency plans for extreme weather, consider support for vulnerable communities during any extreme weather events.	• Testing of emergency planning policies.
• Development of resilience plans to deal with projected changes in climate and extreme weather events	• Major Incident Plan • Significant Incident Plan • Incident Coordination Centre Manual • Adverse Weather manual • Heatwave plan • Training staff on potential impact for awareness and inclusion	• Number of overheating cases per year • Number of climate risks identified in risk assessment • Training attendance
• Design, build and upgrade the estate within governance and local parameter guidance.	• Adhere to targets and requirements set out within Building engineering in the health sector (HTM's/HBN's), the Climate Change Act and the National Adaptation Programme (NAP) to put plans in place to address both the causes and consequences of climate change.	• Ensure designs allow for optimum resource efficiencies including the use of materials and avoiding over-engineering, whilst capturing flexibility and future adaptation.

Communicating and Embedding the Green Plan

To help drive change across the whole organisation, we will take a considered, structured and engaging approach to disseminating the strategy and embedding our approach to sustainability.

A communication plan for the strategy will be developed that shows what we are doing both within and outside of the organisation, highlight key priorities and show excellence in sustainable development leading others to join us in making improvements. We will employ some key themes:

• **Collaboration:** leading on more joined-up thinking

as well as creating stronger links

with the communities we serve.

• **Development:** showcasing sustainability

initiatives for staff as well as opportunities

to work outside the parameters of core roles.

• **Progress:** highlighting visible progress in

delivering sustainability across the 10 areas

of action.

Governance and Reporting

Clear leadership is vital to ensure we successfully deliver the commitments in this Green Plan. As this Plan is broad and encompasses a wide range of work areas, there are other detailed documents that will underpin our approach. Some of these have already been developed, such as the Lincolnshire Climate Change Adaptation Plan and some will be developed or revised in the future such as our Green Travel Plan, Estates Strategy and the sustainability section of the Care Group Operating Plans.

Clear reporting is required to monitor progress and ensure delivery is on track. In addition, there are a number of National reports undertaken to monitor progress. Examples of our reporting are detailed below:

- **Greener NHS Dashboard: A**llows users to view data on a range of measures covering sustainability, including carbon equivalent emissions associated with NHS activity and policy and contractual levers that support progress towards a net zero NHS.

- **NHS Sustainable Assessment Tool:** This will measure our qualitative progress on sustainability for the previous year, inform plans for the coming year, and will enable comparative performance against similar Trusts.

- **Clean Air Hospital framework:** This will measure our qualitative progress on air quality for the previous year, inform plans for the coming year, and will enable comparative performance against similar Trusts.

- **Trust Annual Report Sustainability section:** This reports progress against the Green Plan and provides highlights of the main activities delivered throughout the year.

- **ERIC (Estates Return Information Collection):** A mandatory data collection for all NHS Trusts required by the Department of Health.

- **Progress reports:** Internal progress reports are produced for the quarterly Integration Committee.

- **Related Internal Policies:** Our Green Plan is to be supported by various related policies and guidance documents including: The Green Travel Plan, Waste Management Policy, Lincolnshire Climate Change and Adaptation Plan.

LCHS's Greener Future

As an NHS Trust, we recognise our vital role in addressing the climate emergency and embedding sustainability at the heart of healthcare delivery. This Green Plan represents our firm commitment to reducing our environmental impact while continuing to deliver high-quality, patient-centred care.

By setting clear targets, embracing innovation, and working collaboratively across our staff, partners, and communities, we aim to create a greener, more resilient health system. Our efforts will not only help to safeguard the health of our population today but also protect the wellbeing of future generations.

Sustainability is not a one-time initiative but an ongoing journey. We will continue to monitor progress, adapt to new challenges, and remain accountable to our environmental and social responsibilities. Together, we will lead by example, demonstrating that a sustainable NHS is a stronger, healthier, and more equitable NHS.

I am proud to champion our collective journey toward a greener, healthier future. The NHS has a unique responsibility—not only to care for the health of our communities but also to protect the environment that sustains us. Every decision we make about our buildings, energy use, transport, and waste management is an opportunity to reduce our carbon footprint and lead by example. From retrofitting our estates with sustainable technologies as we are doing at Pilgrim Hospital after securing £23million of funding to support our Net Zero Journey, to empowering our teams with greener practices, we are embedding sustainability into the heart of everything we do.

Achieving Net Zero is not just a target—it's a commitment to future generations. Together, through innovation, collaboration, and determination, we can create a resilient NHS that delivers high-quality care while safeguarding our planet.

Let's lead the change - because a greener NHS is a healthier NHS.

Mike Parkhill
Chief Estates and Facilities Officer and Senior Responsible Officer for Net Zero

Net Zero 2040

Join us on our Greener Journey

What can you do to help?

Visit the LCHS Sustainability Pages

Join the Network of Green Champions
Green Champion Application Form

For further information please contact:

Claire Hall, Group Head of Sustainability and Net Zero

EMERGENCY AMBULANCE

Green Plan 2025-2028

United Lincolnshire Teaching Hospitals NHS Trust

NHS
United Lincolnshire Teaching Hospitals
NHS Trust

Caring and building a healthier future for all

Our Green ULTH Plan

As one of the largest organisations in our region, United Lincolnshire Teaching Hospitals NHS Trust (ULHT) has both the responsibility and the opportunity to help build healthier lives, stronger communities, and a more sustainable future.

Our Green ULTH Plan offers our sustainability and carbon reduction strategy, putting environmental responsibility at the heart of everything we do. While we've made strong progress, we know we must go further and faster to meet our ambitions.

This strategy is our roadmap for real, long-term change, one that evolves continuously to support our patients, our communities, and our workforce. It guides how we design and deliver services now and, in the future, embedding sustainability across all aspects of our care.

But we can't do it alone. Success will only come through shared commitment and action. By working together, with compassion, collaboration, and innovation, we can make a lasting difference.

Read the Green ULTH Plan and join us in making it happen.

Professor Karen Dunderdale

Group Chief Executive

Net Zero 2040
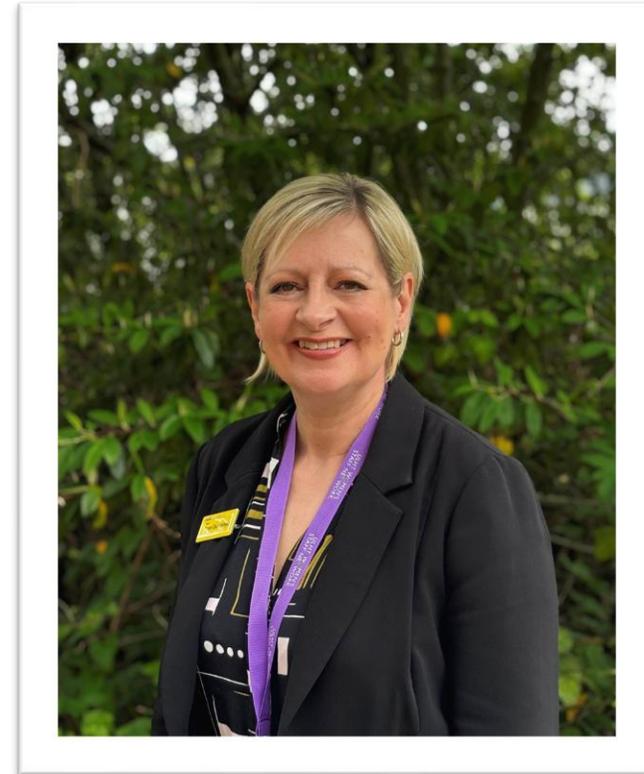
Our achievements

2021 – **Trust Awarded an Innovation in Health Business Award** for the Energy Performance Contract Works to replace lighting with LEDs

2022 – Our **Green Plan** to achieve net zero was published

2025 – Our Network of **Green Champions** was launched. We were awarded with £23million for Energy Improvements at Pilgrim Hospital and our Green Plan receives a refresh

NHS GREEN CHAMPION

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Introduction

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

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

United Lincolnshire Teaching Hospitals NHS Trust (ULTH) is one of the largest organisations in Lincolnshire . Our Hospital Trust has a significant economic, social and environmental impact. We have an income of £873.6 million (2025/26) and we employ over 12,000 people. ULTH operates in with Lincolnshire Community Hospital Services NHS Trust (LCHS) in a Group model. The Group is known as Lincolnshire Community and Hospitals group (LCHG). Our Green agenda is managed as a group function. Our key activity figures below show the number of clinical attendances to the Trust showing a year-on-year increase in the demand for the NHS services in Lincolnshire.

ULTH) Activity	2022/23	2023/24	2024/25
Outpatient	640,532	679,357	730,699
A&E Attendances	141,360	154,418	166,430
Inpatients	134,775	131,213	139,837

*Grantham ED changed to UTC 31 October 2023, this is Lincoln ED, Boston ED & Grantham UTC

As a result of our activity, we consume resources, generate substantial waste materials and are responsible for significant carbon emissions. In addition to these elements the travel and transport to deliver the materials we need and to move staff, patients and visitors impacts on local air quality. In line with the NHS Long Term Plan and as an "Anchor Institution" in Lincolnshire we are committed to embedding sustainability across our own organisation and with partners, leading by example in our sector and improving the health and wellbeing of the communities we serve. Everyone has a part to play in delivering this plan and by working together, we will achieve more and deliver truly sustainable healthcare.

ULTH has a central role to play in reducing health inequalities and helping the NHS to reach net zero.This Refreshed Green Plan serves as the central document for ULTH's sustainability agenda and provides the rationale for sustainability at the Trust. Through this Green Plan, ULTH will work with staff, patients and partners to take sustainable development and climate action as part of the Trust's commitment to offer the highest quality care to the Lincolnshire community.

The Trust has established a Sustainability Group that will meet regularly and manage the delivery of Green Plan activities by multiple teams. The Green Plan will be reviewed annually and updated where necessary to ensure continual improvement.

ULTH has also stablished a Newtok of Green Champions coming together to support the Green Plan actions and raise the profile of the sustainability agenda.

Cornerstone Targets

The National key targets are:

Net Core Carbon Footprint:

Reduced 80% by 2030

Net Zero Carbon by 2040

Carbon Footprint PLUS:

Net Zero Carbon by 2045

Clean Air Hospital

Baseline Assessment 2025

Reduce Use of Resources:

Reduce single use plastics

Zero waste to landfill

100% renewable energy

Carbon Reduction

The diagram shows the elements that make up the NHS carbon emissions – *The Carbon Footprint*

The NHS's Core Carbon Footprint is shown by the green arrow, it includes carbon emissions that are directly produced through the use of building energy, water, waste processes, anaesthetics, inhalers and business travel.

The NHS Footprint PLUS is shown by the blue arrow and includes the other emissions associated with products and services that we purchase.

In line with the NHS commitment to become the world's first Net Zero Carbon National Health Service, ULTH is committed to these targets
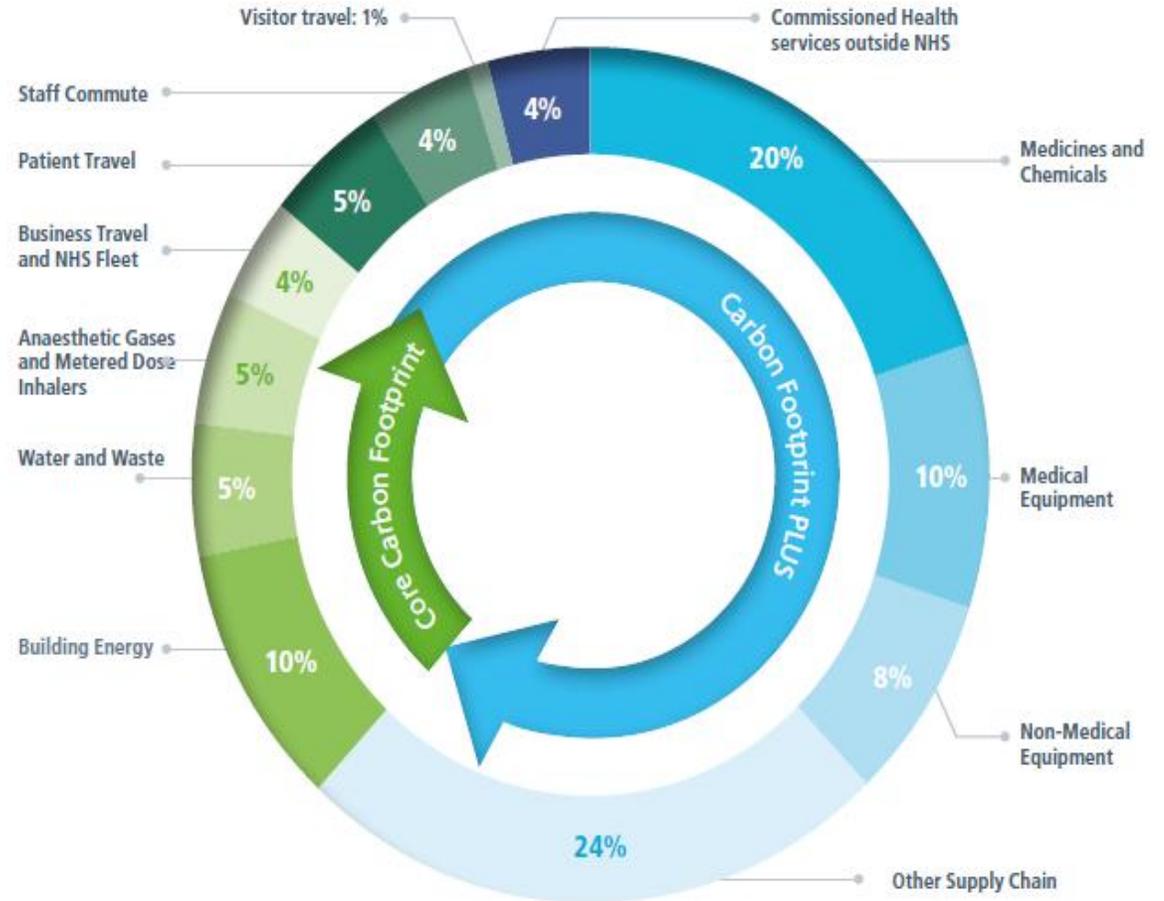
The Challenge Ahead:
Carbon Footprint Plus Emissions

Assessing and decarbonising NHS supply chain emissions is a complex undertaking.

The NHS is working step by step to both reduce emissions and the robustness of emission measurement and reporting.

During 2022/23, the central Greener NHS team carried out a nation-wide carbon foot printing assessment of NHS 2019/20 footprint plus emissions. This assessment provided disaggregated emissions down to trust level, providing ULTH with the most comprehensive data to date for the trust footprint plus emissions.

ULTH's Footprint Plus was 99,523 tonnes CO2e for 2020/21.
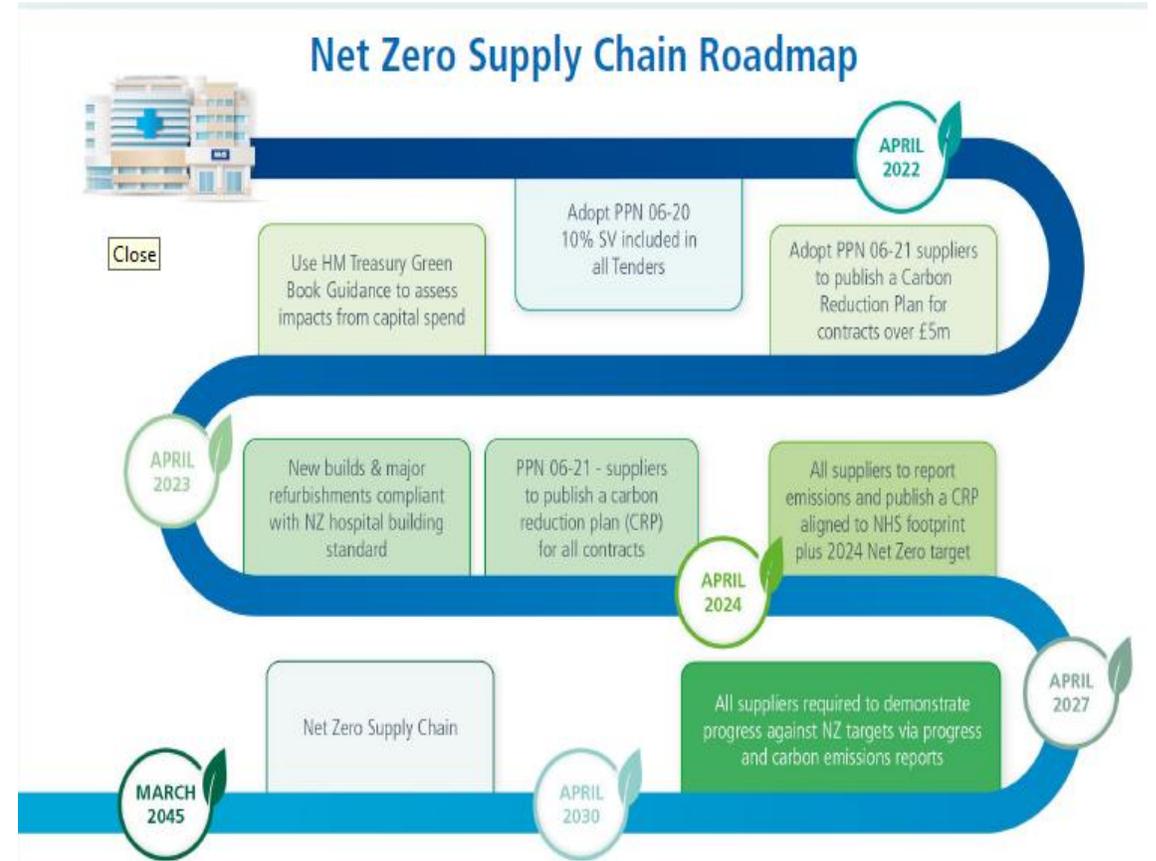
Climate Change is a is a health emergency

"*Unabated it will disrupt care and affect patients and the public at every stage of our lives. With poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer, our efforts must be accelerated.*"

Sir Simon Stevens, NHS Chief Executive

In office 1st April 2014 to 31st July 2021

Our Vision" Caring and building a healthier future for all".

We recognise our role in influencing the wider health and wellbeing of our populations, and along with our system partners have committed to focusing on building healthier, safe and more resilient communities, promoting local skills and employment, decarbonising and safeguarding our world and supporting growth of responsible local/regional business.

Our new Green Plans for 2025 will be key enablers to the delivery of some of our priority Anchor responsibilities and ambitions and we will work with our local communities and partners to deliver even greater local benefits (e.g. through procurement, supply chains, partnership working, community outreach). We will strengthen our relationship with the University of Lincoln to enhance local employment opportunities through the development of a joint strategy with a focus on educating and developing the workforce for the future.

Becoming environmentally sustainable is a growing priority due to the link between environment and health.

We will reduce our carbon footprint and be on track to meet the NHS net zero target by 2040. This Green Plan will be a key enabler on our journey towards net zero in 2040.

Our Green Champions and transformation framework will help to ensure that we consider the sustainability impact of everything we do, from recycling our waste, choosing how we travel to and from work, through to how we reduce environmental impact from the medicines and single use equipment we use and how we spend our money with suppliers who mirror our sustainability and social value ambitions.

Vision: Caring and building a healthier future for all

	PATIENTS	PEOPLE	POPULATION
	Better Care	*Better Opportunities*	*Better Health*
AIMS	Provide timely, high quality, affordable care in the right place	Develop, empower and retain great people	Improve population health
OBJECTIVES	1a Improve patient safety, patient experience and deliver clinically effective care 1b Reduce waiting times for our patients 1c Improve productivity and deliver financial sustainability 1d Provide modern, clean and fit for purpose care settings	2a Enable our people to fulfil their potential through training, development, research and education 2b Empower our people to continuously improve and innovate 2c Nurture compassionate and diverse leadership 2d Recognise our people through thanks and celebration	3a Transform clinical pathways and rationalise our estates, investing more in community care and reducing reliance on acute services 3b Move from prescription to prevention, through a population health management and health inequalities approach 3c Enhance our digital and research and innovation capability 3d Drive forward our improvement, efficiency and sustainability agenda including our Green Plan

Workforce and Leadership Commitment

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

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

The NHS is the biggest employer in Europe and the world's largest employer of highly skilled professionals.

The Trust's Green Plan needs to be embedded within its culture, with the recognition that people are at

the core of the NHS. The Trust will empower staff to deliver this Green Plan at all levels of the organisation.

Workforce and Leadership

🎯 What do we want to achieve?	🚩 How can we achieve it?	🔍 How will we measure it?
• Deliver, monitor and report on sustainability progress.	• Report performance quarterly to the Sustainability Group and Integration Committee plus via the trust annual accounts.	• Number of policies and business cases including a sustainability impact assessment.
• Senior staff, stakeholders and governors are engaged in, and accountable for, delivering our Green Plan.	• Play an active role as an Anchor Institution in Lincolnshire, creating opportunities for local communities to become more sustainable.	• No of staff that have undertaken sustainability training including sustainability induction for new staff.
• Strategies, policies, procedures, business cases and processes always have a meaningful sustainability impact assessment.	• Incorporate the Green Plan into the Trust Strategy	• Delivery against the objective to drive forward our improvement, efficiency and sustainability agenda including our Green Plan.
• Staff are supported and empowered to improve sustainability at work and home.	• Establish an active Network of Green Champions to support embedding the sustainability agenda as a 'green thread' across the organisation	• Carry out annual sustainability surveys to measure staff awareness levels.
• A sustainable workforce, succession planning, recruitment and retention.	• Workforce plans	• Number of apprentices, work placements and volunteers employed.
• Responsible anchor institution showing sustainability leadership and a positive impact for our communities.		
• Encourage staff to actively participate in the Greener NHS community and other forums such as the Greener AHP Hub, Centre for Sustainable Healthcare and related workspaces on the Future NHS platform.		

Our Aim: To have 50% of business cases supported by a sustainability impact assessment by March 2026

Sustainable Models of Care

Sustainable and "green" models of NHS healthcare delivery are important for several key reasons:

- The NHS is one of the largest public sector contributors to carbon emissions in the UK. Hospitals, transport, pharmaceuticals, and medical devices all consume significant energy and resources. Reducing the environmental footprint helps tackle climate change and promotes planetary health.

- Environmental degradation contributes to health problems such as respiratory diseases, cardiovascular conditions, and mental health issues. Greener healthcare reduces air pollution, waste, and chemical exposure, which directly improves public health outcomes.

- Sustainable practices can reduce long-term operational costs. For example, energy-efficient buildings, digital systems that reduce paper waste, and local sourcing of supplies can save money, which can then be reinvested into patient care.

- Sustainable models make the NHS more resilient to climate-related disruptions, such as heatwaves or supply chain breakdowns. They also ensure that the NHS can continue to deliver care in the face of environmental challenges.

- LCHG has committed to supporting the NHS becoming the world's first net-zero health service by 2045. Green models support this goal and demonstrate leadership in public sector responsibility and climate action.

- Patients and the public increasingly value environmental responsibility. A sustainable NHS aligns with societal values and can enhance public trust and engagement in health initiatives.

By approaching our green ambitions as a Group, LCHG can support the delivery of sustainable models of care through the consolidation of estates & facilities, streamlined logistics and transport, joint procurement chains, digital integration and a combined culture of unity as we look to reduce our environmental impact, deliver both the LCHG and NHS ambitions, and support our productivity and efficiency agenda - all whilst still improving patient care.

Sustainable healthcare delivery not only protects the environment but also enhances patient care, reduces costs, supports public health, and prepares the NHS for future challenges.

Sustainable models of care

⊕ What do we want to achieve?	⚑ How can we achieve it?	🔍 How will we measure it?
• Deliver the best quality of care while being mindful of its social, environmental and financial impact and take a whole systems approach to the way it is delivered.	• Through implementation of our Clinical Strategy, including care closer to home, left shift of services and virtual wards. • Facilitate virtual and telephone patients consultations in line with sustainable care pathways.	• Changes in travel data for patients. • Reduction in onsite outpatient follow ups.
• Build on current efforts Getting it Right First Time (GiRFT), National Safety Improvement Programme to reduce health inequalities and improve early intervention, linking this work to potential emissions reductions.	• Work with the Best Practice Manager and Care Groups to ensure GIRFT Greener Pathway Guidance is implemented	• Monitor practice under for example the Greener Bladder Cancer Care Pathway.
• Use the Embedding Public Health into Clinical Services Programme's toolkit and Sustainability in Quality Improvement (SusQI) Framework to ensure the best possible health outcomes with minimum financial and environmental costs, while adding positive social value at every opportunity.	• Management and monitoring of Sustainability Impact Assessments as part of our project methodology	• Develop a carbon footprint trackers for our clinical services
• Continue to collaborate with Lincolnshire system colleagues on the population's health.	• Through the Health Inequalities Group Action Plan	• Improved Patient outcomes/access to services
• Delivery against the objectives detailed in the Group Strategy 2025-2030 (add internet link)	• Care Groups delivery plans	

Our Aim: To develop a carbon calculator to measure the impact of changes to service delivery

Digital Transformation

The Trust is undertaking an ambitious digital transformation programme aimed at transitioning from analogue to digital systems. This will significantly expand the use of digital technologies to enhance the experiences of both patients and staff. The introduction of new digital solutions will enable us to deliver more effective and efficient care, while reducing the limitations and inefficiencies associated with outdated, paper-based processes. This transformation consists of a number of digital programmes:

- **Electronic Patient Record (EPR)**

- **Electronic Document Management System (EDMS)**

- **Enabling Technologies Programme**

The implementation of the EPR and EDMS will enable the Trust to move away from paper dependency. Paper documents received will be scanned and stored digitally within the EDMS, reducing the need for physical storage and transportation of records—both between our sites and from external storage providers by road.

The EPR will also introduce a Patient Portal, enhancing digital engagement by allowing patients to access more of our services remotely. This will support us to deliver care in more convenient locations within the community, reducing the need for patients to travel to hospital sites and continue to support us to reduce the need to use postal services.

Both the EPR and EDMS will support us to transition from legacy, on-premise infrastructure to modern, cloud-based platforms, allowing us to benefit from the efficiencies of large-scale cloud services. The introduction of the new systems will allow us to consolidate and reduce the volume of information held in older and less efficient environments.

The Enabling Technologies Programme is modernising data and communication systems, introducing energy-efficient solutions including in rack, water cooling in place of traditional whole room air conditioning systems. Ongoing investment in network and Wi-Fi upgrades supports flexible working, hot desking, and reduced travel across Lincolnshire, enabling our staff to work in a modern agile way across our hospital sites and community. These technologies also ensure that partners and suppliers can work with the Trust without un-necessary travel to our sites.

The investment made in improving the Trusts infrastructure in support of these programmes has enabled us to provide equipment that is still serviceable and supported to other partners in Lincolnshire to extend the useful life of devices prior to them being sustainably recycled at the end of life. We will continue to explore opportunities to further increase the sustainability of our asset base.

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Digital Transformation

⊕ What do we want to achieve?	⚑ How can we achieve it?	🔍 How will we measure it?
• Offer more digital and remote appointments, build on current practice of engaging staff and care groups in digital care channels, meaning fewer patient journeys.	• Continued use of video consultation capabilities. Further promotions of these capabilities by care groups to be considered. Introduction of EDMS solution will provide further opportunities for staff to work more flexibly from different locations, without physical notes.	• Benchmark use of video consultation capabilities and further promote use, review to determine impact. Measurement of benefits of EDMS and EPR programmes in adoption of digital capabilities, including portal.
• Implementation of an EDMS will support the removal of patient paper notes, enabling paperless workflows, improving resource utilisation and support remote care delivery.	• Introduction of EDMS and scanning capabilities.	• Measure of benefits of EDMS programme in reducing the number of paper records held, used and transported.
• Removal of paper letters to patients using a hybrid mail solution.	• Patient Portal solutions to be reviewed, supporting an increased adoption of hybrid mail in care groups. Opportunities for further integration alongside NHS App through new EPR capabilities.	• Track use of hybrid mail/portal solutions to determine success in reducing post.
• Reduction in carbon footprint of on-premise technical infrastructure.	• EPR and EDMS to be hosted in modern cloud facilities. Introduction of efficient water cooling and purpose-built facilities. Reduction in legacy systems as a result of EPR.	• Measure reduction in the number of systems vs current enabled by EPR/EDMS. Baseline/measure existing cooling vs new.
• Support staff to work from more locations across Lincolnshire, reducing requirements to travel.	• Extension of desk booking solution and hot desking capabilities promoted to staff.	• Review of data from booking solutions to determine increase in usage of shared spaces.
• Continue to explore options for even greater re-use and recycling of digital equipment that no longer meets Trust requirements, increasing re-use over recycling where possible	• The Trust intends to re-procure a secure digital recycling partner, this will present an opportunity to maximise re-use and recycling of digital assets, while maintaining the required levels of secure compliant asset disposal.	• As part of new contracts, we will look to include metrics that evidence the re-use and recycling to support us to improve sustainability of assets.

Travel and Transport

The Trust is committed to developing a Green Travel Plan, outlining the aims and objectives related to reducing congestion, single occupancy travel, and CO2 emissions whilst promoting alternative transport. It will explore how to promote active travel to staff and visitors. In addition, the Trust will produce site-specific plans to focus on the individual challenges of each hospital and their locality concerns, particularly related to the difficulty experienced for the geographical nature of the county.

Commuting, Visitor/Patient Travel

The Trust has implemented a car sharing app to promote the reduction in single occupancy transport.

There has also been a subsidised bus scheme linked to a salary sacrifice process implemented for Lincoln County Hospital, further discussions are underway with providers at the other sites into the possibility of mirroring this scheme.

For alternative travel the Trust offers a salary sacrifice cycle to work scheme. This is supported by cycle storage at all main sites including lockers and showering facilities. Staff have benefited from free bike maintenance and the Trust has actively promoted cycle events. The Trust is currently undertaking a full review of cycling provisions with the view to modernising both the public and staff facilities.

The Trust has worked in collaboration with each local council to install live bus timing screens at various locations across the three acute sites.

Public transport to the sites remains vital to the Trust's employees and communities, helping to reduce health inequalities. The Trust is currently engaging with local councils on improving bus provisions to the sites including accessibility requirements such as safe routes and crossings for wheelchair users.

During 2025 there will be a travel survey conducted to ascertain requirements of both staff and public for accessing the site. There will be supporting analysis conducted such as Shape Atlas to ascertain from a Dutch model of cycling what the potential provision and location of the population could access the Trust's sites by cycle.

Travel and Transport

ULTH Fleet Vehicles

ULTH operates a combined fleet of 115 vehicles. These are a mix of salary deduction lease cars for essential car users, service-based pool cars for business use and commercial vehicles that are used for non-patient transport services for ULTH, LCHS & LPFT, support services e.g. ULTH Digital Services, estate maintenance, diagnostic screening e.g. Breast Screening & Diabetic Eye Screening Programme and cancer care at community locations.

The Trust has a legal duty (Health & Care Act 2022) to meet the NHS Net Zero Travel & Transport (NZTT) targets that relate to the introduction of sustainable travel strategies and the introduction of zero emissions vehicles into Trust operated fleet. By 2027 all new vehicles owned or leased by the NHS must be zero emission and by 2035 all vehicles owned by the NHS must be zero emission (excluding ambulances).

Vehicle replacement strategies are being developed to meet these targets and external funding bids have been submitted along with plans to develop and implement EV charging infrastructure for Trust service vehicles across ULHT sites.

In addition to these 115 vehicles, ULTH offers salary sacrifice lease vehicles that are externally managed by 'NHS Fleet Solutions'. The NZTT targets state that all vehicles offered through these schemes must be zero emissions by 2026.

Employees who use their own privately owned vehicles for business purposes are referred to as the 'Grey Fleet'. These employees are reimbursed through the electronic expenses system, and this Payroll managed system holds the travel and vehicle data for this element of the ULTH vehicle fleet.

Travel and Transport

🎯 What do we want to achieve?	🚩 How can we achieve it?	🔍 How will we measure it?
• Conduct a Trust wide staff and patient/ visitor travel survey	• Working with our Communications, Organisation Development, Staff and Public Representatives, the Travel Team will conduct a survey for all possible users to collect and analyse current methods of travel but also consider barriers to alternative travel.	• This will be measured through a full analysis of collected data and will form part of the overall Travel Plan.
• Publish a Trust Local Travel Plan	• Consider feedback from the travel survey to form the basis of a long-term strategic plan for travel each of the sites • Work with supporting organisation to ensure the first experience of the NHS (travel to site) is supported for all ages and abilities	• Clear KPIs will be established with ongoing review processes to measure the effectiveness of the plan • Work with partners and services to ensure experience of attending the sites is suitable and sufficient for all
• Review and improve cycling facilities on all sites	• Conduct a cycle facility review, explore funding, sponsorship or collaboration opportunities to create new bespoke cycle hubs	• Implement modern cycle provisions which are easily accessed, clean, modern and are designed in such a way to remove barriers to cycling to work
• The Trust has a legal duty (Health & Care Act 2022) to meet the NHS Net Zero Travel & Transport (NZTT) strategy targets (this applies to both emissions that the Trust can **control** and also **influence**)	• Vehicle replacement programme and budget planning to introduce zero emission vehicles into the Trust's fleet • Bid for external funding and grants to facilitate the development of EV charging infrastructure on Trust sites and the introduction of EV vehicles • Review the 'grey fleet' and lease car policies (salary deduction and salary sacrifice) to influence and incentivise the introduction of zero emission vehicles • Tender documents for equipment and services should influence and incentivise a reduction in emissions as a result of travel & transport	• By 2027 all new vehicles owned or leased by the NHS will be zero emission • By 2025 all vehicles owned by the NHS will be zero emission (excluding ambulances) • Monitor the Trust's fleet profile in relation to vehicle numbers, miles travelled and projected CO_2 output • Procurement Teams to consider when evaluating tender responses • Annual NHSE Green Fleet Data collection
• Remove or minimise the requirement for (and impact of) Travel & Transport	• Key stakeholders to consider the impact of travel and transport when making strategic decisions relating to service provision e.g. the centralisation of a service may either increase or reduce travel & transport requirements • Monitor Trust vehicle usage with service leads and potentially reduce vehicle numbers • Implement digital solutions remove or minimise travel and transport requirements	• Monitor the expenses system relating to staff travel claims to identify trends • Monitor the Trust's service vehicle fleet in relation to vehicle numbers, miles travelled and projected CO_2 emissions

Estates and Facilities

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

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

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

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

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

Estates and Facilities is further sub-divided into

- Energy and Emissions

- Water Efficiencies

- Capital Projects

- Waste and Recycling

- Biodiversity and Green Space

Estates and Facilities – Energy and Emissions

🎯 What do we want to achieve?	🚩 How can we achieve it?	🔍 How will we measure it?
• Continue roll out energy efficient lighting across all properties.	• Targeted block schemes and evolutionary maintenance replacements.	• Building coverage by percentage.
• On-site Solar Photovoltaic electricity generation.	• Explore Trust funded and external investment opportunities.	• Annual kWh generation.
• Enhance automated building management systems.	• Develop and modify Building Management Systems with investment into modern emissions focussed equipment and operational strategies.	• Feedback from recorded data streams, including energy usage and Carbon Dioxide emissions.
• Expand heating zone segregation.	• De-steaming and subdivision of heating system distribution, with localised variable valves.	• Heating demand profiling against degree data and more consistent internal temperatures.
• Sub-metering with automated monitoring and targeting.	• Phased roll out of energy metering equipment.	• Increased data availability.
• Improved air quality.	• Air Quality Audit, Plant NOx/particulate monitoring, with targeting of hot spot areas.	• Comparisons against benchmarks.
• Robust piped medical gas networks.	• System testing and removal of unnecessary sections of distribution systems.	• Reduced medical gas usage with a particular focus on N_2O.
• Low Carbon heat generation.	• Installation of low carbon heating solutions in place of traditional heating boilers.	• Annual kWh generation from Heat pump, biomass and other low carbon solutions
• Climate Change Adaptation.	• Review processes and systems to widen operation parameters.	• Minimise periods of site stress during extreme weather events.

Estates and Facilities – Water Efficiencies

What do we want to achieve?	How can we achieve it?	How will we measure it?
• Efficient use of water around the Trust.	• Incorporate appropriate water saving and efficient end use devices where appropriate.	• Comparative water usage on an individual basis.
• Monitoring and targeting of water usage across the Trust.	• Strategic installation of sub-metering across the network.	• Collating and reporting consumption against developed trends.
• Promote awareness for appropriate use of water among staff and other consumers.	• Awareness campaigns for water usage and encouragement to report leaks, regardless of severity.	• Identify changes in water demand linked to campaign success.
• Early identification of water loss.	• Utilisation of technologies to detect adverse water demand changes and actively detect leaks in high-risk locations.	• Key performance indicators for detection and resolution of system leaks.
• Explore options for alternative water sources.	• Review opportunities for rainwater harvesting and reuse of grey water on individual location basis.	• Annual quantity of alternative water consumed.

Capital Projects

The Built Environment of the NHS influences both the quality of care and environmental impact. The Trust's design and construction of buildings will play a key role in the collective ability to achieve net zero carbon emissions.

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

In terms of all Trust construction or refurbishment there are fundamental principles that are adhered to within all conceptual planning.

BREEAM which stands for Building Research Establishment Environmental Assessment Method, is a globally recognized green building certification system used to assess the sustainability performance of buildings and infrastructure. It evaluates various aspects of a building's design, construction, and operation, aiming to reduce environmental impact and improve overall performance. All buildings, construction builds, refurbishments are rated and certified on a scale of "Pass", "Good", "Very Good", "Excellent" and "Outstanding. BREEAM assesses buildings across various stages of their lifecycle, including design, construction, operation, and refurbishment.

By integrating BREEAM principles, projects can reduce life cycle costs, improve asset value, enhance user experience, and demonstrate a commitment to sustainability. BREEAM supports the achievement of various sustainability goals, such as reducing carbon emissions, improving whole-life performance, and enhancing circularity and resilience, this supports the Trust's green plan. BREEAM certification of excellence will ensure and improve the sustainability performance of the build environment through the project and building lifecycle.

The Principal Supply Chain Partner's (PSCP) must be identifying their own Net Carbon Zero (NCZ) policy, this policy must support the Strategic approach for the Trust's green plan and NCZ. This can be supported in many ways, but two fundamental principles are Modern Methods of Construction (MMC) and BREEAM achievements. The MMC must deliver upon offsite manufacturing, design for manufacture and assembly, technological advancements and pre-fabrication.

Modern Methods of Construction (MMC) refer to a range of techniques that aim to improve construction processes, often involving off-site manufacturing and prefabrication, leading to faster, more efficient, and potentially more sustainable building practices. These methods include modular construction, panelised systems, 3D printing, and hybrid approaches that combine elements of different techniques

Estates and Facilities – Capital Projects

What do we want to achieve?	How can we achieve it?	How will we measure it?
• To deliver our Capital Programme in line with Trust Net carbon zero initiative	• We design and build with an ambition to achieve BREEAM excellence	• Post project evaluation and review throughout the design stages that we achieve the BREEAM classification
• To support a carbon neutral design	• Work with designers through all design stages collaboratively with Trust colleagues to discuss alternative methods of MEP services.	• Safety Group discussion and other collaborative meetings as well as Post project evaluation.
• Market leading energy efficient technology	• Through design and collaborative working, provide competent and updated energy efficiencies through modern technology.	• Through design and project initiation documentation, ensuring scope of works includes detailed outcomes and expectations.
• Digital systems aligned with Building Management Systems	• To benchmark and collaborate with other Trusts to seek proactive methods for robust technology services which support effective project delivery and longer terms Trust governance.	• Through compliance and governance processes, audits and data collation
• Innovative design methodology	• To ensure designs are modern, ambitious and innovative. Collaboration with key stakeholders to ensure design meets the brief.	• Through post project evaluation and review from design concept to initiation.
• Heating Ventilation and Air Conditioning systems	• Using robust design and modernisation, to improve HVAC systems across the sites ensuring efficiency methods and savings are captured and presented positively.	• In collaboration with teams to ensure HVAC design achieves expectations.
• Modern Methods of Construction	• Using a range of techniques that aim to improve construction processes, including (but not limited to); off-site manufacturing, panelised systems, prefabrication, achieving faster production and utilising more sustainable products.	• Through design and post project review, aligning with BS standards and other guidance where appropriate.

Estates and Facilities – Waste and Recycling

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

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

The Trust has a legal duty under The Environmental Protection Act (EPA) 1990 to ensure all waste generated through its activities are responsibly managed and a safe system of work is in place for the segregation, collection, storage, handling and transportation of waste from point of production to point its final disposal.

Our aim: to maximise the amount of waste that is recycled

Estates and Facilities – Waste and Recycling

⌖ What do we want to achieve?	⚑ How can we achieve it?	🔍 How will we measure it?
• Better segregation of waste across the Trust	• Development of training sessions to include mandatory and waste awareness days. Development of a waste strategy for the Trust. Continued review also of the groups waste policy in line with any new waste regulations.	• Pre acceptance audits conducted across the Trust to gauge levels of compliance. Change in tonnage rates of waste streams to determine that measures are working, e.g. reduction in high temperature treatment as an example.
• Reduce waste costs by the correct waste going into the right waste stream	• Education of all staff. Reusables sharps system.	• From reports from our waste collection companies and reduced costs
• Zero land fill being carried out by our waste contractors in relation to the Groups waste streams	• Produce waste contracts that detail the requirement of zero land fill. Clear instruction on the sustainability and green plan section of the contract specification.	• Waste Manager to conduct audits of the contractor's premises to ensure compliance. • Reporting will be part of the contracts for general waste streams. • Data provided to inform Estates Return Information Collection return.
• Better working together with Infection Prevention and Control colleagues to reduce Health Care Waste streams for example reduce where we can Orange to Tiger stripe waste in clinical areas.	• Review of Health Care waste and the environment its being produced by working with the Infection Prevention and Control.	• Reduced costs and compliance in external audits such as the Integrated Care Board and NHS England
• Improved waste recycling and compliance to any new waste regulations.	• Work in conjunction with our waste contractors to achieve recycling options. This will need to include better education for staff and visitors	• External and internal audits. • Reduced waste costs across the Trust
• Improved general waste and recycling contract for the Trust to detail the different waste streams (including estates waste) under one contract as apposed to different contracts.	• Working together with colleagues from across the group along with purchasing on the development of a clear specification on the different waste streams.	• Improved compliance measured from internal and external auditing
• Re use of equipment etc. rather than disposal of it.	• Any fit for purpose equipment to be stored and then reused as apposed to ordering new.	• Reduced new purchase orders being raised and reduce waste costs

Biodiversity and Green Space

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

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

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

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

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

We are proud to work with our Charity team to promote access to green spaces across our sites.

Creating a green and tranquil environment that people want to visit and spend time

Providing health and wellbeing benefits and connecting people to nature

Creating wildlife habitats and improving biodiversity

UNITED LINCOLNSHIRE HOSPITALS *Charity*

Estates and Facilities – Biodiversity and Green Space

⊙ What do we want to achieve?	⚑ How can we achieve it?	🔍 How will we measure it?
• Maintain and improve our green spaces and biodiversity on-site.	• Develop a biodiversity and greenspace strategy that encompass the challenges and opportunities across our Estate.	• NHS Sustainability Assessment Tool score for Greenspace and biodiversity section.
• Help improve the physical and mental wellbeing of staff, patients and the wider community through access to green space, biodiversity and interactions with nature.	• Produce a biodiversity and greenspace action plan that details actions and those responsible for maintaining our green spaces.	• Habitat and biodiversity site surveys.
• Help to mitigate climate change and biodiversity loss through our biodiversity strategy.	• Ensure tight integration of biodiversity and greenspace plan with capital projects policy to underpin the approach for major new works and refurbishments.	• Achievement of Biodiversity Net Gain standards
• Increase access to Green Space for staff, patients and visitors	• Work with staff, local community organisations and strategic partners to enable increased access to green space and nature both on-site and traveling to and from site.	• Assessment of staff and patient use of and interaction with greenspace via staff surveys.

Food and Nutrition

Food illustrates the links between climate change and public health. The NHS Long Term Plan commits us to promoting plant-forward diets and reducing unhealthy options like sugary drinks on NHS premises, accepting that plant forward items need to be navigated with care, as some are now classified as ultra processed foods.
The Trust only provides diet drinks in vending machines. Not only will these actions help prevent obesity and non-communicable disease, but they will also play a role in reducing greenhouse gas emissions and environmental impact.

Food waste contributes 10% to global emissions, but 9 out of 10 countries Nationally Determined Contributions, fail to focus on food loss and waste (source Nov 2024 The Waste and Resources Action Programme, which operates as WRAP). In the financial year 2023-2024, catering waste represented 9.9% of the overall Trust waste (source 2023-2024 ERIC submission).

At ULTH, annual patient meals served at all 3 hospitals are 1,336.400 in the 2023-2024 financial year, with a monthly average of 110,000 enjoyed by patients, the implementation of an electronic meal ordering system, scheduled to go live this summer 2025, will reduce food wastage by tracking patient moves and avoiding meals being sent where they are not required, flag if a ward is ordering more than its bed capacity, which will allow a deep dive into why that is happening, monitor ward food issues against budget and ward bed numbers, and other real time reports to pinpoint waste reduction action plans, to reduce wastage, volume, transportation and the associated emissions.

The retail meals in the financial year 2023-2024 served were a total of 613,550 meals across all sites, with a monthly average of 51,212 purchased by staff and visitors. Retail catering has introduced a delicious and varied event plan, which celebrates as an example, vegetarian week, and incorporates vegan and vegetarian choices in the menu offers, supporting increased plant-based choices for customers, contributing to lowering emissions at the Trust.

Catering is actively engaged in a joint update of the Trust Nutrition and Hydration Policy, working with the Trust Lead Dietitian and Chair of the Nutrition and Hydration Steering Group, to review, update and improve food provision in a sustainable way. The catering department at the Trust, strives to be a respectful and responsible member of the rural community, using local suppliers where possible, to reduce the footprint from field to fork, improving the impact on the rural biodiversity and supporting local community SME's wherever possible.

Food and Nutrition

⊙ What do we want to achieve?	🚩 How can we achieve it?	🔍 How will we measure it?
• Meet the sustainability and wider standards set out in the National Standards for Healthcare Food and Drink.	• Review food and catering to explore opportunities to push forward long term plans to obesity, benefit ULHT's local area, and reach net zero emissions.	• The measure of plans to support obesity and other health issues, will be measured by the Trust approved new patient menus uptake, created by catering and clinical colleagues. The procurement team and supply chain measure net zero emissions, further details may be obtained directly from supply chain governance.
	• Explore a digital meal system for at least one NHS site, to enable accurate meal planning and reduce food waste.	• The measure will be the imminent introduction of an electronic meal ordering system, with the capability to report on the types of wastage in catering, providing data to inform an action plan of targeted waste reduction.
	• Phase in more plant –forward diets and other updated NHS requirements, and explore seasonal menu changes	• The measure will be an evaluation of the success of the updated core menus and new menus, to be introduced with the electronic meal ordering system, with reports on popular menu items.
	• Limit sugary drinks sales at Trust facilities and fulfil other updated requirements.	• The Trust has the authority at any time to reduce the lines of sugary drinks it purchases to sell, it balances that with the retail customer expectations and requirements to have a choice of retail products, the measure would be the further replacement of these products with more water based flavoured drinks.
	• Work with NHS supply chain to ensure positive impacts from contract management and maintain update for Government buying standards sustainable food criteria	• The measure will be a review of contracted food products against current GBS criteria, with an annual compliance report.
	• Work with regional partners to identify opportunities for local SME food producers.	• The measure will be the number of new regional SMEs engaged through procurement exercises or pilots, with reporting on spend allocation, supplier profiles, and outcomes of local sourcing initiatives.

Food and Nutrition Continued

⌖ What do we want to achieve?	⚑ How can we achieve it?	🔍 How will we measure it?
• Meet the sustainability and wider standards set out in the National Standards for Healthcare Food and Drink.	• Ensure all food providers meet or exceed the requirements outlined in the report of the independent review of NHS hospital food.	• The measure will be an assessment and annual audit against the Hospital Food Review standards, with supporting evidence from site inspections, feedback, and menu compliance checks.
	• Review internal and NHS strategies for sustainable food procurement, including sustainable fish, reduction of palm oil or limit RSPC certified palm oil, and the inclusion of fairtrade items where relevant.	• The measure will be a documented review of procurement policies and supplier specifications, with report on the number/percentage of sustainable product lines included in food contracts.
	• Continue to work with patients and partners on the link between food, health and obesity, and the emissions impact.	• The measure will be an evaluation of engagement activities, including feedback from patient groups and staff, with outcome data from nutrition and sustainability campaigns or pilot initiatives on healthier, lower emission meals.

Medicines

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

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

Compact nitrous oxide cylinders attached directly to the back of anaesthetic machines can now be used. There are innovations in capturing and catabolising exhaled nitrous oxide, including 'cracking' devices. Such devices are being trialled by other NHS Trusts, and if rolled out, will dramatically reduce the amount leaking into the atmosphere. Furthermore, nitrous oxide use is steadily falling in surgery, as more efficacious anaesthetic and analgesic agents are superseding its use. However, Equanox™ still plays an important role in maternity.

Methoxyflurane (Penthrox™) pen-inhalers can be used to treat moderate to severe pain associated with trauma in the Accident and Emergency department. Methoxyflurane can be self-administered under medical supervision, in a similar fashion to nitrous oxide. It has a lower global warming potential (GWP) than nitrous oxide and switching to methoxyflurane would lessen emissions at point-of-use. However, this comes at a cost, as methoxyflurane is delivered in non-reusable 3ml inhaler pens, creating additional non-recyclable waste.

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

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

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

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

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

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

Medicines

⌖ What do we want to achieve?	⚑ How can we achieve it?	🔍 How will we measure it?
• Reduction of environmental impact of medicines prescribed by ULTH (carbon footprint and ecotoxicology).	• Establish Nitrous Oxide waste minimisation programme and review of volatile anaesthetic gas emission reduction options. • Explore alternative treatments for pain relief.	• Monthly consumption of all anaesthetic gases by type.
• Reduction in Pharmaceutical waste	• Working with wards and departments to make reductions in waste produced through changes to clinical process such as IV Paracetamol to tablets, use of patients own medication supply and inventory management systems.	• Reduction in costs of medicines and waste generated
• Reduce use of single use plastics in medicines distribution.	• Educate staff/patients on sustainable medicines use and disposal	• Reduction in waste

Supply Chain and Procurement

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

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

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

Procurement and Climate Action

Supply chain emissions represent a huge portion of ULTH's overall carbon footprint.

Net zero supplier roadmap

- **From April 2022**: All NHS procurements include a minimum 10% net zero and social value weighting. The Net zero and social value guidance for NHS procurement teams helps to unlock health-specific outcomes (building on PPN 06/20). Net Zero and Social Value will be applied via the Evergreen assessment for NHS England Medicines tenders.
- **From April 2023**: for all new contracts above £5 million per annum, the NHS requires suppliers to publish a Carbon Reduction Plan for their UK Scope 1 and 2 emissions and a subset of scope 3 emissions as a minimum (aligning with PPN 06/21). The Carbon reduction plan and net zero commitment requirements for the procurement of NHS goods, services and works guidance outlines what is required from suppliers and how it should be implemented.
- **From April 2024**: The NHS has proportionately extended the Carbon Reduction Plan requirements to cover all new procurements.
- **From April 2027**: All suppliers will be required to publicly report targets, emissions and publish a Carbon Reduction Plan for global emissions aligned to the NHS net zero target, for all of their Scope 1, 2 and 3 emissions.
- **From April 2028**: New requirements will be introduced overseeing the provision of carbon footprinting for individual products supplied to the NHS. The NHS will work with suppliers and regulators to determine the scope and methodology.

Supply Chain and Procurement

🎯 What do we want to achieve?	🚩 How can we achieve it?	🔍 How will we measure it?
• Meet national legal and regulatory requirements such as NHS Standard Contract and Net Zero Procurement Roadmap.	• Include sustainability criteria in procurement, tender evaluations, framework design and selection, and product selection, in line with PPNs	• Assess the use of Evergreen system to support trust green plan objectives.
• Implementation of an Inventory Management System (IMS) Trust-wide	• Roll-out of the IMS	• Reduction in stock waste
• Work with local SMEs and Business Groups to support the requirements of them to fulfil Evergreen Supply Chain requirements and evidence their Carbon Reduction Plans	• Workshops with local business groups	• Number of local business attendees • % of contracts awarded to suppliers with a carbon reduction plan (CRP).
• Ensuring social value compliance in procurement	• Tenders include minimum 10% Social Value criteria and assessment	• Social Value trackers
• Re-use of materials and items where appropriate	• Replace single use products with reusable alternatives where there is a viable, more sustainable option e.g. re-usable sharps bins • • Promote a culture of reuse and refurbishment of items	• Track the positive carbon and other environmental impacts from procurement initiatives e.g. introduction of reusable materials

Adaptation

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

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

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

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

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

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

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

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

Adaptation

	What do we want to achieve?		How can we achieve it?		How will we measure it?
	• Ensure our whole organisation is prepared to deal with the effects of climate change, particularly extreme weather events such as heat waves and flooding, and continues to invest in adaptation and mitigation measures.		• Nominate an adaptation lead and incorporate adaptation into our sustainability governance structure, corporate risk register and reporting processes.		• BREEAM Building Standard or other sustainable buildings methodology scores.
	• Ensure our infrastructure, services, procurement, local communities and colleagues are prepared for the impacts of climate change.		• Work with Lincolnshire system partners and other stakeholders to create and approve a Climate Change Adaptation Plan (CCAP)		• Review and Approve the recommendations within the Lincolnshire Climate Change Adaptation Plan
	• Understanding our risks		• Develop a Climate Change Risk Assessment (CCRA) Adaptation plan to mitigate risk to continuity and resilience of services		• The overall risk rating in our climate change risk assessment.
	• Emergency preparedness		• Ensure that our emergency plans for extreme weather, consider support for vulnerable communities during any extreme weather events.		• Testing of emergency planning policies.
	• Development of resilience plans to deal with projected changes in climate and extreme weather events		• Major Incident Plan • Significant Incident Plan • Incident Coordination Centre Manual • Adverse Weather manual • Heatwave plan • Training staff on potential impact for awareness and inclusion		• Number of overheating cases per year • Number of climate risks identified in risk assessment • Training attendance
	• Design, build and upgrade the estate within governance and local parameter guidance.		• Adhere to targets and requirements set out within Building engineering in the health sector (HTM's/HBN's), the Climate Change Act and the National Adaptation Programme (NAP) to put plans in place to address both the causes and consequences of climate change.		• Ensure designs allow for optimum resource efficiencies including the use of materials and avoiding over-engineering, whilst capturing flexibility and future adaptation.

Communicating and Embedding the Green Plan

To help drive change across the whole organisation, we will take a considered, structured and engaging approach to disseminating the strategy and embedding our approach to sustainability.

A communication plan for the strategy will be developed that shows what we are doing both within and outside of the organisation, highlight key priorities and show excellence in sustainable development leading others to join us in making improvements. We will employ some key themes:

• **Collaboration:** leading on more joined-up thinking

as well as creating stronger links

with the communities we serve.

• **Development:** showcasing sustainability

initiatives for staff as well as opportunities

to work outside the parameters of core roles.

• **Progress:** highlighting visible progress in

delivering sustainability across the 10 areas

of action.

Governance and reporting

Clear leadership is vital to ensure we successfully deliver the commitments in this Green Plan. As this Plan is broad and encompasses a wide range of work areas, there are other detailed documents that will underpin our approach. Some of these have already been developed, such as the Lincolnshire Climate Change Adaptation Plan and some will be developed or revised in the future such as our Green Travel Plan, Estates Strategy and the sustainability section of the Care Group Operating Plans.

Clear reporting is required to monitor progress and ensure delivery is on track. In addition, there are a number of National reports undertaken to monitor progress. Examples of our reporting are detailed below:

- **Greener NHS Dashboard: A**llows users to view data on a range of measures covering sustainability, including carbon equivalent emissions associated with NHS activity and policy and contractual levers that support progress towards a net zero NHS.

- **NHS Sustainable Assessment Tool:** This will measure our qualitative progress on sustainability for the previous year, inform plans for the coming year, and will enable comparative performance against similar Trusts.

- **Clean Air Hospital framework:** This will measure our qualitative progress on air quality for the previous year, inform plans for the coming year, and will enable comparative performance against similar Trusts.

- **Trust Annual Report Sustainability section:** This reports progress against the Green Plan and provides highlights of the main activities delivered throughout the year.

- **ERIC (Estates Return Information Collection):** A mandatory data collection for all NHS Trusts required by the Department of Health.

- **Progress reports:** Internal progress reports are produced for the quarterly Integration Committee.

- **Related Internal Policies:** Our Green Plan is to be supported by various related policies and guidance documents including: The Green Travel Plan, Waste Management Policy, Lincolnshire Climate Change and Adaptation Plan.

ULTH's Greener Future

As an NHS Trust, we recognise our vital role in addressing the climate emergency and embedding sustainability at the heart of healthcare delivery. This Green Plan represents our firm commitment to reducing our environmental impact while continuing to deliver high-quality, patient-centred care.

By setting clear targets, embracing innovation, and working collaboratively across our staff, partners, and communities, we aim to create a greener, more resilient health system. Our efforts will not only help to safeguard the health of our population today but also protect the wellbeing of future generations.

Sustainability is not a one-time initiative but an ongoing journey. We will continue to monitor progress, adapt to new challenges, and remain accountable to our environmental and social responsibilities. Together, we will lead by example, demonstrating that a sustainable NHS is a stronger, healthier, and more equitable NHS.

I am proud to champion our collective journey toward a greener, healthier future. The NHS has a unique responsibility—not only to care for the health of our communities but also to protect the environment that sustains us. Every decision we make about our buildings, energy use, transport, and waste management is an opportunity to reduce our carbon footprint and lead by example. From retrofitting our estates with sustainable technologies as we are doing at Pilgrim Hospital after securing £23million of funding to support our Net Zero Journey, to empowering our teams with greener practices, we are embedding sustainability into the heart of everything we do.

Achieving Net Zero is not just a target—it's a commitment to future generations. Together, through innovation, collaboration, and determination, we can create a resilient NHS that delivers high-quality care while safeguarding our planet.

Let's lead the change - because a greener NHS is a healthier NHS.

Mike Parkhill
Chief Estates and Facilities Officer and Senior Responsible Officer for Net Zero

Net Zero 2040

Join us on our Greener Journey

What can you do to help?

Visit the ULTH Sustainability Pages

Join the Network of Green Champions
Green Champion Application Form

For further information please contact:

Claire Hall, Group Head of Sustainability and
Net Zero

Integrated Performance Report

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2nd September 2025*
Item Number	*11*

Performance Report for July 2025 (ULTH)

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Daren Fradgley, Group Chief Integration Officer*
Author(s)	*Sharon Parker, Performance Manager*
Recommendations/ Decision Required	• *The Board is asked to note the current performance. The Board is asked to approve action to be taken where performance is below the expected target.* *Key to note:* *Quality* • *Medication incidents reported as causing harm has increased slightly in July at 13.8% against a trajectory of 10.7% compared to 12.9% in June.* • *Duty of Candour for verbal compliance in June has improved to 97%, compared to 72% in May.* *Written compliance in June has also improved to 85%, compared to 76% in May.* *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 73.78% in July signifying a 1.20% decline compared to June 2025.* • *12.01% of patients (T1 only) exceeded 12 hour wait in department in ED.* • *Average response time for Cat2 ambulance conveyances in July was approximately 34.75 minutes reflecting a decrease of 2.69 minutes compared to June 2025, within the 45 minute maximum offload average.* • *Long Waiters - at the end of June, the Trust reported 0 patients waiting longer than 104 weeks; 0 patients waiting over 78 weeks, 13 patients waiting over 65 weeks.*

- *July DM01 data release is past the deadline for this committee, so data contained is the same as last month. Performance for DM01 in June showed an improvement to 75.96% from 73.01% in May. 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 June achieved 77.7% This has bounced back after not meeting the standard in April.*

- *62-day (Combined) performance for June decreased slightly to 64.68%.*

- *104+ day waiters slightly increased to 103 as of 13th July, 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 £12.3m deficit, which is £0.1m favourable to the planned £11.2m deficit.*

- *CIP position - The Group YTD has delivered CIP savings of £15.1m, which is £0.9m favourable to planned CIP savings of £14.2m.*

- *Capital position - The Group YTD has delivered capital expenditure of £9.2m, which is £4.6m lower than planned capital expenditure of £13.8m.*

- *Agency position – The Group YTD has expenditure of £6.0m on agency staffing, which is £0.6m higher than planned agency expenditure of £5.4m.*

- *Cash position - The Group's cash balance is £36.8m, which is £1.9m higher than the planned cash balance of £34.8m.*

Workforce

- *Mandatory training for July is 93.06% against a plan of 90%*

- *July sickness rate is 5.26% against Q2 target of 4.31%*

- *Staff AfC appraisals at 81.17% for July against Q2 target 85.00%*

- *Staff turnover at 8.93% for July against Q2 target of 9.00%*

- *Vacancies at 6.47% for July against Q2 target of 6.81%*

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

MRSA Bacteraemia

There were no patients who was reported as an MRSA bacteraemia.

Pressure Ulcers

There were 46 category 2 and 4 category 3 pressure ulcers in July. The number of Category 2 incidents in July has decreased by 1 and category 3 have decreased from five to 4 from June 2025. 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.

VTE

In July, compliance remained below the 95% target, reaching 91.84%. The ongoing challenge lies in the inconsistent use of ePMA, the only system that reliably records the actual time of risk assessment completion. Some clinicians continue to complete VTE risk assessments within the clerking proforma, which are then transcribed into CareFlow by ward clerks. As CareFlow captures the time of data entry, not the actual time of assessment, this can result in underreported compliance. Additionally, using both systems presents a risk of duplicates entries, making accurate reporting more difficult. To support this transition, the team will be piloting the use of stickers in the clerking proforma as an interim solution from September. These stickers will serve as prompts for clinicians to complete VTE risk assessments in ePMA only, avoiding completion in the proforma itself.

Medications

Medication incidents reported as causing harm has slightly increased to 13.8% 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. 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.

| Quality | Operational Performance | Workforce | Finance |

Patient safety Alerts

There was 1 Patient Safety Alert with a deadline for completion in July with all actions completed within deadline. 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 to 108.47 for July and remains within expected limits. Any diagnosis group alerting is subject to a case note review. HSMR is at 100.75 (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

The Trust is at 91% for sending eDDs within 24 hours of a patients discharge. A dashboard has been developed for Divisions to monitor their compliance.

Sepsis compliance – based on June data

IVAB ED Children – The administration of IVAB for children in ED decreased to 44% (target 90%). 7 children out of 16 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) – June Data

DoC compliance increased in June; verbal was 97% and written was 85%. Dedicated members of the Incident Team have been aligned to Divisions to improve compliance.

Quality | Operational Performance | Workforce | Finance

Operational Performance

This report evaluates the performance metrics observed during the month of July 2025.

In July, there was a notable increase in attendance across the Urgent and Emergency Care (UEC) pathways, reflecting a 7.43% rise compared to the average attendance recorded during July for the years 2022, 2023, and 2024. Furthermore, an upward trend in patient acuity was observed, with 11.98% 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) falling by 20.98% in comparison to the average attendance for July across the years 2022, 2023, and 2024, which corresponds to an decrease of 13 patients. Seasonal infections continue to exert pressure on our services. By the conclusion of July, the Trust had documented 14 PCR confirmed inpatients with positive COVID-19 test results, which represents an decrease of 39 cases compared to the previous year.

Throughout the month, a total of 426 flu tests were administered, indicating a 15.45% increase relative to July 2024. Of these tests, 2 yielded positive results, resulting in a positivity rate of 0.47%. In comparison, among the 413 patients tested for respiratory syncytial virus (RSV), 3 were found to be positive, leading to a positivity rate of 0.73%. Additionally, the month of July witnessed a 26.30% 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 July 2025, the trust recorded a performance rate of 73.78%, signifying a 1.20% decline compared to June 2025 however a 1.20% increase to July 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, Lincoln County Hospital have observed a decline in Type 1 performance, with the Lincoln Emergency Department demonstrating a decrease from 57.77% to 55.94%. However, the Pilgrim Emergency Department also experienced a decrease from 60.48% to 58.37%. Overall, Type 1 performance achieved a final performance rate of 57.04% which is a 1.94% decrease to June 2025.

Quality | Operational Performance | Workforce | Finance

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, 12.01% of patients exceeded the 12-hour benchmark (Type 1 only); this figure indicates a 0.01% decrease compared to June 2025, equating to 68 more patients surpassing this threshold.

In June, the average mean response time for Category 2 cases was approximately 34.75 minutes, reflecting a decrease of 2.69 minutes compared to June 2025, within the 45 minute maximum offload average. 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 21.46% 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, 21.78% of paediatric patients arriving via the East Midlands Ambulance Service (EMAS) scored 4 or greater, while the percentage for adult patients was 21.45%.

Fractured Neck of Femur 48hr Pathway (#NOF)
Trauma demand has been at its highest level to date, putting continued pressure on access to theatres. After several months of worsening performance, July saw a significant improvement delivering with 67.95% of patients making it to theatre within 48 hours.

Length of Stay
In July, the Non-Elective Length of Stay experienced a decrease of 0.15 days compared to June 2025, with the current performance level recorded at 4.34 days, which stays under the maximum threshold by 0.16 days. The average bed occupancy rate, with respect to "Core General and Acute," stood at 92.31%. To maintain safe and efficient operational flow within acute care settings, an average of 15 escalation beds or boarding spaces has been allocated, resulting in an occupancy to escalation ratio of 91.00%, which complies with the national standard of less than 92%. Additionally, approximately 44 beds have been ring-fenced for elective patient flow at Grantham. Excluding this facility from the metrics indicates that the core occupancy would result in 94.69%, while the core plus escalation occupancy would yield 93.32%.
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.

Quality | Operational Performance | Workforce | Finance

Referral to Treatment
June has continued to improve delivering a performance of 54.6% compared to 54.18% in May. The Trust continues to report patients waiting over 104, 78, 65 & 52 weeks. At the end of June, the Trust reported zero patients waiting longer than 104 weeks. The trust exited June with 0 patients waiting more than 78 weeks and 13 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 June the Trust reported 1,805 patients waiting over 52 weeks which demonstrates a reduction after three months of increasing numbers.

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 but has increased slightly over the last two months with June reporting 70,366

DM01
July DM01 data release is past the deadline for this committee, so data contained is the same as last month. The report for DM01 in June showed an improvement to 75.96% 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
July outturn for cancelled operations on the day improved slightly to 1.76%. Lack of time and lack of theatre staff were again the main reasons for cancellations.

Included in the 1.76% of on the day cancellations, 40 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 June sat at 77.7%. This has bounced back after not meeting the standard in April

31 day (Combined) performance for June Improves slightly to 86.6%.

Quality   Operational Performance   Workforce   Finance

62-day (Combined) performance for June decreased slightly to 64.68%.

104+ day waiters slightly increased to 103 due to a high number of complex patients. The highest risk specialities are colorectal, head & neck and lung. The divisions are working hard to resolve but are facing challenges from a high number of complex and disengaged patients.

Workforce

Mandatory Training – Our July 2025 Core Learning Rate is 93.06% against a Target of 90.00%. This is an increase in compliance when compared to last month, and 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 July 2025 Sickness Rate is 5.26% against a Q2 Target of 4.78%. This is outside of the Q2 target, but it should be noted that this is a stabilised position over recent months.

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 July 2025 appraisal rate is measured against a Q2 Target of 85.00%, and in month we have achieved a Trustwide position of 82.17%. This is an increase when compared to the previous month, which is expected as we have moved into an appraisal window for Agenda for Change staff. It is the Agenda for Change appraisals which require the focus. The move in 2025/26 to an appraisal window 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 July 2025 Turnover Rate is 8.93% against a Target of 9.00%, this is exceeding the target. It should be noted that we have seen reduced levels of turnover that we have seen within previous months, and at the same time last year (July 2024) we saw rates as high as 10.00%.

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.

Quality   Operational Performance   Workforce   Finance

Continue to work closely with Divisional colleagues to reduce the impact of staffing and associated operational pressures.

Vacancies – Our July 2025 Vacancy Rate is 6.47% which is an increased rate when compared to last 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. This includes staff groups such as Medical & Dental, Allied Health Professionals and Health Care Support Workers.

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.

Quality   Operational Performance   Workforce   Finance

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 £12.3m deficit, which is £0.1m favourable to the planned £11.2m deficit.

CIP position - The Group YTD has delivered CIP savings of £15.1m, which is £0.9m favourable to planned CIP savings of £14.2m.

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Agency position – The Group YTD has expenditure of £6.0m on agency staffing, which is £0.6m higher than planned agency expenditure of £5.4m.

Cash position - The Group's cash balance is £36.8m, which is £1.9m higher than the planned cash balance of £34.8m.

Month 4 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)	(12.4)	(12.3)	0.1	(1.9)	(1.7)	0.1	(10.6)	(10.6)	0.0
CIP Delivery	14.2	15.1	0.9	1.3	1.4	0.1	12.9	13.7	0.7
Capital Spend	13.8	9.2	(4.6)	2.1	1.7	(0.4)	11.7	7.4	(4.2)
Agency Spend	(5.4)	(6.0)	(0.6)	(0.5)	(0.3)	0.3	(4.8)	(5.8)	(0.9)
Cash Balance	34.8	36.8	1.9	24.6	27.5	2.8	10.2	9.3	(0.9)

Daren Fradgley
Group Chief Integration Officer
August 2025

Quality > Operational Performance > Workforce > Finance

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.

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-25	Jun-25	Jul-25	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	5	13	7	34	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	1	0	0	1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.01	Data Not Available	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	0.03	0.02	Data Not Available	0.03		
	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	0.11	0.19	0.10	0.13	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	5	4	10	?	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	1	2	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	93.62%	92.28%	91.84%	92.58%	F	L
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	0	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	4.20	4.76	5.45	4.86	P	

Performance Overview - Quality

Caring and building a healthier future for all

NHS Lincolnshire Community and Hospitals NHS Group

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-25	Jun-25	Jul-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%	12.20%	12.90%	13.80%	13.13%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	None due	None due	100.00%	50.00%	F	
	Hospital Standardised Mortality Ratio - HSMR+ (basket of 41 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	100.24	99.76	100.75	N/A		
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 5 month time lag)	Effective	Patients	Medical Director	100	109.34	108.57	108.47	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%	91.00%	91.10%	91.00%	90.80%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	92.28%	91.33%	Data Not Available	91.82%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	90.00%	95.00%	Data Not Available	94.33%	P	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	96.00%	94.96%	Data Not Available	96.13%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	100.00%	88.00%	Data Not Available	96.00%	P	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	94.73%	92.87%	Data Not Available	93.74%	P	

Quality > Operational Performance > Workforce > Finance

Performance Overview - Quality

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-25	Jun-25	Jul-25	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90.00%	93.00%	89.00%	Data Not Available	91.67%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	94.00%	95.78%	Data Not Available	95.14%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	57.00%	44.00%	Data Not Available	56.00%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	2.75	2.98	3.20	2.98	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%	72.00%	97.00%	Data Not Available	87.67%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	76.00%	85.00%	Data Not Available	85.00%	F	

Quality → Operational Performance → Workforce → Finance

Pressure Ulcers category 3

Jul-25	
4	
Variance Type	
Common cause variation	
Target	
4.3	
Achievement	
Variation indicates inconsistently passing and falling short of the target	
Executive Lead	
Director of Nursing	

Legend: Data — Mean — Target --- Control Limits

Background:
Category 3 Pressure Ulcers

What the chart tells us:
The Trust recorded 4 Category 3 incidents against a target of 4.3 per month.

Issues:
The number of Category 3 incidents in July have decreased by 1 from June 2025. None of these were device related.

All these pressure ulcers would have previously been classified as unstageable.

Themes identified as areas of focus for improvement are:
• Deterioration of previously reported hospital acquired pressure damage.

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 and regular oversight to areas with increased number of incidents.

Quality | Operational Performance | Workforce | Finance

Venous Thromboembolism (VTE) Risk Assessment

Jul-25	
91.84%	
Variance Type	
Special cause variation - cause for concern (Indicator where low is a concern)	
Target	
95.00%	
Achievement	
Variation indicates consistently falling short of the target	
Executive Lead	
Medical Director	

Chart legend: Data, Mean, Target, Control Limits

Background:
Completion of VTE risk assessments within 14 hours of admission remains a patient safety requirement

What the chart tells us:
In July, compliance was recorded at 91.84%, showing a further decline from previous months and remaining below the national target of 95%. This figure reflects assessments completed within the required timeframe, using data from both Careflow and ePMA systems.

Issues:
As with previous months, the core issue lies in inconsistent use of ePMA, which is the only system that reliably captures the actual time of VTE risk assessment completion. Many assessments are still completed within the clerking proforma and later entered into Careflow by ward clerks, with the recorded time reflecting data entry rather than the time of clinical assessment. This not only contributes to underreporting but also raises the risk of duplicated records when both systems are used inconsistently.

Actions:
Although the goal remains to move to ePMA – only reporting, we continue to include data from both ePMA and Careflow. Ensuring that all clinicians consistently use ePMA is a prerequisite for this transition. To support this, we plan to introduce a 3 – month trial of using prompt stickers in clerking proforma on selected wards with the lowest ePMA compliance. These stickers will remind clinicians to complete the VTE risk assessment in ePMA, rather than in the clerking proforma. The trial is expected to begin in September, once the stickers have been delivered. Outcomes will be evaluated before considering expansion to other areas.
The VTE Nurse Specialist continues to work closely with the matron leading on VTE to address these operational issues and support compliance level at ward level.

Mitigations:
These challenges were formally discussed at the Clinical Effectiveness Group meeting and a focused plan of action is now in place. In addition to the planned sticker trial, we continue to engage with Information Systems Manager to improve system functionality and data accuracy. The goal remains to ensure accurate compliance reporting and full transition to ePMA – based assessment recording.

Quality | Operational Performance | Workforce | Finance

Caring and building a healthier future for all

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

Jul-25
13.80%
Variance Type
Common cause variation
Target
10.70%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Legend: Data — Mean — Target --- Control Limits

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

What the chart tells us:
In the month of July the number of medication incidents reported was 209. This equates to 5.45 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 13.8 % 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:

Quality | Operational Performance | Workforce | Finance

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Patient Safety Alerts responded to by agreed deadline

Legend: Data — Mean — Target --- Control Limits

Jul-25
100.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Patient safety alerts responded to by agreed deadline

What the chart tells us:
There was 1 Patient Safety Alerts due for closure in July 2025 with all actions completed within deadline.

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.

Quality | Operational Performance | Workforce | Finance

21/08/2025 14:16

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

Legend: ━●━ Data   ━━━ National Baseline
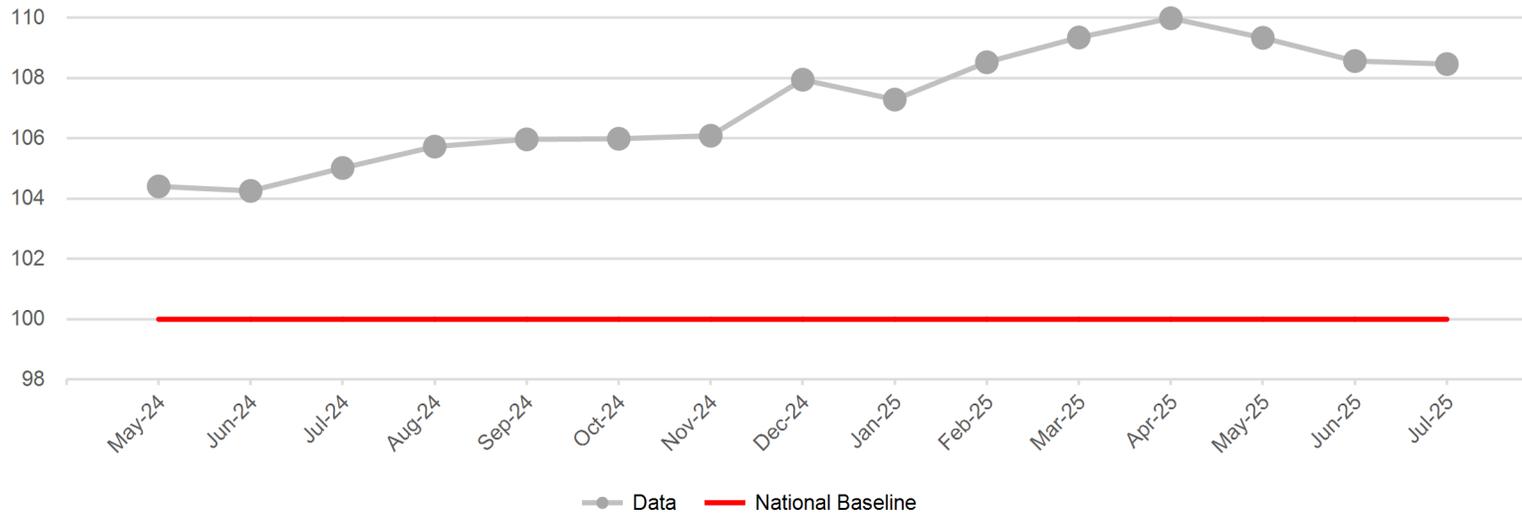
Jul-25	
108.47	
Variance Type	
Target	
To remain in 'as expected' range	
Achievement	
Executive Lead	
Medical Director	

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.

eDD issued within 24 hours

Legend: — Data — Mean — Target - - - Control Limits

Jul-25
91.00%
Variance Type
Common cause variation
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director
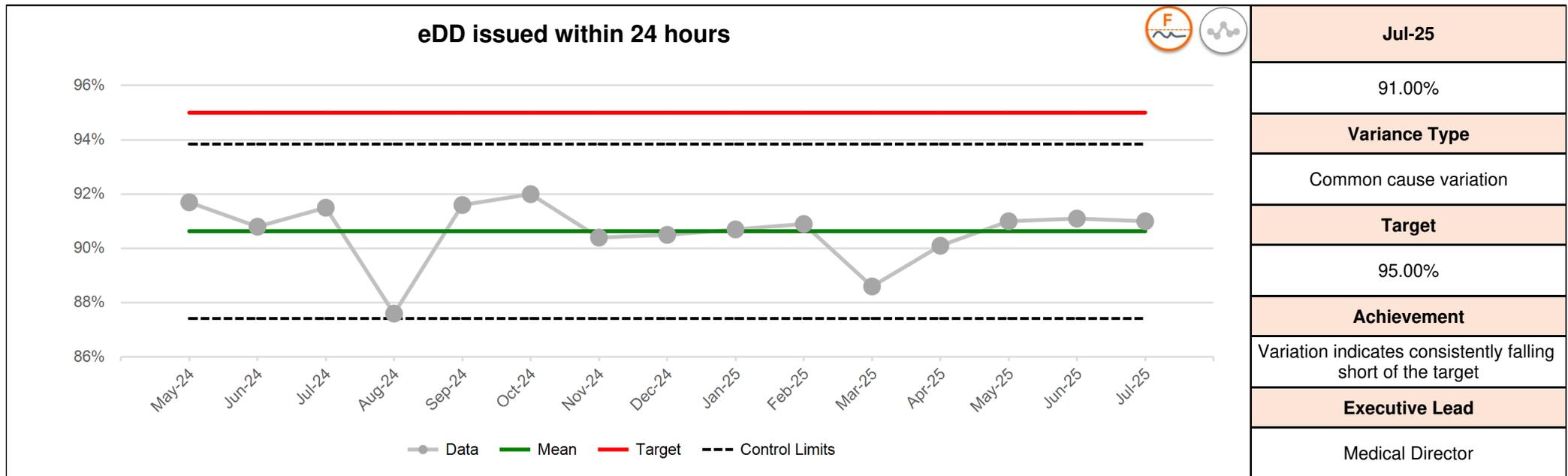
Background:
eDDs to be sent within 24 hours of a patients discharge.

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.

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

Jun-25
44.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

Legend: Data — Mean — Target --- Control Limits

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 44%, which, although an improvement, is well below the 90% standard. Only 7 out of 16 patients received their antibiotics within a timely manner.

Issues:
There were 9 patients this month with delayed Sepsis treatment. Themes for delays were:
- Difficult cannulation
- Staff in ED unable / unsure how to give IM antibiotics
- Waiting for Paediatric teams before making a diagnosis or plan of care.
- Discussions around where patients should be cared for e.g. CYP area v Resus, leading to delay in starting treatment.
- waiting for blood results before treating
- Delays between prescribing and administration

Actions:
Themes escalated to ED manager, Sepsis link nurses and Consultant.
IM training planned for all ED staff that care for children.
Meeting held with new Sepsis link Nurse and plan for audit and future training made.
New meeting to be held monthly with Paeds ED team to discuss themes and action plans alongside current meeting. Working on getting Medical engagement.

Mitigations:
Harm reviews completed for all patients with delayed treatment – No harm found.
CYP area did contact ward for help when needed but ward unable to support. Sepsis Practitioner contact details now in department.

Quality | Operational Performance | Workforce | Finance

Duty of Candour compliance - Verbal

Legend: Data — Mean — Target --- Control Limits

Jun-25
97.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
Compliance remains 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.

Quality | Operational Performance | Workforce | Finance

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Duty of Candour compliance - Written

Jun-25
85.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director
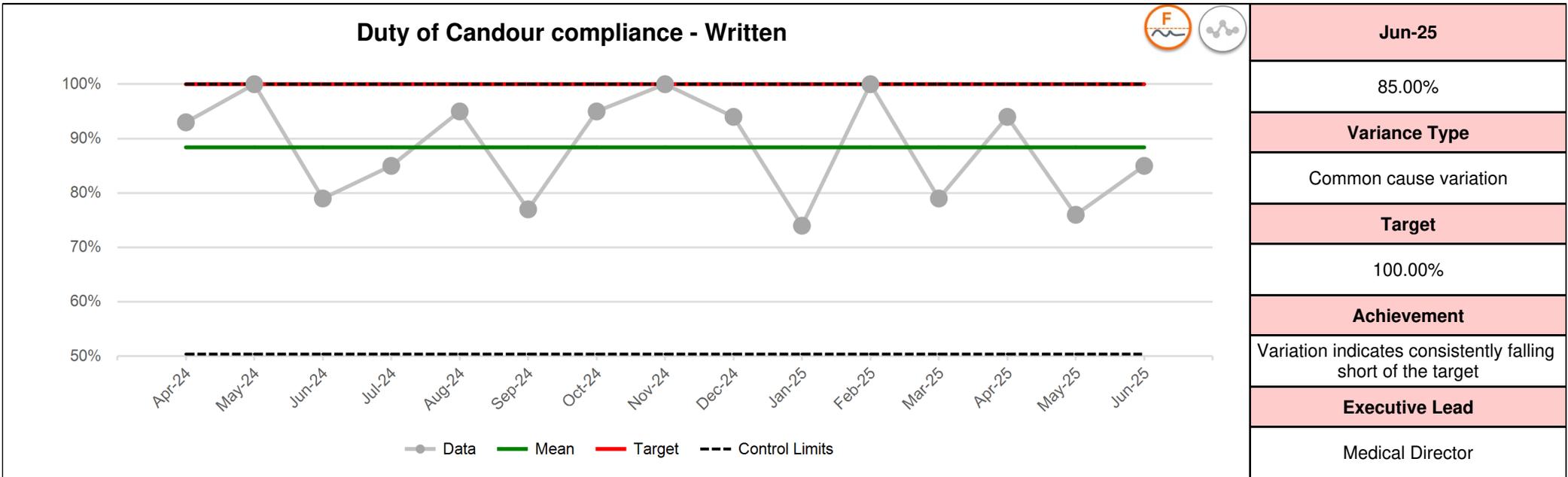
Background:
Compliance with the written follow up to Duty of Candour, which applies to all patient safety incidents where harm is moderate or above, is a statutory requirement

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.

Quality | Operational Performance | Workforce | Finance

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Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-25	Jun-25	Jul-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.24%	0.28%	0.43%	0.30%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	78.00%	75.86%	74.98%	73.78%	75.49%	78.00%	F	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	942	1,077	1,027	4,015	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	74.80%	74.30%	76.32%	76.20%	88.50%	F	
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	1,951	1,805		N/A	N/A	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	16	13		N/A	N/A	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	54.18%	54.60%		54.19%	84.10%	F	H
	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	70,185	70,366		N/A	N/A	F	
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	75.80%	77.70%		75.33%	75.00%	P	
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	65.90%	65.00%		64.20%	85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	74.80%	69.60%		73.63%	93.00%	F	

Quality > Operational Performance > Workforce > Finance

Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-25	Jun-25	Jul-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	49.50%	42.40%		53.33%	93.00%	F	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	89.10%	90.70%		89.87%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	95.80%	97.20%		97.13%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	47.20%	48.60%		56.30%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	80.20%	85.60%		79.03%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	68.20%	57.70%		69.73%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	70.40%	65.90%		70.13%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	73.01%	75.96%		72.15%	99.00%	F	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.13%	1.88%	1.76%	1.55%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	27	19	40	120	0	F	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	46.67%	38.96%	67.95%	50.40%	90.00%	F	

Quality | Operational Performance | Workforce | Finance

Performance Overview - Operational Performance

NHS
Lincolnshire Community and
Hospitals NHS Group

Caring and building a
healthier future for all

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-25	Jun-25	Jul-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	27.78%	20.78%	38.46%	28.76%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,907	4,654	4,818	4,723	4,657	P	
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	413	388	388	352	0	F	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	98	97	103	N/A	N/A	F	H
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.96	3.03	2.89	2.87	2.80	F	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.55	4.49	4.34	4.50	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	38,948	39,943	41,605	39,616	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	38.70%	38.14%	38.69%	38.17%	45.00%	F	

Quality | Operational Performance | Workforce | Finance

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% Triage Data Not Recorded

Legend: Data — Mean — Target — — Control Limits

Jul-25
0.43%
Variance Type
Common cause variation
Target
0.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer
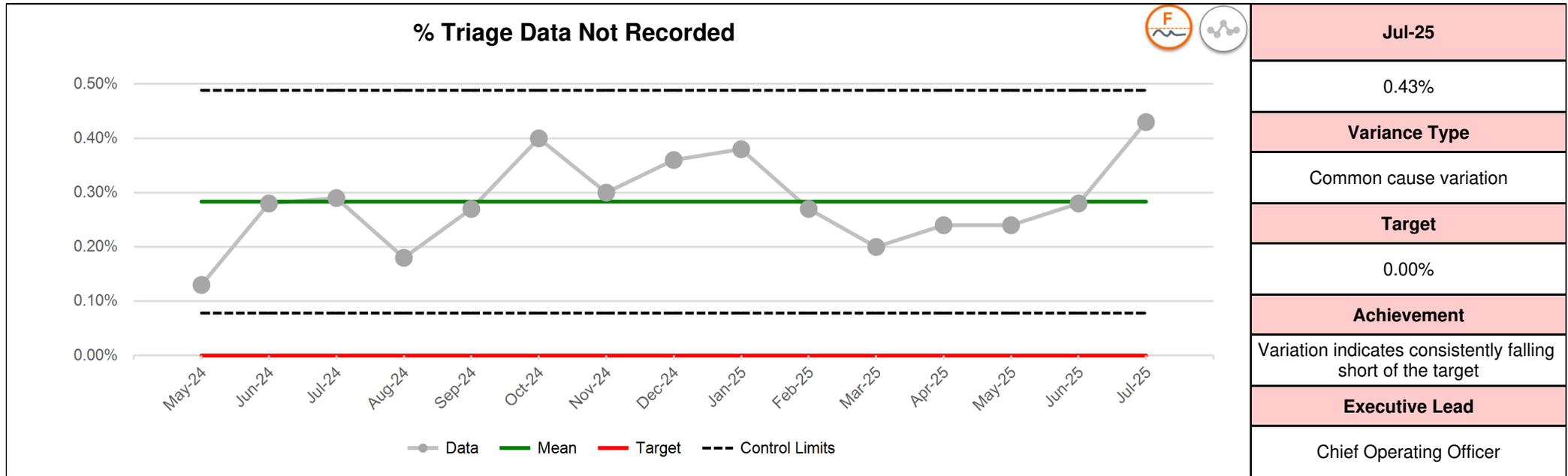
Background:
Percentage of triage data not recorded

What the chart tells us:
July reported a non-validated position of 0.43% of data not recorded versus the target of 0%. To note, 51.32% 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 92 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.

Quality | Operational Performance | Workforce | Finance

Performance Overview - Operational Performance

NHS
Lincolnshire Community and
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Caring and building a
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%Triage Achieved under 15 mins

Legend: ● Data — Mean — Target --- Control Limits
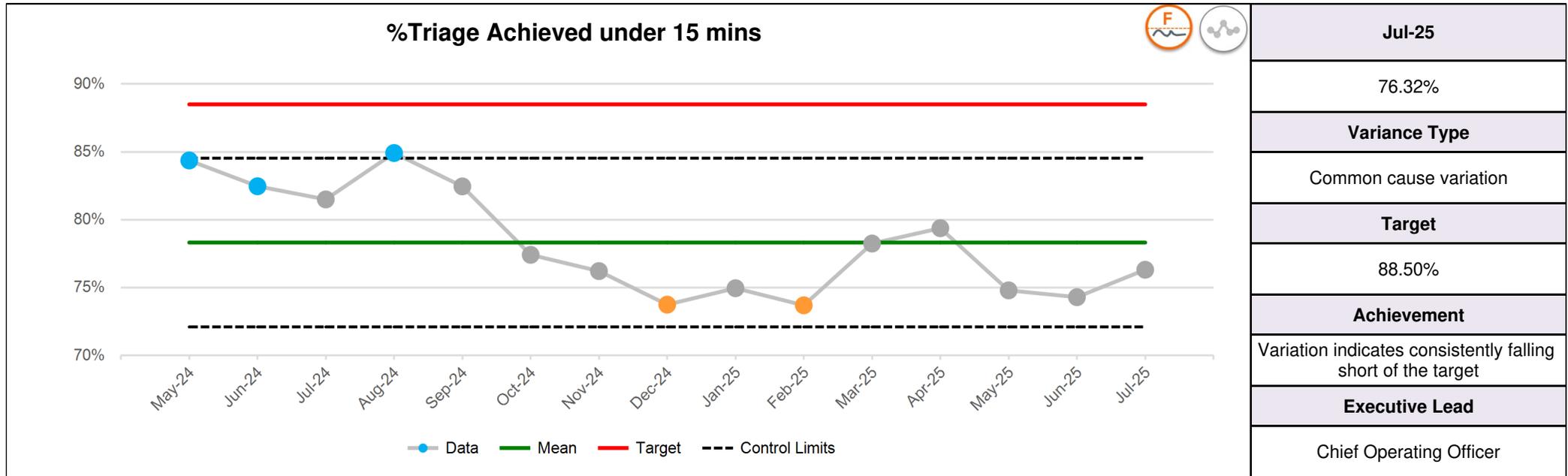
Jul-25
76.32%
Variance Type
Common cause variation
Target
88.50%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage achieved under 15 minutes

What the chart tells us:
July outturn was 76.32%, compared to 74.30% in June (validated). This represents a negative variance of 12.18% from the target of 88.50%. July performance shows a 5.18% 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.

Quality | Operational Performance | Workforce | Finance

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4hrs or less in A&E Dept
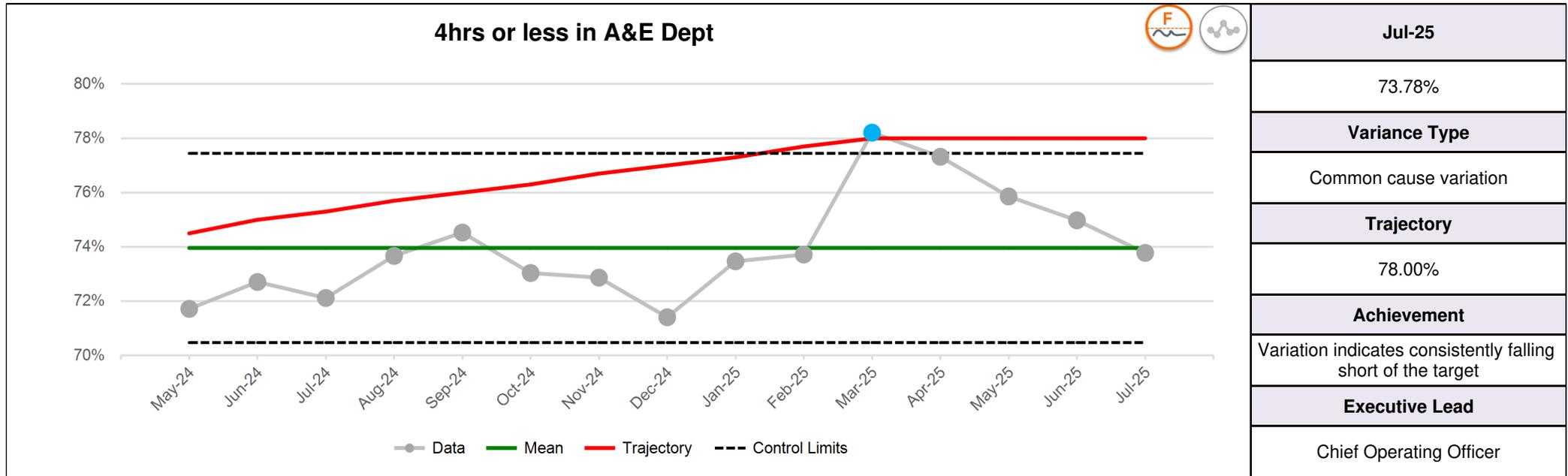
	Jul-25
	73.78%
Variance Type	
	Common cause variation
Trajectory	
	78.00%
Achievement	
	Variation indicates consistently falling short of the target
Executive Lead	
	Chief Operating Officer

Legend: Data — Mean — Trajectory --- Control Limits

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 73.78%, representing a decline over June's performance of 74.98%. It is important to note that the chart does not account for the increased volume and acuity of presentations to the department.

Issues:
In July 2025, Type 1 witnessed an average daily patient volume of 556.2, reflecting an 0.12% increase from the 555.7 patients attended to in June 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 440 daily patients, representing a 2.87% 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.

Quality | Operational Performance | Workforce | Finance

Performance Overview - Operational Performance

12+ Trolley waits
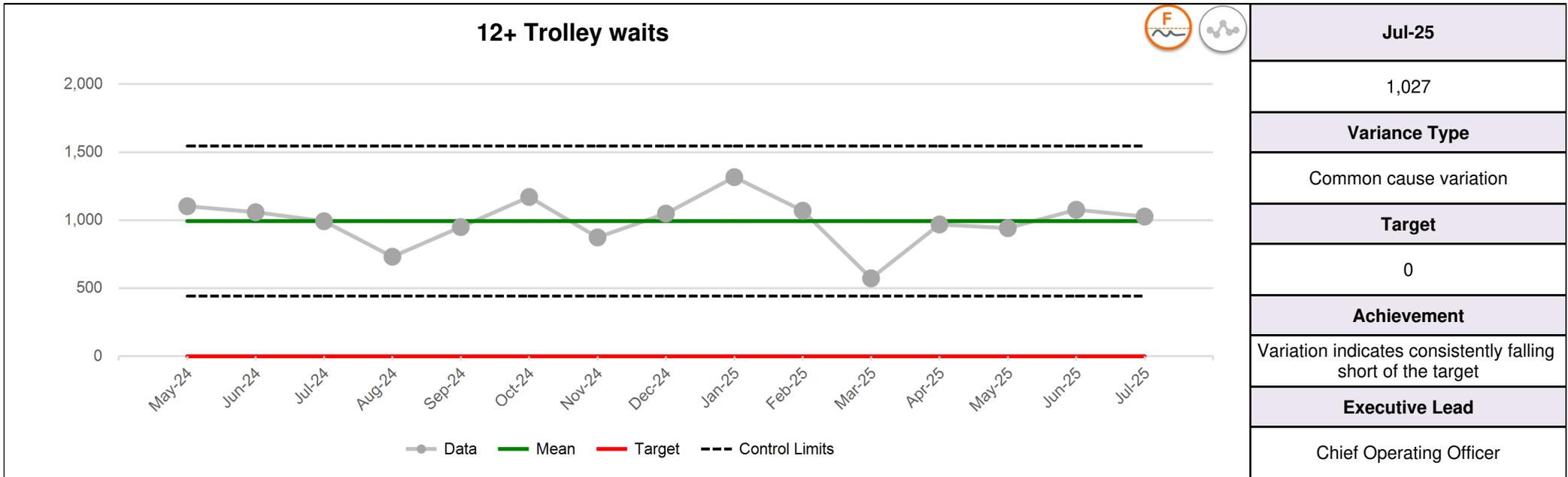
	Jul-25
	1,027
Variance Type	
	Common cause variation
Target	
	0
Achievement	
	Variation indicates consistently falling short of the target
Executive Lead	
	Chief Operating Officer

Legend: Data — Mean — Target — - - - Control Limits

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

What the chart tells us:
July experienced 1,027 breaches, an improvement from 1,077 in June, marking a variance of 4.64% (50 less patients). The 1,027 breaches accounted for 5.96% 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 UECteam, 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 andoperational 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.

Quality → **Operational Performance** → Workforce → Finance

EMAS Conveyances Delayed >59 mins
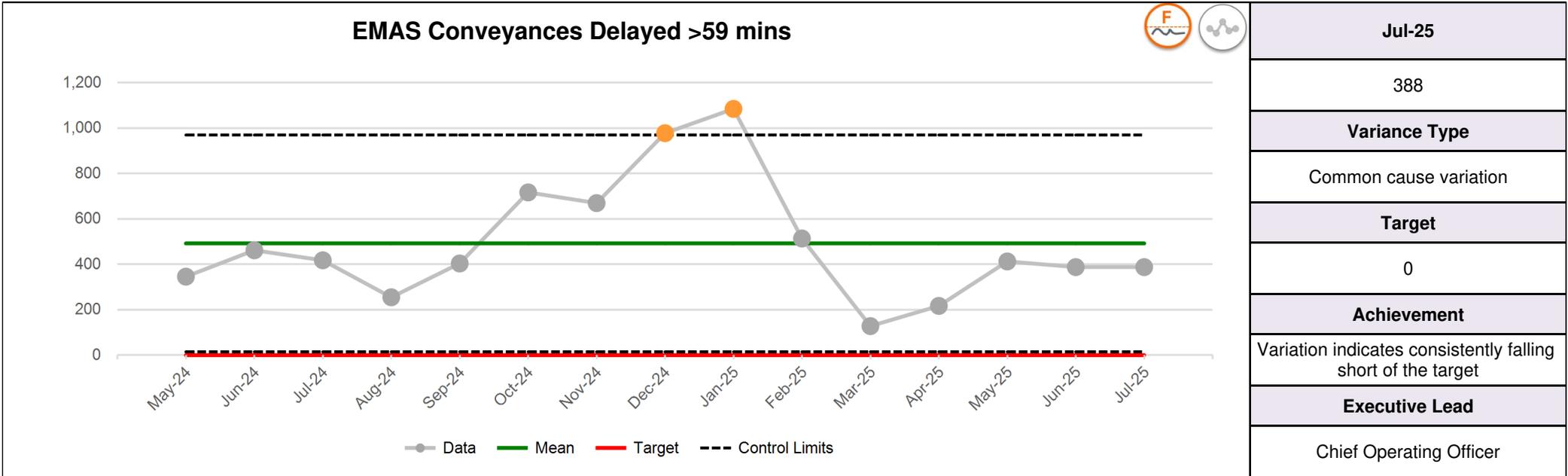
Jul-25	
388	
Variance Type	
Common cause variation	
Target	
0	
Achievement	
Variation indicates consistently falling short of the target	
Executive Lead	
Chief Operating Officer	

Legend: Data — Mean — Target — Control Limits

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 static position in July with 388 arrivals recorded in contrast to the 388 arrivals documented in June. This accounted for 8.05% of all handovers in July 2025. 21.46% 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 few 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.

Quality > Operational Performance > Workforce > Finance

Average LoS - Elective (not including Daycase)

Legend: Data — Mean — Target --- Control Limits
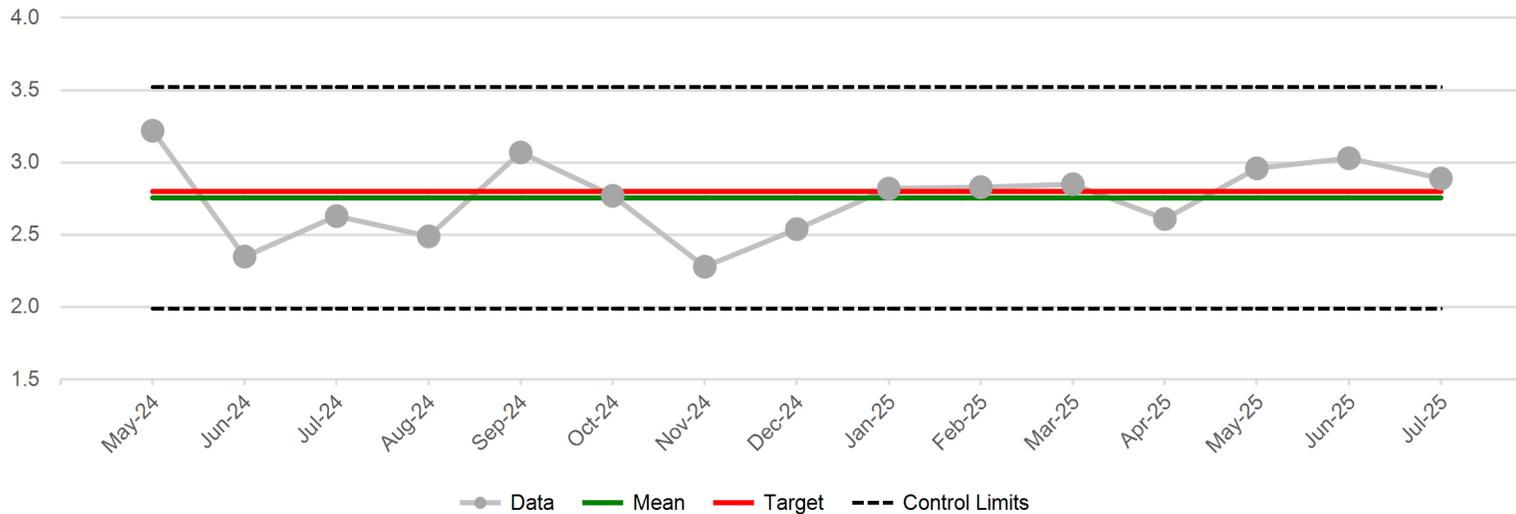
Jul-25	
2.89	
Variance Type	
Common cause variation	
Target	
2.80	
Achievement	
Variation indicates consistently falling short of the target	
Executive Lead	
Chief Operating Officer	

Background:
The average length of stay for Elective inpatients

What the chart tells us:
The average LOS for Elective stay has decreased to 2.89 days compared to 3.03 days in the preceding month. This represents a negative variance of 0.09 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.

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Average LoS - Non Elective
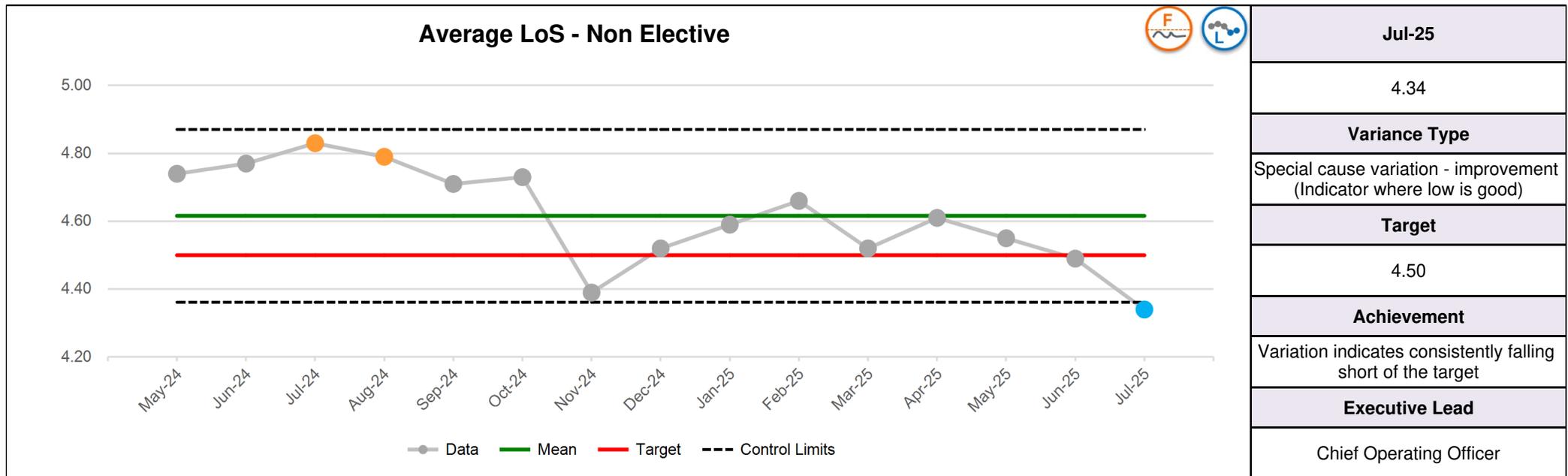
Jul-25	
4.34	
Variance Type	
Special cause variation - improvement (Indicator where low is good)	
Target	
4.50	
Achievement	
Variation indicates consistently falling short of the target	
Executive Lead	
Chief Operating Officer	

Legend: Data — Mean — Target --- Control Limits

Background:
Average length of stay for non-Elective inpatients

What the chart tells us:
July outturn of 4.34 is a improvement of 0.15 days and a 0.16-day positive variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (0.3) less days
Pathway 1 (0.4) less days
Pathway 2 (1.6) more days
Pathway 3 (0.0) change

Issues:
In July, there was a increase in performance in the number of super-stranded patients, with the daily average decreasing to 125 from 128. However the number of stranded patients (14 days) has increased to 203 daily from 200. Weekend discharges consistently remained lower than weekdays, with a 36.02% reduction and an average of 48 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.

Quality | Operational Performance | Workforce | Finance

52 Week Waiters

	Jun-25
	1,805
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

Legend: ● Data — Mean — Trajectory --- Control Limits
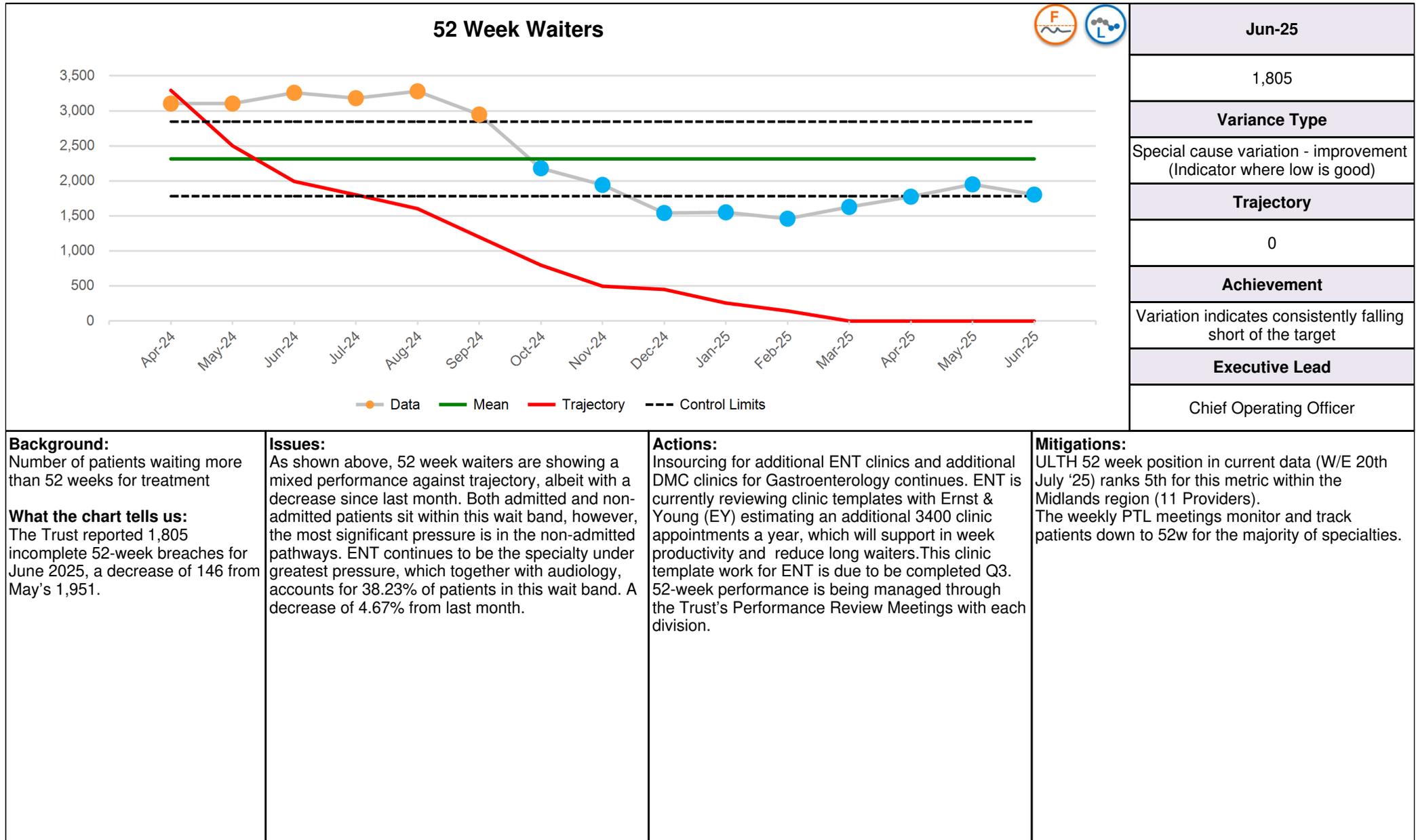
Background:
Number of patients waiting more than 52 weeks for treatment

What the chart tells us:
The Trust reported 1,805 incomplete 52-week breaches for June 2025, a decrease of 146 from May's 1,951.

Issues:
As shown above, 52 week waiters are showing a mixed performance against trajectory, albeit with a decrease since 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 38.23% of patients in this wait band. A decrease of 4.67% from last month.

Actions:
Insourcing for additional ENT clinics and additional DMC clinics for Gastroenterology continues. ENT is currently reviewing clinic templates with Ernst & Young (EY) estimating an additional 3400 clinic appointments a year, which will support in week productivity and reduce long waiters. This clinic template work for ENT is due to be completed Q3. 52-week performance is being managed through the Trust's Performance Review Meetings with each division.

Mitigations:
ULTH 52 week position in current data (W/E 20th July '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.

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65 Week Waiters

	Jun-25
	13
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

Legend: Data — Mean — Trajectory --- Control Limits
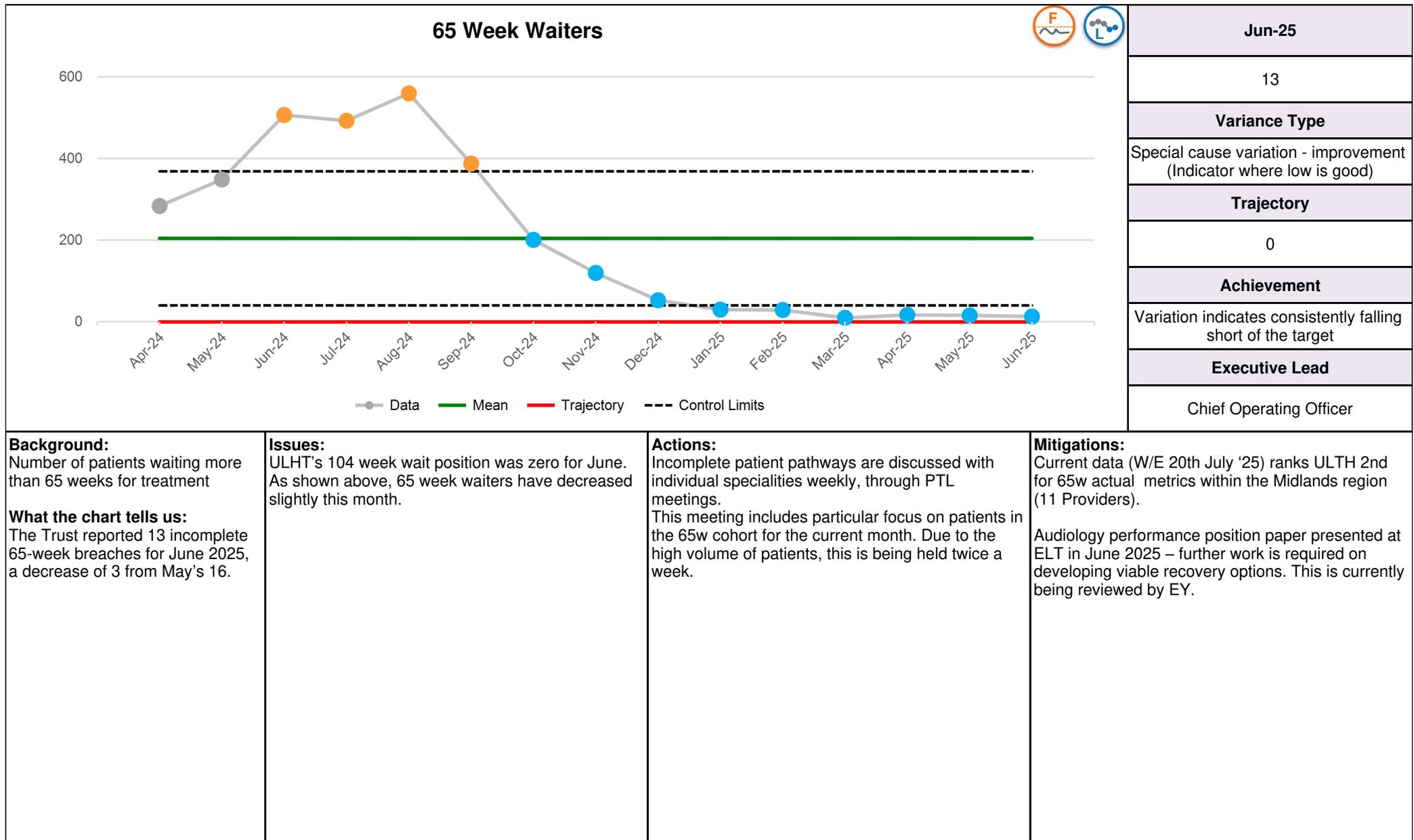
Background:
Number of patients waiting more than 65 weeks for treatment

What the chart tells us:
The Trust reported 13 incomplete 65-week breaches for June 2025, a decrease of 3 from May's 16.

Issues:
ULHT's 104 week wait position was zero for June. As shown above, 65 week waiters have decreased 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 20th July '25) ranks ULTH 2nd for 65w actual metrics within the Midlands region (11 Providers).

Audiology performance position paper presented at ELT in June 2025 – further work is required on developing viable recovery options. This is currently being reviewed by EY.

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18 week incompletes
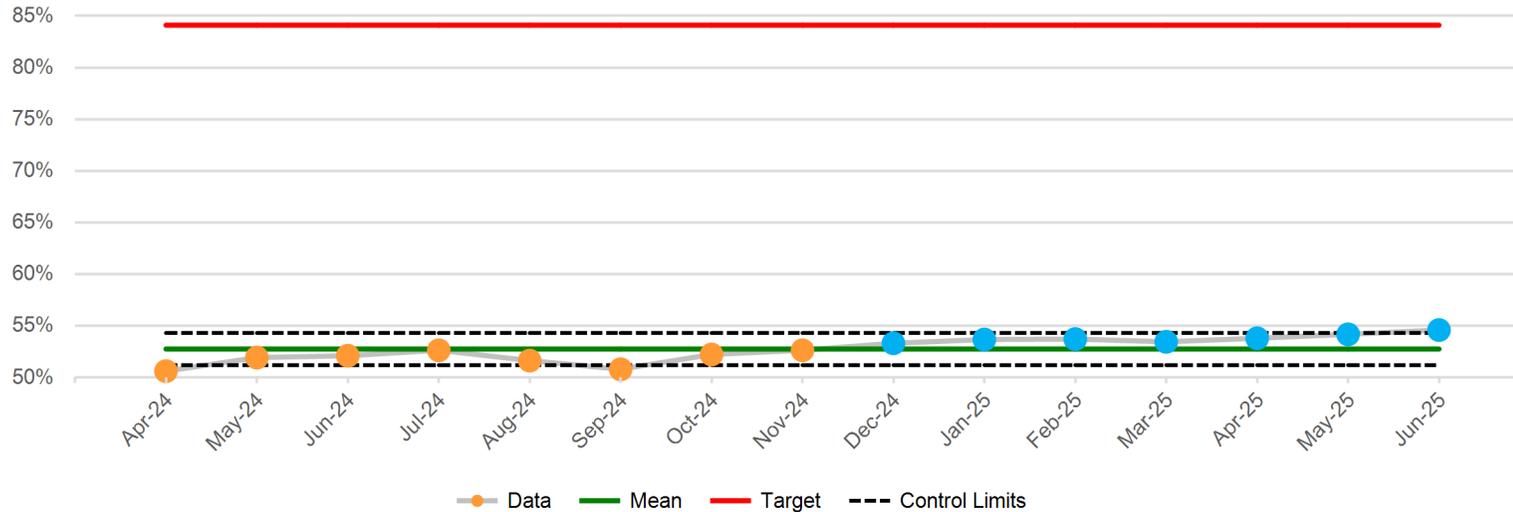
Jun-25
54.60%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
84.10%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Chart legend: Data, Mean, Target, Control Limits

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

What the chart tells us:
There is significant backlog of patients on incomplete pathways. June 2025 saw RTT performance of 54.60% against an 84.1% target, which is 0.43% up from May.

Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:
ENT– 5,016 (decreased by 364)
Gynaecology – 3,147 (increased by 25)
T&O–2,893 (decreased by 4)
Ophthalmology – 2,520 (increased by 60)
Gastroenterology – 2,350 (increased by 21)

Actions:
Priority remains focussed on clinically urgent and Cancer patients. National focus is on patients that are waiting 65 weeks and over, with the target to achieve zero by the end of the current month. Resource is targeted at patients who have the potential to be >65 weeks.
Schemes to address the backlog include;
1. Outpatient utilisation
2. Tertiary capacity
3. Outsourcing/Insourcing
4. Use of ISPs
5. Reducing missing outcomes

Mitigations:
To support delivery of actions and to maintain drive on recovery,
focus continues on capturing all activity. Current data (W/E 20th July '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.

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NHS
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Waiting List Size

Legend: Data · Mean · Trajectory · Control Limits

Jun-25
70,366
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 increased from May, with June showing an increase of 181 to 70,366
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 – 8,296
Trauma & Orthopaedics 6,373
Ophthalmology – 6,340
Gynaecology – 6,101
Gastroenterology – 5,150

Actions:
EY commissioned to help trust focus on improvement of productivity. Specifically focusing on
- RTT
- Clinic Utilisation
- Outpatient 6-4-2
- Theatre 6-4-2
The internal validation team in conjunction with the EACH are currently undertaking National validation sprint 2, 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 20th July '25) ranks ULTH =1st for this metric and 4th for total waiting list size within the Midlands region (11 Providers).

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Caring and building a healthier future for all

NHS Lincolnshire Community and Hospitals NHS Group

Diagnostics achieved

Jun-25	
75.96%	
Variance Type	
Common cause variation	
Target	
99.00%	
Achievement	
Variation indicates consistently falling short of the target	
Executive Lead	
Chief Operating Officer	

Legend: Data — Mean — Target --- Control Limits

Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
.DM01 for June was 75.96% 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.

Quality   Operational Performance   Workforce   Finance

Cancelled Operations on the day (non clinical)

Legend: Data — Mean — Target --- Control Limits
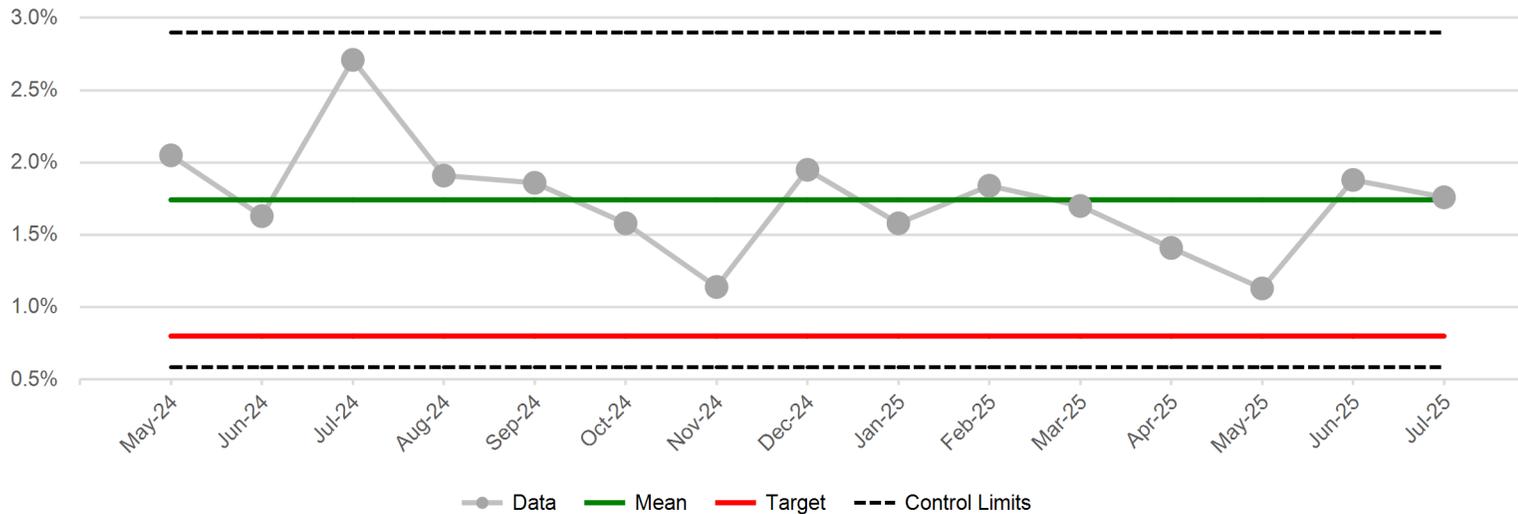
Jul-25
1.76%
Variance Type
Common cause variation
Target
0.80%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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 decrease in the number of non-clinical cancellations in July, though this remains over the 0.80% target.

Issues:
Top 3 theatre cancellations for July were:

Lack of time
Staff unavailable
Treatment/surgery deferred

There has been significant on the day staff sickness during July which has had significant impact on our patients and cancellations.

Actions:
Working with EY to look at procedure timings.

Continue to strengthen pre meets and 642 processes.

Discussions with surgeons and anaesthetists ongoing to ensure lists are reviewed prior to the day of surgery.

Mitigations:
Improved 642 and pre meets now in place, involving wider members of the theatre teams.

Significant challenge in place by senior lead against all non-clinical cancellations.

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Not treated within 28 days. (Breach)

Legend: Data | Mean | Target | --- Control Limits

Jul-25	
40	
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 an increase from 19 in June to 40 in July.

Issues:
There have been significantly fewer lists running due to refusal of additional cover for planned absence for both surgeons and anaesthetists. This impacts our availability treat these patients within 28 days.

Actions:
Focus to remain on improved utilisation on our lists using 642 with focus on effective pre meets.

Mitigations:
New agreement in place for additional activity which will support extra lists for long waiters and 2ww patients – this will support activity in the background for redating within 28 days.

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#NOF 48 hrs

Legend: Data — Mean — Target - - - Control Limits

Jul-25
67.95%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of femur fractures patients time to theatre within 48 hours

What the chart tells us:
The average percentage across both sites for July was 67.95%

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

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Partial Booking Waiting List

Jul-25	
41,605	
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	

Legend: Data · Mean · Target · Control Limits

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

What the chart tells us:
Currently at 41,605 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 is being revised again to decrease clinic cancellations, improve capacity and vacant slots. Clinic Scheduler x 2 in post. Digital room booking system at initial project phase support clinic scheduling 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.

Quality | Operational Performance | Workforce | Finance

Caring and building a healthier future for all

NHS
Lincolnshire Community and Hospitals NHS Group

% discharged within 24hrs of PDD

Legend: Data · Mean · Target · --- Control Limits

Jul-25
38.69%
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 June. Resulting at 38.69%.

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.

Quality | Operational Performance | Workforce | Finance

62 day classic

Jun-25
65.00%
Variance Type
Common cause variation
Target
85.39%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Chart legend: Data, Mean, Target, Control Limits

Background:
Percentage of patients to start a first treatment within 62 days combined.

What the chart tells us:
We are currently at 65% 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, not achieve planned trajectory of 68.21% for June.

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 started June 2025.
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. 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.

.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.

Quality | Operational Performance | Workforce | Finance

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2 week wait suspect

Jun-25
69.60%
Variance Type
Common cause variation
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Legend: Data — Mean — Target --- Control Limits

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 69.6% 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 23.9% of the Trust's 14 day breaches.
Additionally, Gynaecology speciality were responsible for 10.8% of the Trust's 14 day breaches in June.
Skin tumour site accounted for 57% of the Trust's 14-day breaches in June. There continues to be 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, funded extended to September 2025. Referral process have now returned to C&A, the division continue to monitor to ensure a streamlined transition.
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 are 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.

Quality > Operational Performance > Workforce > Finance

21/08/2025 14:16

2 week wait breast symptomatic

Legend: Data — Mean — Target --- Control Limits

Jun-25
42.40%
Variance Type
Common cause variation
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer
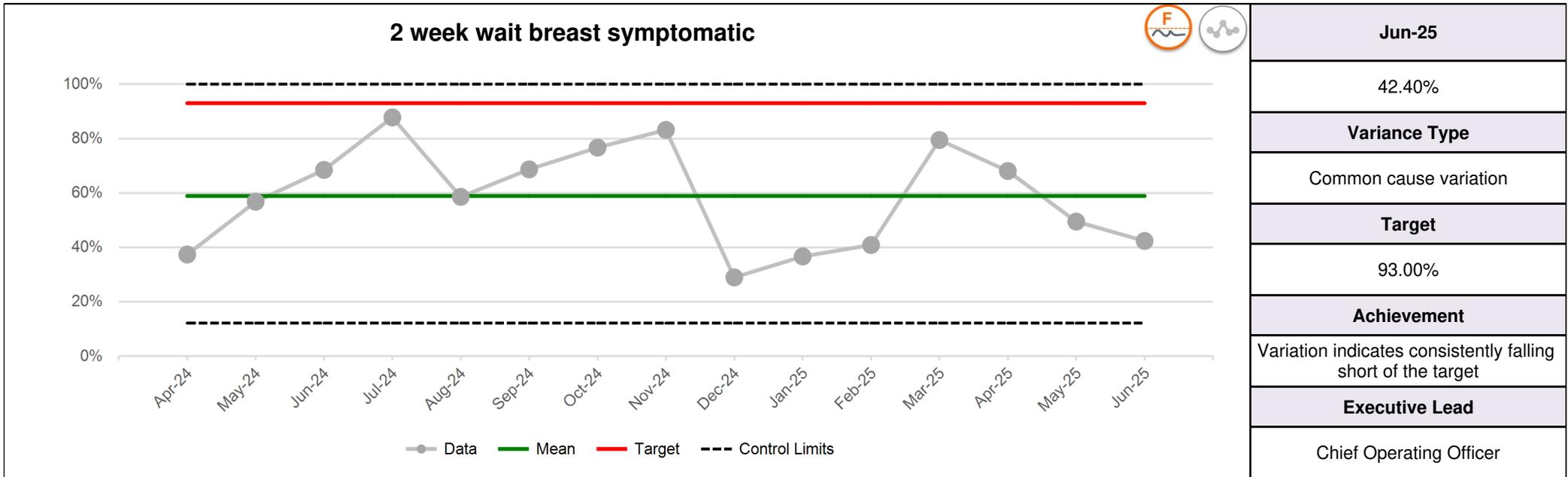
Background:
Percentage of patients urgently referred for breast symptoms (where cancer was not initially suspected) seen within two weeks of referral.

What the chart tells us:
We are currently at 42.4% 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:
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.

Quality | Operational Performance | Workforce | Finance

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31 day first treatment

Chart legend: Data, Mean, Target, Control Limits

Jun-25
90.70%
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 90.7% 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 started June 2025.
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.

Quality | Operational Performance | Workforce | Finance

Caring and building a healthier future for all

NHS Lincolnshire Community and Hospitals NHS Group

31 day subsequent drug treatments

Legend: Data — Mean — Target — Control Limits

Jun-25
97.20%
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 97.2% 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 started June 2025.
Continuous work 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.

Quality | Operational Performance | Workforce | Finance

21/08/2025 14:16

31 day subsequent surgery treatments

Jun-25	
48.60%	
Variance Type	
Common cause variation	
Target	
94.00%	
Achievement	
Variation indicates consistently falling short of the target	
Executive Lead	
Chief Operating Officer	

Legend: Data — Mean — Target - - - Control Limits
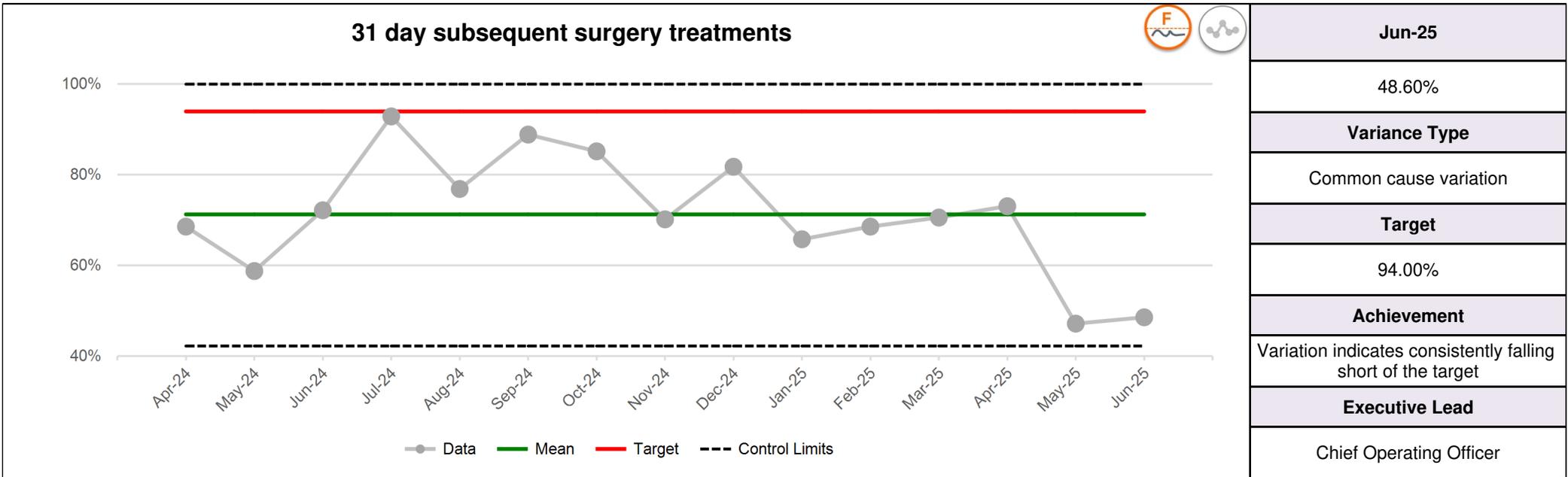
Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was surgery.

What the chart tells us:
We are currently at 48.6% 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 piece of work is being undertaken to improve documentation to ensure the Trusts captures treatment adjustments/ECAD. 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.
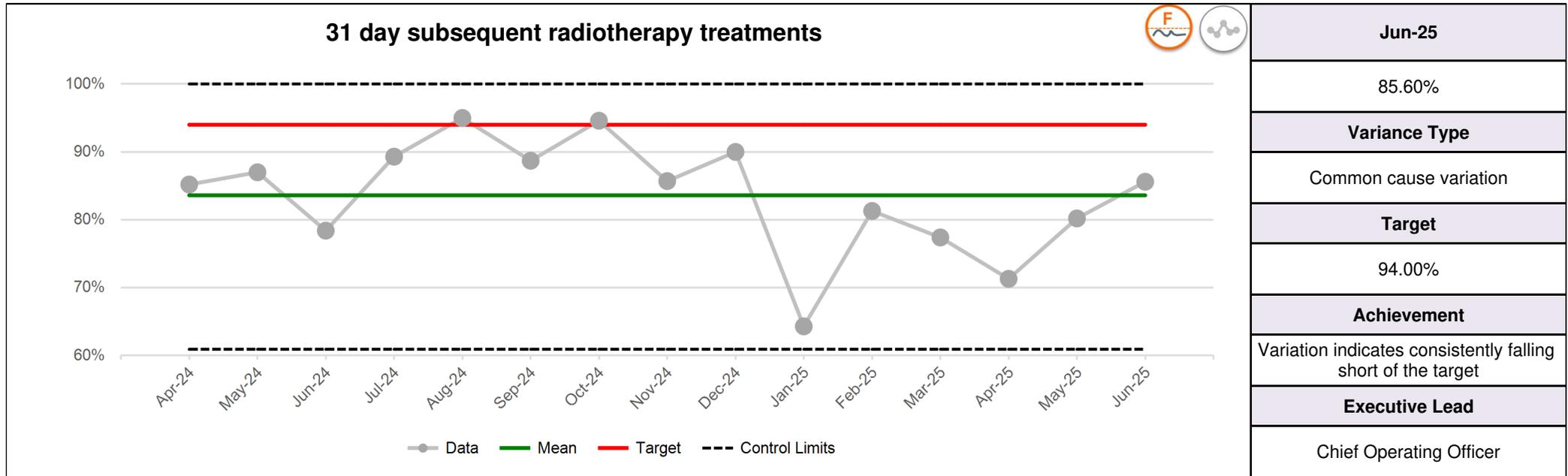
Quality | Operational Performance | Workforce | Finance

31 day subsequent radiotherapy treatments

Legend: Data — Mean — Target --- Control Limits

Jun-25
85.60%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 85.6% 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 started in June 2025.
Continuous work is being undertaken to ensure shared access to information to ensure breach reasons and treatment 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.

Patients referred into radiotherapy are managed through OWL and the system has been set up to provide the Radiotherapy Scheduling team with a target date of 28 days. This enables us to comfortably meet the 31 day target if no issues arise.
Patients are being prioritised based on the Royal College of radiologists guidelines for their start date if we are unable to meet the 31 day target liaising with the clinical oncologists to manage the start dates for radiotherapy.

Quality | Operational Performance | Workforce | Finance

62 day screening

Legend: Data — Mean — Target --- Control Limits

Jun-25
57.70%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer
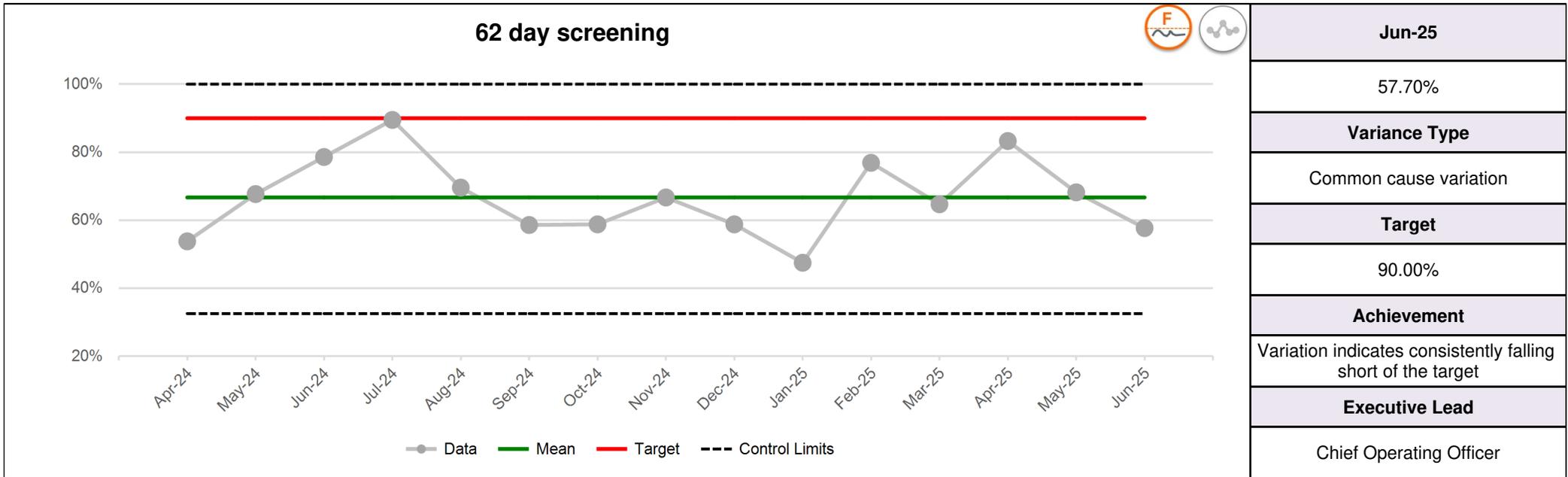
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 57.7% 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:
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. 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.

Mitigations:
Please also see Mitigations on accompanying pages.

Quality | Operational Performance | Workforce | Finance

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62 day consultant upgrade
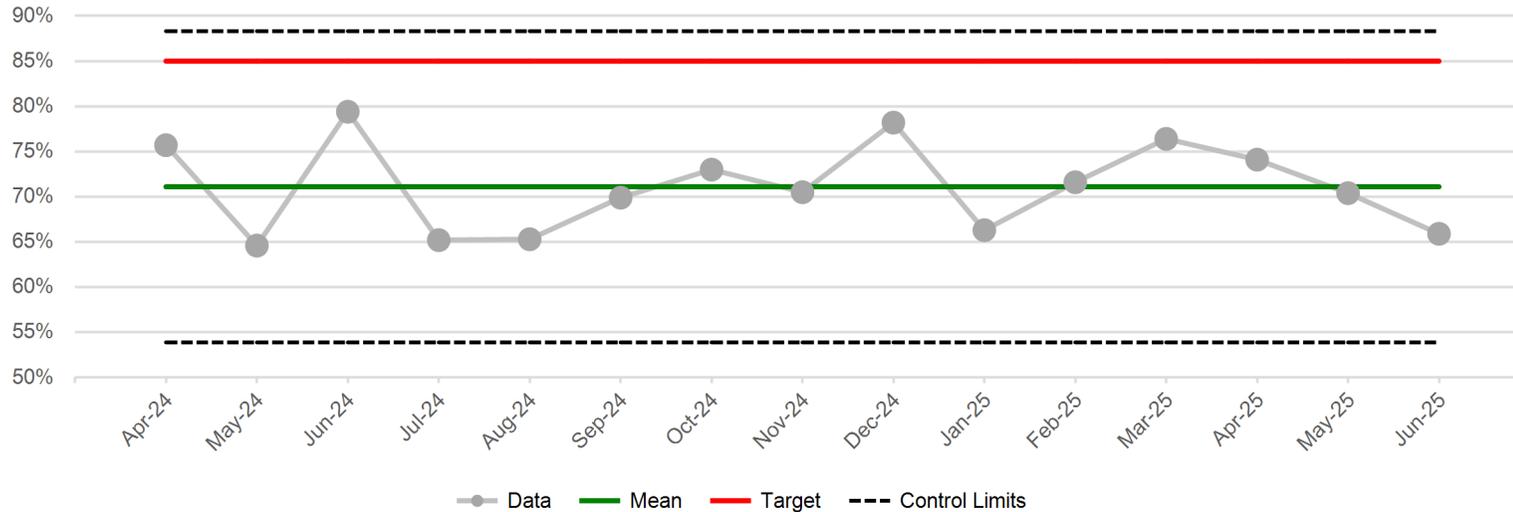
	Jun-25
	65.90%
Variance Type	
	Common cause variation
Target	
	85.00%
Achievement	
	Variation indicates consistently falling short of the target
Executive Lead	
	Chief Operating Officer

Legend: Data — Mean — Target — - - Control Limits

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

What the chart tells us:
We are currently at 65.9% 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 started June 2025.
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.

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Quality | Operational Performance | Workforce | Finance

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104+ Day Waiters

	Jul-25
	103
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

Legend: Data — Mean — Target — Control Limits

Background:
Number of cancer patients waiting over 104 days.

What the chart tells us:
As of 13th August the 104 Day backlog is at 103 patients.
There are 3 main tumour sites of concern:-

Colorectal 39
Lung 17
Head and Neck 15
Upper GI 12

Issues:
The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is available.
Reduced OP, diagnostic and theatre capacity across the Trust, all Specialties vying for additional sessions.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Head & Neck, Gynaecology, and Lung.
Approximately 15.53% 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.

Quality | Operational Performance | Workforce | Finance

Performance Overview - Workforce

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-25	Jun-25	Jul-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%	92.83%	92.78%	93.06%	92.81%	90.00%	P	
	Number of Vacancies	Well-Led	People	Director of HR & OD	6.81%	6.05%	5.85%	6.47%	6.09%	6.96%	P	L
	Sickness Absence	Well-Led	People	Director of HR & OD	4.31%	5.29%	5.27%	5.26%	5.28%	4.53%	F	
	Staff Turnover	Well-Led	People	Director of HR & OD	9.00%	9.14%	9.01%	8.93%	9.07%	9.00%	F	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	85.00%	76.68%	78.69%	81.17%	77.89%	81.25%	F	

Quality | Operational Performance | Workforce | Finance

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Sickness Absence

Legend: Data | Mean | Trajectory | Control Limits

Jul-25
5.26%
Variance Type
Common cause variation
Trajectory
4.31%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD
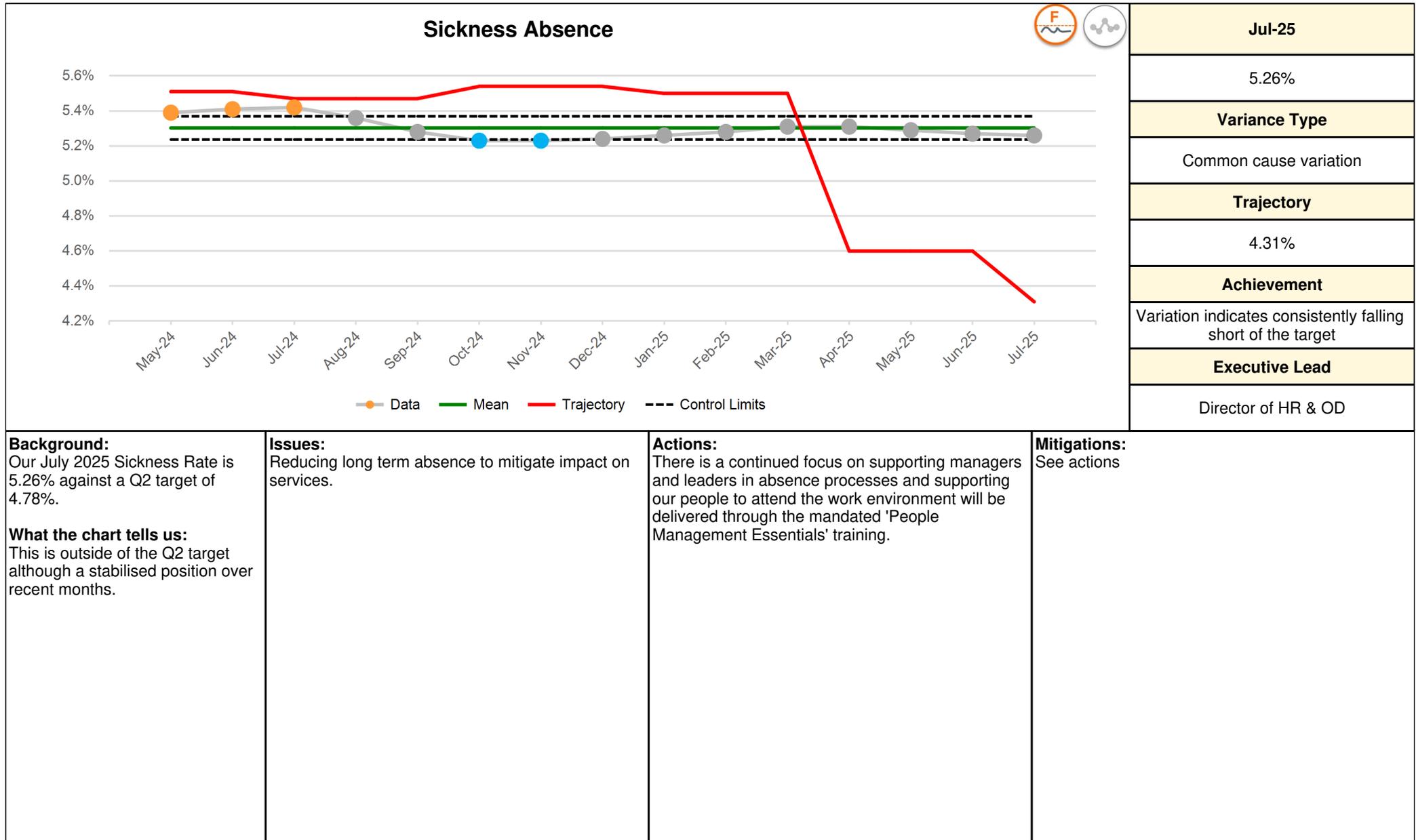
Background:
Our July 2025 Sickness Rate is 5.26% against a Q2 target of 4.78%.

What the chart tells us:
This is outside of the Q2 target although a stabilised position over recent months.

Issues:
Reducing long term absence to mitigate impact on services.

Actions:
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.

Mitigations:
See actions

Quality | Operational Performance | Workforce | Finance

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Staff Turnover

	Jul-25
	8.93%
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

Legend: Data • Mean — Trajectory — - Control Limits

Background:
July 2025 reported Turnover Rate is 8.93% against a Q1 target of 9.00%.

What the chart tells us:
That we are within target and have achieved the year-end target in month.

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 line with plan.

Quality | Operational Performance | Workforce | Finance

Lincolnshire Community and Hospitals NHS Group

Staff Appraisals

Legend: Data | Mean | Trajectory | Control Limits

Jul-25
81.17%
Variance Type
Common cause variation
Trajectory
85.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
July 2025 completion is currently 81.17% for Agenda for Change staff which is outside of the Q2 target of 85.00%.

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 2025/26 we introduced 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.

Quality | Operational Performance | Workforce | Finance

LCHS Integrated Performance Report (July Data)

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2nd September 2025*
Item Number	*11*

Integrated Performance Report

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Daren Fradgley, Group Chief Integration Officer*
Author(s)	*STORER, Ben*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the content of the report*

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

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

Executive Summary

Performance up until the end of July 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:

		SPC Variation		
		Special Cause Improvement	No Variation	Special Cause Deterioration
Target Capability	Consistently Capable	1	12	2
	Inconsistently Capable	1	11	3
	Not Capable	1	2	0
	No Target	2	19	0

Committee to Note: Due to non-availability of some data or Clinical narrative's the Quality and Risk report will have the following missing. (These areas are highlighted in yellow in the report)

1. Care Hours per Patient Day (Data and Narrative missing)

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.

5 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. 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.

5 indicators are currently showing special cause improvement, which is a strong indication of our continuous improvement culture:
1. Staff Turnover;
2. Agency Expenditure
3. Ops Centre – Emails Offered
4. Discharge to Assessment – Distinct Patient Contacts
5. Home Visting Compliancy

INTEGRATED PERFORMANCE REPORT

July 2025 Performance Data

Contents

SPC Scorecard

		SPC Variation		
		Special Cause Improvement	**No Variation**	**Special Cause Deterioration**
Target Capability	**Consistently Capable**	Staff Turnover		Environmental Cleanliness Community Hospital Bed Occupancy Community Hospital Falls per 1000 OBDs MRSA Screening Mandatory Training Compliancy UTC Discharge Summaries Training Compliancy Completion Of NHS Numbers for A&E Data Sets Chlamydia Screening Positivity Rate Compliance Ops centre -Emails answered within 24 hours GU Patients seen within 2 working days Combined Home Visiting & UCR 2-Hour Compliance
	Inconsistently Capable	Agency Expenditure	Sickness Absense 15 Minute Ambulance Handover Better Payment Practice Code Long Term Sickness UTC 4 Hour UTC 15 Minute Assessment Ops Centre Calls: Answered in Timescale Complaints - Rate per 1000 WTE Friends & Family Test Community Hospital Discharge Summaries Average Length of Stay	Ops Centre Calls Abandoned Ops Centre - Priority Calls Answered In 2 Minutes Vacancy Rate
	Not Capable	Home Visiting Compliancy	Ethnicity In A&E Data Sets Patient Incidents Per 1000 WTE	
	No Target	Ops centre - Emails offered Discharge to Assessment: Distinct Patient Contacts	Urgent Community Response- Accepted Referals Discharge to Access Accepted Refferals Ops Centre Calls Answered UTC Activity Home Visiting Activity Virtual Wards: Frailty Refferals Ops Centre- Calls Offered Combined Home Visiting & UCR Cases Virtual Wards: Cardiology Refferals Total Medication Incidents Complaints CHPPD Total Falls Overdue Datix Transitional Care Activity Compliments Children in Care Community Pressure - Rate per 1000 (C2, C3 & C4) Community Hospital Injurious Falls per 1000 OBDs Community Hospital Pressure Ulcers - Rate per 1000 OBDs (C2, C3 &C4)	

Executive Summary

Safe

 X Total LCHS Patient Medication Incidents has increased in July to 52 from 28 in June.

✓ Total Community Hospital Falls performance rates per 1000 OBD has decreased from 2.77 for June to 2.31 for July

X Injurious Community Hospital Falls performance rates per 1000 OBD has increased from previous month.

✓ MRSA compliance achieving target.

✓ Patient Incidents Community Rate per 1000 WTE increased from 224.21 in June to 263.90 in July.

Caring

X FFT scores not achieving 95% target.

✓ Complaints have decreased from previous month.

X Compliments decreased slightly from the previous month.

Responsive

 X Discharge Summaries – Community Hospitals, not achieving target of 98%.

✓ Discharge Summaries – Urgent Treatment Centres achieving target.
 X Performance against the UTC targets-4-hour waits is not achieving the 95% target

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

✓ 15-minute Ambulance Handover is achieving 95% target.

✓ 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.

Effective

X Community Hospitals Pressure Ulcers rate per 1000 OBDs – increase from previous month

✓ Environmental Cleanliness achieving target.

✓ Bed Occupancy rate is achieving 89.6% while the target is at 85%.

X Average Length of Stay is not achieving the 16 Day target
✓ Chlamydia positivity rate of 15-24 years old achieving target.

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

Well-Led

✓ Vacancy rate within the 8% target.

✓ Training Compliance is achieving the 90% target.

X Total Sickness Absence is not achieving 4.35% target.

X Long-Term Sickness Absence has deteriorated slightly from previous month.

✓ 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.

X Month 04 position is -£265k unfavourable to plan.

✓ Overall efficiency (CIP) ahead of plan.

✓ Cash balances are slightly higher than forecast.

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

X Capital expenditure is in behind plan.

✓ Vacancy rate within the 8% target and beating the national benchmark.

✓ Training Compliance is achieving the 90% target.

X Total Sickness Absence is not achieving the 4.35% target.

X Long-Term Sickness Absence has deteriorated slightly from previous month.

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
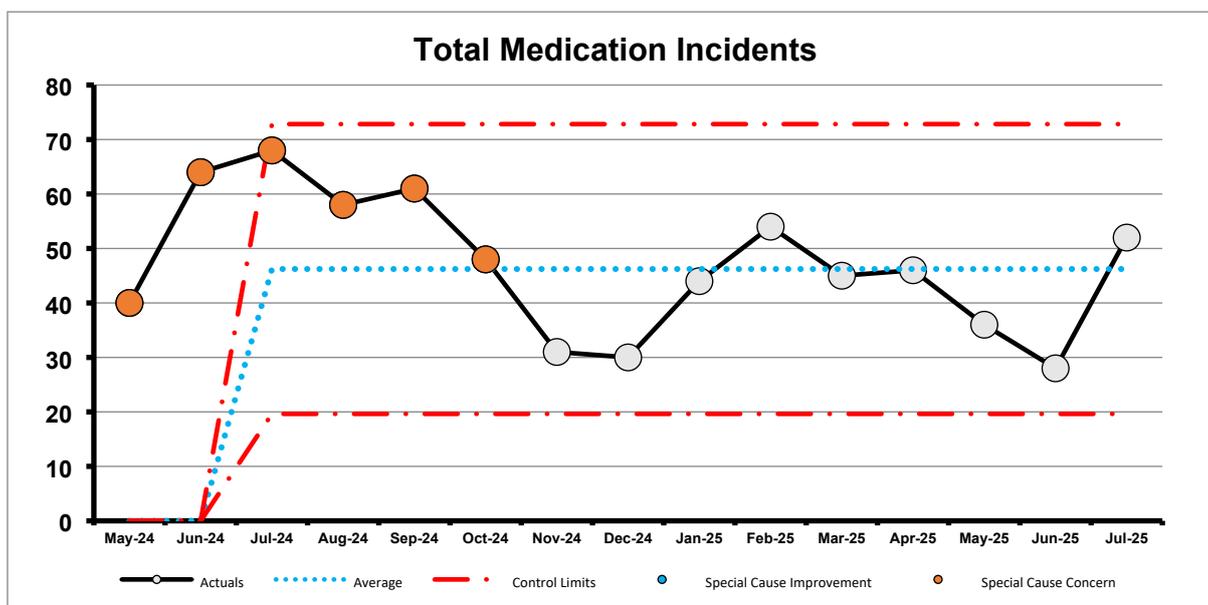
Narrative

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. Administration of time Critical medicine incidents will continue to be tracked to ensure that improvement is embedded & sustained. Examples of time critical medicines include anti-parkinsons, 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 has 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
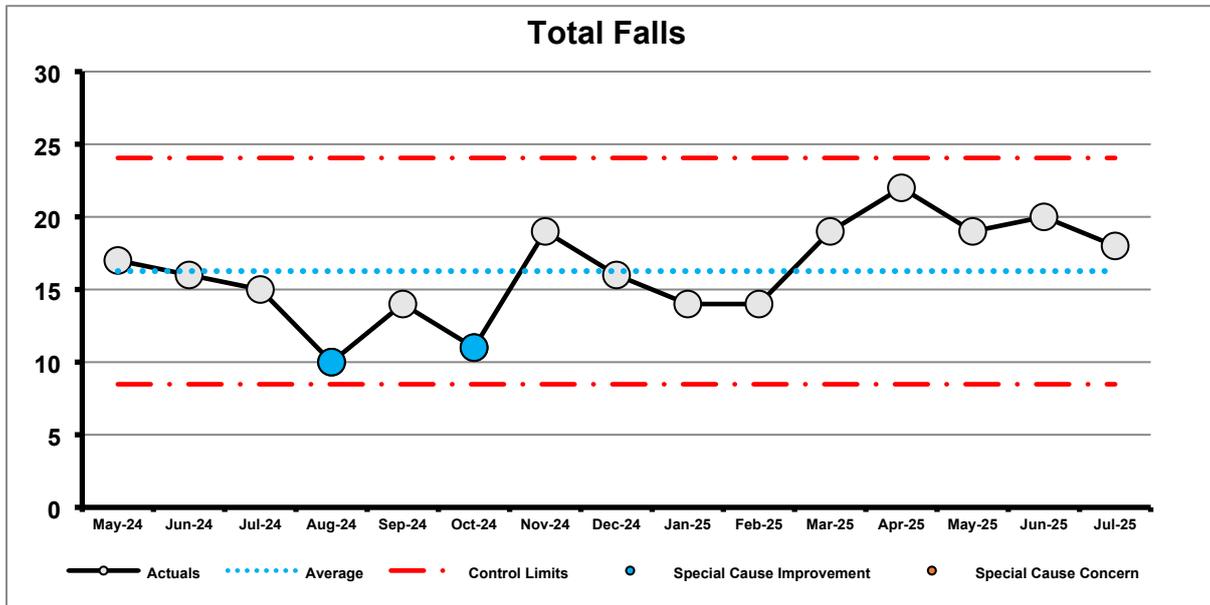
Narrative

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

Current Performance

Community Hospital Falls per 1000 OBDs

Community Hospital Injurious Falls per 1000 OBDs
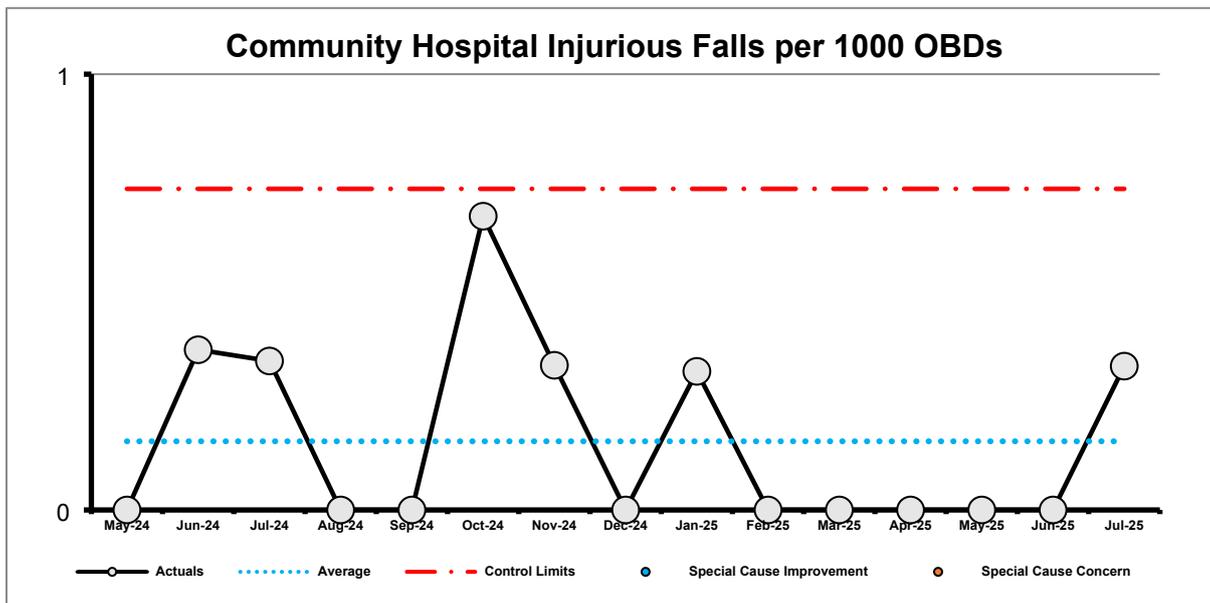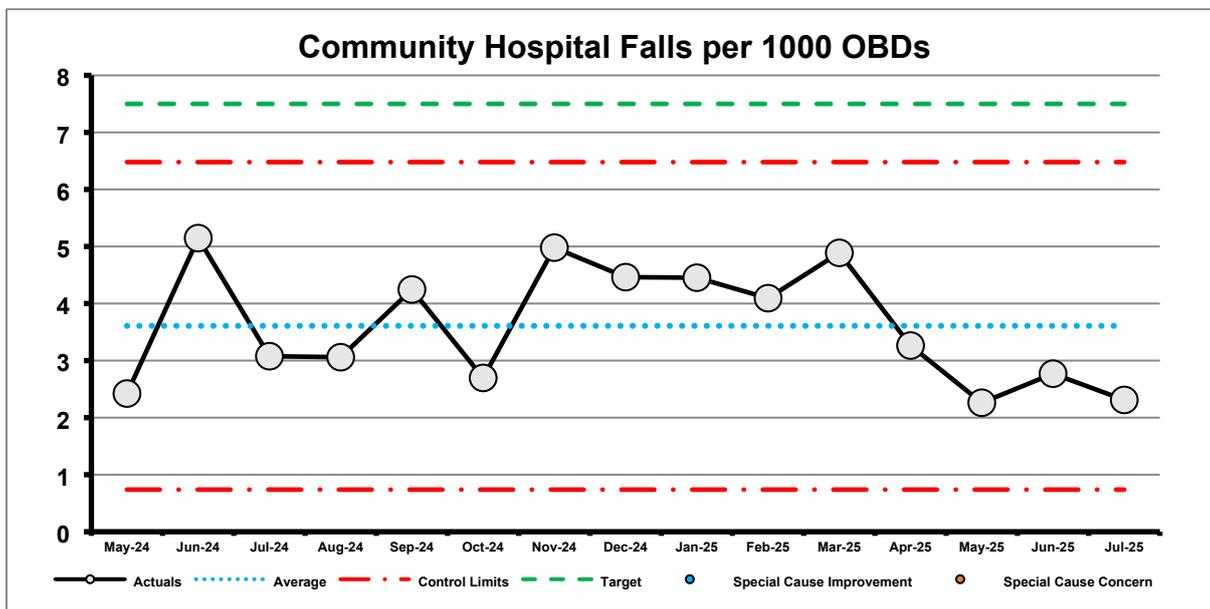
Narrative

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 has not varied significantly in the period.

Community Hospital Injurious Falls per 1000 OBDs

SPC for Community Hospital Injurious falls per 1000 OBDs shows common cause no variation for July 2025.

MRSA Screening

Background

The Trust undertakes targeted MRSA colonisation screening for inpatients and surgical patients in line with the DH "Implementation of modified admission MRSA screening guidance for NHS (2014)".

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

Across LCHS those patients known to be previously MRSA positive or from high-risk groups are identified on admission/or at pre-admission screening and

necessary infection prevention risk management strategies applied.

Benchmark / Target

The target range for screening is 100% of eligible patients.

Current Performance
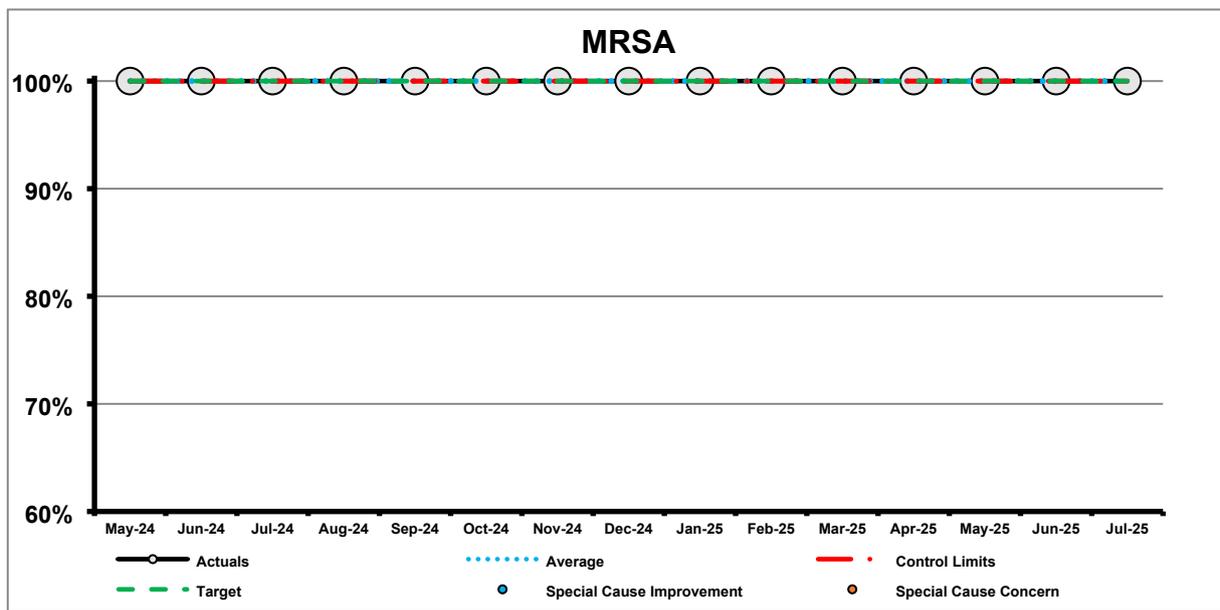
Narrative

Of the 148 patients admitted across all sites, 7 patients were eligible for MRSA screening, of which all 7 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

Patient Incidents Per 1000 WTE

Legend: Actuals, Average, Control Limits, Target, Special Cause Improvement, Special Cause Concern
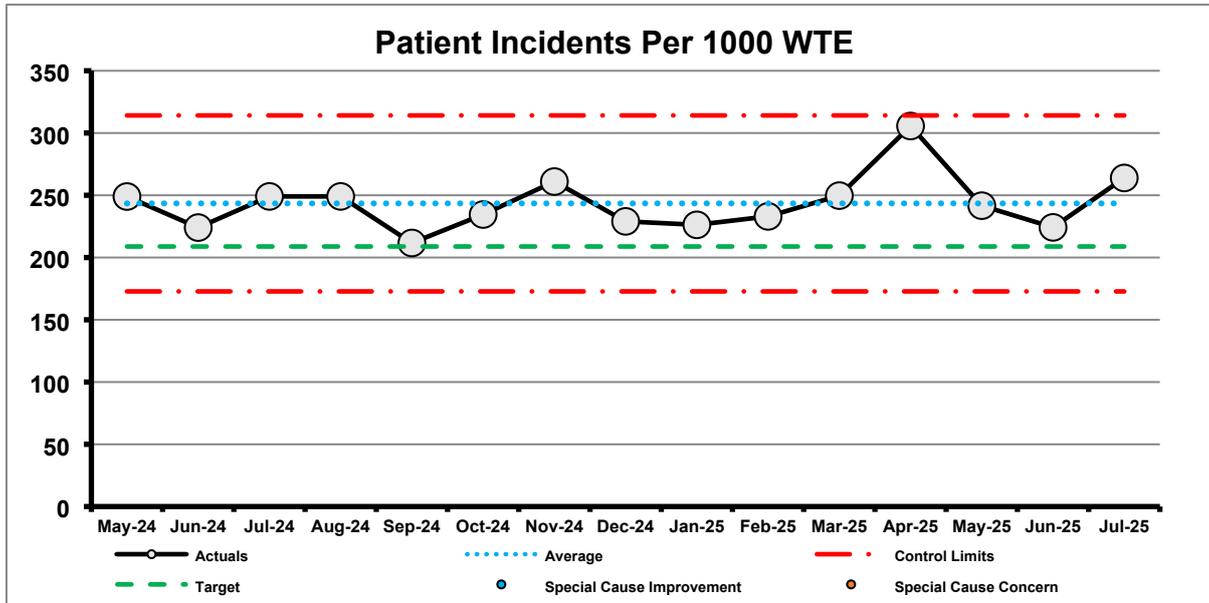
Narrative

- The graph shows LCHS patient safety incidents per 1000 WTE from 1st May 2024 to 31st July 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.
- 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

Pressure Ulcer - Rate per 1000 contacts (C2, C3 & C4) - Community

Community Hospital Pressure Ulcers - rate per 1000 OBDs (C2, C3 & C4)
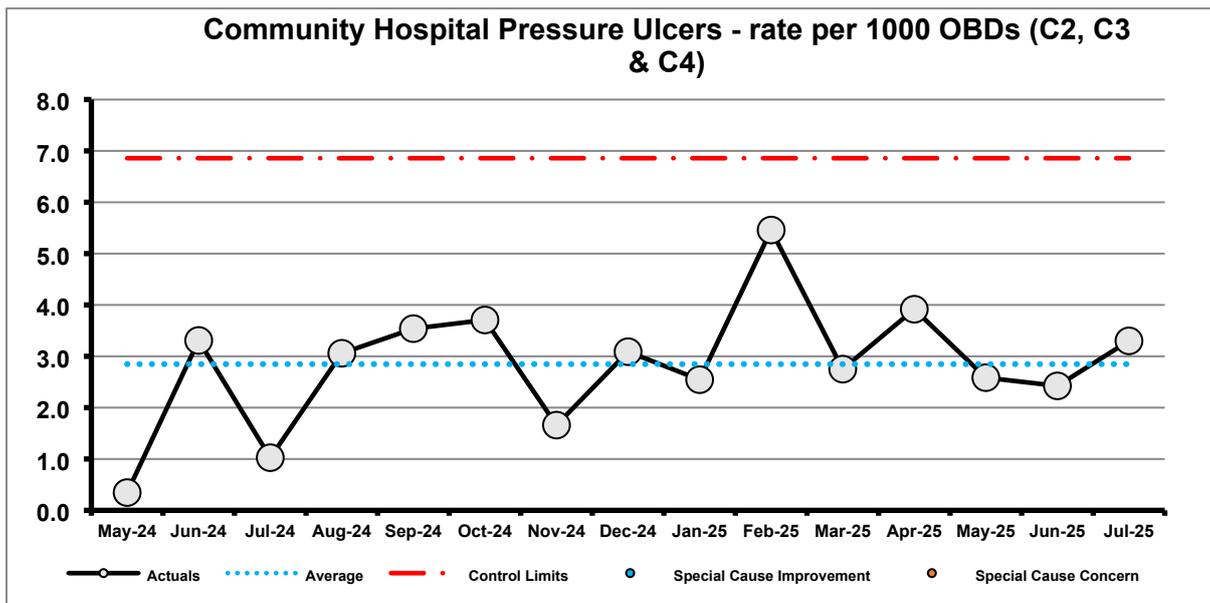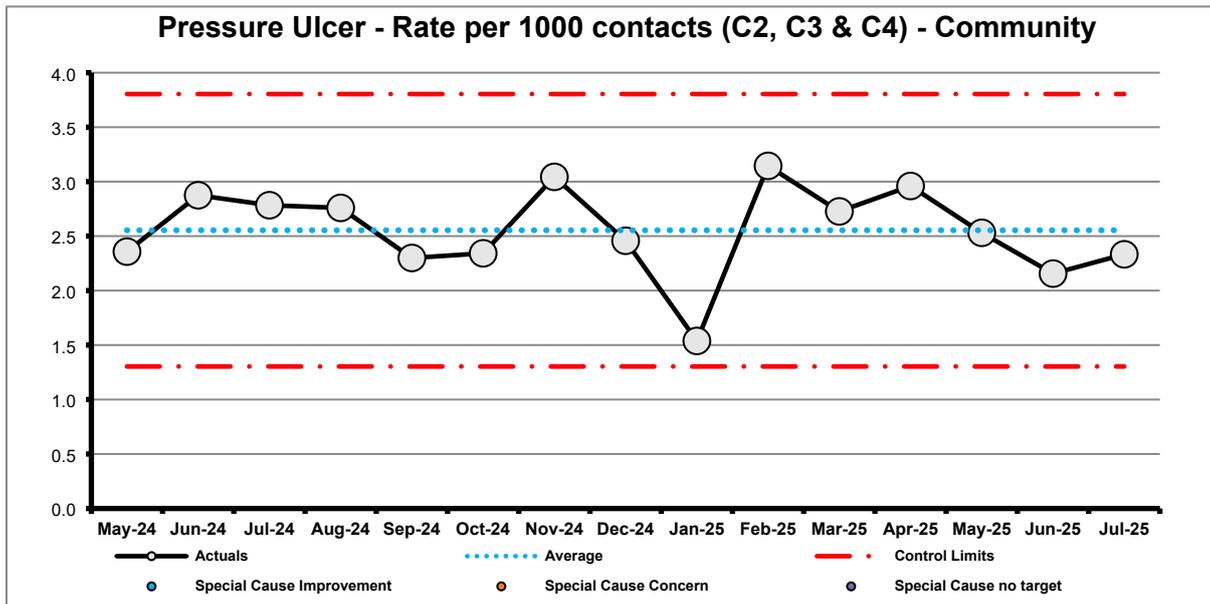
Narrative for Community:

There has been a slight increase of reported Pressure Ulcers in July but these still remain under trust average. Focus on sharing learning across all teams using new PU learning meeting.

Narrative for Community Hospitals:

Similarly to falls number of pressure damage incidents track near to our long term averages. A pressure ulcer care quality improvement plan is to be published to explore what else we can do to continue driving improvements.

SPC

Pressure Ulcers - rate per 1000 contacts (C2, C3 & C4) – Community
For Pressure Ulcer rate/1000 SPC has not varied significantly in the period 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 not varied significantly in the period.

Care Hours Per Patient Day (CHPPD)

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

Care Hours Per Patient Day
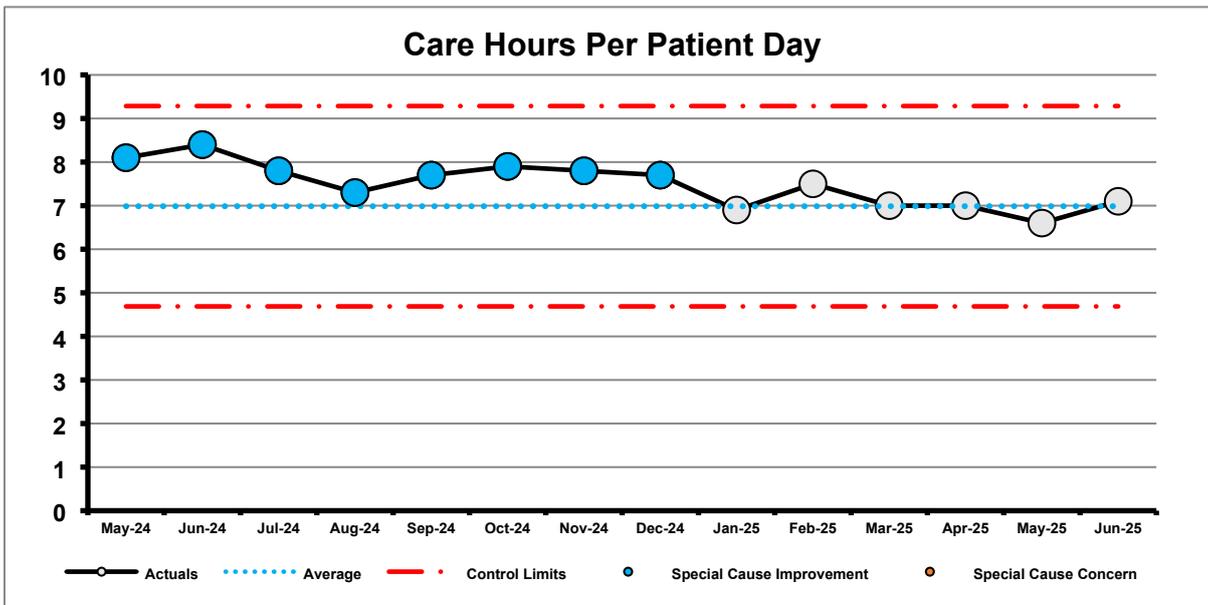
Narrative

Actions

A full complement of registered nurse staffing is seen within wards.

HCSW vacancy remains in some areas with recruitment to entry posts held to potential changes to future bed modelling in community hospitals. There continues to be noticeable offset in hours allocated to registrant posts in areas with lower HCSW levels backfilled by international nursing recruits. This level is though reducing as staff transition into other roles and through normal levels of movement within staffing teams. A review of safe staffing levels will be undertaken in July to give assurance of safe staffing numbers within these environments.

SPC

Awaiting July Data

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
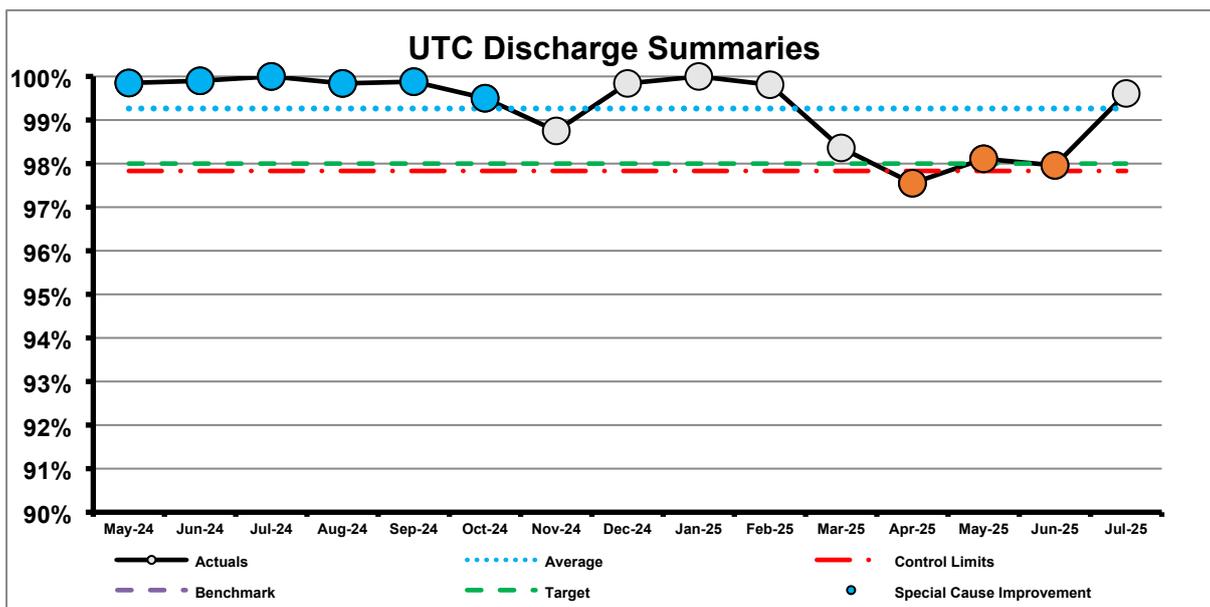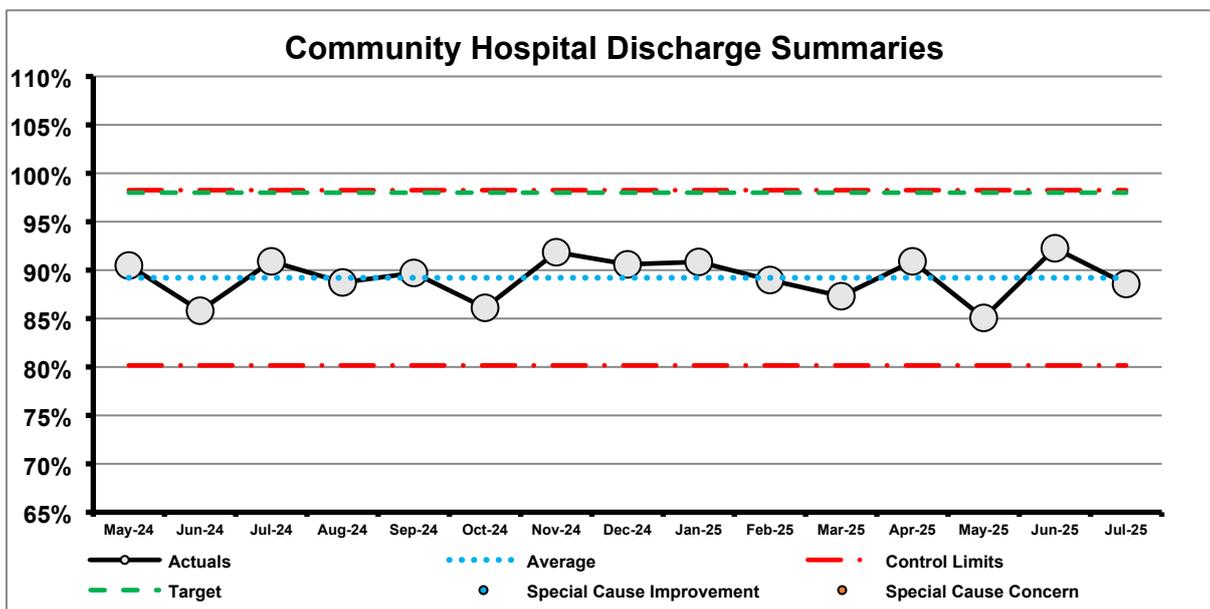
Narrative

Community Hospitals

Continued tracking the baseline for this measure.

Urgent Treatment Centres

The Urgent Treatment Centres (UTC) have achieved 99.61%, which is continued and assures that GPs are getting discharge summaries in a timely manner, ensuring Communications between UTCs and GPs is in place and providing a safe discharge for patients.

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 out Special cause deterioration in July 2025, showing common cause no variation.

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 June 2025). Reported Datix are reported at the end of the reporting month.

Current Performance
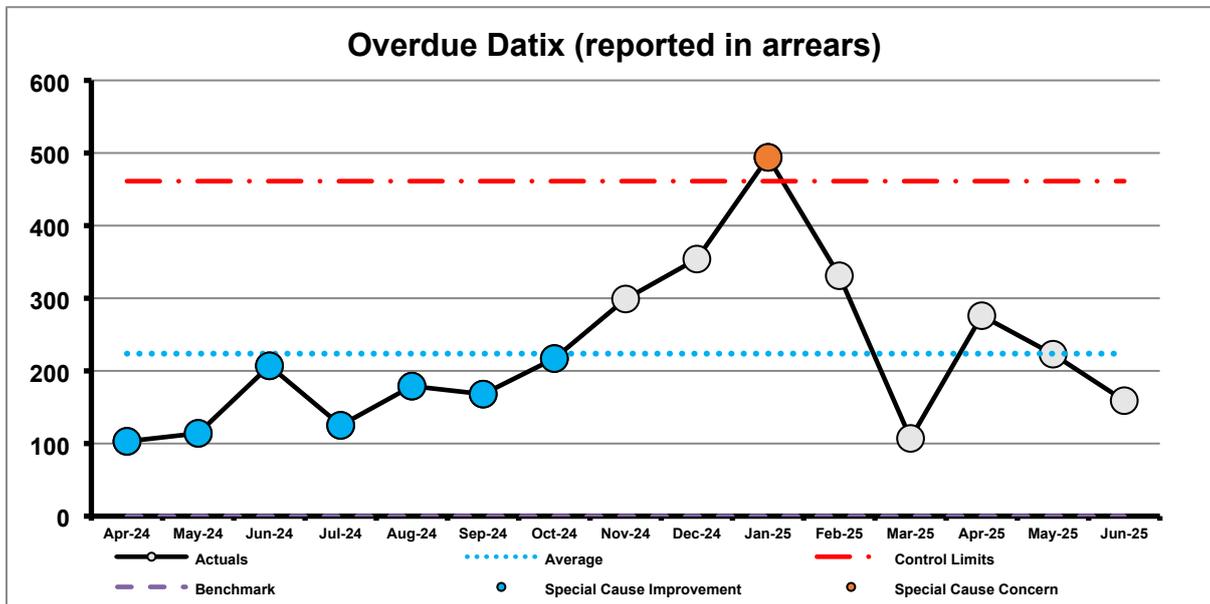
Narrative

An incident is marked as overdue 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 IQ. A trajectory has been agreed to ensure that all incidents still open 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 (comparative numbers, but different incidents). 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

IHA completed in Lincs (reported in arrears)
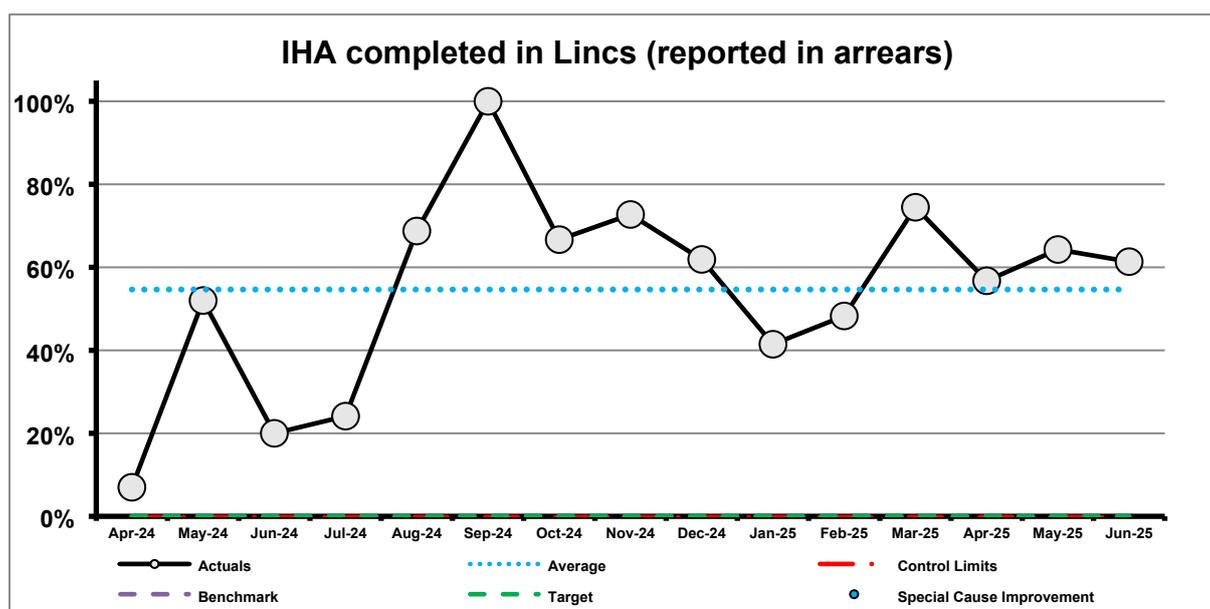
Narrative

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 June, 44 children were in cohort to be assessed in Lincolnshire, and 27 received an initial health assessment within 20 working days of them becoming looked after.

SPC

The SPC for IHA Performance has not varied significantly in the period and is above average in June.

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
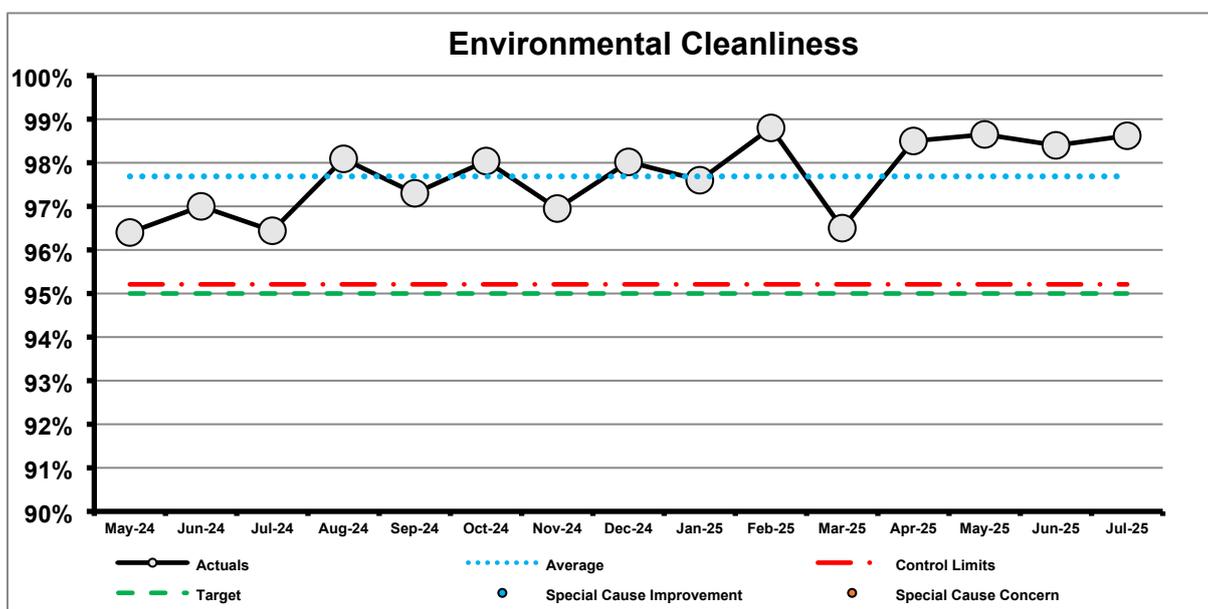
Narrative
LCHS reported 98.62% compliance of cleanliness audits and has achieved the 95% target every month. Visible improvements in the cleaning standards across all the community premises are being sustained. During the quarter, all sites achieved scores that would rate them as either 4 or 5 stars, 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%. Bed occupancy target for the community hospitals was 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

Community Hospital Bed Occupancy

Legend: Actuals, Average, Control Limits, Target
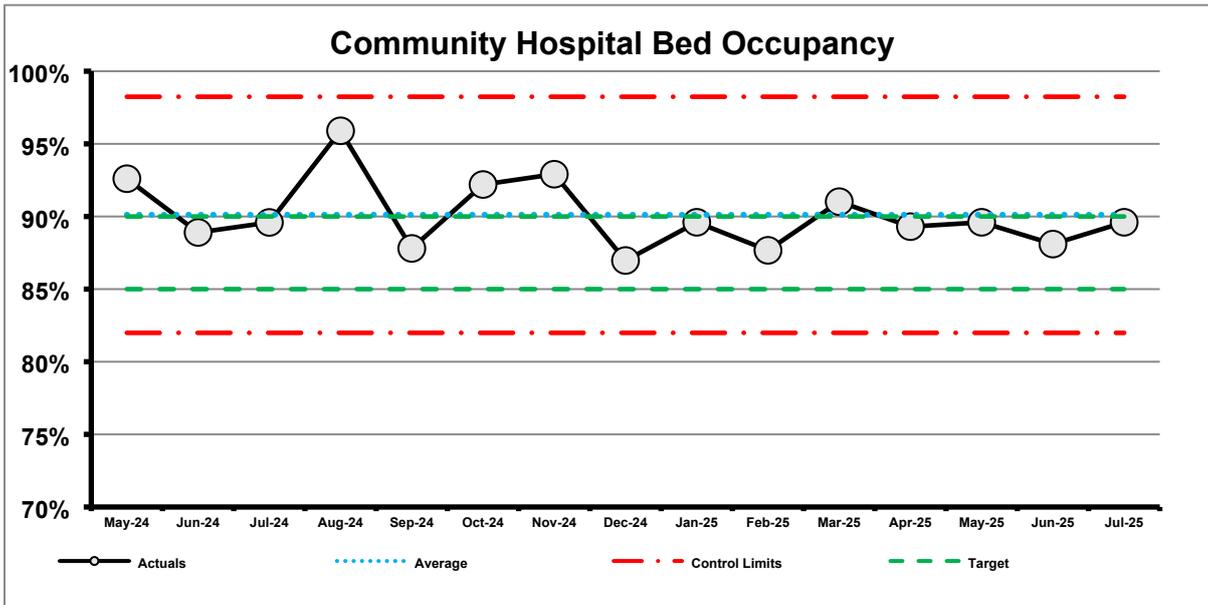
Narrative

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 in reality 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.

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
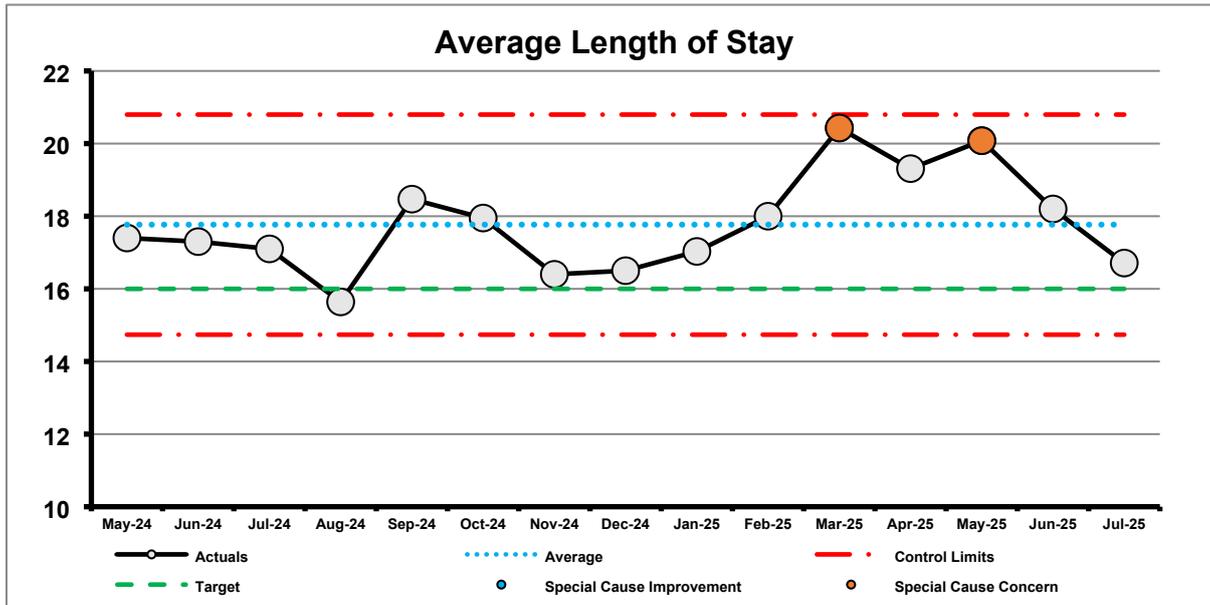
Narrative

Working with external partners has improved to unpick some issues that kept the most complex patients in beds which drove the increase in Length of Stay. Having explored these cases much of the delay was unavoidable. However, the closer joint working has resulted in some minor improvements to processes.

SPC
Average length of stay SPC has not varied significantly in this period.

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
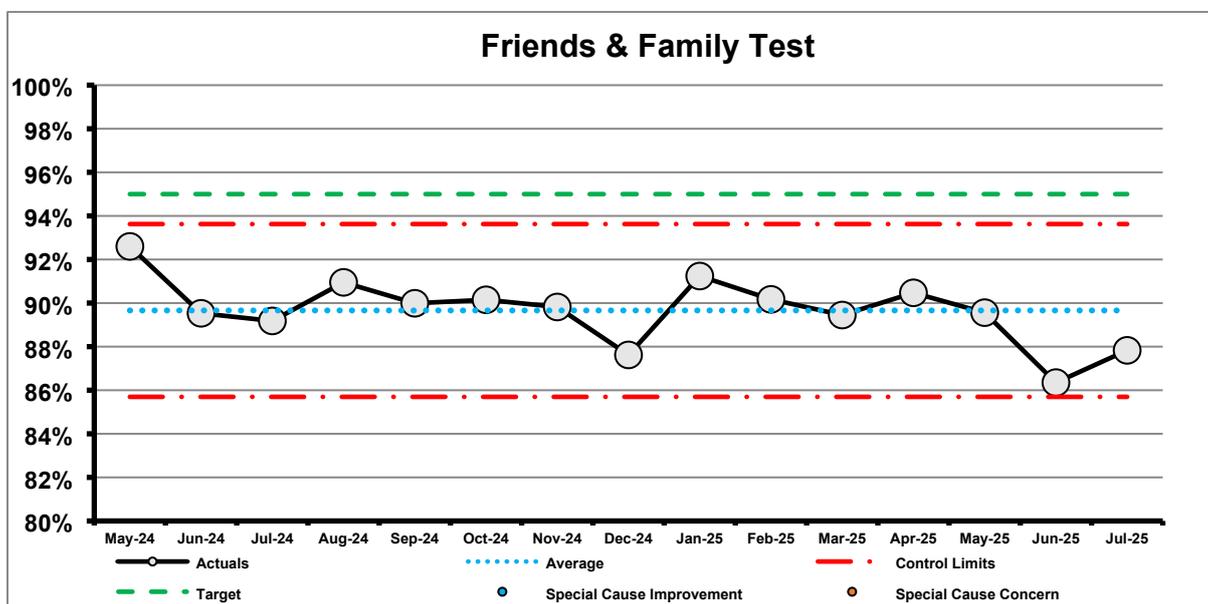
Narrative

FFT figures for June (87.83%) shows an increase on last month's performance activity (86.35%).

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
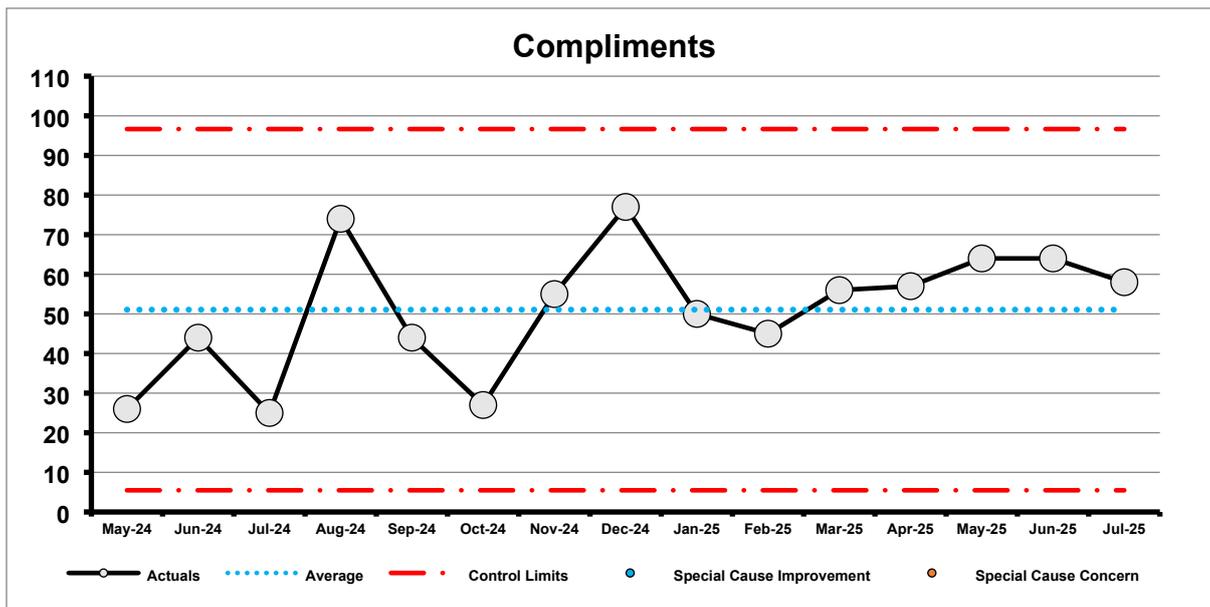
Narrative

Compliments decreased slightly from 64 to 58 in July. These are mainly Community Hospitals (22) Children's and Specialist Services (23), Collaborative CC (4) and Urgent Care (5). The pals and complaints team also received 4 this month.

SPC

SPC shows that compliments have not varied significantly in the period.

Complaints

Benchmark / Target

LCHS is benchmarked by the number of complaints reported per 1,000 WTE budgeted staff.

Current Performance
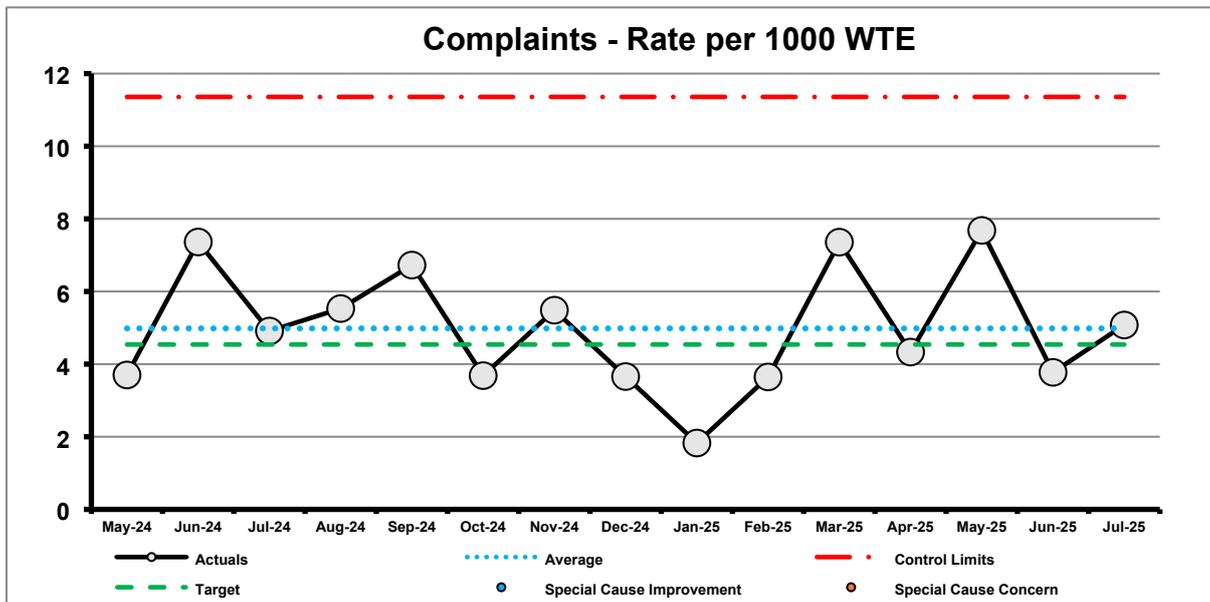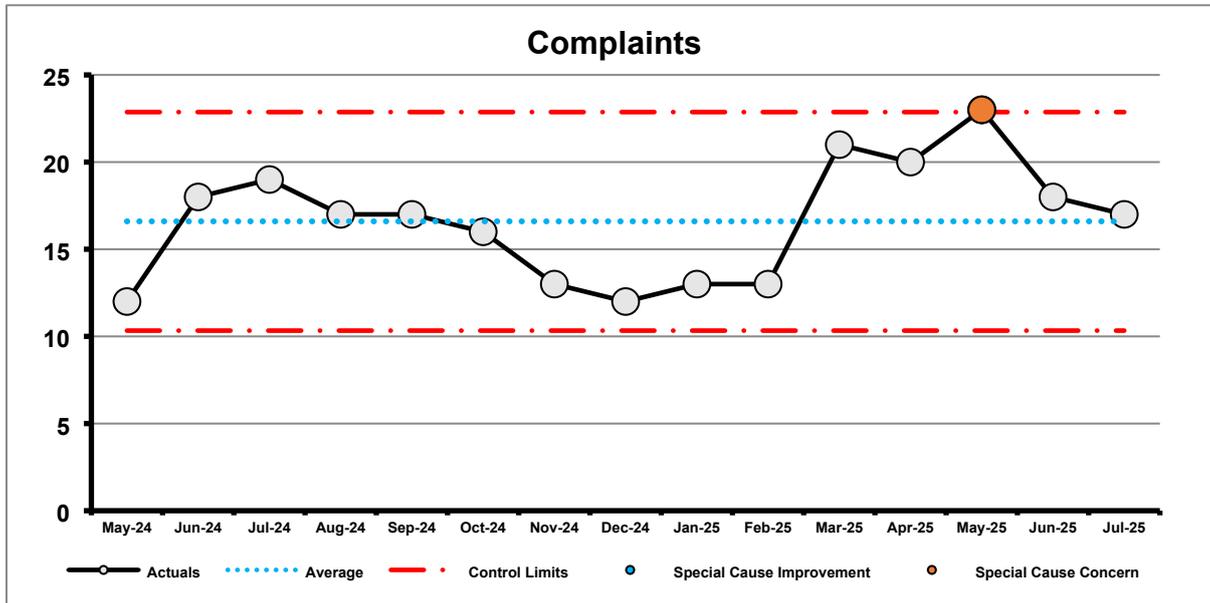
Narrative

As a Trust we are keen to resolve any complaints or issues concerning contact that patients or family members have with our services.

We are currently working with divisions to streamline the complaints process; we have implemented a complaint handler for each complaint who will work more closely with the investigator of the complaint. Significant work will take place over the coming months to improve the flow of the complaint process across the Trust and align the complaints process with colleagues at ULHT. Discussions are being held with the divisions to gain feedback before implementing a new process.

Actions

The complaints team are continuing to improve the complaints process. There will be more changes to the current process over the next few months and talks have started with some of the divisions regarding the planned new process.

SPC
SPC for complaints has not varied significantly in the period. Complaints rate per 1000 WTE has 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.

Commissioned Waits Monthly Snapshot

Snapshot Date: 31 July 2025

Patients Waiting	Breaches	Not Linked to Referral
6207	1522	77

Patients Waiting

Service Name	0-1	1-2	2-4	4-12	12-18	18-52	52-104	Total
		5	9	3	17	8	35		77
Adult Speech & Language Therapy		41	32	56	143	19	35		326
Bladder and Bowel Team		62	58	107	374	235	339		1175
Cardiac Rehabilitation		38	31	62	24				155
Cardiology Virtual Ward		2	2						4
Children in Care		5	18	8	34		1		66
Children's Occupational Therapy	1	1	2	3	3				10
Children's Physiotherapy	2	48	12	38	50				150
Children's Speech and Language Therapy	8	38	42	70	300	122	153		733
Community Adult Therapy	1	137	105	138	245	104	21	1	752
Complex Needs Rapid Response		3		1	1				5
Continence CNS		22	30	38	108	19	10		227
Diabetes	1	67	58	121	285	81	9		622
Electronic Assistive Technology Service (EATS)	17	5	6	17	6				51
Heart Failure		38	30	24	19				111
Leg Ulcer Clinics		26	10	25	28	1			90
Lipidology		2							2
Lymphoedema Service		10	8	13	29	16	77	21	174
MSK	3	255	178	312	189				937
Parkinson's Service		14	9	17	31	1	1		73
Podiatry		97	31	70	84	5			287
Post Covid Assessment Service			1	3					4
Pulmonary Rehab	1	34	25	5	4				69
Respiratory Care		18	5	8	20				51
Respiratory Virtual Ward		1							1
TB Service	34	11	4	5	1				55
Total	68	980	706	1144	1995	611	681	22	6207

Click on the Numbers in the Table/Graph and then Click Here to view more Details (Please Note that this will not work for Averages or Percentages)

Longest Wait (Weeks)

67, 71, 76, 80, 84, 81, 85, 89, 68

Average Wait (Weeks)

4, 4, 5, 4, 5, 5, 4, 5, 6

Note: the average wait above refers to patients with a completed wait (referral to first clinical contact). This excludes those still waiting and rejected referrals.

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 July 2025, 16 services have patients waiting in excess of the service's maximum target wait time including two services, Adult Community Therapy and Lymphoedema who have 1 and 21 patients waiting longer than 52 weeks respectively. 88.7% of patients are waiting less than 18 weeks. 0.37% 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 explore ways to manage overwhelming demand and mitigate risks within existing resources. Services are working flexibly to mitigate challenges at an operational level through prioritisation, skill mix, innovative practice and integrated collaborative working with partners.

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).
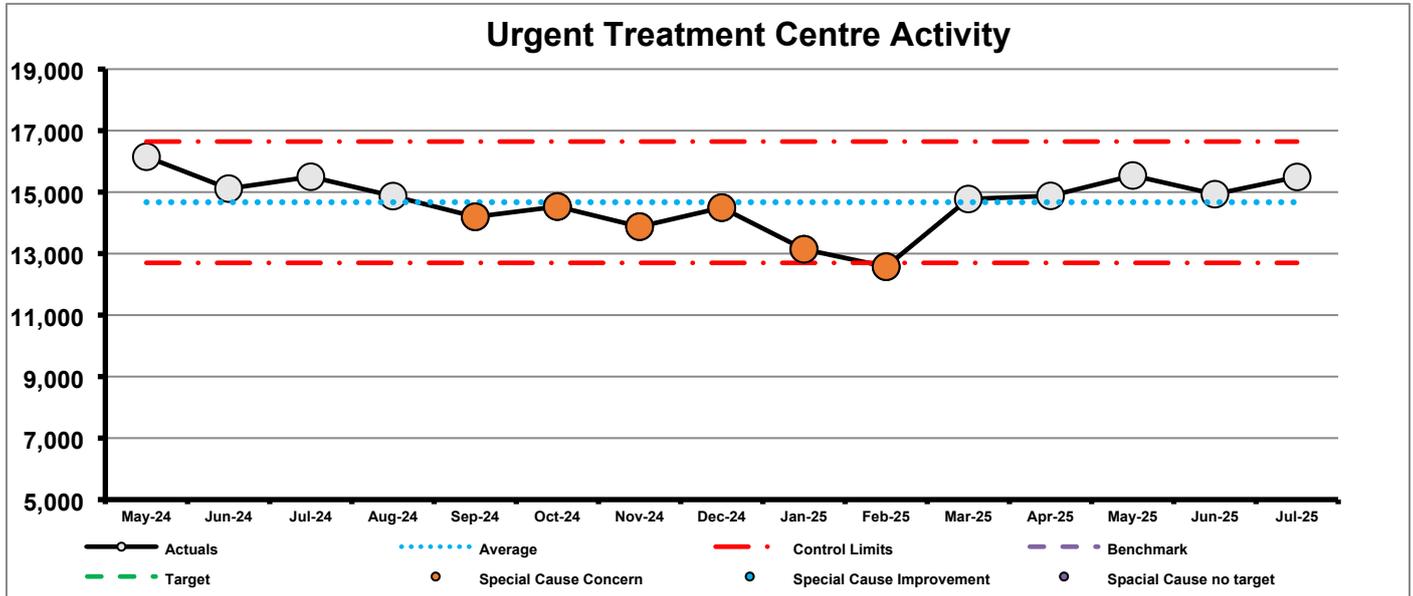
Narrative

In July 2025, UTC footfall rose to 15,493 attendances. While this represents an increase, the activity remains within expected seasonal parameters and is consistent with national trends observed across urgent care services. Nationally, UTC attendances continue to fluctuate, with seasonal variation being a key driver—this pattern is mirrored in our local data, indicating that current demand levels are typical for this time of year.

Looking ahead, we anticipate a modest rise in activity, particularly across our coastal sites, due to expected summer migration. This trend aligns with patterns observed in other coastal regions nationally. In response, we are actively monitoring attendance data to ensure a dynamic and responsive approach to service delivery. By identifying peak periods, we can optimise staffing and resource allocation to maintain timely, high-quality patient care.

National data highlights a broader increase in attendances across urgent and emergency services, underscoring the mounting pressure on UTCs and their critical role in managing patient flow and reducing strain on emergency departments—especially during seasonal peaks. Locally, our coastal centres are expected to experience increased demand, further reinforcing the importance of UTCs in supporting system resilience.

Since September 2024, UTC activity has remained stable, reflecting the strength of our strategic planning and proactive demand management. As we progress through the summer months, we remain committed to continuous monitoring and agile resource deployment to ensure we meet patient needs effectively.

SPC

UTC activity performance has not varied significantly over the period.

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.
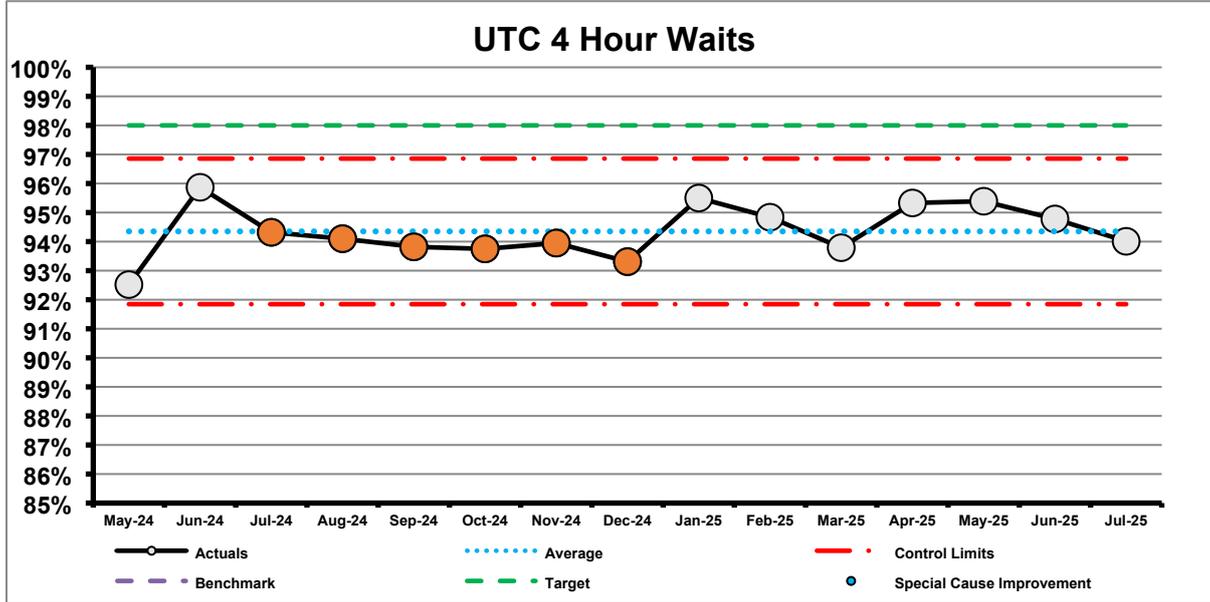
Narrative

Performance across the Urgent Treatment Centres (UTCs) in July 2025 remains stable, with 4-hour wait times reported at 94.01%. This sustained level of performance reflects ongoing efforts to improve patient flow and care delivery across the system.

A key driver of this progress has been the increased consistency across UTC sites, supported by proactive collaboration and shared learning. Locally, UTCs continue to outperform the national average for 4-hour wait times, demonstrating the dedication of clinical and operational teams in maintaining high standards of care despite persistent system pressures.

While the national target of 98% remains challenging, all sites are actively pursuing improvement through innovative service models, real-time pathway optimisation, and strengthened cross-sector collaboration. Structured efforts are underway to close the gap, with steady progress being made.

However, performance challenges persist—particularly at co-located UTCs in Lincoln and Boston—were external factors impact delivery. These include:

- Delays in specialty referrals (e.g. orthopaedics)
- Limited access to diagnostics, including x-ray and pathology services
- Acute hospital bed pressures affecting admission and discharge processes

These constraints reflect broader system-level issues seen nationally. In response, UTC teams are working closely with acute care partners and system leads to escalate concerns and implement solutions aimed at reducing delays and improving patient experience.

Key mitigation strategies include:

- Daily breach validation

- Early identification of delays
- Streamlined escalation to specialty services

These measures have been instrumental in maintaining performance levels above the national UTC average, which in many regions continues to fall below 90%.

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.

Chart: UTC 15 minute assessment — with legend: Actuals, Average, Control Limits, Benchmark, Target, Special Cause Improvement.
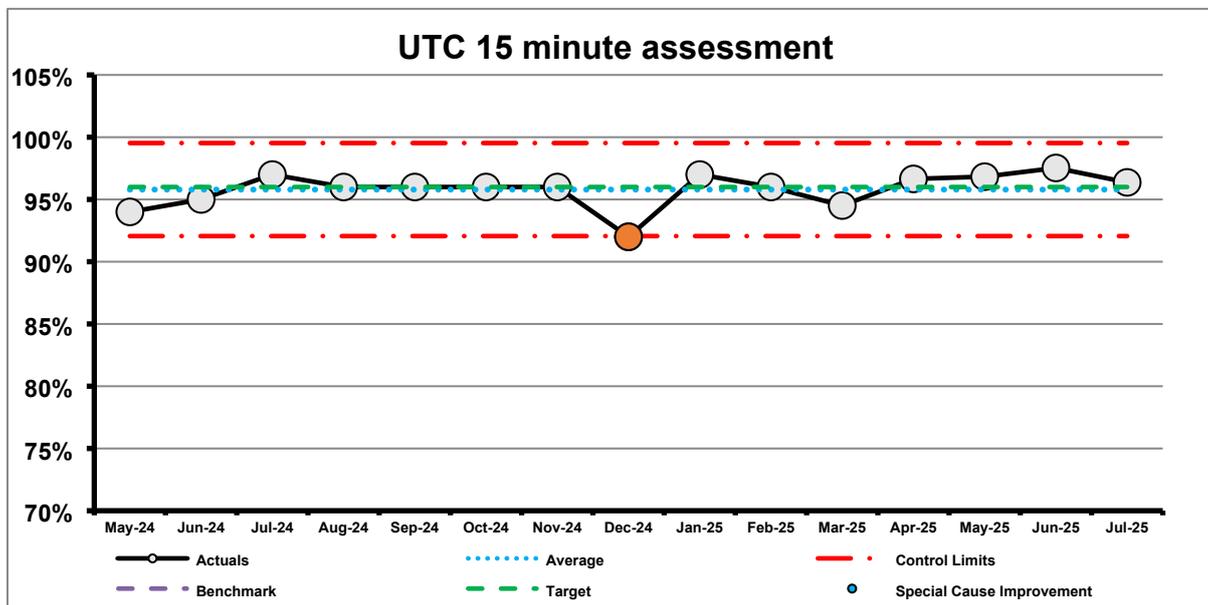
Narrative

The Urgent Treatment Centres (UTCs) continue to deliver excellent performance in 15-minute initial patient assessments, with July achieving 96.37% which is slightly decreased from the previous month of 97.53%. However this still exceeds the national target of 95%, but also places our local UTCs ahead of many regions where performance remains more variable.

This sustained 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.

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,
- Optimised 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

The UTC 15-minute has not varied significantly over the period.

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.
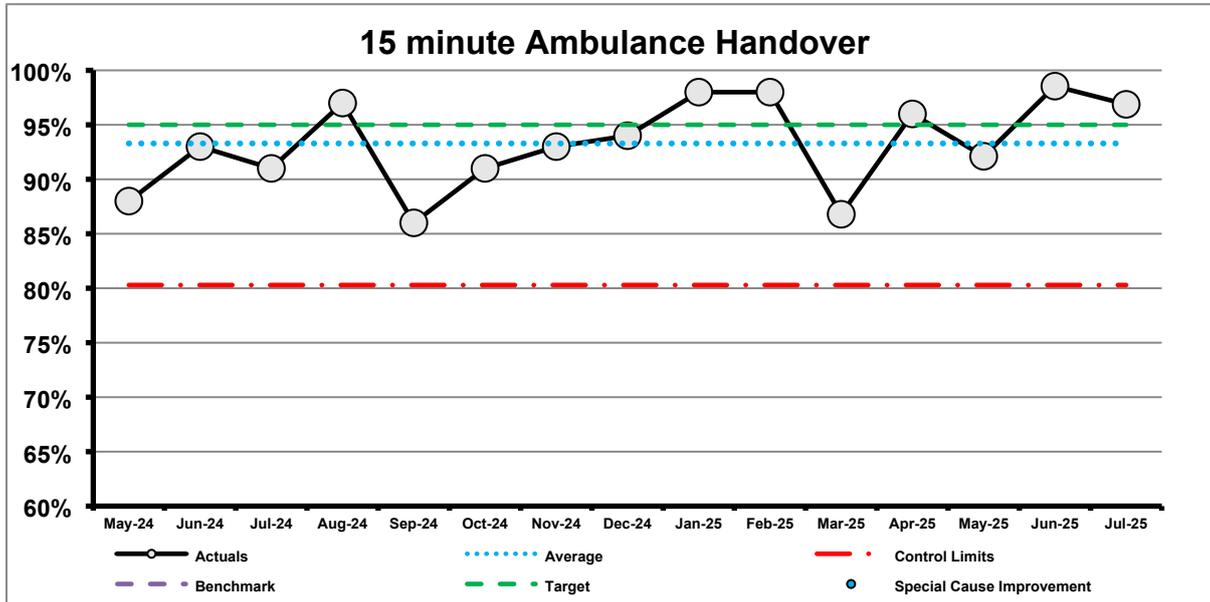
Narrative

Local partnership working with East Midlands Ambulance Service (EMAS) continues to be a key strength, with a sustained focus on timely handovers and enhancing patient experience at the point of arrival. In July 2025, 96.88% of ambulance handovers were completed within 15 minutes—a slight decrease from 98.55% in the previous reporting period, yet still consistently above the national average.

Over the past 12 months, performance has regularly met or exceeded the national 95% target. While some fluctuation has occurred, this is reflective of the dynamic operational pressures across urgent and emergency care systems. The continued high performance underscores the commitment of frontline teams to maintaining efficient and safe handover processes.

Collaborative working with EMAS remains strong, supported by:

- Regular joint operational meetings
- Initiatives focused on admission avoidance
- Enhanced use of alternative care pathways
- Continuous monitoring and responsive adjustments to operational pressures

These efforts are aligned with our shared goal: to ensure swift, safe, and seamless patient transfers with minimal delay. The proactive, system-wide approach adopted locally positions us ahead of many regions in terms of handover efficiency and patient flow management.

SPC

The 15-minute Ambulance Handover performance has not varied significantly over the period.

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.
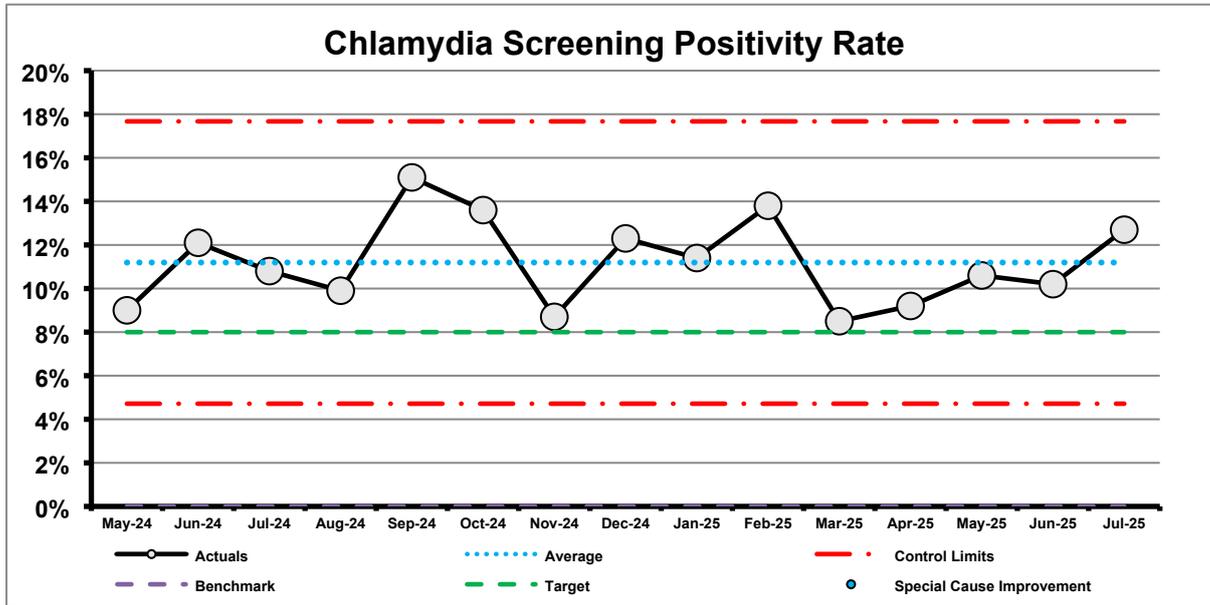
Narrative

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

GU Pts seen within 2 working days

Legend:
- —○— Actuals
- ······· Average
- — · Control Limits
- — — · Benchmark
- — — · Target
- ● Special Cause Improvement
- ○ Special Cause Concern
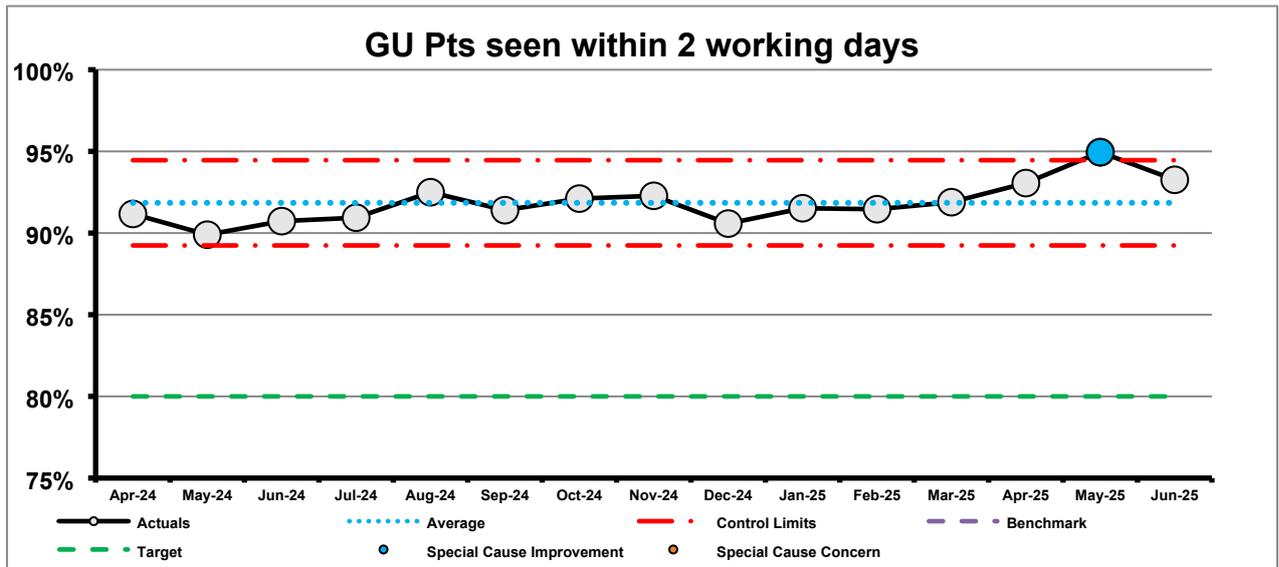
Narrative

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.
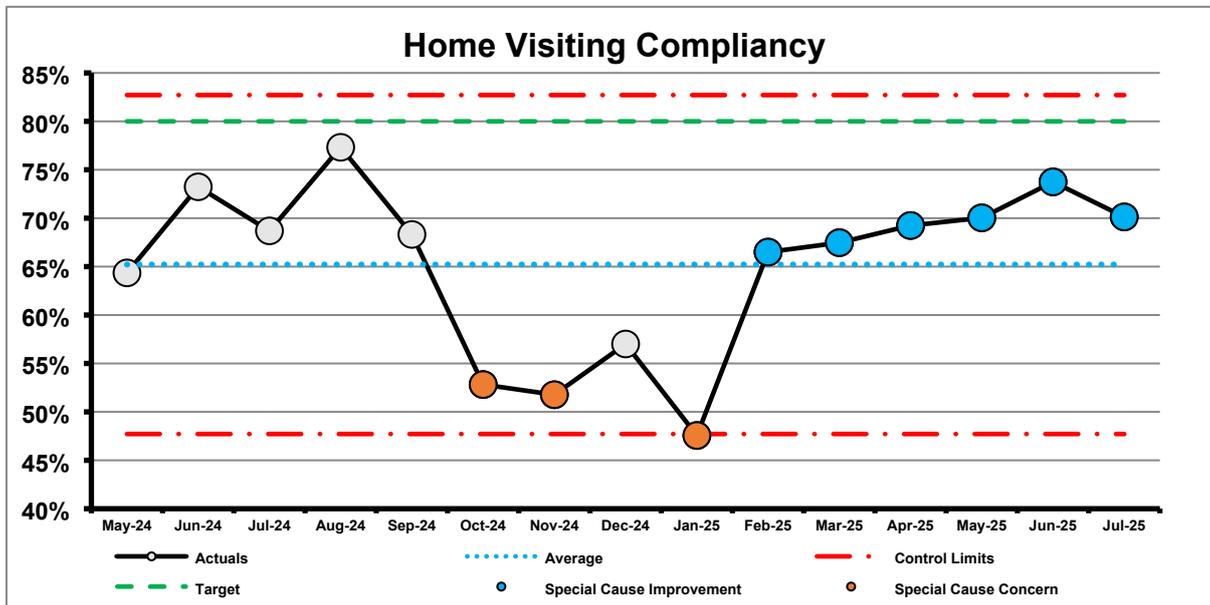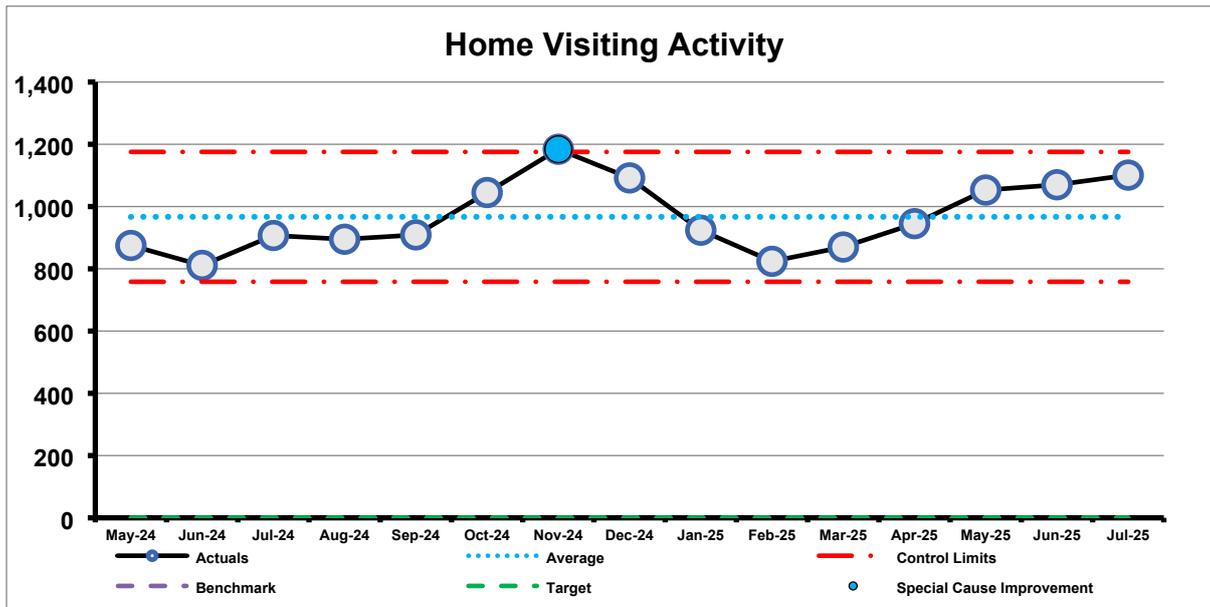
Narrative

As expected, home visiting activity has increased in line with the pilot process. These 1101 cases are for patients who required a medical led response, including falls activity. The compliance should be celebrated as a success given the increase in activity. We now have a process in place to support breach validation.

SPC

Home Visiting activity not varied significantly in the period.

Compliance has moved into Special cause improvement.

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.

Combined Home Visiting & UCR Cases

Combined Home Visiting & UCR 2 Hour Compliance

Urgent Community Response: Accepted referrals
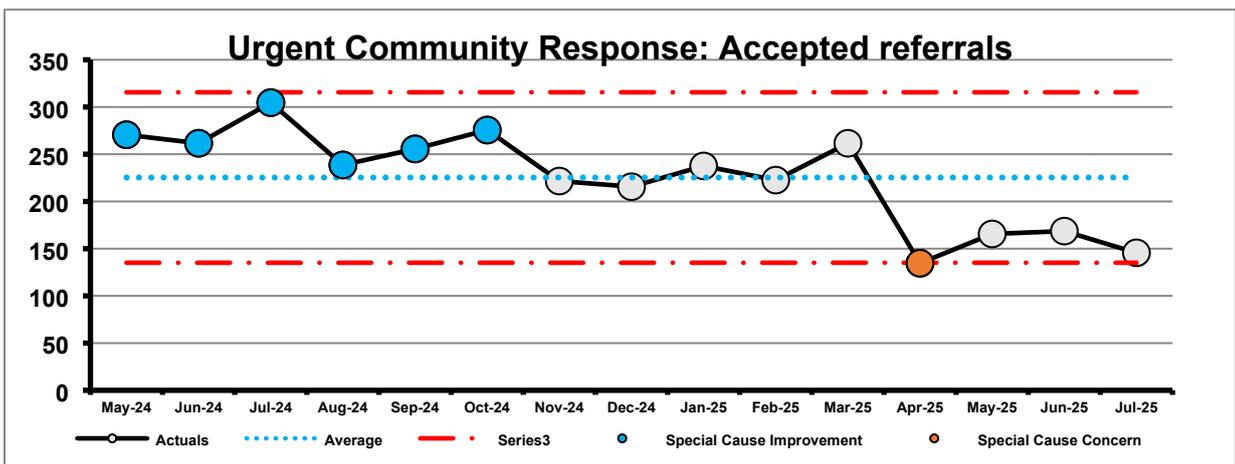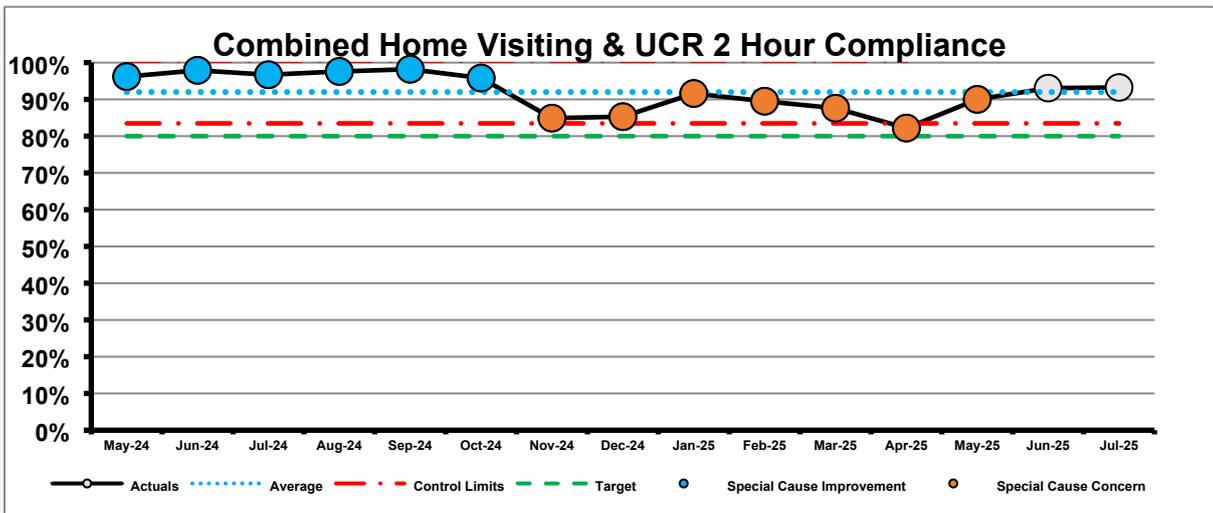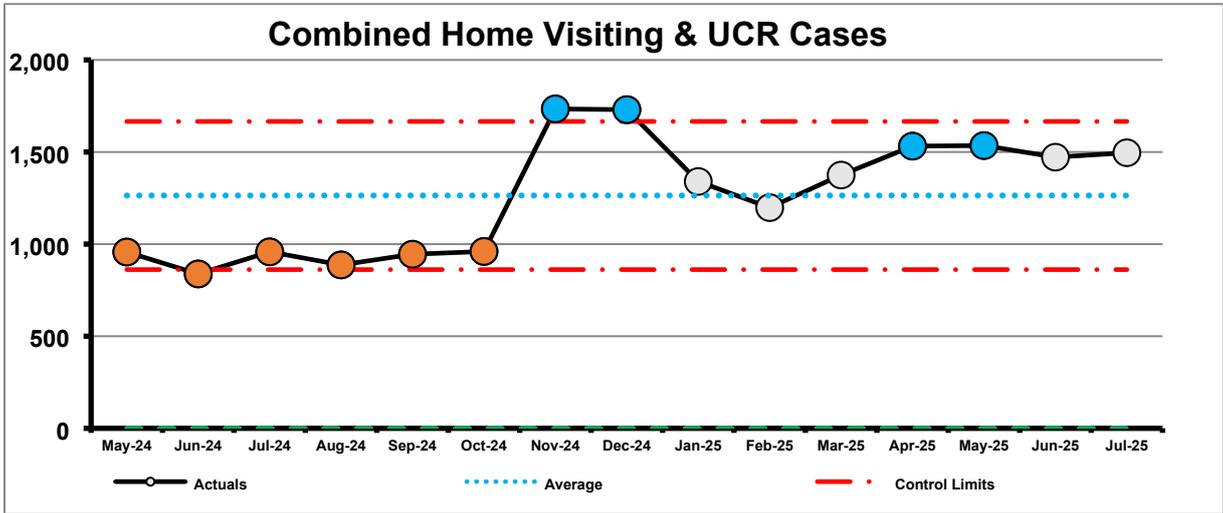
Narrative

This data reflects the current pilot in place whereby UCR and HV are working in an integrated way to provide the 2-hour urgent community response. Due to the pilot process, we are now able to collate all cases requiring a 2-hour response; for the period of July this was 1496. The national target from June 2025 is 180 referrals. The compliance is achieved by measuring the time between the referral being made and the initial assessment (completed in CAS). A compliance of 93.25% supports the level of activity and national target requirements.

In line with the pilot the current referrals being recorded in the UCR unit are those primarily requiring a therapy led response as per the UCR standards. There was an expectation that this would reduce slightly due to changes made at point of triage to signpost patients appropriately and ensure the patients requiring a therapy led response meet the UCR operating standards for referrals.

SPC

The Combined Home Visiting & UCR 2 Hour Compliance has not varied significantly in the period, and it is consistently capable of meeting its 80% target.

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.

Discharge to assessment - Distinct Patient Contacts

Discharge to Assessment - Accepted referrals
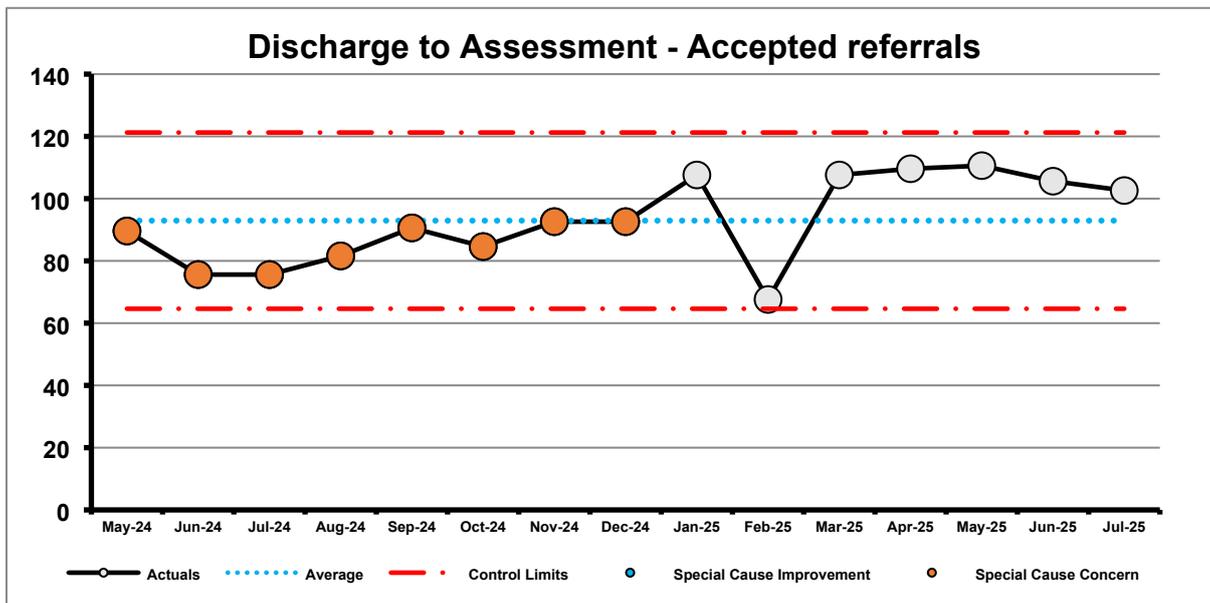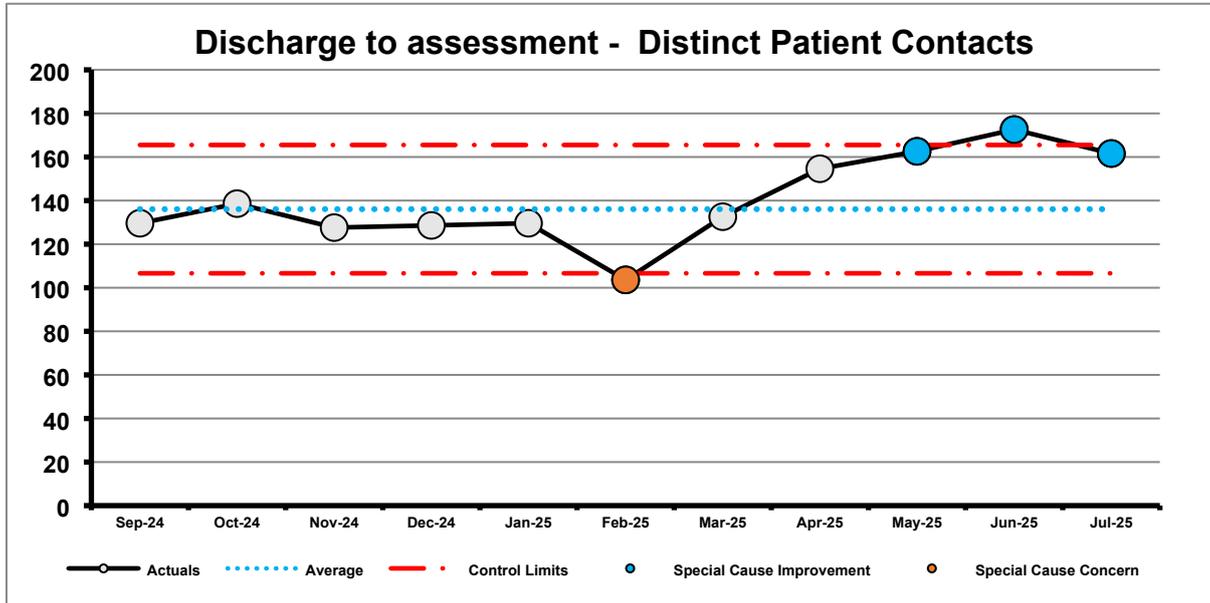
Narrative

The number of referrals accepted into the Pathway 1 D2A service decreased slightly in July, however remained well above the average. The number of distinct patient contacts dropped slightly however, as with number of accepted referrals, remains above average. This represents an increase in the average patient need, as D2A works to promote earlier discharge from acute and community bed stock (with patients, on average, requiring a higher frequency of intervention). 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.

SPC

The number of distinct patient contacts remain above average and has shown special cause improvement since May 2025.

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.

Virtual Wards - Frailty Referrals

Virtual Wards - Cardiac Referrals
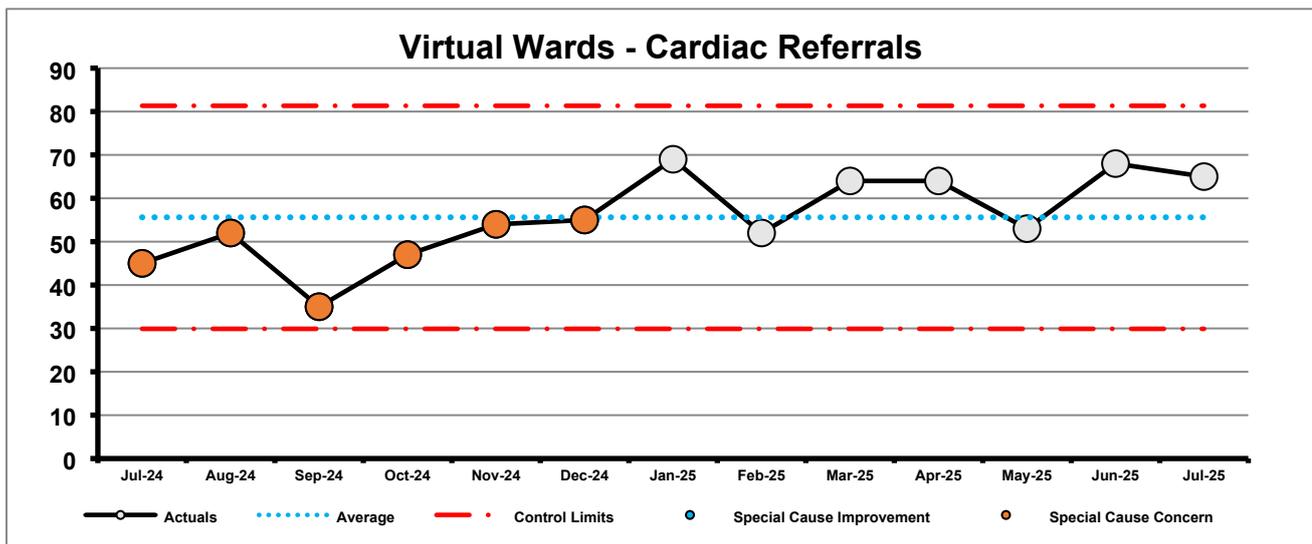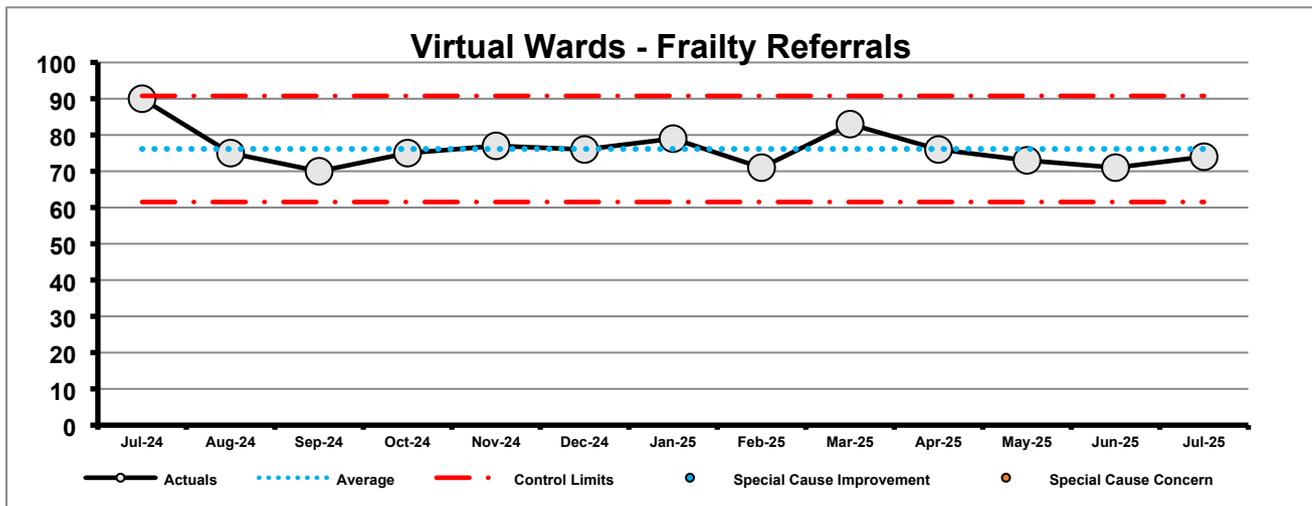
Narrative

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. The increase in this month's cardiac activity is inline with the hot weather. Their activity increased to 40 when they only have 20 beds, the impact of this is that routine patients will wait longer to manage the surge of the complex.

SPC

The number of referrals to the frailty virtual ward has not varied significantly in the period.

The number of referrals to the cardiology virtual ward has not varied significantly in the period.

CAS Activity

Background

The CAS was initially commissioned as a proof of concept and commissioners asked providers to collaborate to develop an Alliance Agreement. The service has since demonstrated significant positive system impacts in supporting and reducing A&E attendances. This is now an integral part of the LCHS and Lincolnshire System Integrated Urgent Care offer.
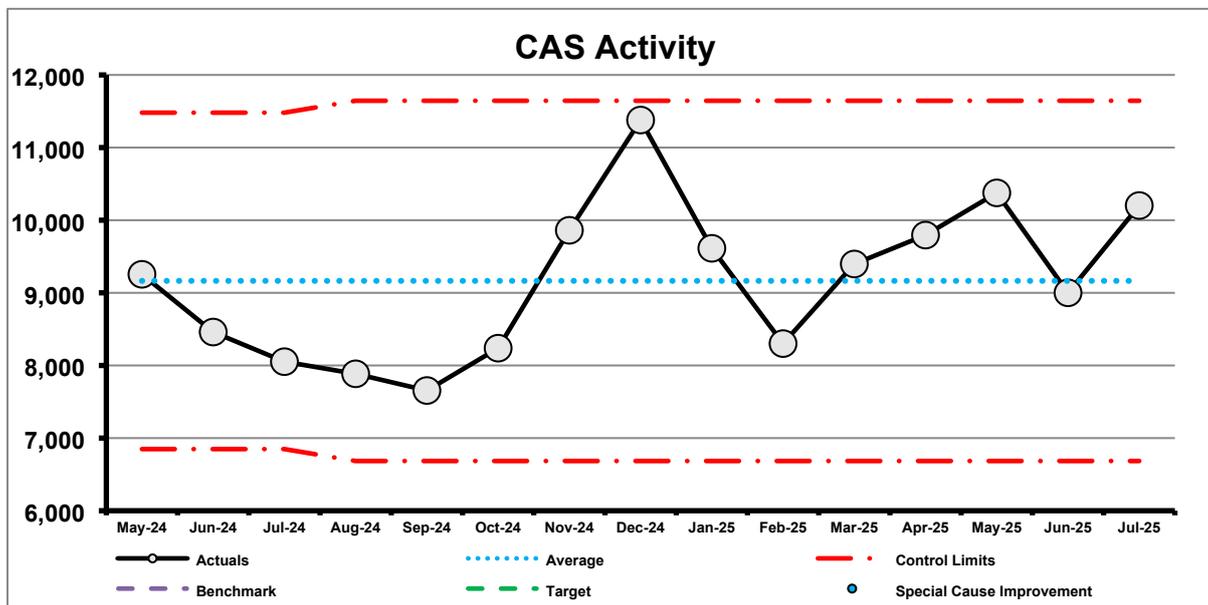
Narrative

July activity has shown an increase in activity on last month and has returned to a similar level as May and sits well above the expected average. Historically there is usually a seasonal drop-in activity during the summer months. Some of this increase may be explained by the additional activity from the support that CAS now give to the UCR service to complete the first clinical assessment/triage (to ensure patients are receiving the appropriate outcomes) and from the return of ED dispositions from DHU

 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 have been ongoing discussions with the ICB regarding the return of interim dispositions from DHU to CAS.

SPC

The SPC has not shown any significant variation 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.
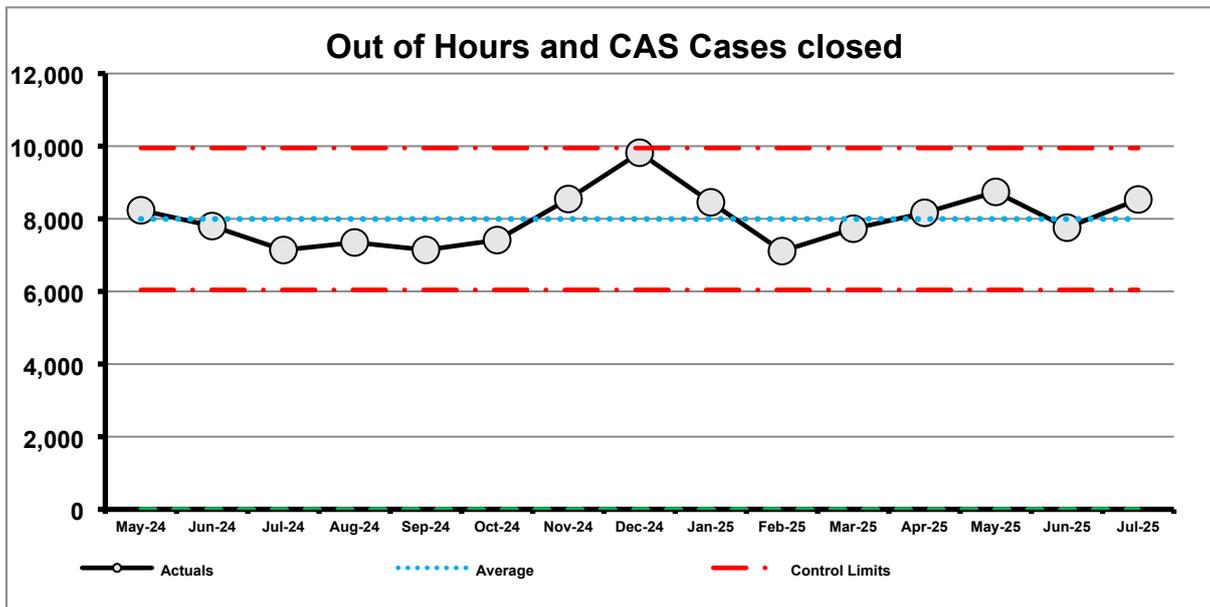
Narrative

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). July activity has increased from last month and is above the expected average. It is also an increase on the same period for last year. Some of this activity may be due to DHU contract changes which have resulted in the return of some 111 dispositions 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.

Operations Centre Calls Answered

Actuals — Average ····· Control Limits — · —
Benchmark — · — Target — — — Special Cause Concern
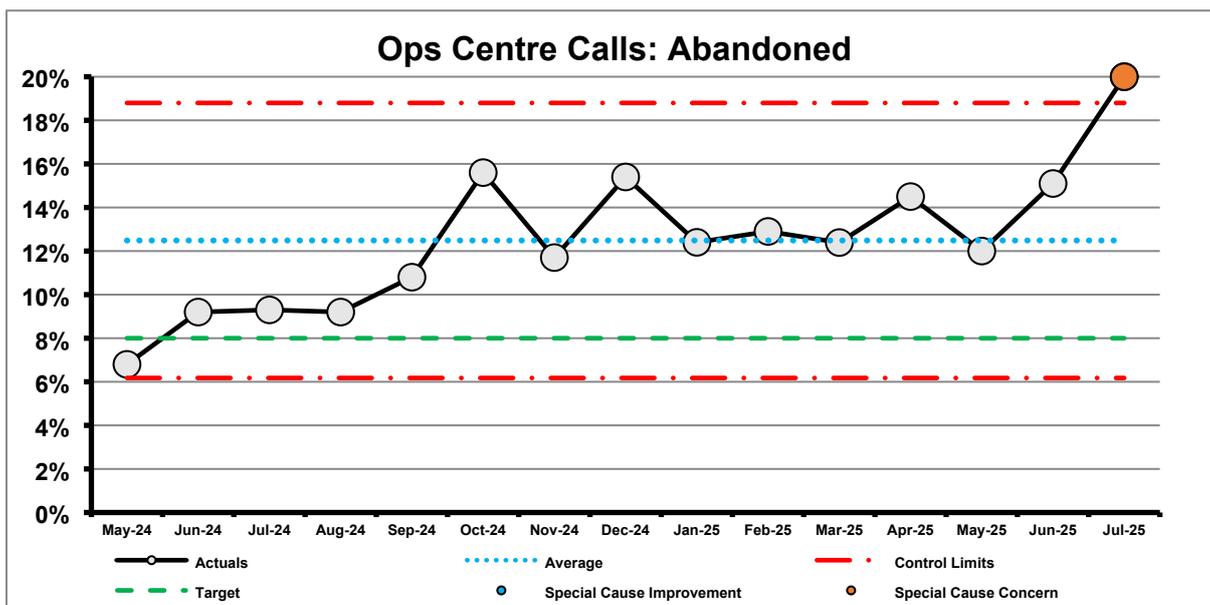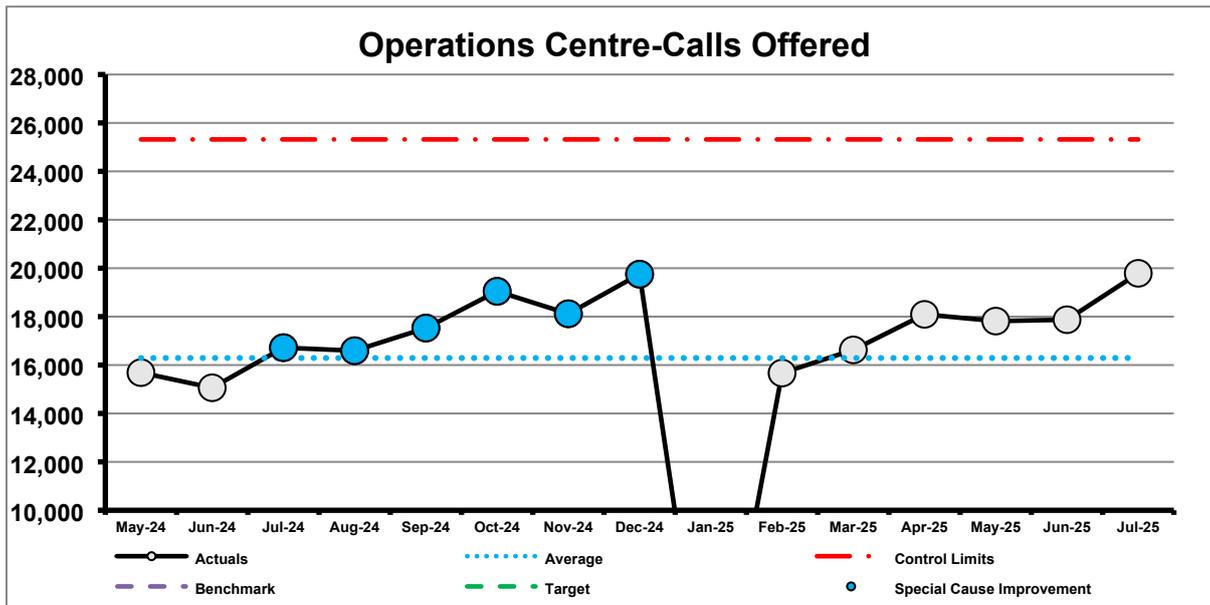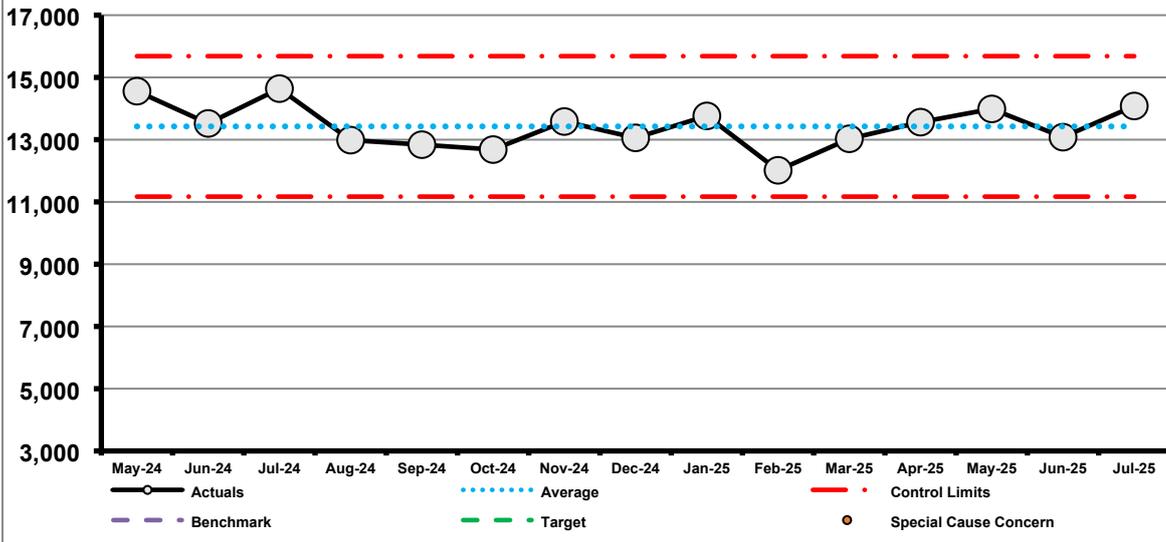
Operatins Centre - Priority Calls Answered in 2 Minutes

Actuals — Average ····· Control Limits — · —
Benchmark — · — Target — — — Special Cause Improvement
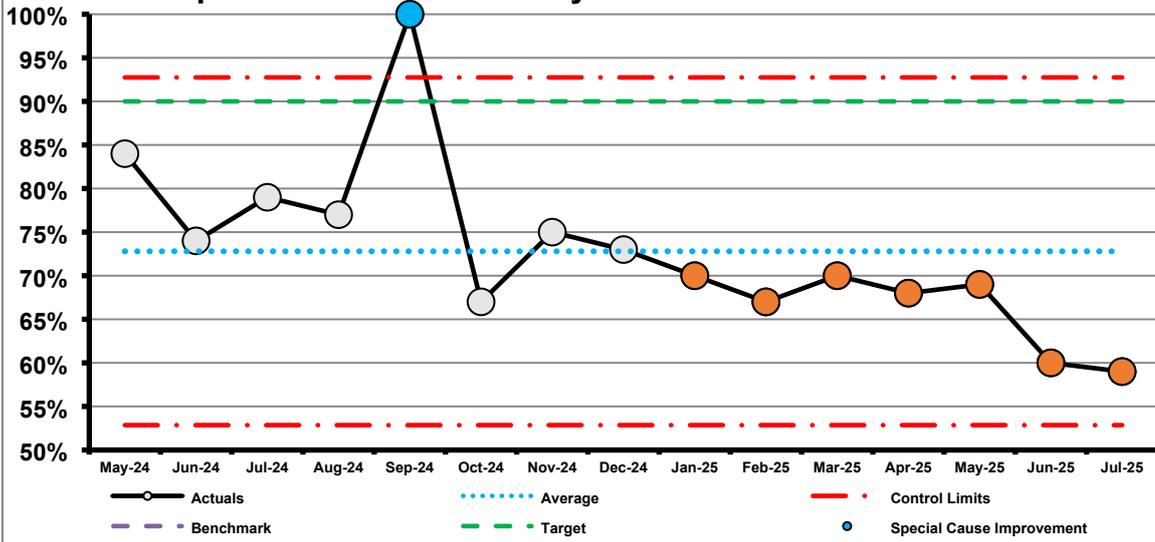
Operations centre - Standard calls answered within 10 minutes

Actuals — Average ····· Control Limits — · —
Benchmark — · — Target — — — Special Cause Improvement

Operations Centre-Emails answered in 24 hours

Legend: Actuals, Average, Control Limits, Benchmark, Target, Special Cause Improvement

Operations Centre-Emails Offered

Legend: Actuals, Average, Control Limits, Benchmark, Target, Special Cause Improvement, Special Cause Concern
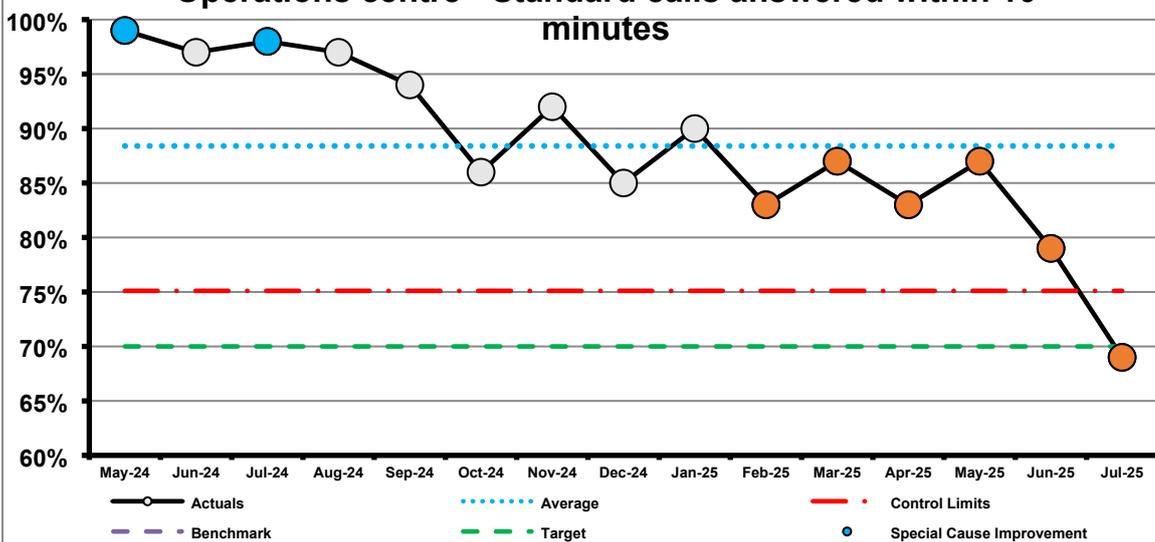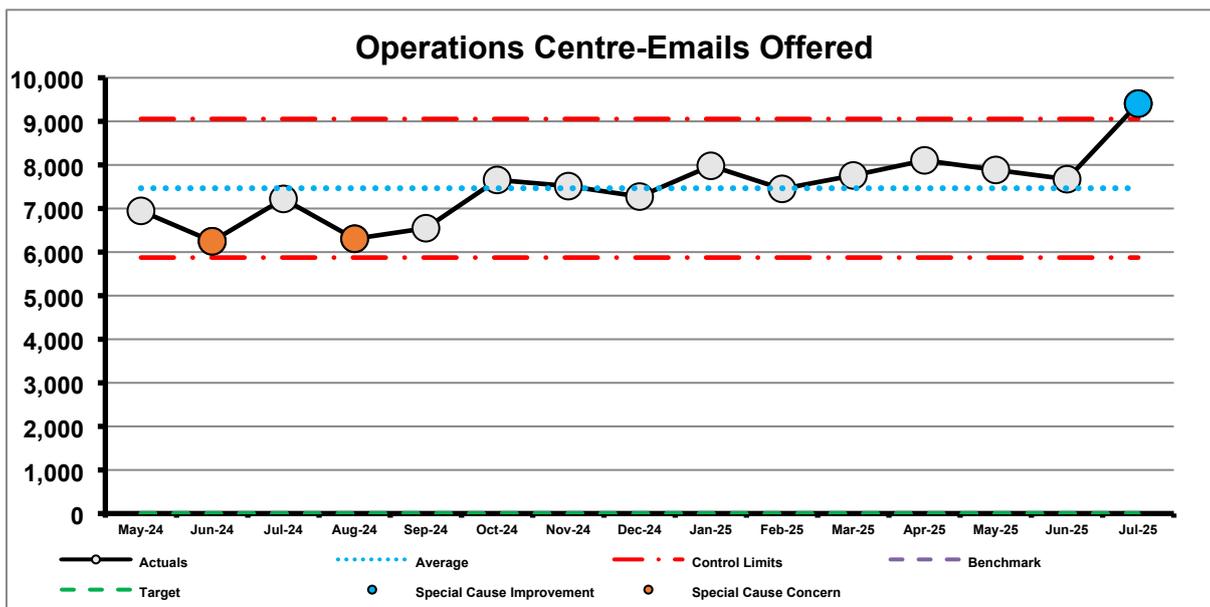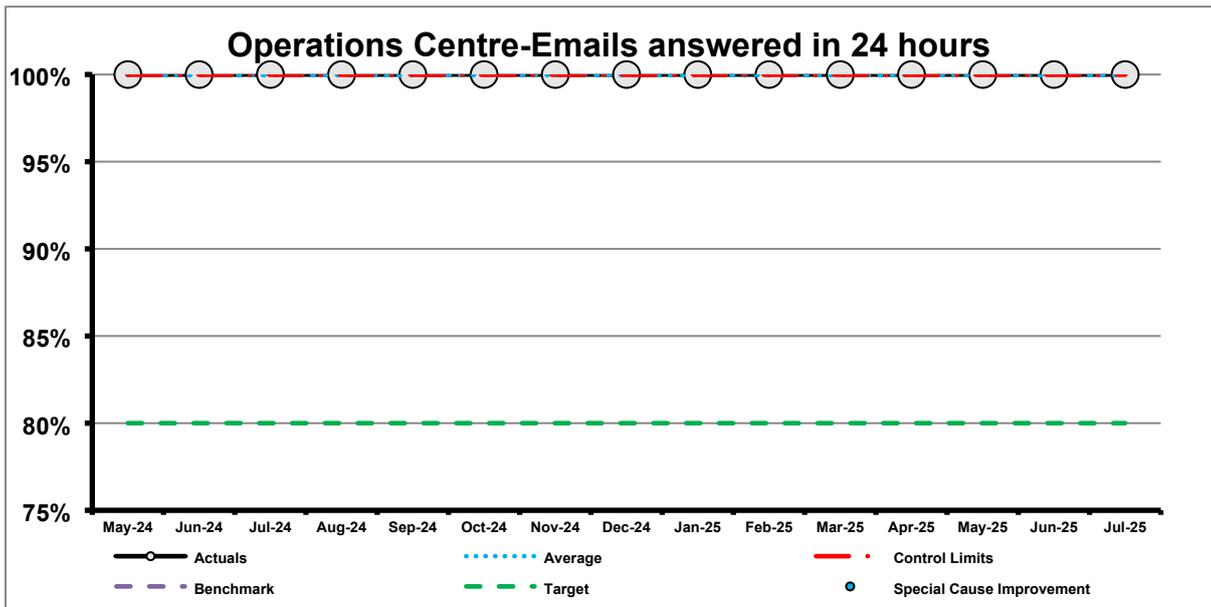
Narrative

In July 2025, the Operations Centre received a total of 16,815 calls, although due to 5 separate incidents of Netcall failure at the end of the month, there is a gap in the reporting; the total number of calls is closer to 19,000. Email volumes continue to steadily rise month on month

- **Priority Calls:** 61% were answered within the defined SLA, reflecting ongoing challenges in managing high-priority contact volumes.
- **Standard Calls:** Performance exceeded SLA targets, with 72% answered within the specified timeframe.

Our ongoing efforts are focused on operational agility and efficiency, with new dynamic call and resource management tactics in place from the end of the month. Unfortunately, the Netcall challenges have hampered our efforts somewhat, but early indications are positive and are anticipated to reflect in August's performance.

A recent recruitment round has been completed to bring staffing back up to template before the start of winter, which we hope will reduce the pressure and burnout of our current staffing team and to further reduce bank and overtime spend.

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 in July 2025. It is inconsistently capable of achieving the 8% target but achieves target more often than not.

Operations centre calls answered has not varied in the period

Operations centre - Priority Calls (answered in 2 minutes) shows special cause concern since Dec 24.

Ops centre Standard calls (answered within 10 minutes). Shows special cause for concern since February 2025.

Ops centre Emails answered within 24 hours has not shown any significant change in the period.

Ops centre Emails offered moved into Special cause improvement in July 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.

Transitional Care Activity - Block, Spot Beds and HART

Legend:
- Actuals
- Average
- Control Limits
- Benchmark
- Target
- Special Cause Improvement
- Special Cause Concern
- Spacial Cause no target
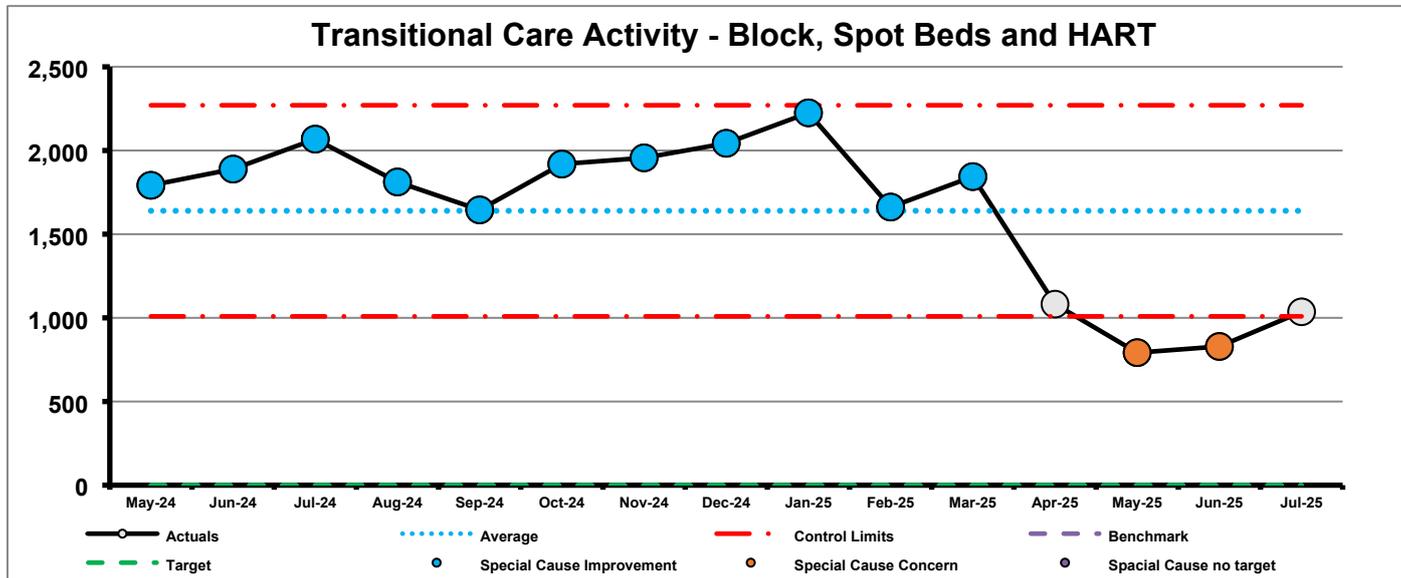
Narrative

The number of Transitional Care beds procured by LCHS has reduced due to ongoing transformation work and new contracting arrangements being managed with Lincolnshire County Council: at present, LCHS is spot purchasing beds when required.

In effect, LCHS are at 100% bed occupancy, in that the Trust only pays for beds that it uses. In July, the number of spot purchase beds increased, in line with demand for flow across the system, and with the intention of mirroring the number of beds due to go live once the current procurement process is concluded.

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 not varied significantly in the period.

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.

Completion of a valid NHS Number in A&E Data Set
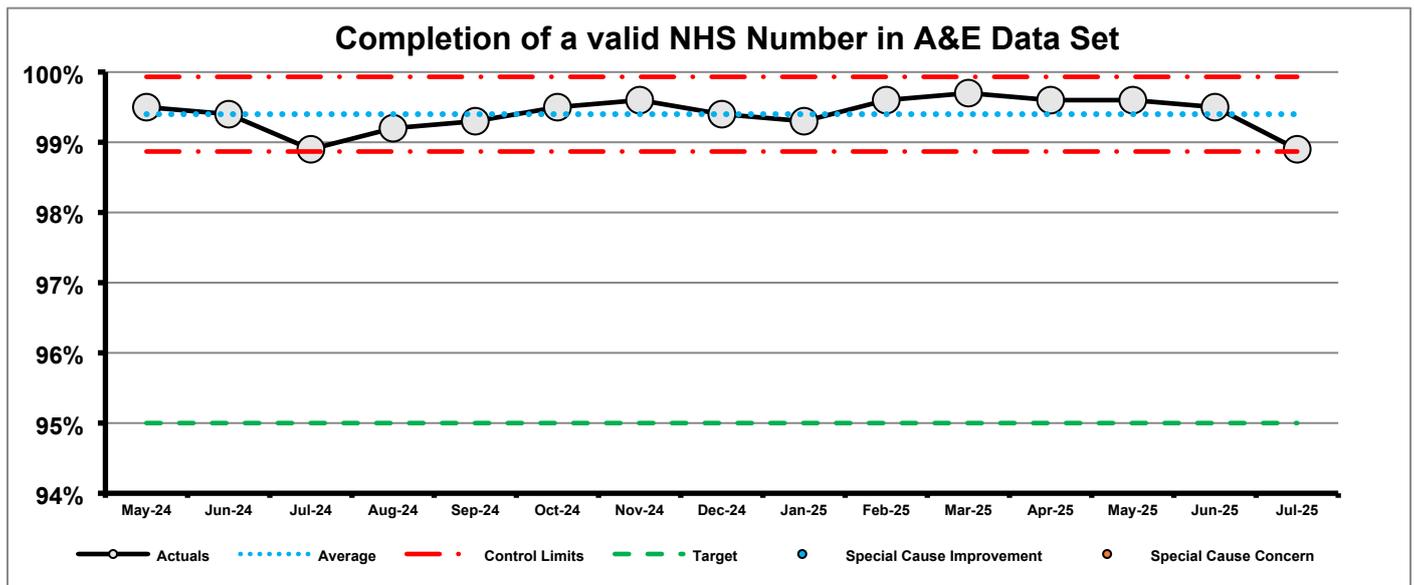
Narrative

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
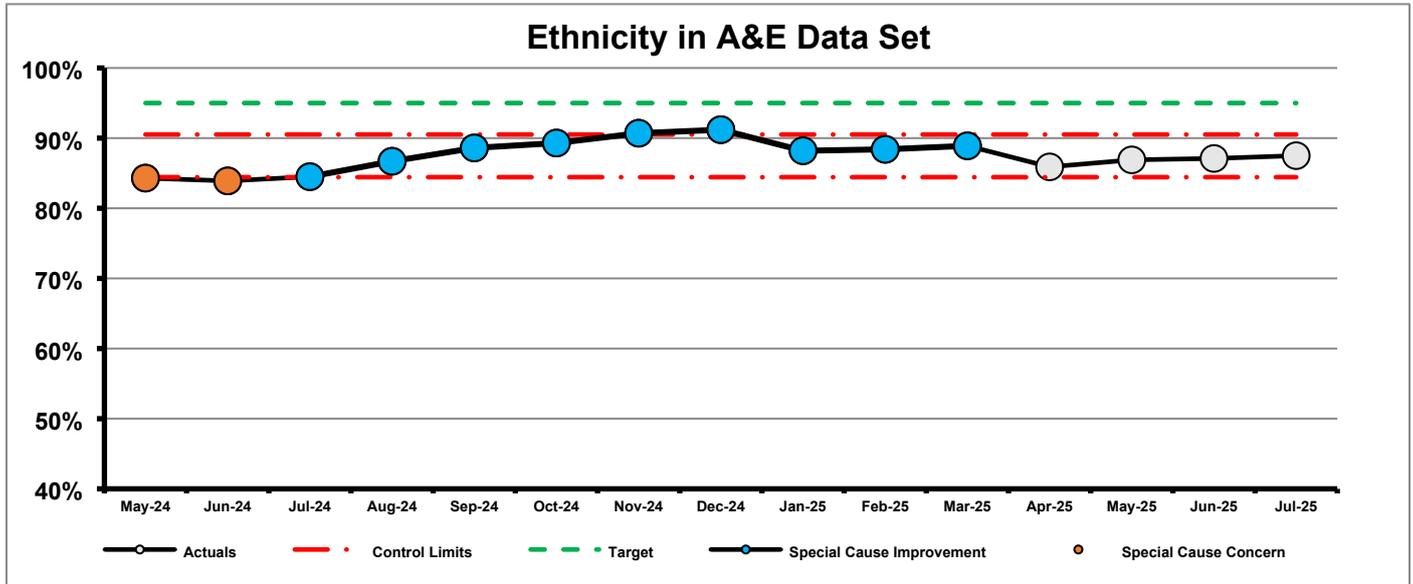
Narrative

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.
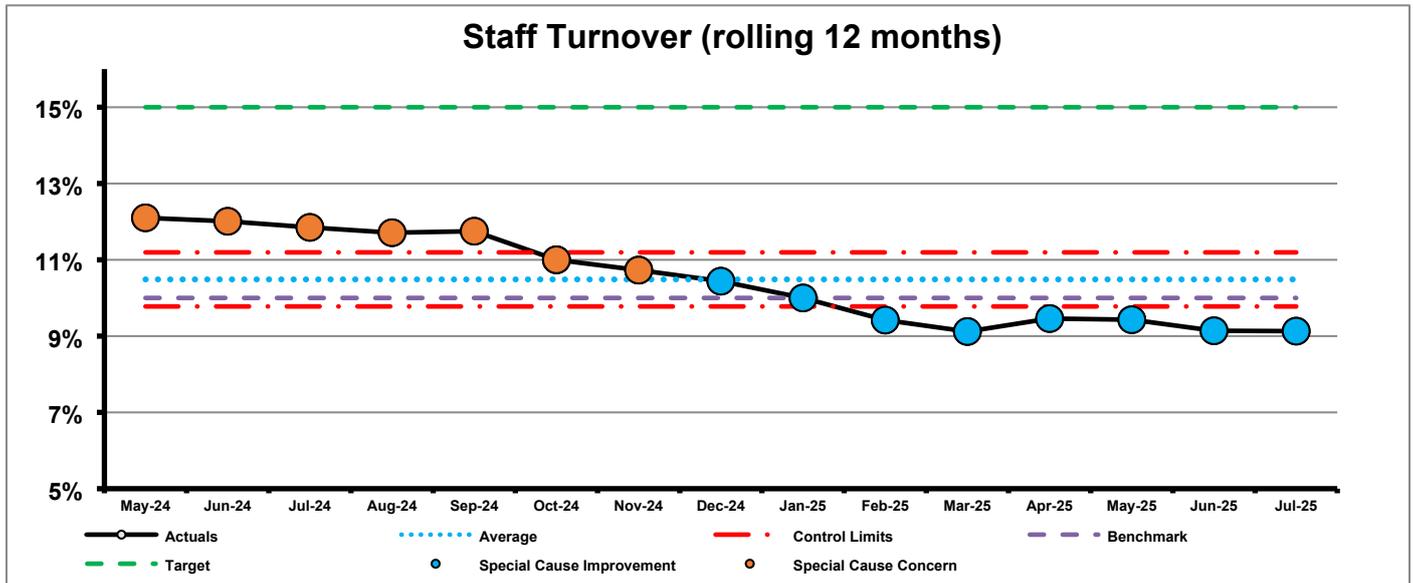
Narrative

The graph above shows the total staff turnover, with rolling 12-monthly turnover lower than the average at 9.13% 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 4)	
Description	**Narrative**
Position in July	£-265k deficit
Position YTD	£-1736k deficit
Position FOT	Breakeven
CIP in July	£422k against plan of £496k
CIP YTD	£1.363m against plan of £1.274m
CIP FOT	£4.2m against plan of £9.5m
Agency in July	£73k against plan of £133k
Agency YTD	£266k against plan of £533k
Agency FOT	£1.3m against plan of £1.6m
Capital in July	£503k against plan of £12k
Capital YTD	£1.7m against plan of £2.1m
Capital FOT	£3.3m against plan of £3.3m
Cash	£27.5m against forecast plan of £24.6m

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.

Agency Spend Vs Plan

Agency Expenditure
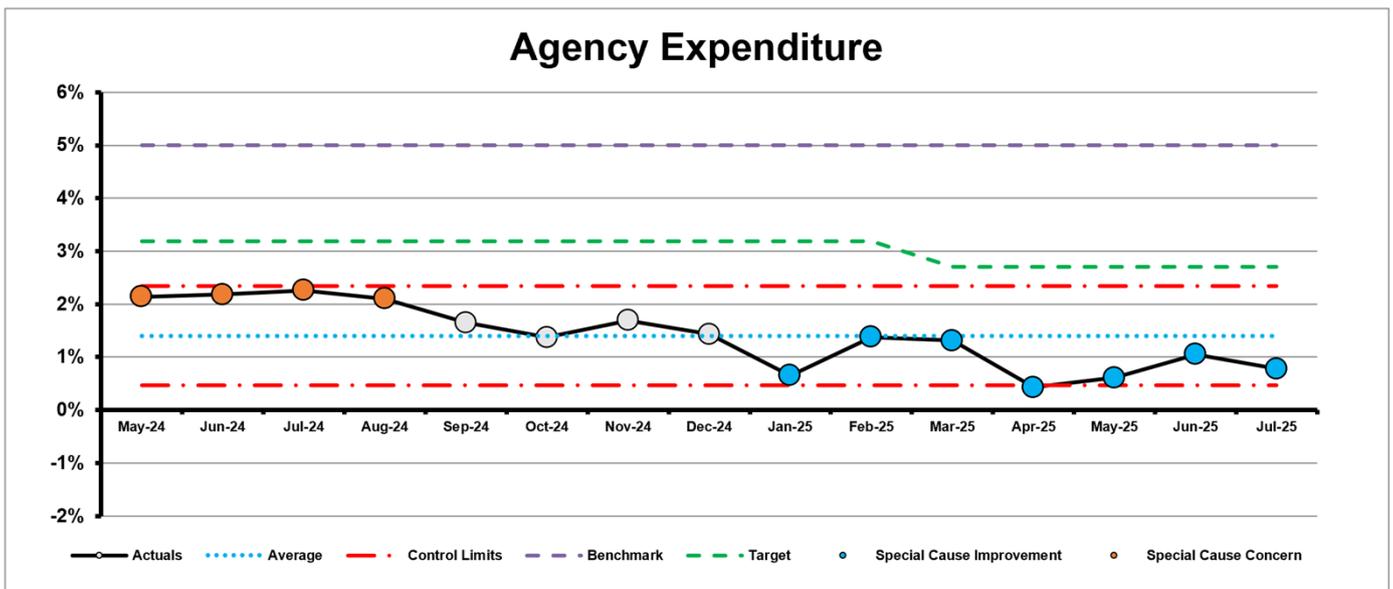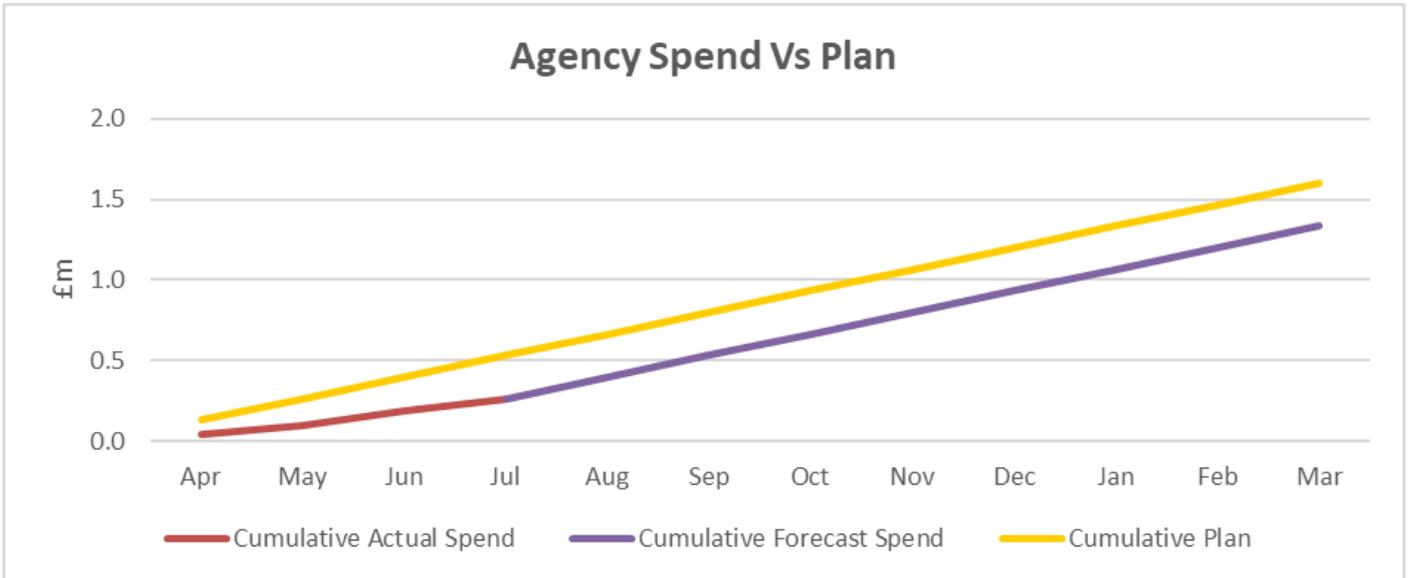
Narrative

- M04 agency spend was £73k compared to £133k plan, this was a favourable result in month and works towards the temporary staffing CIP. Agency reduced from, June but was still impacted by long-term sickness within Skegness UTC for which GP agency cover was required to maintain the service. It is expected that this will reduce as the staff return to work.

- Nursing agency accounted for 19% of total spend YTD, with M&D agency being significantly higher.

- Full Year Agency Spend Plan is £1.6m

SPC

Agency expenditure has special cause improvement since January 2025. It is inconsistently capable of achieving the 2.7% target but expected to achieve target more often than not.

Efficiencies Plan (CIP)

Background

This information represents year-to-date delivery against the planned Cost Improvement Plan (CIP).

Cost Improvement Headlines

	Plan Month 4 £000	Actual Month 4 £000	Variance Month 4 £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	£0	£274,192	High	Rejected at Board
Vacancy Factor - Ops	-£71,204	-£130,380	-£59,176	-£284,815	-£501,788	-£216,973	-£854,446	-£1,071,419	-£216,973	Low	
Agency/Bank Reduction	-£112,439	-£60,021	£52,418	-£449,757	-£109,857	£339,900	-£1,349,270	-£1,009,370	£339,900	Medium	
Approved Cost Pressures	£13,889	£11,899	-£1,990	£55,556	£50,937	-£4,618	£166,667	£162,049	-£4,618	Medium	changes
Bank Sickness Reduction	-£21,917	£0	£21,917	-£87,667	£0	£87,667	-£263,000	-£175,333	£87,667	High	Increases already identified bank savings
Pay T&C's	-£5,222	£0	£5,222	-£5,222	£0	£5,222	-£47,000	-£41,778	£5,222	High	Sprint work - awaiting further detail
DoF Corp Target	-£32,667	-£11,420	£21,247	-£32,667	-£30,170	£2,497	-£294,000	-£131,170	£162,830	Medium	Portion remains unidentified
Medical Director Corp Target	-£14,889	£0	£14,889	-£14,889	£0	£14,889	-£134,000	£0	£134,000	High	Unidentified
DoO Corp Target	-£19,778	-£26,699	-£6,922	-£19,778	-£26,699	-£6,922	-£178,000	-£26,699	£151,301	High	Unidentified
DoP&I Corp Target	-£131,333	-£32,031	£99,302	-£131,333	-£133,180	-£1,847	-£1,182,000	-£251,844	£930,156	High	Unidentified
DoN Corp Target	-£16,743	-£3,281	£13,462	-£16,743	-£3,281	£13,462	-£150,690	-£3,281	£147,409	High	Unidentified
Chief Exec Corp Target	-£15,889	-£854	£15,035	-£15,889	-£854	£15,035	-£143,000	-£10,854	£132,146	High	Unidentified
Current unidentified/opportunities	£0	£0	£0	£0	£0	£0	-£1,173,437	£0	£1,173,437	High	Was TCB/UCR adjustment, not viable due to D2A
Closure of 2x Community Wards	£0	£0	£0	£0	£0	£0	-£921,626	-£214,842	£706,784	High	One ward approved, one rejected
Vacancy Factor - Corp	-£13,349	-£67,790	-£54,441	-£53,395	-£298,455	-£245,060	-£160,186	-£405,246	-£245,060	Low	
Wholly Owned Subsidiary	£10,000	£0	-£10,000	£40,000	£0	-£40,000	-£878,932	-£878,932	£0	High	Sprint work - awaiting further detail
1.5% Reduction across services	-£64,243	-£77,894	-£13,651	-£256,970	-£254,576	£2,394	-£1,541,821	-£831,536	£710,285	Medium	Over 50% awaiting full plans to progress
Bank interest over plan	£0	-£23,462	-£23,462	£0	-£85,286	-£85,286	£0	-£245,286	-£245,286	Low	Expected bank interest over plan
2025-26 CIP Programme	**-£495,783**	**-£421,932**	**£73,851**	**-£1,273,570**	**-£1,393,209**	**-£119,639**	**-£9,488,933**	**-£5,245,541**	**£4,243,392**		

	Plan Month 4 £000	Actual Month 4 £000	Variance Month 4 £000	Plan YTD £000	Actual YTD £000	Variance YTD £000	Annual Plan £000	Forecast £000	Variance £000		
Recurrent	-£425,119	-£212,199	£212,920	-£990,915	-£558,617	£432,298	-£8,640,968	-£3,685,639	£4,955,328		
Non-Recurrent	-£70,664	-£209,733	-£139,069	-£282,655	-£834,592	-£551,937	-£847,965	-£1,559,902	-£711,937		
	-£495,783	**-£421,932**	**£73,851**	**-£1,273,570**	**-£1,393,209**	**-£119,639**	**-£9,488,933**	**-£5,245,541**	**£4,243,392**		

• 2025/26 CIP Target is £9.5m

• Month 4 delivery was £0.1m adverse to plan, this represents a significant increase monthly as the target almost doubled in month.

• There are several red schemes at this point in the year, there are a number of plans that are not likely to be taken forward and have therefore been removed from forecast. These include the Overnight Closure of Louth & Skegness UTC and the closure of Scarborough ward. There were also funds identified in relation to movements between Transitional Care and UCR, however this has been moved to support an increase in D2A capacity.

• Forecast reflects £4.2m currently unidentified.

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:
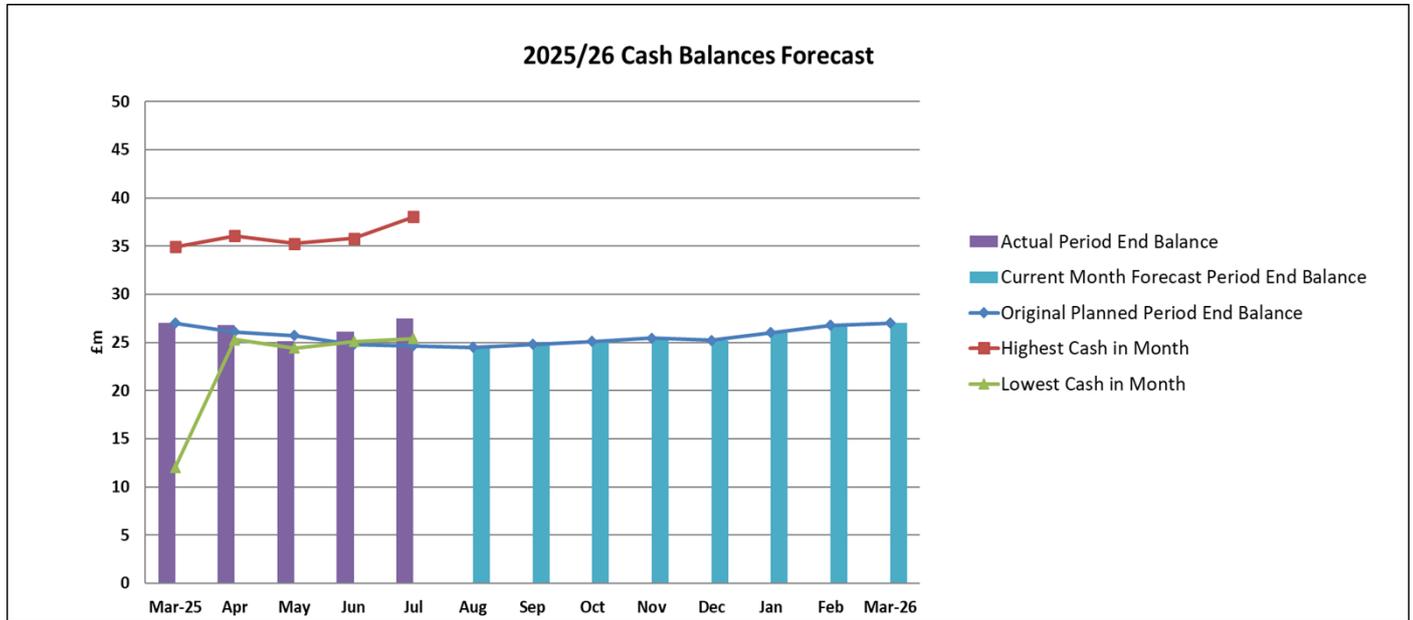
Narrative

- The LCHS cash balance for M4 was £27.5m, this is slightly higher with forecast (£24.6m).

- 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%.

Better Payment Practice Code (Volume)

Legend: Actuals, Sigma, Average, LCL, NHS Median, Target
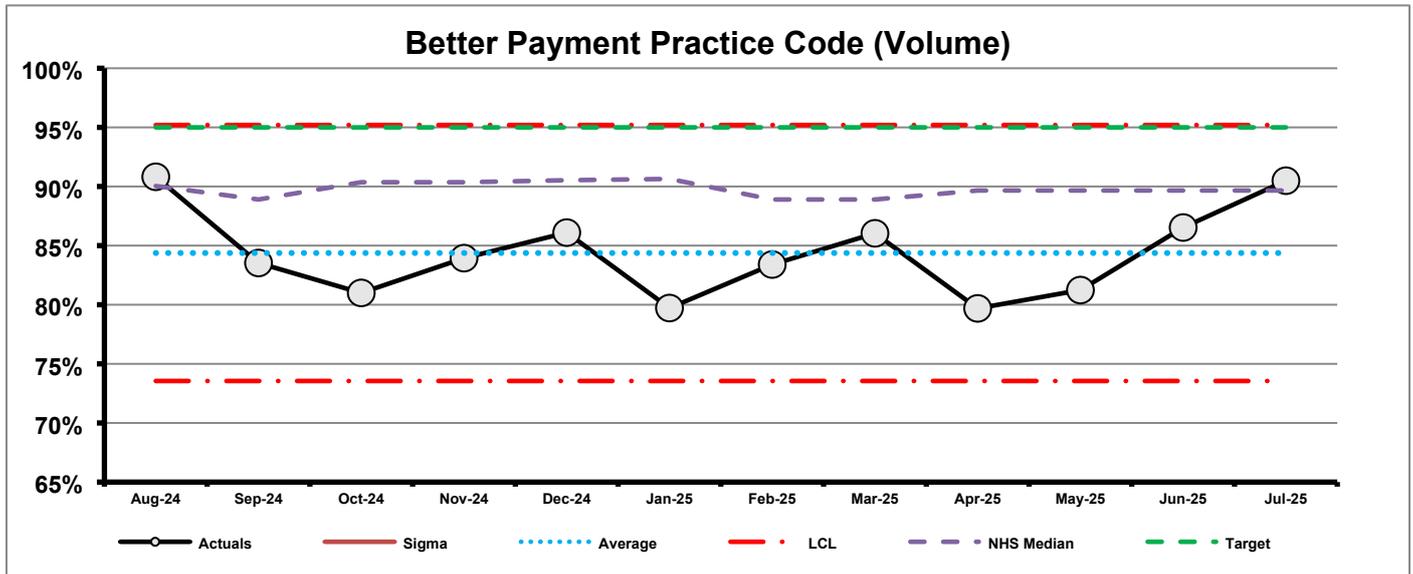
Narrative

- Number of invoices for July at 90.5% continuing to show an increased trajectory.
- Finance have updated the structure in line with the new Care Groups and corporate structure and are reviewing ASD hierarchy access to ensure this continues.
- There is a renewed focus in 2025/26 on achieving 95%, reflected in the upturn of payments. Working closely with ULTH accounts payable team to understand areas of concern and agreed actions to address.

SPC

Monthly Better Payment Practice Performance by volume has not varied significantly over the period. This metric is inconsistently capable of achieving the 95% target and is expected to miss the target more often than not.

Cumulative Capital Expenditure Plan vs Actual (£000)

Background

This metric tracks year-to-date expenditure of the Trust Capital Programme against plan. Capital Expenditure includes investment in maintaining, replacing, and transforming the Trust asset base.

Capital Plan inc. PDC 2025/2026
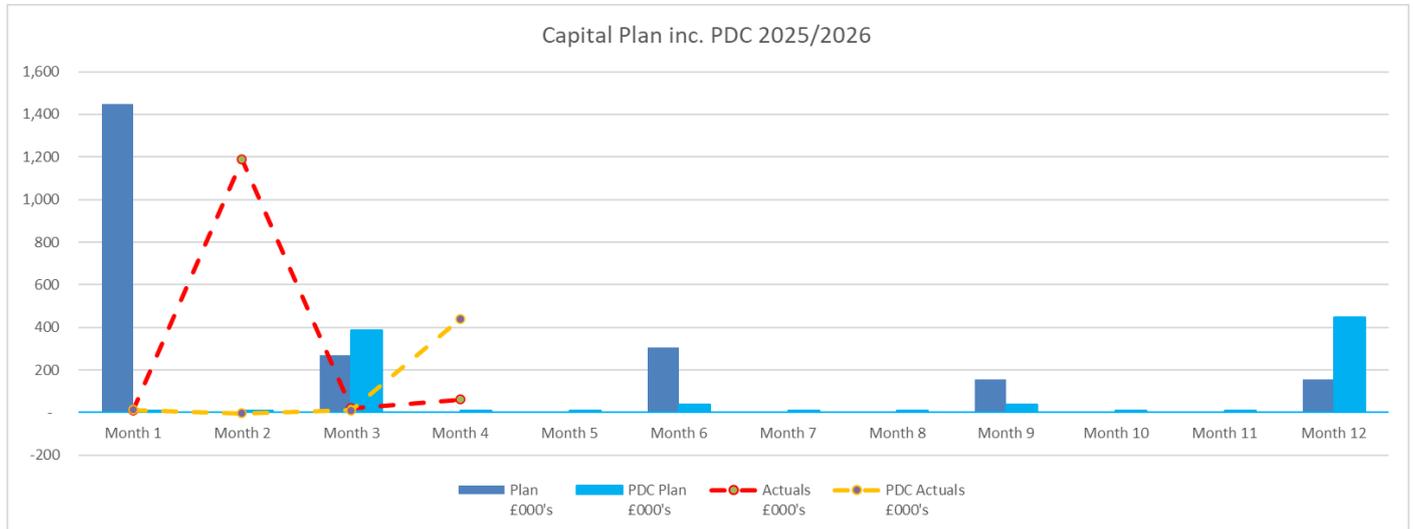
Narrative

- The LCHS capital plan for the financial year totals c£3.3m, £2.3m of capital allocation and £1m of PDC funding.
- Month 4 spend equated to £503k. The Plan assumed that the IFRS lease adjustments would transact in Month 1, the forecast was adjusted to incur in Month 2 and has been largely transacted. The Plan assumes the remaining capital spend would be incurred quarterly.
- There is a YTD underspend (£0.4m) against plan, which largely relates to the IFRS16 adjustment forecast to be adjusted in M6. The underspend last month on the PDC spend, has now caught up with forecast.
- The year to date spend has been incurred in the following areas (bracketed numbers are full year plan)
    - Information Management & Technology - £22k (£265k)
    - Estates investment schemes - £5k (£62k)
    - Clinical Equipment schemes - £50k (£558k)
    - IFRS16 - £1.2m (£1.45m)
    - PDC – £462k (£1m)

Vacancy Rate

Background

The Vacancy Rate target for LCHS is 8%.
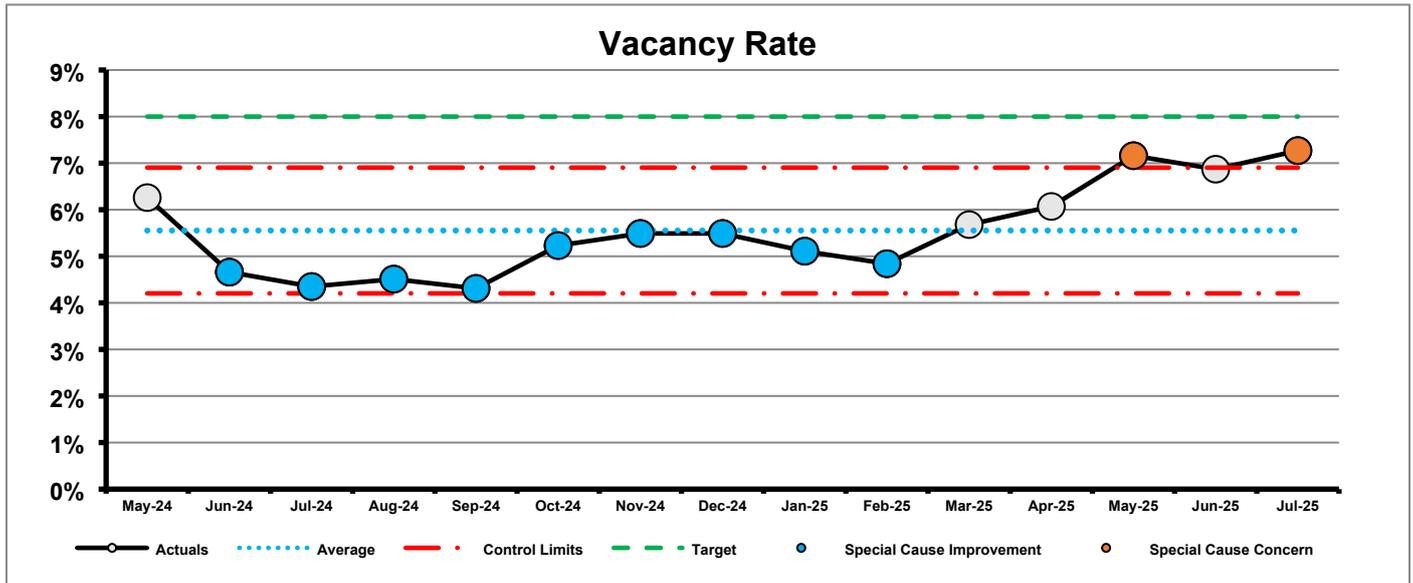
Narrative

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.
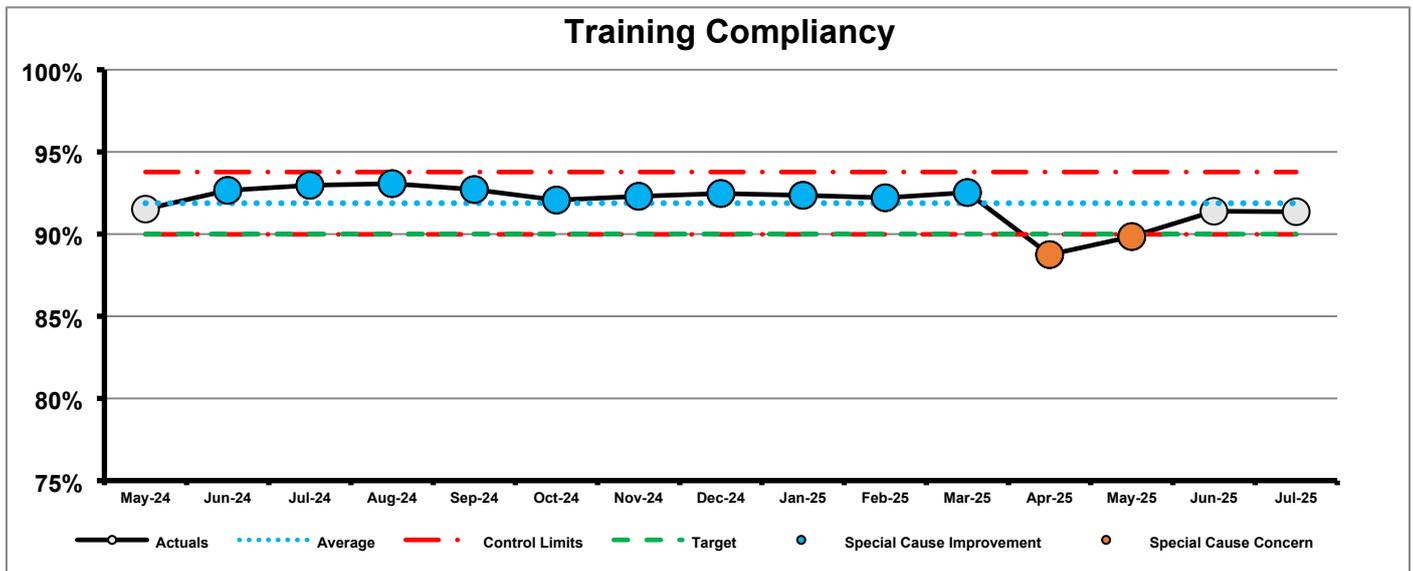
Overall mandatory compliance as of 31st July 2025:

The overall mandatory training compliance rate which includes all core and role specific modules has increased to 91.36 % which is above the local and national target of 90%.

Core mandatory training compliance (requirements for all staff):

Overall compliance for the **core** mandatory modules has increased to 94.94% which exceeds the national/local target of 90%.

As of 1st July, Resuscitation L2 – Adult & Paediatric Basic Life Support – has been removed as a core requirement for non-clinical staff. This will reduce training time for this group of staff and aligns with Group requirements.

There have been slight fluctuations up and down this month. CYPSS, Collaborative Community Care, Corporate, Operational Business Services and System have **overall** compliance remaining above the national/local target of 90%, IUEC and Operational Leadership remain under target.

Children's, Young People's, and Specialist Services	93.41%	↑
Collaborative Community Care	90.89%	↓
Corporate Services	96.64%	↑
Integrated Urgent and Emergency Care	87.25%	↓
Operational Business Services	96.32%	↑
Operational Leadership	87.44%	↑
System	92.49%	↑

SPC

Mandatory Training compliance has not varied significantly in the period. The measure is consistently capable of achieving the 90% target.

Sickness Absence

Background

The Trust target for total sickness absence is 4.35%.

Sickness Absence

Long Term Sickness Absence
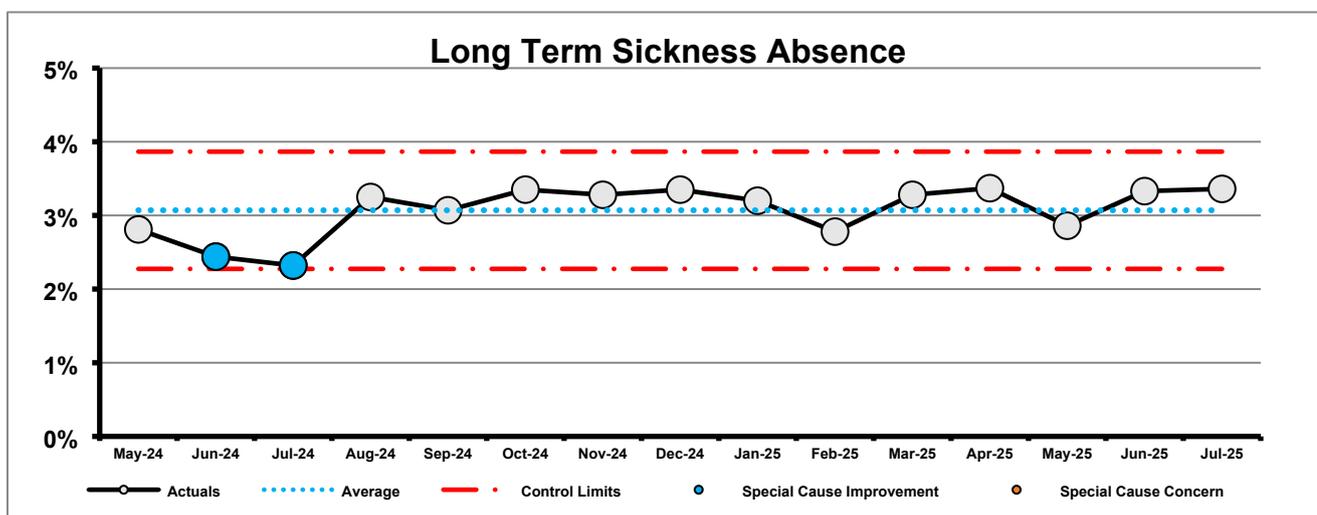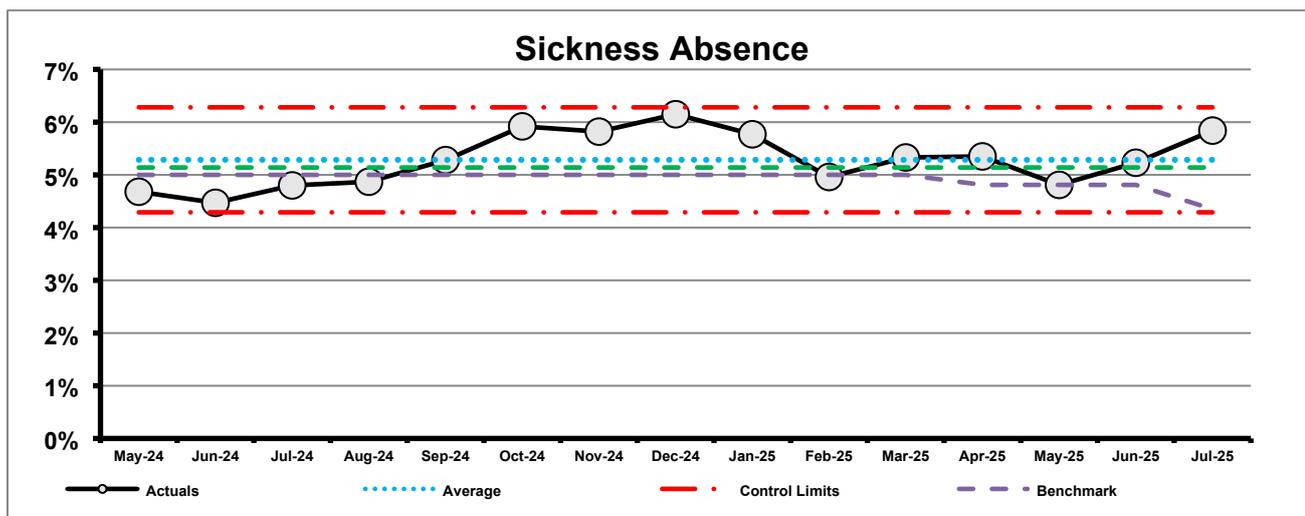
Narrative

The overall sickness levels in July have increased to 5.84% when compared with 5.23% in June and is over the agreed target of 4.35%.

For overall sickness absence, Operational Business Services (9.11%), Collaborative Community Care (6.07%), Integrated Urgent and Emergency Care (6.41%) and Children's, Young People and Specialist Services (6.43%) were all above target. Corporate (1.95%) and System (0.39%) are the only areas below target.

The top three reasons accounting for overall sickness absence in July were anxiety, stress, and depression (43.66%), Gastrointestinal Problems (11.22%), and other musculoskeletal (7.93%) which remains consistent with previous months.

Long Term

The long-term sickness level in July has also seen an increase to 3.36% from 3.33% in June, which is a red light in accordance with the new workforce targets as it is an increase on the previous month.

In relation to long term absence, CYPSS and Operational Business Services have seen an increase on the previous month and are therefore red in accordance with the new workforce targets. CCC, Corporate and

IUEC have all seen a reduction in their long-term absence since June and are therefore rated Green in accordance with the new workforce targets.

The top three reasons for long term sickness absence for May were: Anxiety/stress/depression (52.04%), other musculoskeletal (9.62%) and Benign and malignant tumours at (6.3%). All reasons being consistent with the data for June.

<u>Short Term</u>

The short-term sickness level in July has seen an increase to 2.48% from 1.91% in June, which is a red light against the new workforce targets due to it being an increase against the previous month.

In respect of short-term sickness, all areas with the exception of Operational Business Services have seen an increase against the previous month and are therefore red against the new workforce targets.

The top three reasons for short term sickness absence in June were: anxiety/stress/depression (32.33%), gastrointestinal problems (18%), cough/cold/flu (7.75%). This has remained consistent with the data from previous months.

Actions

- As absence has risen to the highest level within the last 6 months an absence summit meeting has been held in August, delivered by the HR team to all SLT operational leads across LCHS in order to fully analyse the data, identify trends and opportunities to improve and intervene. This meeting will be extended out to CSL and CTL levels and a review meeting is planned for September.

- 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 and remain available to book onto on ESR.

- 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 4.35% 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 target. The target is expected to be missed more often than achieved.

Workforce Dashboard

July 2025

Division	FTE Budgeted	FTE Actual	FTE Vacant	Vacancy Rate	Annual Turnover Rate	Monthly Turnover Rate	Total Absence Rate	Short Term Absence Rate	Long Term Absence Rate	Training Compliance Rate	Appraisals Rate	Supervision Rate
Children's, Young People's and Specialist Services	549.24	498.65	50.59	9.21%	9.47%	0.51%	6.43%	1.92%	4.50%	93.41%	95.84%	93.56%
Collaborative Community Care	753.03	737.61	15.42	2.05%	6.69%	0.55%	6.07%	2.65%	3.42%	90.89%	88.21%	82.43%
Corporate Services	232.58	202.03	30.55	13.13%	17.68%	1.98%	1.95%	1.14%	0.81%	96.64%	79.71%	93.18%
Integrated Urgent & Emergency Care	429.09	377.72	51.37	11.97%	6.50%	0.11%	6.41%	4.03%	2.39%	87.25%	96.69%	96.14%
Operational Business Services	114.32	100.38	13.94	12.19%	12.04%	1.00%	9.11%	1.79%	7.33%	96.32%	93.64%	
Operations	14.44	12.40	2.04	14.13%	24.19%					87.44%	66.67%	87.50%
System	14.00	24.71	-10.71	-76.48%	26.17%		0.39%	0.39%		92.49%	79.17%	92.86%
Total	**2,106.70**	**1,953.50**	**153.20**	**7.27%**	**9.13%**	**0.61%**	**5.84%**	**2.48%**	**3.36%**	**91.36%**	**91.03%**	**88.93%**

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	232.58	202.03	30.55	13.13%	17.68%	1.98%	1.95%	1.14%	0.81%	96.64%	79.71%	93.18%
Chief Exec	15.07	11.23	3.84	25.46%	35.61%					99.32%	45.45%	
Finance & Business Intelligence	54.20	46.33	7.87	14.51%	24.17%	4.32%	0.08%	0.08%		97.92%	85.11%	
Medical Directorate	23.95	23.09	0.86	3.60%	15.16%		5.34%	5.34%		92.97%	83.33%	83.33%
People & Innovation	96.97	87.10	9.87	10.18%	12.64%	2.30%	2.38%	0.51%	1.87%	96.85%	84.44%	100.00%
Quality	42.39	34.28	8.11	19.13%	17.50%		1.79%	1.79%		96.87%	68.57%	100.00%
Total	**232.58**	**202.03**	**30.55**	**13.13%**	**17.68%**	**1.98%**	**1.95%**	**1.14%**	**0.81%**	**96.64%**	**79.71%**	**93.18%**

Risk Report

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2 September 2025*
Item Number	*12.1*

Risk Report

Accountable Director	*Kathryn Helley, Group Chief Clinical Governance Officer*
Presented by	*Kathryn Helley, Group Chief Clinical Governance Officer*
Author(s)	*Helen Shelton, Group Deputy Chief Clinical Governance Officer* *Lorna Adlington, Head of Patient Safety and Quality Governance, LCHS* *Sarah Davy, Risk and Datix Manager, ULTH*
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

The following report includes information pertaining to risks scoring 15 – 25 which are in relation to the highest risks across the Group.

There are 720 (108 LCHS and ULTH 612) active and approved risks reported to lead committees in August 2025, this is a reduction of 25 since the July 2025 report.

LCHS

There is 1 Very High risk (20 - 25) reported to the Quality Committee. This relates to:

- o   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 7 Very High risks (20-25) reported to the Quality Committee this month, a reduction of 2 since the July report, these relate to:

- o   4731 - Reliance on paper medical records
- o   4879 - Recovery of planned care cancer pathways
- o   4947 – NICE Medicines reconciliation compliance
- o   5016 - Patient flow through Emergency Departments
- o   5101 - Delivery of paediatric epilepsy pathways - across acute and community
- o   5200 - Backlog of Paediatric Cardiology clinics
- o   5450 - Risk of Gastro service not being viable due to current fragility of Consultant workforce

Since the last reporting period the following risks have been presented at Risk Register Confirm and Challenge which were agreed to be closed:

- • 4828 - Reliance on manual prescribing processes
- • 5100 - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards

There are 4 Very High risks (20-25) reported to the People Committee this month, remaining stable since the July report:

- o   4844 – Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service
- o   4996 - Consultant workforce capacity (Haematology)
- o   4997 – Service configuration (Haematology)
- o   5093 – Procurement service staffing levels

There are 6 Very High risks (20-25) reported to the Finance Committee this month, an increase of 1 since the July report, these relate to:

- • 4657 - Compliance with Subject Access Requests
- • 4664 - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff

- 4839 - Lack of pharmacy capacity for Intravenous Immunoglobulin (IVIG) - Risk presented at **Risk Register Confirm and Challenge meeting on 23rd July** and **increased to 5 x 4 = 20** (previous score 3 x 4 = 12)
- 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
- 5447 - Cancellation of elective lists due to lack of theatre staff
- 5672 - Risk of failure to deliver the CIP target in full for 2025/2026 - **New Risk validated at Risk Register Confirm and Challenge** on 23rd July Score **agreed 5 x 4 = 20**

Following review at the Risk Register Confirm and Challenge meeting in July, the following risk has been presented and it was agreed to be closed:

- 4665 - Failure to meet 24/25 CIP – **Risk closed and replaced with risk 5672.**

There is 1 Very High risks (20-25) reported to the Integration Committee this month, an increase of 1 since the July report, this relates to:

- 5563-Neurology – Service sustainability - Risk presented at **Risk Register Confirm and Challenge Meeting in July** and **validated for increase in score to 5 x 4 = 20** (previous risk score 4 x 4 = 16).

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 720 (108 LCHS and ULTH 612) active and approved risks reported to lead committees in August 2025, this is a reduction of 25 since the July 2025 report.

2.2   **LCHS**

There is 1 risk with a current rating of Very High risk (20-25) and 9 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)
3 (-2) (3%)	31 (-) (29%)	64 (-6) (59%)	9 (-5) (8%)	1 (-) (1%)

2.3   **ULTH**

There are 18 risks with a current rating of Very High risk (20-25) and 59 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)
47 (-6) (8%)	155 (-3) (25%)	333 (-) (54%)	59 (-3) (10%)	18 (-) (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	A QIA has been completed to propose a new model of working for pre-schools with effect from September 2025. The impact of new ways of working to be monitored for level of impact. There will continue to be a waiting list for children of school age. As such there is no change to waiting times or score.	17/07/25

2.5   **ULTH**

There are 7 Very High risks and 23 High risks recorded in relation to this objective. A summary of the Very High risks is provided below:

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
4731	Reliance on paper medical records	Very high risk (20-25)	Corporate	Risk reviewed, remains at current level. 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. Once complete this risk will be closed	09/07/2025
4879	Recovery of planned care cancer pathways	Very high risk (20-25)	Clinical Support Services	Risk transferred to corporate risk under Operations. Meeting booked for full risk review.	11/07/2025
4947	Inability to meet NICE medicines reconciliation targets	Very high risk (20-25)	Clinical Support Services	Risk approved at CSS Cabinet on 15/07/2025. To be presented at RRC&C in August for closure.	15/07/2025
5101	Delivery of paediatric epilepsy pathways-Acute Paediatrics & Community	Very high risk (20-25)	Family Health	Community and Acute risk now amalgamated due as dependent upon the same risk reduction plan. No further progress, team are working to make improvements within current service but this does not address the risk and further mitigation is dependent on the business case being approved.	15/07/2025

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
5200	Backlog of Paediatric Cardiology clinics	Very high risk (20-25)	Family Health	Local Cardiologist in place, waiting list being worked through at pace. Proposal to reduce risk score to 4x4=16 to be taken to Governance and then RRCC for approval. Working with Corporate Team to develop business case for this service.	12/08/2025
5450	Risk of Gastro service not being viable due to current fragility of Consultant workforce	Very high risk (20-25)	Medicine	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. 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.	14/07/2025

Updates from the previous report:

- 4828 - Reliance on manual prescribing processes – Risk reviewed at the July Risk register Confirm & Challenge meeting and the decision made to close the risk as the digital risk register has risk 5648 which covers this risk and provides mitigations.

- 5100 - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards – following the Quality Committee deep dive is was agreed to close this risk and amalgamate both the community and acute paediatric epilepsy risk into risk 5101 due to the same risk reduction plan in place.

Strategic objective 1b: Reduce waiting times for our patients

2.6 **LCHS**

There are no Very High risks, and 1 High risk recorded in relation to this objective.

2.7 **ULTH**
There is 1 Very High risk, and 2 High risks 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	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.	10/07/2025

Strategic objective 1c: Improve clinical outcomes Improve productivity and deliver financial sustainability

2.8   **LCHS**
There are no Very High or High risks recorded in relation to this objective.

Update from previous report:

- 444 – **Failure to deliver the financial plan 2024 / 2025** - validated for closure at the July RRC&C meeting. This will be replaced with a new risk for the financial year 2025 / 2026 due to be presented to August RRCC meeting.

2.9   **ULTH**
There are 5 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	PATIENT: New temp staff in post and currently being trained. DATIX backlog has been reduced to x2 requests. x2 LCHS staff currently being trained to provide support. Supervisor for team has recently resigned- plan to be discussed for future. STAFF: Ongoing issues with defining new process under national tenant for accessing email data. Contact made with NHSE asking for support.	15/07/2025
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. While in June, expenditure of £1.2m was in line with plan, the Trust YTD has spent £4.4m or £0.6m more than planned. Both Lincolnshire ICS and our regulator will expect/require the Trust to take actions at the scale to address this.	24/07/2025
4839	Lack of pharmacy capacity for Intravevenous Immunoglobulin (IVIG)	Very high risk (20-25)	Clinical Support Services	Risk presented at the July RRC&C meeting and validated for an increase in score due to the capacity within the pharmacy team to support the NHSE immunoglobulin framework. Benchmarking is underway to inform the business case. Recruitment of HCD posts.	09/07/2025
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.	14/07/2025

ID	Title	Risk level (current)	Division	Progress Update	Date of latest risk review
5672	Risk of failure to deliver the CIP target in full for 2025-26	Very high risk (20-25)	Corporate	Increased CIP governance & monitoring arrangements introduced through PRM's to ensure oversight (including additional one off detailed executive review sessions with care groups). Business cases submitted to NHSE for Delivery support in key areas where capacity & expertise require.	23/07/2025

Updates from the previous report:

- 4665 - Failure to meet 24/25 CIP – **Risk closed and replaced with a new risk for the 2025-26 financial year - 5672.**

Strategic objective 1d: Provide modern, clean and fit for purpose care settings

2.10   **LCHS**
There are no Very High risks, and 1 High risk recorded in relation to this objective.

2.11   **ULTH**
There are no Very High risks and 12 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 2 High risks recorded in relation to this objective.

2.13   **ULTH**
There is 1 Very High risk and 7 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 Level (Current)	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 (20-25)	Recruitment of further substantive consultants - April 2025 Cancer Services paper written awaiting CRIG invitation - April 2026	**Date added to the Trust Register:** **22/08/2022** **Date of latest review:** **18/07/2025**

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 Level (Current)	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 (20-25)	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:** **22/07/2025**
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 (20-25)	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:** **18/07/2025**

Risk ID	What is the risk?	Risk Level (Current)	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.	Very high risk (20-25)	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	**Date added to the Trust Register:** **16/02/2023** **Date of latest review:** **24/07/2025**

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 is 1 Very High risks (20 - 25), and 4 High risks (15 -16) recorded in relation to this objective. A summary of the Very High risk is provided below:

Risk ID	Title	Risk Level (Current)	Division	Progress Update	Date of latest review
5563	Neurology – Service sustainability	Very high risk (20-25)	Medicine	**Agreed increase in score at RRC&C on 23/7/25 to 5 x 4 = 20** (previously 4 x 4 = 16). 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.	23/07/2025

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 4 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 There are 720 (108 LCHS and ULTH 612) active and approved risks reported to lead committees in August 2025, this is a reduction of 25 since the July 2025 report.

3.2 **LCHS**

There is 1 Very High risk (20 - 25) reported to the Quality Committee. This relates to:

- o   403 - Children SLT Therapy Treatment Delays

There are no Very High risks (20-25) reported to the Finance, People, or Integration Committees this month.

3.3 **ULTH**

The are 7 Very High risks (20-25) reported to the Quality Committee this month, a reduction of 2 since the July report, these relate to:

- o   4731 - Reliance on paper medical records
- o   4879 - Recovery of planned care cancer pathways
- o   4947 – NICE Medicines reconciliation compliance
- o   5016 - Patient flow through Emergency Departments
- o   5101 - Delivery of paediatric epilepsy pathways - across acute and community
- o   5200 - Backlog of Paediatric Cardiology clinics
- o   5450 - Risk of Gastro service not being viable due to current fragility of Consultant workforce

Since the last reporting period the following risks have been presented at Risk Register Confirm and Challenge which were agreed to be closed:

- • 4828 - Reliance on manual prescribing processes
- • 5100 - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards

There are 4 Very High risks (20-25) reported to the People Committee this month, remaining stable since the July report:

- o   4844 – Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service
- o   4996 - Consultant workforce capacity (Haematology)
- o   4997 – Service configuration (Haematology)
- o   5093 – Procurement service staffing levels

There are 6 Very High risks (20-25) reported to the Finance Committee this month, an increase of 1 since the July report, these relate to:

- • 4657 - Compliance with Subject Access Requests
- • 4664 - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- • 4839 - Lack of pharmacy capacity for Intravenous Immunoglobulin (IVIG) - Risk presented at **Risk Register Confirm and Challenge meeting on 23rd July** and **increased to 5 x 4 = 20** (previous score 3 x 4 = 12)
- • 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
- • 5447 - Cancellation of elective lists due to lack of theatre staff
- • 5672 - Risk of failure to deliver the CIP target in full for 2025/2026 - **New Risk validated at Risk Register Confirm and Challenge** on 23rd July Score **agreed 5 x 4 = 20**

Following review at the Risk Register Confirm and Challenge meeting in July, the following risk has been presented and it was agreed to be closed:

- 4665 - Failure to meet 24/25 CIP – **Risk closed and replaced with risk 5672.**

There is 1 Very High risks (20-25) reported to the Integration Committee this month, an increase of 1 since the July report, this relates to:

- 5563-Neurology – Service sustainability - Risk presented at **Risk Register Confirm and Challenge Meeting in July** and **validated for increase in score to 5 x 4 = 20** (previous risk score 4 x 4 = 16).

3.4   The Group Board is invited to review the content of the report. There are no further escalations at this time.

LCHS High & Very High Risks August 2025

ID	Group Strategic Objective	Group Risk Type	Executive Director	Risk Lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Title	There is a risk that:	Caused by:	Resulting in	Controls in place	Date of last review	Likelihood (current)	Consequence (current)	Risk level (current)	Rating (current)	Updates by reviewers	Risk level (Target)	Next review date	Movement of risk
754	2a: Enable our people to fulfil their potential through training, development and education	Physical or Psychological Harm	Group Chief Estates & Facilities	Chaytor, Sarah	People Committee (Lead assurance committee), Health and Safety Committee (Accountable for)	09/10/2024	15	Corporate	Quality	Moving and Handling	Clinical staff are inadequately trained in moving and handling	Poor compliance with expected standards. Training content currently being re evaluated. As a consequence there has been a pause in delivery. 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)	Mutual support request to ULHT. Internal sources of alternate training support being identified. Reviewing training schedule and package. Action plan in place to increase attendance when training is reinstated. Engagement with operational colleagues to confirm appropriate staff requiring training. Training for new staff continues.	10/04/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	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.	Very Low Risk (1-3)	10/07/2025	No change
403	1a: Improve patient safety, patient experience and deliver clinically effective care	Physical or Psychological Harm	Group Chief Operating Officer	Griffiths, Claire	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)	13/09/2022	9	Children, Young People, and Specialist Services	Children's Therapy	Children SLT Therapy Treatment Delays	Children & young people will not receive the speech and language support they require to meet their social, emotional, educational, and health needs in a timeframe appropriate for their development.	Demand has increased nationally & regionally for SLT support overwhelming commissioned capacity. Referrals 188% higher in 2023/24 than in 2019.	Untreated speech, language, and communication needs (SLCN), which leads to: Children 6-11 times more likely to be behind educationally & more likely to be excluded from schools; 60-70% of young offenders reported to have poor language skills; 81% children with emotional behaviours problems have SLCN; SLCN children are twice as likely to be unemployed as an adult due to poor cognitive & social outcomes increasing lifelong health inequalities. Reputational damage from increased complaints & appeals to MPs & press	1. Advice and activities are given the patient's family and/or educational setting, ensuring they are safe to wait. 2. An appropriate skill mix is used, for example assessments are carried out by SLT and most therapy blocks completed by SLTAs. 3. Mix of face to face and virtual sessions 4. Increased the referral acceptance criteria: focused on highly complex patients only	17/07/2025	Extremely likely (5) >90% chance	Severe (4)	Very High Risk (20-25)	20	[17/07/2025 15:07:51 Ana Morgan] Risk reviewed at CYPSS Quality SMT 17/07/25: QIA completed (proposal of new model of working for pre-schools), which is currently going through the relevant governance meetings. New way of working is due to start in September. Waits will still be there for children of school age. No change to waiting times or score, but the impact of the changes will be tracked to ascertain if any resource is released. [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 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. No change to score. [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:	Low Risk (4-6)	21/08/2025	No change

ID	Strategic Objective	Risk Category	Owner (role)	Owner	Committee	Date	Score	Service Area	Risk Title	Risk Description	Causes	Consequences	Controls	Review Date	Likelihood	Severity	Risk Rating	Score	Progress Notes	Current Risk	Next Review	Change
695	2b: Empower our people to continuously improve and innovate	Service Disruption	Group Chief Operating Officer	Brunton, Michael	People Committee (Lead assurance committee)	12/03/2024	16	Collaborative Community Care	Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care	Community nursing teams fail to provide high quality care due to reduced levels of District Nurse Qualified staff within the team structure	Lack of value placed upon the importance of the DNSPQ qualification within community nursing teams. Failure to reimburse staff undertaking the role relevant to their responsibilities and thereby retaining them. Failure to train sufficient number of DNSPQ qualified staff. Lack of standard use of the Enhanced Practitioner role in community nursing teams and defined role. Lack of qualified DN	Insufficient levels of qualified DNSPQ support for junior members of teams. Lack of oversight for complex case management. Identified theme in case of patient harm. Reduced safe management of caseload sizes in community nursing teams. Lack of professional support and guidance for team development	BSAFE initiated for daily oversight of safe care. BSAFE audits by CSL level staff. Reallocation of qualified DNSPQ staff to teams with low levels to aid safety. Identification of new assessors for DNSPQ trainees. Allocation of trainers to training places for increased trajectory of DNSPQ training. Recovery trajectory and commitment to model of care for excellence to be submitted to ELT as part of a wider strategy for service	03/06/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	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 written 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	Low Risk (4-6)	04/09/2025	No change
715	2a: Enable our people to fulfil their potential through training, development and education	Physical or Psychological Harm	Group Chief Operating Officer	Brunton, Michael	People Committee (Lead assurance committee)	16/05/2024	16	Collaborative Community Care	There is a risk that the Community nursing lacks capacity and skill set to meet community demand	The community nursing service is unable to meet the demand of patients within Lincolnshire	Increased demand for service of 8%. Care unit allocation above the maximum of 15 care units daily. Case load levels above 150 max levels. Reduced numbers of DNSPQ qualified staff	Variance in care delivery. Ineffective case load management. Poor patient experience. Reduced complex caseload efficiency. Task based service provision with a lack of holistic care planning	Daily BSafe - escalation/oversight review. Twice daily matron led safety huddles. Re allocation of senior resource to at risk areas. Operational oversight of risk daily. Service evaluation of DNSPQ role. Support from UCR and CYPSS services to aid meeting unplanned demand when required	03/06/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	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 on 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 Execs. 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	Low Risk (4-6)	04/09/2025	No change
792	1a: Improve patient safety, patient experience and deliver clinically effective care	Physical or Psychological Harm	George, Elizabeth	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)	Collaborative Community Care – Community Hospitals Outpatients Department, Johnson Hospital	13/05/2025	15	Collaborative Community Care – Community Hospitals	Reduction of Phlebotomy appointments breaching the ICB service spec	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	Highlighted risk to CSL- Discussion at QSG Add to risk register	10/07/2025	Extremely likely (5) >90% chance	Moderate (3)	High Risk (15-16)	15	[11/07/2025 17:19:24 Lisa Jennings] Update from Divisional risk meeting provided by CSL EG: Recruitment of x2 HCSWs approved. Recruitment process in progress. New recruits to be in post by end of August 2025. Bank staff covering gaps at present. Waiting time for both routine and emergency phlebotomy appointments much improved. [06/06/2025 10:10:25 Ana Morgan] New risk agreed at RRCC 04/06/25.	Very Low Risk (1-3)	10/10/2025	No change

ID	Strategic objective	Risk type	Accountable	Name	Committee	Date	Score	Service	Risk title	Risk description	Consequences	Controls	Mitigations	Review date	Likelihood	Consequence	Risk level	Updates	Current rating	Date	Movement
719	1a: Improve patient safety, patient experience and deliver clinically effective care	Physical or Psychological Harm	Group Chief Operating Officer	Mckee, Nat	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)	10/06/2024	6	Integrated Urgent & Emergency Care. Clinical Assessment Service (CAS)	Impact of DHU Contract Changes on CAS Model	That patients will come to harm or experience delays to their care due to clinical validation by external partners.	Regional agreement with no input from Lincs ICB. New contract for clinical validations of all interim dispositions and ED validation to DHU from CAS. Loss of approx 100 CAS calls per day	System impact will be significant (increased EMAS attendance, increased demand for ED). Reputational impact. Poor patient experience. Barrier to care. Potential for reduction in funding for CAS; reduction in booked appointments, unneeded attendance to UTCs, attendance to inappropriate UTC (non-collocated), reduced referrals to community services. Reduced staff morale.	Support and regular updates to staff. Close monitoring of staffing levels. Data monitoring. Monitoring of Datix. CAS clinician sitting in EOC pilot. Conversations with ICB. Dynamic redistribution of skill mix	08/07/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16) 15	[10/07/2025 14:58:34 Ana Morgan] Risk reviewed at IUEC Quality Scrutiny Group pre-meet 08/07/25: no changes noted. [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 For review at the Risk Register Confirm and Challenge meeting Nov'24. [18/10/2024 08:25:17 Pamela Brundle] Discussed at IUEC Quality Scrutiny Group pre-meet 08/10/24: incidents have remained consistent and regularly reported, no change to score. [18/09/2024 10:41:00 Pamela Brundle] Discussed at IUEC QSG pre-meet 10/09/24: No...	Low Risk (4-6)	14/10/2025	No change
773	1b: Reduce waiting times for our patients			Thompson, Daniel	Finance Committee (Lead assurance committee)	13/01/2025	16	Children, Young People, and Specialist Services. Speech and language Therapy (Adult)	Community Adult SLT - demand and capacity	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	Clinical prioritisation - dysphagia as the priority due to severe impact of delays. Changes to waiting list management - delay offer / opt in for any communication assessments as unable to provide the therapy intervention / assessment. Prioritise training for new starters in Dysphagia and Voice assessments to manage these caseloads. Provision of care home pack for all referrals. Conversion to video consultations / reviews where possible. Support from partners in the acute 1 day / week with dysphagia & high priority communication assessments.	17/07/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16) 16	[17/07/2025 15:22:31 Ana Morgan] Risk reviewed at CYPSS Quality SMT 17/07/25: moved staff from the acute to community. Longest wait is 37 weeks for communication. Plan in place to reduce the longest waits (which are due to long term absence) and is being implemented. Recruiting for B3 posts in process, which means the service will be able to offer communication therapy once the new starters are in post and trained. [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.	Low Risk (4-6)	16/10/2025	No change

ID	Strategic Objective	Risk Type	Accountable Officer	Owner	Assurance Committee	Date Opened	Initial Score	Directorate	Service	Risk Title	Risk Description (Cause)	Risk Description (Event)	Risk Description (Effect)	Controls	Assurances	Review Date	Likelihood	Consequence	Current Risk	Current Score	Progress Updates	Target Risk	Target Date	Direction of Travel
714	1a: Improve patient safety, patient experience and deliver clinically effective care	Physical or Psychological Harm	Group Chief Operating Officer	Brunton, Michael	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)	16/05/2024	16	Collaborative Community Care		Delivery of pressure ulcer care in the community	Patients are not always receiving the correct level of care for pressure ulcers within community nursing settings	Variability in the delivery of care for pressure ulcers across community Lack of consistent senior clinical case review Variable clinical skill set of team members in delivering pressure ulcer care	Deterioration in pressure ulcers Increasing referrals for S42 safeguarding responses Poor patient and family/carer experience ICB/CQC oversight of pressure ulcer care	Daily BeSafe reviews of patient care Service action plan to improve pressure ulcer care implemented ICB oversight Educational training plan for all community clinicians initiated Assurance programme commenced Monthly thematic review of pressure ulcers highlighting themes and risks in care		05/08/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[05/08/2025 15:20:40 Zoe Wills] 05/08/2025 - Due to challenges of equipment ordering this risk continues to be high. Ongoing work in Community Teams on PU management. Re established and focused monthly meeting for sharing learning across teams and to keep track of improvement actions. [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 created.	Moderate Risk (8-12)	05/11/2025	No change
783	3b: Move from prescription to prevention, through a population health management & h	Service Disruption	Group Chief Operating Officer	Humphreys, Julie	Integration Committee (Lead assurance committee), Risk Register Confirm & Challenge (Accountable for)	04/03/2025	20	Community Partnerships	Tuberculosis Adult Services	TB Service Provision - Capacity & Demand	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).	Additional temporary resource allocated from another budget (band 7 and band 3) to manage LTBI backlog. Cost pressure FTC resourcing has led to reduction in care units (active TB only) from 53.73 in July 2024 to 16.22 in Feb 2025. Specific pathway developed to manage Occupational Health LTBI staff.		23/07/2025	Quite likely (4) 71-90% chance	Severe (4)	16	16	[12/08/2025 16:12:14 Ana Morgan] Discussed at CDRT Quality Scrutiny Group 23/07/2025: B6 and B3 substantive staff now in post. The B3 is still going through induction. Working group is looking at service redesign. Online consultation pilot has been agreed through QIA panel and due to start WC 18/08/25. Propose to reduce score from L4 x C4 = 16 to L3 X C4 =12. For discussion at Risk Register Confirm and Challenge meeting 20/08/25. [25/06/2025 08:16:50 Julie Humphreys] Final VCP outcome awaited for Band 6 RN and Band 3 HCSW WTE substantive posts. Posts supported by Daren Fragley. Working group established to plan, act, study , implement service redesign inc. digitalisation [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	Moderate Risk (8-12)	20/08/2025	Decrease in score

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	12/08/2025	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	[12/08/2025 08:55:00 Gemma Staples] We now have a local cardiologist in place and we are going through our waiting list at pace, I believe we can bring the risk down slightly to an 16 as we increased it to a 20 without any local PEC or cardiologist on site. (This is to be agreed at Governance and then taken to RRC&C for approval). We are now working with the corporate team to develop a business case for this service. [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	8	30/06/2024	30/06/2025	12/09/2025
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	10/07/2025	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.	[10/07/2025 14:02:42 Nicola Cornish] Risk reviewed by Wendy Rojas, no further update. [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 14:57:19 Nicola Cornish] Risk reviewed, no further update. [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	8	30/06/2025		10/08/2025
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.	15/07/2025	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.	[15/07/2025 13:00:21 Fiona Hobday] PATIENT: New temp staff in post and currently being trained. DATIX backlog has been reduced to x2 requests. x2 LCHS staff currently being trained to provide support. Supervisor for team has recently resigned- plan to be discussed for future. STAFF: Ongoing issues with defining new process under national tenant for accessing email data. Contact made with NHSE asking for support. [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	6	31/12/2024	01/09/2025	29/08/2025

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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	18/07/2025	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	[18/07/2025 11:01:57 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 therefore risk remains the same. [18/06/2025 10:08:43 Gemma Staples] 20 at risk posts now to be put into the run rate and therefore will be added to Cancer Services budget lines. Further investment will be required, business case written, awaiting CRIG to reopen. [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	8	30/09/2023	01/04/2025	18/08/2025
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;	15/07/2025	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.	[15/07/2025 13:14:03 Nicola Cornish] No further progress, team are working to make improvements within current service but this does not address the risk and further mitigation is dependent on the business case being approved. [18/06/2025 11:50:34 Rachael Turner] Email confirmation for risk score to remain added to documents. [18/06/2025 11:47:28 Rachael Turner] Epilepsy risk was reviewed recently, and it remains high at 20. This is partly due to the business case to expand the workforce has been suspended [17/06/2025 14:43:50 Nicola Cornish] Risk reviewed with Debbie Flatman, no further update. [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 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.	8	14/03/2024	16/02/2024	15/08/2025
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)	24/07/2025	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	[24/07/2025 13:11:49 Nicola Cornish] The Trust's financial plan for 2025/26 includes a total agency plan of £12.7m. While in June, expenditure of £1.2m was in line with plan, the Trust YTD has spent £4.4m or £0.6m more than planned. Both Lincolnshire ICS and our regulator will expect/require the Trust to take actions at the scale to address this. [17/06/2025 14:51:58 Rachael Turner] The Trust's financial plan for 2025/26 includes a total agency plan of £12.7m and at the end of May 2025 the Trust has spent £3.2m or £0.6m more than planned. Both Lincolnshire ICS and our regulator will expect/require the Trust to take actions at the scale to address this. [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.	8	31/03/2023	31/03/2024	24/08/2025

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 (current)	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	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	15/07/2025	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 Further business case development to be decided.	[15/07/2025 13:12:50 Gemma Staples] Risk approved at CSS Cabinet on 15/07/2025. To be presented at RRC&C in August. [19/06/2025 12:25:33 Gemma Staples] Risk has been merged with risk 4844 - therefore request to close this risk. To go to cabinet and then RRC&C for approval. [21/05/2025 11:41:56 Lisa Hansford] Workforce review in progress. All business cases on hold. [22/04/2025 11:02:30 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 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	8	30/06/2021	30/04/2025	15/08/2025
1c: Improve productivity and deliver financial sustainability	4839	328	Finances	Bassi, Sangeeta	Moore, Lisa-Marie		19/01/2022	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of not having pharmacy capacity to support NHSE Intravenous Immunoglobulin (IVIG) framework switch, there is a financial risk that the Trust will not be able to deliver to expected CIP £1.8 million and unable to support to system HCD risk which sits at £2.8 million. Missed opportunity of savings of Circa £3,200 through the NHSE financial enabler scheme. There is also a reputational risk, due to litigations if patients perceive that they have not had the correct management. There is a risk of financial loss of income (£2.7 million) if not compliant with the switch. NHSE will not reimburse drug costs and introduce financial penalties on top of this. There is also a risk that the Trust will not meet monthly KPI's.	NHSE IVIG Framework NHSE Immunoglobulin Clinical Commissioning Policy Governance arrangement in place: - Local Immunoglobulin Panel (IAP) and Subregional Immunoglobulin Panel (SRIAP)	National framework switch being completed/not completed in time by September 2025) Financial enabler scheme/CIP targets being met/not met by December 2025 Monthly contract challenges from NHSE (challenge value and non-payment accrued) Monthly KPIs monitored by subregional IVIg panel (SRIAP) Monthly KPIs monitored by local IVIg panel (ULTH IAP) Financial reporting (Pharmacy, Finance and CSS) Prescribing data indicating the use of non-framework products	06/08/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Benchmarking- Sue Leo July 2025 IVIG business case – Sue Leo Dec 2025 Recruitment of HCD posts - LMM Oct 2025	[06/08/2025 09:03:46 Lisa Hansford] Trust agreement to support utilisation of NHSE funding for 0.5wte 8b, 1wte 8a and 0.5wte 7. QIAs approved and jobs placed on trac w/c 4th August. Retrospective case on a page to be submitted to CSS cabinet August [23/07/2025 14:38:57 Gemma Staples] Amendment: below should state 5x4(20) [23/07/2025 14:35:21 Sarah Davy] Agreed at RRC&C on 23/7/25 increase in score to 4x5=20 from 3x4=12. [09/07/2025 12:46:48 Lisa Hansford] Risk has been reworded and amended from physical harm to a financial risk. Therefore the request that the scoring be increased to match the severity and likelihood of the financial risk. [03/07/2025 12:59:20 Gemma Staples] Request for risk to be increased from a 3x4(12) to a 5x4(20). This was agreed at cabinet, risk now needs to be presented at RRC&C for approval. [03/07/2025 10:59:58 Lisa Hansford] Risk reworked. Patient complaint received and one incident relating to patient experiencing an allergic reaction - low harm incident reported. [23/06/2025 12:54:46 Lisa Hansford] Risk currently under review and will be updated in due course [21/03/2025 12:43:01 Lisa Hansford] Risk is under review as will likely be superseded by a new risk that is currently going through the approval process [16/12/2024 10:34:49 Lisa Hansford] No update [19/09/2024 12:56:41 Lisa Hansford] No further update. Risk remains the same [19/06/2024 14:40:12 Gemma Staples] Risk linked to Web 4843 / IQ 57 - Supplies are still constrained. Risk remains the same. [04/04/2024 08:52:57 Lisa Hansford] no progress [29/12/2023 13:43:57 Lisa Hansford] No further issue [26/09/2023 14:29:54 Rachel Thackray] Risk with supply issues remain. Meeting took place with Medical Director to review. [27/06/2023 09:41:44 Alex Measures] Discussed in risk register review meeting- no	4	01/10/2021	31/03/2023	09/09/2025
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	23/07/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	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.	[28/07/2025 11:50:09 Gemma Staples] Agreed increase in score at RRC&C on 23/7/25 to 5x4=20 (not a 4x5 as previously stated) [23/07/2025 15:38:40 Gemma Staples] Agreed increase in score at RRC&C on 23/7/25 to 4x5=20 [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 been had with ICB. Neurology is a difficult area to recruit. Risk validated at 4x4: 16 High Risk	8	19/12/2025		23/08/2025

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	5016	22	Physical or psychological harm	Hamer, Fiona	Lentz, Blanche		02/09/2022	25	Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's Introduction of "Pit stop" model. The development of a CDU in October 2024 will enable some flow from the emergency department to home for patients requiring treatment to discharge. This will be monitored through UEC improvement work to ensure area is fit for purpose. If CDU is utilised to enable ambulances to offload before 2 hours this will effect the flow through CDU.	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	15/08/2025	Quite likely (4) 71-90% chance Extreme (5)	Severe (4)	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.	[15/08/2025 09:34:38 Rachael Turner] New national navigation process to be instigated at the front door to signpost to patient specific pathways to reduce pressures in ED and for ED to be moving towards life and limb only. [14/07/2025 08:53:18 Rachael Turner] Risk reviewed, risk remains at current level with no new update from last month. [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.	10	02/09/2023	31/03/2024	15/09/2025
2b: Empower our people to continuously improve and innovate	5093	40	Service disruption	Bassi, Sangeeta	Baines, Andrew	Workforce Strategy Group	16/04/2023	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	24/07/2025	Extremely likely (5) >90% chance Severe (4)	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	[24/07/2025 09:15:23 Lisa Hansford] Member of the procurement approved under the MARS scheme. Which has now reduced the workforce even further. Band 2 invoice invoice clerk vacancy is going through the recruitment process. 0.6 WTE invoice clerk has left the post. [04/07/2025 09:02:13 Lisa Hansford] QIA approved for invoicing vacancy and recruitment now in progress, Risk remains the same for now. [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	4	16/02/2024	16/02/2024	26/08/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	4879	28	Physical or psychological harm	Carter, Mr Damian	Carter, Mr Damian		28/03/2022	20	Corporate	Operations	Operations	Trust-wide	As a result of National long waits there may be significant delays within the cancer pathway and as a consequence patients may experience extended waits for diagnosis and surgery which would lead to a failure in meeting national standards and potentially reducing the likelihood of a positive clinical outcome for many patients.	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group Intensive support meetings in association with the ICB - 2/52 Cancer Delivery and recovery - 2/52 Cancer Board - Monthly	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait Diagnostic standard less than 6 weeks	11/07/2025	Extremely likely (5) >90% chance Severe (4)	Severe (4)	very high risk (20-25)	20	Recovery trajectory of 62+ waits to 0 – Damian Carter – March 2025 Through the intensive support process, specialties to identify and assess any areas of specific risk not addressed through the recovery trajectory, putting in place necessary mitigating actions – Damian Carter – March 2025	[11/07/2025 12:10:11 Rachael Turner] Risk transferred to Operations. [23/06/2025 09:20:38 Gemma Staples] 14 wte of the 20 wte posts approved at risk by the previous CEO / COO have now been included in 25/6 funded establishment. Whilst this does not satisfy the scope of the submitted investment business case, the posts have supported cancer standards improvement in 24/25 and the Cancer CBU will review what step change having these staff and service capacity have afforded against the national cancer recovery plan. [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	8	31/03/2023	31/03/2023	11/08/2025

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1c: Improve productivity and deliver financial sustainability	5020	6	Finances	Hamer, Fiona	Lentz, Blanche	WORK Safety Group	02/09/2022	20	Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	15/08/2025	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[15/08/2025 09:38:45 Rachael Turner] Job planning process instigated, current position for first level formal meeting 3rd September with Chief of Service. [14/07/2025 12:03:57 Rachael Turner] Risk reviewed.no current change to risk scoring. [17/06/2025 14:54:45 Rachael Turner] Risk reviewed, remains at current position [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.	10	02/09/2023		15/09/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	4731	33	Physical or psychological harm	Landon, Caroline	Landon, Caroline	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.	13/08/2025	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.	[13/08/2025 14:37:26 Rachael Turner] Risk to be presented at RRC&C in September for closure as this risk will be included in risk ID 5680. [09/07/2025 09:59:53 Rachael Turner] Risk meeting booked to add this record to 5680. Risk currently remains at current level with no change to scoring. [17/06/2025 10:59:46 Rachael Turner] Risk reviewed, remains at current level. 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. Once complete this risk will be closed. [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.	4	30/06/2018	31/03/2025	13/09/2025
1c: Improve productivity and deliver financial sustainability	5672	883	Finances	Antunes Goncalves, Paul	Sargeant, Paula	Corporate	17/06/2025	25	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has a £69.8m Financial improvement target for 25/26. 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 6% target of £48m plus the impact from systemwide schemes of £21.8m, totalling £69.8m to breakeven. This is greater than any financial improvement the trust has delivered in previous years. This requires delivery at the same time that the organisation is going through vast amounts of transformation, both as a Group and as part of the Lincolnshire system. This target represents a significant reduction in headcount, and needs to be delivered either without invest to save options or with additional CIP delivered over and above target to support additional resource. 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 - Breakeven Plan - Acute to Community, Analogue to digital. ULHT policy: - Detailed Financial plan inclusive of the headcount reductions has been submitted and ownership is in place for delivery. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial recovery plan aligned to CIP. - Development of Care Group level Schemes assured through PRM's and GLT (Transactional) - Establishment of future looking programme to develop schemes for a sustainable cost improvement programme for the future. This incorporates Acute to Community pathways across the group (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Group Improvement Strategy supported by the transformational team resource. (Targeted) - Divisional CIP targets allocated as part of the budget setting process and removed from budgets. ULHT governance:	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE and through ICB. For 2025/26 the Trust continues to be monitored weekly on the status of the CIP programmes and their level of maturity. The Trust monitors internally against its CIP targets inclusive of specific Care Group and Transformational scheme targets through the PRM's, GLT and PITOF. Scrutiny & oversight is increased as all committees	23/07/2025	Extremely likely (5) >90% chance	Severe (4)	very high risk (20-25)	20	- Support offered to all Care Groups. - Increased CIP governance & monitoring arrangements introduced through PRM's to ensure oversight (including additional one off detailed executive review sessions with care groups). Business cases submitted to NHSE for Delivery support in key areas where capacity & expertise require. - Alignment with the Group Strategy for Acute to Community, Digital To Analogue. - CIP is embedded across the group and resources shared and is not seen as a separate annual work stream. - Development of future programme of cost improvement.	[23/07/2025 12:38:04 Sarah Davy] Agreed at RRCoC 23/7/25 - initial rating 5x5; current rating 5x4 [17/06/2025 11:48:23 Rachael Turner] Risk to be presented at July RRC&C for validation of Very High Risk score of 5x4:20.	4	01/04/2026		23/08/2025

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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	Patient Safety Group	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)	14/07/2025	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.	[14/07/2025 19:07:26 Rachael Turner] Risk reviewed, no change to risk score at this current time. [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. Rota: 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	8	05/06/2025		14/08/2025
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	18/07/2025	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	[18/07/2025 11:02:15 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 therefore risk remains the same. [18/06/2025 10:09:12 Gemma Staples] 20 at risk posts now to be put into the run rate and therefore will be added to Cancer Services budget lines. Further investment will be required, business case written, awaiting CRIG to reopen. [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	8	01/04/2023	01/04/2023	18/08/2025
2b: Empower our people to continuously improve and innovate	4844	38	Service disruption	Bassi, Sangeeta	Saddick, Ahtisham	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 service at ULTH. Current funding allows for the dispensaries to open Monday to Friday 9-5 and weekends mornings only and clinical cover Monday to Friday 9-5. 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. 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.	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 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	22/07/2025	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	[22/07/2025 11:43:44 Lisa Hansford] Awaiting outcome of pharmacy workforce review, which will inform actions to be taken. [23/06/2025 09:22:45 Gemma Staples] The COO commissioned a review of Pharmacy services against local and regional benchmarking against appropriate peer trusts in May 2025. First draft output of this is available to the COO on 23/06/25. Any investment case to extend to 7 day working will potentially follow the output of the review, following improvement initiatives and considering digital development. [19/06/2025 12:23:32 Gemma Staples] Work force review in progress, awaiting outcome before proceeding with business case [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.	4	29/10/2021	21/06/2023	22/08/2025

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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 |
| 2a: Enable our people to fulfil their potential through training, development and education | 5142 | 65 | Physical or psychological harm | Thomson, Cheryl | Lentz, Blanche | WORK | 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. | 26/06/2025 | 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. | [26/06/2025 09:27:15 Rachael Turner] Job planning instigated on the 12th June 25. Implementation October 25.
[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 | 9 | 31/08/2023 | 01/11/2023 | 26/09/2025 |
| 1b: Reduce waiting times for our patients | 5267 | 485 | Physical or psychological harm | Mooney, Mrs Katy | Marsh, David | WORK | 26/09/2023 | 16 | Medicine | Cardiovascular CBU | Cardiology | Trust-wide | 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. | 07/07/2025 | 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.
5. Additional imaging consultant recruited (starts September 2025)-joint funding from CDC/radiology
6. Submitted paper to the Exec Team for £35,000 for an external company to clear 200 scans from the backlog. | [07/07/2025 12:07:42 Rachael Turner] Risk remains, no change to risk score.
[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 are also 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 | 3 | 01/07/2024 | | 07/10/2025 |

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1a: Improve patient safety, patient experience and deliver clinically effective care	4855	207	Physical or psychological harm	Chantry, Chris	Chantry, Chris		10/02/2022	16	Family Health	Women's Health and Breast CBU	Breast Services		There is a risk of delayed diagnosis of breast cancer and increased waits for treatment of confirmed cancers as a result of insufficient staffing and clinic capacity within the Breast service, Pathology and Oncology, which could lead to increased patient harm. This could also lead to staff fatigue through the provision of additional clinics to reduce delays.	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.	[18/06/2025 16:07:11 Gemma Staples] Quality Committee requested that risk be reviewed and the narrative made clearer. Risk description has been updated. [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 priority risk – Risk ID001 on the corporate ICB cancer risk register. Increase in likelihood to Quite Likely - to be presented to RRC&C in January for	4	31/12/2021	29/12/2023	15/08/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5520	753	Physical or psychological harm	Landon, Caroline	Constantin, Dr Carmen		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.	[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	24/06/2025	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.	[30/06/2025 19:05:24 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. [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	4	31/03/2023	31/03/2023	24/06/2025

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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	04/08/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ICB having conversations regionally - Lauren Rigby - August 2025	[04/08/2025 11:07:18 Gemma Staples] Risk reviewed and remains the same. The waiting time is currently 14 weeks for this service. [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	4		07/05/2026	04/11/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5533	754	Physical or psychological harm	Mooney, Mrs Katy	Constantin, Dr Carmen		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 had have 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	07/05/2025	07/08/2025
2a: Enable our people to fulfil their potential through training, development and education	5469	697	Service disruption	Rinaldi, Dr Ciro	Chabani, 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 liaising 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	21/06/2024	21/06/2025	19/08/2025

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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	18/07/2025	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	[18/07/2025 11:00:02 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 therefore risk remains the same. [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 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	4	31/03/2023	31/03/2023	17/10/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5306	713	Physical or psychological harm	Cooper, Mrs Anita	Rambani, Reena		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 Complaints and PALS Survey Pending Infection prevention & control surveillance and audits	16/06/2025	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.	[16/06/2025 11:55:54 Gemma Staples] The risk remains unchanged. Royal college of Pathology workforce Survey suggest a median of 5.6–7.2 infection consultants per 1,000 acute beds. In our case, we have an establishment of only 6 WTE Consultant Microbiologists covering two acute NHS Trusts – NLaG and ULHT – with a combined bed base of over 2,000, in addition to diagnostic support for GP surgeries across Lincolnshire, North Lincolnshire, and North East Lincolnshire. Currently, we have 4 substantive consultants and 2 long-term locums. Even if all posts were filled substantively, we would still fall below recommended levels. The Microbiology service is under significant pressure due to rising demand for infection services, increasing antimicrobial resistance, and workforce shortages. Consultant microbiologists are critical for infection prevention and control (IPC), diagnostic stewardship, and antimicrobial stewardship (AMS), both in hospital and community settings. However, the current workforce is stretched beyond capacity. Consultant microbiologists often cover multiple hospital sites, provide 24/7 support, and manage increasingly complex clinical and diagnostic workloads. This contributes to staff burnout and compromises service resilience and patient safety. There is an urgent need to expand the consultant microbiologist workforce. Investing in additional posts will ensure robust IPC, reduce avoidable infections, improve antimicrobial prescribing, and support high-quality, sustainable infection services across our system. [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	4	30/11/2025	01/06/2025	16/09/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	4868	64	Physical or psychological harm	Bassi, Sangeeta	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.	19/06/2025	Quite likely (4) 71-90% chance	Severe (4)	High level (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.	[19/06/2025 10:46:19 Gemma Staples] Our plan is to audit current practice, complete risk assessments, confirm boxes to purchase for them, review any other mitigations that arise, agree with Chief Pharmacist the way forward and monitor through S&S - Completion date August 2025. [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	4	30/09/2022	31/03/2023	19/09/2025
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		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.	03/07/2025	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.	[03/07/2025 14:09:11 Nicola Cornish] Business case has been written and seals of approval obtained - due to be presented to CRIG on 29th July and then submitted to the ICB for values framework assessment. [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		03/10/2025
2b: Empower our people to continuously improve and innovate	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

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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	24/07/2025	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.	[25/07/2025 10:40:46 Nicola Cornish] Charitable funds have been requested to assist with refurbishing the room currently used to make this a more comforting environment for bereaved parents to be in. [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		24/10/2025
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	24/07/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Exploring with theatres the ability to provide further El LSCS lists across both sites.	[24/07/2025 15:21:32 Nicola Cornish] This has been approved at cabinet for reduction to 3x4 due to mitigations in place. List for RRC&C meeting in August for final approval. [18/06/2025 13:39:54 Gemma Staples] Following a deep dive with Quality Committee, it was asked if this risk was still a high risk due to the mitigations in place. Risk reviewed and agreed this could be lowered from a 4x4(16) to a 3x4(12). To be taken to cabinet for agreement and would then need to go to RRC&C for approval. [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		24/10/2025
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.	24/07/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To inform teams of the risk controls in place. Coordinate Estates to undertake the works on Theatre 8a to minimise disruption as soon as practicably possible.	[24/07/2025 15:43:53 Nicola Cornish] No further update, no adverse incidents being reported. [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 picked up as part of overall refurb at Pilgrim. [04/04/2024 10:33:53 Nicola Cornish] Risk reviewed, no change. [31/01/2024 13:01:35 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024. Need to know frequency when this is happening. Agreed currently that this sits at a 4x4: 16 High Risk. Link to be added around regulations.	6	01/01/2025		24/10/2025

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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 the ICB's non-commissioning of Senior Medical Immunology expertise within Lincolnshire, there is a risk that medication will be prescribed, supplied and administered by ULTH healthcare staff without clear senior medical input for clinical review, monitoring, and escalation, for the IVIG patients that reside within Lincolnshire. This could lead to patient harm (inappropriate treatment and risk of adverse drug reactions including when switching molecules, inappropriate treatment duration), reputational damage, and is a professional, and regulatory risk. There is also a financial risk as ULTH will be unable to switch patients in accordance with the national NHSE IVIG framework by September 2025 because the is no expert clinical review of the patients.	NHSE Immunoglobulin clinical commissioning policy Local Immunoglobulin Panel (IAP) and Sub regional Immunoglobulin Panel (SRIAP)	Patient incidents and complaints reported through Datix National framework switch being completed/not completed in time by September 2025 Financial enabler scheme/CIP targets being met/not met by December 2025 Monthly contract challenges from NHSE (challenge value and non-payment accrued) Monthly KPIs monitored by sub regional IVIg panel (SRIAP) Monthly KPIs monitored by local IVIg panel (ULTH IAP)	17/04/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Work with ICB to either employ an immunologist or have a local agreement with a neighbouring Trust to access senior immunologist input - Sunil Hindocha/Colin Farquharson - August 2025 Shared Care arrangements and prescribing accountabilities to be reviewed - Sunil Hindocha/Colin Farquharson - August 2025	[19/06/2025 22:55:24 Gemma Staples] Risk reviewed and reworded. [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	4	01/10/2021	31/07/2023	17/07/2025
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.	10/06/2025	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	30/06/2024	10/09/2025	
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 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 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	

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2a: Enable our people to fulfil their potential through training, development and education	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	06/08/2025	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	[06/08/2025 09:36:54 Gemma Staples] The training package is not on ESR yet, hoping once been through NMAFF group at the end of August that it will be on early part of Sept. [19/06/2025 10:25:39 Gemma Staples] Awaiting update from Lovelyn Ndubuisi Okoroezi by 20th June. [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	8	31/03/2025	31/03/2025	06/11/2025
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.	04/07/2025	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	[04/07/2025 13:01:35 Rachael Turner] Work currently being undertaken to review this risk for possible closure and replacement with new risk looking at estates CBU perspective. Update to be provided. [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).	10	28/03/2024	28/03/2024	04/10/2025
1d: Provide modern, clean and fit for purpose care settings	5234	510	Service disruption	Lynch, Diane	Biddulph, Victoria		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	26/08/2024	29/08/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	4746	121	Physical risk of 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		As a result of a backlog of patients on the Trust-wide Ophthalmology Partial Booking Waiting List, patients are waiting longer for follow up than timescale specified by clinician. There is a risk of undetected deterioration of their eye condition whilst waiting to be seen which may result in permanent sight loss.	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. Both clinical and non-clinical validation undertaken to prioritise according to urgency and verify that patients are accurately recorded and still require an appointment. Ophthalmology pathway prioritisation project plan led by project management team following peer review visit to Exeter.	Monitoring Ophthalmology PBWL Clinical harm reviews / reported incidents due to appointment delays	25/07/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to ensure future sustainability once recovered.	[25/07/2025 12:17:39 Nicola Cornish] Risk reviewed with Leanne Chamberlain. There has been an increase of severe harm incidents being reported and the PSRPM suggested that the scoring this risk should be reviewed for a potential increase. Proposal is to increase from 4x4 to 5x4 to reflect the increase in likelihood and Cabinet has agreed to. To be listed for RRC&C in August for final approval. [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.	4	31/07/2021	30/06/2022	25/10/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5614	825	Service disruption	Fullowby, Mr Ian	Woods, Mr Michael	Clinical Effectiveness Group	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 IQIPS 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.	24/06/2025	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 - August 2025 Action planning from the UKAS Benchmarking visit is underway - Michael Woods - August 2025 Review of waiting list currently underway - Michael Woods + Victoria Biddulph - August 2025 Reviewing with Procurement options around temporary booth hire as an interim resolve for the CoN for refurbishment – this is not possible without significant investment in enabling works - Michael Woods + Clare Wright – September 2025	[24/06/2025 13:24:48 Gemma Staples] We have not been able to source a locum paediatric Audiologist, we have just appointed a temporary support post to Bank, but that's only short term for part time hours in a supporting role and will have to go through the full Trust process to appointment No movement on the paperwork due to the increased clinical demands on the service. Case of need still in progress + paper being written to support insourcing. Review of waiting list on hold due to staff shortages due to the vacancy freeze. Temp booth hire and installation at Pilgrim site is not possible without significant investment in enabling works. No new spaces for a paediatric booth identified as yet by Estates. No responses to requests for information on the replacement booth lost from Newborn Screening service. [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	31/03/2025	31/03/2026	24/09/2025
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 Specialist Palliative Care service being severely under resourced we are not being compliant with the Health Act, NHS England Service specification, NICE guidance and integrated care systems. There is a deficit in access and inequity to specialist palliative care for patient's, care partners and other health care professionals. This will result in patient harm including delays in assessment, increase length of stay, readmissions and dying outside of preferred place of care.	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 Lincolnshire - 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	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

Strategic Objective	ID	DCQI 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	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 pic 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 to be 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 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 | 23/05/2025 | 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 | [19/06/2025 10:58:29 Rachael Turner] Emergency lighting included following assurance and PPM review. new Fire group policy reviewed within FSG prior to approval. New staff training protocol reviewed in FSG with implementation of new training programme commencing June 2025
[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 benefits 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 | 10 | 31/03/2022 | 31/03/2025 | 23/08/2025 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 4789 | 32 | Service disruption | Landon, Caroline | Venugopal, Mr Vinod | | 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. | 07/07/2025 | 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 | [04/08/2025 08:42:18 Gemma Staples] Below should state 4x4(16) and not 4x4(12)
[23/07/2025 15:33:27 Gemma Staples] Risk increase 4x4(12) presented at RRC&C 23/07 and approved.
[07/07/2025 11:37:01 Rachael Turner] Risk is being presented at Risk Confirm and Challenge this month for increase in score.
[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 have 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. | 4 | 01/02/2024 | | 07/10/2025 |

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
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		Lincoln County Hospital	As a result of prolonged and unresolved estates related issues, including temporary relocation of Occupational Therapy staff into Physiotherapy Department and the decanting of the Rehabilitation Medicine Team into reduced and unsuitable space at Lincoln County Hospital, staff and patients continue to be affected by environmental and infrastructure shortcomings. These include overcrowding, poor temperature control and ventilation, inadequate clinical and patient facilities, and general deterioration of furnishings and building systems. Despite being approved as a temporary measure, the situation has remained unresolved for over 12 months. There is a risk that the ongoing substandard working and treatment environment will result in reputational damage to the organisation, stemming from negative staff and patient experiences and perceptions.	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 Ongoing review of space Curtains in place in the clinical area which will increase clinical space, which will also reduce noise levels. Staff who want to come to work in their uniform are doing so Hot desking room created in the department Increase in laptops provided so staff can go and work on the wards New site lead office to increase space in the department Bookable clinic room procedure made more robust Use of onsite facilities for meetings	IPC flo scores / Monthly audits Datix incidents Staff surveys / leavers feedback Staff concerns / complaints Complaints / PALS H&S audits Walkaround with Estates and log jobs	30/07/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Work with Estates to identify better facilities – Ruth Taylor – December 2025 Business Case is required to implement any service move to another space – Rebecca Johnson – December 2025	[30/07/2025 16:57:07 Gemma Staples] Following RRC&C meeting on 23/07 for an increase in scoring for risk 5428. It was asked that the risk be taken away and include the wording of the deteriorating situation and liaise with Chris Davies. We reviewed all risks and identified this risk is the same risk so have merged them both together and updated the wording of this risk to combine both risks together. A meeting is to be arranged with Estates. [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	4	31/03/2022	31/03/2023	30/10/2025
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 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	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 resilience. 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 a 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

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1a: Improve patient safety, patient experience and deliver clinically effective care	5491	701	Physical or psychological harm	Parkhill, Michael	Bailey, Karen	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.	18/07/2025	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 risk.	[18/07/2025 11:41:52 Gemma Staples] Risk reviewed and there is no further update, however attached to the risk are the latest action plans and reports. [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		17/10/2025
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	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
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	5598	853	Physical or psychological harm	Landon, Caroline	Constantin, Dr Carmen		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	07/07/2025	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. Action 4. Risk reduction Ward co-ordinator along with On-call consultant and/or ACP to identify any individuals suitable to be stepped down when appropriate, consider outlying stable ward patients to ensure flow through pathway re-instated when able. Action 5. Risk reduction & feed into increased HASU Capacity	[07/07/2025 11:35:34 Rachael Turner] Risk reviewed, risk remains at current level with no current change risk score. [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		07/10/2025

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2b: Empower our people to continuously improve and innovate	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	Anderton, Kerry		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.	23/06/2025	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.	[23/06/2025 17:18:27 Rachael Turner] Currently undergoing a service review of HOOH's. They are looking at everything; what we do, where we cover, reviewing our overnight staffing levels and the whole weekend service. We hope to go to CRIG in the next couple of months. The first steps are a comprehensive review utilising Nerve centre's audit function, and surveying the resident Dr's on weekend working and how the team may (or may not) help them and their wellbeing. [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		23/09/2025
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

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3c. Enhance our digital, research and innovation capability	5519	739	Regulatory compliance	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 or 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	08/10/2024		27/08/2025
2d: Recognising our people through thanks and celebration	4780	74	Service disruption	Mooney, Mrs Katy	Constantin, Dr Carmen		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	07/07/2025	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 Action 4. Further consultant stroke practitioner post & support Stroke registrars to become stroke consultants. Action 5. Redesigned stroke pathway.	[07/07/2025 11:39:58 Rachael Turner] Risk reviewed, recruitment still remains at issue due to national shortage. Risk remains at current level. [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.	8	31/03/2022	01/07/2024	07/10/2025
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	14/08/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[14/08/2025 15:48:30 Rachael Turner] Risk reviewed, specialty teaching fellow for HCoLL – this remains the same. [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	14/11/2025

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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 NHS England Service specifications for specialist palliative care. Resulting in lack of skilled professionals to provide specialist palliative care and negative impact on staff wellbeing. Specialist Palliative currently has absence data way above national average with a risk of poor staff retention, recruitment and impacting sustainability. Staffing deficit results in increase in 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	02/07/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business Case written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026	[02/07/2025 13:38:44 Gemma Staples] RTW in progress for staff member who was on long term sick leave Potential withdrawal of Macmillan In reach service could increase demand on service by approx. 200 patient/year. Still under review. Options appraisal and QIA submitted. New data process in place to showcase demand on current resource. Business case has not moved forward. Still awaiting invite to CRIG Morning huddle and check out sessions continue SOP in progress. Draft circulated to team for comment. [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.	8	30/12/2024		02/10/2025
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.	18/07/2025	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.	[18/07/2025 12:17:26 Gemma Staples] Risk reviewed and remains the same. [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 243m³/243,000L, This is potable quality water & will supply the hospital for approx. 20 hours.	5	31/03/2026	31/03/2026	17/10/2025
1b: Reduce waiting times for our patients	5381	560	Service disruption	Landon, Caroline	Anderton, Kerry		09/02/2024	15	Corporate	Operations	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 within budget and relies 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.	23/06/2025	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.	[23/06/2025 17:22:40 Rachael Turner] Risk reviewed, risk remains at current risk score [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		23/09/2025

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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.	24/07/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	[24/07/2025 15:28:23 Nicola Cornish] Immediate IPC actions were undertaken as required and work continues with Estates to agree the refurb configuration. [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.	6	31/03/2025	31/03/2025	24/10/2025
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	Trust-wide	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
2b: Empower our people to continuously improve and innovate	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.	30/07/2025	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	[08/08/2025 08:38:10 Gemma Staples] Following the request to review if the risk can be reduced from the People Committee deep dive. The risk owner confirmed that the rationale for not reducing is related to therapies still supporting areas where there is now increased resource allocated, this isn't likely to change as we go into winter eg escalation beds, the Lancaster ward project. We also need to complete workforce review piece of work. I would envisage that once that is done, we could then reduce the risk. I wouldn't want to reduce until we have some stability if that makes sense. We are also still trying to on board vacancies and reduce bank and agency use. [30/07/2025 11:30:52 Gemma Staples] Capacity & demand delivery work ongoing. Some improvements in Therapy establishment now being filled. Neuro Rehabilitation transformation work commenced with LCHS and relevant stakeholder partners. [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	9	30/09/2023	18/12/2023	30/10/2025

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
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	5535	784	Physical or psychological harm	Mooney, Mrs Katy	Constantin, Dr Carmen		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	07/07/2025	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	[07/07/2025 11:44:37 Rachael Turner] Risk reviewed, no current change. Risk score to remain at current level. [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		07/10/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5196	309	Regulatory compliance	Bass, Sangeeta	Moore, Lisa-Marie		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. | 19/06/2025 | 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 | [19/06/2025 10:31:10 Gemma Staples] Reviewing current audit tool and any other audits related to medicines with a view to closing this risk in September. [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 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 | | 19/09/2025 |
| 1d: Provide modern, clean and fit for purpose care settings | 4830 | 11 | Service disruption | Parkhill, Michael | Savill, Allen | Estates Infrastructure and Environment Group; Medicines Quality Group | 17/01/2022 | 15 | Corporate | Estates and Facilities | Estates | 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 his 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 | 30/06/2025 | 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 | [30/06/2025 14:44:45 Rachael Turner] Risk reviewed to include updates from Estates perspective of risk reduction plan. Agreed that risk score should remain as 5x3:15 High Risk. [25/06/2025 09:25:24 Rachael Turner] Risk agreed to be transferred to Estates. Meeting booked Monday 30th June for full review. [23/06/2025 09:11:45 Gemma Staples] Risk remains the same. The risk has been requested to move to Estates - awaiting a response from Estates. [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 at 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 | 6 | 30/09/2021 | 31/03/2022 | 30/09/2025 |

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 (current)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
2b: Empower our people to continuously improve and innovate	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 to maternity cover.	2	05/07/2025		13/09/2025
1d: Provide modern, clean and fit for purpose care settings	5498	726	Regulatory compliance	Parkhill, Michael	Prydderch, Andrew	Health and Safety Group	19/08/2024	15	Corporate	Estates and Facilities	Estates	Trust-wide	As a result of the poor condition of the PHB and LCH helipads they pose a risk to arriving crews (they cannot see it due to poor lighting and no demarcation) but also carry risk where they are accessible for anyone to get onto the helipad during landing. The helipads fail against the CAP1264 Civil Aviation standard for NHS Helipads due to the above concerns, design and fabric. There is a severe risk of harm or death to persons in the vicinity of the helipads (up to 50m) from the downwash. Issues at other NHS sites with downwash have resulted in a visitor death. LCH has also incurred incidents with people accessing the pad during landing and at other times.	Estates maintain the pads as best resources allow. Security attend the pads during landings when aware and able.	Datix, ED arrival mode data, data from the air ambulance service and anecdotal information from the Lincs & Notts Air Ambulance Unit Chief Pilot	13/06/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Action 1. Estates and Facilities take immediate action when notified of issues. Action 2. Working with the Hospital Emergency Landing Pad (HELP) appeal and Green Deck Operations, obtaining surveys for options and developing a business case to improve conditions and become compliant. Green Deck appeal have offered to fund the works required to existing pads once the plan is developed. Currently we need to review options available at Lincoln & Boston. Action 3. Once investment in place, Ops to work on Governance compliance for CAP1264 Civil Aviation standard. Action 4. Meeting to be had with Lee Taylor as we need to have an accurate recorded data process for recording when a helipad lands.	[23/07/2025 13:02:25 Sarah Davy] Agreed to increase in score at RRCoC 23/7/25 - 5x3 = 15 from 5x2 = 10 [13/06/2025 10:04:36 Rachael Turner] Risk reviewed, risk updated to be a regulatory compliance risk. We are currently not compliant as a Trust against the CAP1264 Civil Aviation standard for NHS Helipads due to the above concerns, design and fabric. Risk reduction plan updated to reflect current position. Due to change in risk type risk score proposed for increase in score to 5x3:15 High Risk. This risk will be presented at RRC&C in July for increase in score [21/01/2025 12:22:03 Rachael Turner] Risk assessment has been carried out, paper was due to be presented to Execs-feedback required from Richard Townsend. [25/09/2024 14:13:35 Rachael Turner] Risk presented at Risk Confirm and Challenge 25/09/2024. Risk score agreed as 2x5:10 Moderate Risk. [19/08/2024 13:19:12 Rachael Turner] Risk to be presented by Richard Townsend at RRC&C for validation for score of 15 High risk at September meeting.	3	31/03/2026		13/09/2025
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	5169	60	Physical or psychological harm	Constantin, Dr Carmen	Constantin, Dr Carmen		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	04/08/2025	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	[04/08/2025 09:23:02 Gemma Staples] The Consultant AHP post has been appointed, work continues in regards to increasing bed base and staffing levels, currently the risk continues. [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.	3	13/05/2024		04/11/2025

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 (current)	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		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	07/07/2025	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	[07/07/2025 16:27:20 Gemma Staples] We're still waiting for an update from Estates regarding whether they can carry out the work and, if so, what the cost would be. This has been escalated to Sarah Chester-Buckley. [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	3	13/02/2025	13/02/2025	07/10/2025

Group Board Assurance Framework (BAF)

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2 September 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;* • *Confirm the proposal for the change to the assurance rating of objective 2a, from amber to green;* • *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

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.

The BAF has reviewed by all Committees during July and August and narrative updates provided. During the August People Committee consideration of the assurance ratings, in respect of objective 2a, was held with a view that this should be moved from amber to green due to the increased assurances being offered to the committee. There was recognition that this was support through the reporting group as well as the quality of the papers being presented, demonstrating that 'effective controls are definitely in place and the board is satisfied that appropriate assurances are in place.

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;

- Confirm the proposal for the change to the assurance rating of objective 2a, from amber to green due to the increased assurances being received by the People Committee;

- agree the need for any additional actions or assurances at this stage.

Lincolnshire Community & Hospitals NHS Group (LCHG)

Group Board Assurance Framework (BAF)

As at August 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:

Risk type	Impact / Severity score & descriptor (with examples)				
	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 August 2025

Strategic Aim	Strategic Objective	Strategic Risk	Executive Lead(s)	Board Committee Oversight	Current Risk Score (as at August 2025)	Target Risk Score (March 2026)	Assurance Rating (as at August 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			**12** **(Moderate)**	**8** **(Moderate)**	**Amber**	**Green**
	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)

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Last Review Date:	August 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	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	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	There are a significant number of policies across the group which are out of date
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

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 as a priority for bringing all out of date documents into compliance. Performance to be monitored through monthly PRMs with escalation to ELT / GLT as required	Group Director of Corporate Affairs	Deputy Trust Secretary	30 September 2025 (Agreement of Improvement Trajectory) 31 March 2026 (Improvement Performance)	Underway – paper being submitted to ELT on Thursday, 31 July 2025. Performance also being monitored from an assurance perspective through the Audit Committee
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	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

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)		Gaps in Assurance	
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	1	Reporting sub-groups not yet aligned
2	Reporting on quality & safety KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)	2	IPR not yet aligned
3	QIAs reviewed by care groups and executives with Quality Committee oversight	3	QIAs not universally used across the group
4	Learning from incidents reported to the Patient Safety Group and disseminated across the group	4	The occurrence of repeated or same type incidents suggests processes for learning lessons are not yet fully embedded across the group
5	Incident themes & trends monitored through the Patient Safety Group	5	None identified
6	Delivery of quality & safety KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight	6	None identified
7	Local level and Group Board Maternity & Neonatal Safety Champions in place with reporting to the Group Board	7	None identified
8	Internal & external audit, external reviews and visits provide independent assurance of the robustness of the group's quality governance arrangements	8	None identified
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	9	Medical Devices Group to be renamed to be representative of the LCH group

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	Board and board committees have been aligned and executive governance structures agreed. Some final work to complete to align the committee reporting sub-groups. **Proposed revised deadline 31 August 2025**
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	Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet complete. **Proposed revised deadline of 31 August 2025**
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	4879	20	Recovery of planned care cancer pathways
ULTH	4947	20	Inability to meet NICE medicines reconciliation
ULTH	5016	20	Patient flow through ED
~~ULTH~~	~~5100~~	~~20~~	~~Acute paediatric epilepsy pathway~~
ULTH	5101	20	Community and Acute paediatric epilepsy pathway
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)

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Last Review Date:	August 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	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	Amber	Amber							

	Identified Controls *(What are we already doing to manage the risk?)*		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 agreed	1	Quality & safety and patient experience priorities and KPIs being refreshed
2	Patient Experience & Involvement Team in place	2	• Group approach to Patient Panels agreed and being implemented • There are currently workforce gaps in the Patient Experience Team
3	Established complaints & PALS teams	3	None identified
4	Group Complaints & PALS Policy agreed	4	None identified
5	Improvement Plans developed in response to national patient experience surveys	5	Lack of staff engagement has the potential to lead to a lack of timely implementation of improvement plans
6	PLACE reviews completed and improvement plans developed	6	PLACE improvement plan not yet delivered

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	Completed
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

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)		Gaps in Assurance	
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	1	Reporting sub-groups not yet aligned
2	Reporting on quality & safety and patient experience KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)	2	IPR not yet aligned
3	Patient Stores are heard at the Group Board	3	None identified
4	Patient Experience data is gathered and improvements tracked through the Patient Experience & Involvement Group	4	Triangulation of patient experience data with other sources of information e.g. complaints, PALS etc. requires strengthening
5	Delivery of patient experience KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight	5	None identified
6	Internal & external audit, patient surveys, PLACE reviews etc. provide independent assurance on the quality of the patient experience	6	None identified

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	Board and board committees have been aligned and executive governance structures agreed. Some final work to complete to align the committee reporting sub-groups **Proposed revised deadline 31 August 2025**
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	Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet

							complete. Proposed revised deadline of 31 August 2025

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:	August 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	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	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 and governance groups require strengthening
3	None identified
4	None identified
5	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					

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)		Gaps in Assurance	
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	1	Reporting sub-groups not yet aligned
2	Reporting on quality & safety and clinical effectiveness KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)	2	IPR not yet aligned
3	Learning from deaths reported to the Clinical Effectiveness Group and disseminated across the group	3	None identified
4	There is oversight of delivery of the clinical audit programme through the Clinical Effectiveness Group with reporting to the Quality Committee as required	4	'Outlier' status has been received for some of the National audit projects
5	There is oversight of compliance with NICE guidance through the Clinical Effectiveness Group with escalation to the Quality Committee as required	5	None identified
6	Delivery of clinical effectiveness KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight	6	None identified
7	Internal & external audit, external reviews and visits provide independent assurance	7	None identified

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	Board and board committees have been aligned and executive governance structures agreed. Some final work to complete to align the committee reporting sub-groups. **Proposed revised deadline 31 August 2025**
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	Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 /

				26 and alignment of the IPR is not yet complete. **Proposed revised deadline of 31 August 2025**

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)

Assurance Rating & Movement since last review:

Amber

Last Review Date:	June 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

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	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	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
8	45 minute ambulance 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 capacity not substantially funded
5	SDEC on both sites not large enough
6	Debate regarding 'send' to assessment areas remains ongoing
7	Not all specialty teams attend ED within 30 minutes of request in line with IP standards
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	Work is ongoing internally to increase SDEC / assessment centres 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	Completed
4	Escalation Policy & Full Capacity Protocol to be reviewed and aligned	Group Chief Operating Officer	Group Deputy Chief Operating Officer	31 July 2025	Underway

Sources of Assurance (1st, 2nd and 3rd Line) *(How we know the controls are working effectively)*		Gaps in Assurance	
1	OPEL triggers regularly used and activated	1	None identified
2	ED activity, flow and LoS regularly reviewed by site teams and issues escalated through the #daily capacity meetings	2	
3	Improvement trajectories in respect of ED performance and expectations agreed for all specialties	3	
4	Suite of metrics in place to measure improvements and focus Care Group leadership teams on discharge target	4	
5	ED performance monitored through the Unplanned Care Group and System Unplanned Care Partnership Board	5	
6	Delivery of ED performance and improvements reviewed through the Care Group PRMs	6	
7	Reporting on ED performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board as required	7	
8	Sustained improvements seen across the UEC pathway: standard currently being delivered	8	

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:	June 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	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	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 '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

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	Group Chief Operating Officer	Deputy Group Chief Operating Officer	31 October 2025	Underway

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)		Gaps in Assurance	
1	RTT and cancer improvement trajectories agreed for all specialties	1	IPR is not comprehensive
2	Theatre dashboard in place and monitored through the Planned Care Group	2	Reports to committee and ELT require improvement
3	RTT & cancer performance monitored through the Planned Care Group	3	
4	Delivery of RTT and cancer performance and improvements reviewed through the Care Group PRMs	4	
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	5	
6	Improved performance: sustained backlog reduction	6	
7	Internal audit review of RTT pathways within ULTH during 2025 / 26 provided 'reasonable assurance)	7	

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	Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet complete. **Proposed revised deadline of 31 August 2025**

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:	August 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	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	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 organisation 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.

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	Completed – 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	31 October 2025	Underway – 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	Group PMAF approved 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 – Terms of Reference being finalised on investment process

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)		Gaps in Assurance	
1	Oversight of finance and key risks by the Finance & Performance Committee and reporting sub-groups with escalation to the Group Board as required	1	Reporting sub-groups not yet aligned
2	Reporting on finance KPIs to the Finance & Performance Committee and Group Board through the Integrated Performance Report (IPR)	2	IPR not yet aligned
3	Internal & external audit arrangements in place	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 performance management and data quality within ULTH during 2024 / 25 provided 'reasonable assurance'	4	Internal audit review of overseas and contracts within ULTH provided 'limited assurance'
5	Assessment of 'grip and control' undertaken by external parties including through ICB and regulator challenge	5	None identified

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	Completed – clarity on reporting of efficiency (PITOF and PRMs) and activity (Planned and Unplanned Steering Groups), further work ongoing on other finance indicators
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	Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet complete. Proposed revised deadline of 31 August 2025
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
ULTH	5672	20	Risk of failure to deliver the CIP target in full for 2025/2026

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

ULTH	4839	20	Lack of pharmacy capacity for intravenous immunoglobulins

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:	August 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	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	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 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 £123m 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

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~~Completed
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	Completed
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	Specification market tested & evaluations currently being undertaken to appoint a provider ~~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 & Facilities Officer	Group Chief Estates & Facilities Officer	30 April 2025	Completed
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

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)		**Gaps in Assurance**	
1	Increased levels of compliance with EFM statutory compliance requirements as demonstrated through internal audits, external condition surveys, AE audits etc.	1	EFM compliance dashboards not yet fully aligned
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	2	LCHS: AE audit programme for relevant HTMs not yet in place for LCHS premises ULTH: None identified
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 improvement in compliance across most domains	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	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	4	Reliability of LCHS Estates Returns Information Collection (ERIC) scores to be evaluated
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	5	Shortfalls in housekeeping staffing levels, due to difficulties in recruiting, have the potential to impact on PLACE scores
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'	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 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	Align the process for the completion and submission of the PAM by the 30 September deadline and strengthen the process for the delivery and oversight of agreed improvement actions through the year	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	30 September 2025	Underway
4	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 Officer	Group Director of Corporate Affairs	6 May 2025	Complete: Board Committee Work Plans & '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:	August 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~~Green

⇅

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	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	Amber	Green							

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%. ESR Hierarchy reviews planned twice per year to support accurate reporting and management of non-compliance.
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

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 There is a plan in place to now send out ESR Hierarchy Reports twice per year to the Care Groups across the Group (planned to take place March in line with readiness for new financial year, and August (post Dr rotation) for mid-year review). Monthly reporting in place for Key Performance Indicators for the regular oversight of training, appraisal and workforce metrics to support compliance monitoring – this reports via a dashboard to Workforce Strategy Group and People Committee.	Group Chief People Officer	Head of Workforce Planning & Reporting / People Systems Manager	30 June 2025	Completed – embedded and added to controls and assurances continues to be embedded
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	31 May 2025	Completed – continues to be embedded
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 embedded
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 ULTH has currently 'stood down' FPMA meetings so packs have not been created within 2025/26. It is not yet confirmed if these will be re-instated in year or not. Work had been done on the packs prior to cancellation of meetings and will continue once refreshed meeting are in place (as required).	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	Completed – continues to be fully embedded **Proposed revised deadline of 31 March 2026**
6 People Promise work streams embedded within the Reward, Recognition & Engagement Manager role within the Education, Learning & Organisational Development Team to maintain oversight of People Promise themes	Group Chief People Officer	Education & Learning Manager	31 March 2026	Underway – on track

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)		Gaps in Assurance	
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	1	Sub-Groups ensuring that agenda items and upward reports are in line with People Committee annual plan
2	Reporting on People KPIs to the People Committee and Group Board through the Integrated Performance Report (IPR). Mandatory training compliance continues to improve	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	Reporting on medical and non-medical education and medical revalidation to the People Committee	3	None identified
4	Reporting on safer staffing (including training and knowledge gaps) to the People Committee	4	None identified
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	5	Alignment to PRM Packs required to ensure consistency of data and reporting by exception
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'	6	Limited oversight of group-wide audit schedule where there is an impact on people. Audit of LCHS areas unclear
7	National and regional benchmarking data considered through the People Committee and reporting sub-groups	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	External oversight and assurance in respect of people performance is undertaken through the Lincolnshire People Board/Workforce Committee	8	None identified

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 work plan and ensuring that each sub-group is aware of its reporting objectives in year. This is now in place with enhanced communication by way of agenda sharing and workplan being accessible from Trust Board papers which sets out workplan.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	31 July 2025	Completed – embedded and added to controls and assurances 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 embedded
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
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	30 September 2025	Underway – on track

				Planning & Reporting	
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
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 embedded
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 embedded
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

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)

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Last Review Date:	August 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	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	Amber	Amber							

Identified Controls (What are we already doing to manage the risk?)		Gaps in Controls (What are the gaps in control that are required to manage the risk)	
1	Education, learning and development programmes and KPIs in place	1	Delivery of action plans and improvements at operational level needs to be incorporated into the Performance Management & Accountability and PRM process
2	Engagement 'Tube Map' – 'Better Together' Programme in place and ongoing including OD support	2	Staff awareness at all levels of group strategy, values and approach to innovation and continuous improvement remains ongoing
3	Improved job planning compliance rate to 95% with supporting evidence in place, and a move towards a prospective cycle.	3	2023 / 24 and 2024 / 25 job plans are still being finalised although significant improvements have been made
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	4	Division/Clinical Care Groups not yet fully owning the '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	5	Capacity of staff to engage with improvement agenda to be determined
6	Creating a culture of research and innovation recognised as a group priority	6	Culture of research and innovation not yet embedded

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
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	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 & embedded and added to controls or assurances**~~Completed – continues to be embedded~~
4	Plan for Every Post standardised framework in development to support ownership at Divisional Care Group level with clarity on roles and responsibilities and core enablers.				

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 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 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 Planning & Reporting	30 June 2025	Completed – continues to be embedded
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 embedded
3	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing	Group Chief	Deputy Group	30 June 2025	Completed –

4	the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year.	People Officer	Chief People Officer / Head of Workforce Planning & Reporting		continues to be embedded
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	Completed – continues to be embedded

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**
ULTH	4997		Service configuration (Haematology)
ULTH	5093		Procurement service staffing levels (Pharmacy)
ULTH	4844	20	Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service

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:	August 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	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	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

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	Group Chief People Officer	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	Group Chief People Officer	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	Group Chief People Officer	Head of Education & Learning/Occupational Health	31 March 2026	Underway – on track

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 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 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 embedded
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 work plan 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 embedded

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:	August 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	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	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 work streams 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

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 embedded
2	Review how the Reward, Recognition and Engagement Manager role aligns to wider LCHG work streams and how the role can bring insights to wider work streams, 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 embedded

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	Gaps in Assurance
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)	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 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	2 Monitoring of action plan progress not fully embedded within sub-groups and relevant upward reporting
3 Pastoral care award received for recruitment and on-boarding of international nurses	3 None identified
4 Internal audit of people agenda provides independent assurance	4 None identified in respect of reward and recognition

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	Completed – continues to be embedded
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	Group Head of OD	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:	August 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	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	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
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 rationalisation 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 has met twice with internal group representations in June and July (stood down in August due to number of apologies/availability of key members)
2	Alliance Steering Group sub-groups on planned / unplanned care group transformation, left shift re-design programme are all now in place and integrated neighborhood teams not yet commenced (HI group well-established)
3	Governance and reporting being refined in support of transformation programme, with a Programme Manager allocated to support good governance and oversight of the 4 programmes
4	Sub-groups being established with partners supported by the diagnostic by Newton's (commencing in August), supported by workshops on each work stream and the Alliance in development
5	Partnership Strategy needs to be refreshed in line with the Group Strategy and Alliance Model (aiming to table at September Integration Committee)
6	Spectrum of integration options to be formalised for all partners based on Partnership Strategy
7	Read-across to the other three working groups to be established as they are developed
8	No aligned Estates Strategy across the 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	Alliance Steering Group first meeting with external partners expected to be arranged for September~~July~~ 2025 with terms of reference and sub-groups to be agreed with members (August meeting stood down)	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	31 July 2025	Meetings to formally commence from August 2025 **Proposed revised timescale September 2025**
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, staff engagement workshops have commenced	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	31 July 2025	Underway but some slippage due to date of first meeting moving to August 2025. **Proposed revised timescale 30 September 2025**
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	Complete & ongoing
3	Partnership Strategy to be refreshed with sign off by the Integration Committee	Group Chief Integration Officer	Deputy Director of Strategic Partnership	30 June 2025	Underway. **Proposed revised timescale 30 September 2025**
4	Work with EFM to contribute to developing the Estates Strategy	Group Chief Integration Officer	Chief Estates Officer	31 March 2026	Underway

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
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Gaps in Assurance	
1	Integration Committee in place work plan developed and reporting sub-groups fully established in 3 of the 4 work streams
2	External partners not yet meeting as part of the Alliance Steering Group
3	PITOF focus has been CIP. Reporting on the 4 Alliance programmes is being refined for August to provide a high level update on each programme.
4	Work streams, KPIs and timelines still being worked up, to be finalised in Q2
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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 including external partners where appropriate (with support from Newton's for INW)	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	31 May 2025	Underway – Integration Committee Work Plan developed. Some work to completed in respect of reporting sub-groups. **Proposed revised timescale 30 September 2025**
2	Left shift specialties being identified, phasing model for delivery in development, 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	Underway. **Proposed revised timescale 30 September 2025**
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	Complete & ongoing
4	Integration brochure to provide options for collaborative working being developed. – is in draft and will be finalised as part of the Partnership delivery plan.	Group Chief Integration Officer	Director of Improvement and Integration	31 May 2025	Underway. **Proposed revised timescale 30 September 2025**

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**
ULTH	5563	20	Neurology – Service sustainability

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)

Last Review Date:	August 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	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	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.

Gaps in Controls
(What are the gaps in control that are required to manage the risk)

1	None identified
2	None identified
3	Health inequalities action plan reviewed and approved for review and approval by Alliance Steering Group and Integration Committee in August July 2025
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 in June last month as an example
6	Data packs and a workshop format being developed with support from ICB business analyst as .System PHM Programme Director secondment has ended. LCHG business analysts fully supporting.

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 September (an initial ASG meeting to brief internal members on the ToR and work programme took place in June and July and (August ASG stood down due to apologies)July 2025 (NB. An initial ASG meeting to brief internal members on the Terms of Reference and work programme took place on 2 June 2025 and a further internal meeting is scheduled for 9 July 2025	Group Chief Integration Officer	Director of Integration and Improvement / Deputy Chief Integration Officer	31 July 2025	Underway – initial work complete and formal meetings to commence from August 2025 **Proposed revised timescale September 2025**
2	Health Inequalities action plan in development and will be shared with Alliance Steering Group in July 2025 and Integration Committee in AugustJune 2025	Group Chief Integration Officer	Deputy Director of Strategic Partnerships	30 June 2025	Underway. **Proposed revised timescale August 2025**
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 work stream.	Group Chief Integration Officer	Director of Integration and Improvement / Deputy Chief Integration Officer	31 July 2025	Underway - dates arranged for first workshop in 3 specialties. **Proposed revised timescale 31 August 2025**

Sources of Assurance (1st, 2nd and 3rd Line) *(How we know the controls are working effectively)*		Gaps in Assurance	
1	Health Inequalities Working Group upward report into the new Alliance Steering Group and Integration Committee and Group Board	1	Health inequalities action plan completed, for approval by Alliance Steering group and Integration Committee July 2025
2	Development of a LCHG Co-production Strategy to support the health inequalities and personalisation agenda and reduce health inequalities	2	Co-production lead for the Group appointed and Strategy in development working with ICB Health Inequalities and Personalisation Teams with pilot approach in Dermatology left shift project
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	3	Consistent utilisation of PHM data through all our specialty reviews.
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7		7	

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 August September 2025 (ASG stood down in August due to availability of key members)	Group Chief Integration Officer	Deputy Director of Strategic Partnerships	31 August 2025	Underway **Proposed revised timescale September 2025**
2	Health Inequalities Action Plan completed and will be provided to the Alliance Steering group/Integration Committee in July/AugustMay 2025	Group Chief Integration Officer	Associate Director of Partnership	31 July 2025	Underway

			Group Chief Integration Officer	Deputy Director of Strategic Partnerships/Deputy Director of Communications and Engagement	31 July 2025	~~Underway~~Complete
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					
4	New LCHG Strategy being deployed via Roadshow and in communications cascade		Group Chief Integration Officer	Director of Integration and Improvement	30 June 2025	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**

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:	June 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	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	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.
4	EPR and EDMS programmes under way, both strategic enablers,
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.
4	Capacity within the digital team to deliver the digital transformation
5	Effectiveness of operational business continuity plans
6	None identified
7	LCHG Research & Innovation Strategy not yet developed
8	Application paused

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.	Group Chief Integration Officer	Group Director of Digital Services	TBC to alignment with EMAP	Scoping in progress June 2025
2	LCHG Research & Innovation Strategy to be developed	Chief Medical Officer	Head of Research & Innovation	30 September 2025	Underway - First meeting with stakeholders to be held September 2025
3	Recruitment into key project team positions, including the commencement of the EPR Programme Director position	Group Chief Integration Officer	Group Director of Digital Services	Ongoing	Underway - EPR Programme Director joined 30 June 2025
4	Meeting to be arranged with DHSC to confirm the position on the LCHS teaching status application and timescales	Group Chief Integration Officer	Deputy Director of Strategic Partnerships	1 April 2026	**Paused**
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

Sources of Assurance (1st, 2nd and 3rd Line) *(How we know the controls are working effectively)*		Gaps in Assurance	
1	Oversight of digital strategy, digital transformation and key risks by the Integration Committee	1	None identified
2	Digital Maturity Assessment completed	2	None identified
3	Digital Innovations Group established to assess and accelerate safe use of AI technologies	3	None identified
4	Oversight of AGEM IT service transition to LCHG via upward reporting to Integration Committee to manage risk, including agreement of structures.	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	Digital led business continuity exercise to identify improvement and learning, with departments providing assurance to Emergency Planning Group.	5	Output of exercise upwardly reported and actions owned

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.	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 2025 and to Emergency Planning Group (Operational Resilience)	Group Chief Integration Officer	Group Director of Digital Services	30 June 2025 (Report) 31 August 2025 (Digital Oversight	Underway and ongoing

		Group)	

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)

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Last Review Date:	August 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. Dashboard under development to track carbon impact of improvement projects.
5	Network of Green Champions formed
6	Green Group meetings scheduled
7	Sustainability agenda embedded in new Group Strategy
8	The ~~Director of~~Group Chief Estates & Facilities Officer 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	
4	Green Plan areas of oversight to be agreed by GLT
5	None identified
6	None identified
7	Refreshed ~~Sustainability &~~ Green Plan being drafted for board approval in September 2025
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	Care Group transformation programme being finalised 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	**Update required**
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	**Update required**
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 **Proposed revised timescale 31 August 2025**

Sources of Assurance (1st, 2nd and 3rd Line) *(How we know the controls are working effectively)*		Gaps in Assurance	
1	Oversight of productivity, improvement & transformation by the Integration Committee	1	Clarity is needed on oversight responsibilities of Integration Committee v Finance & Performance Committee
2	Sustainability report to the ~~Alliance Steering~~Green Group for oversight and assurance. Upward reporting to the Integration Committee and Group Board	2	None identified
3	Green Plan for LCHS and ULTH due to Board in September 2025	3	Green Plan not yet approved by the Board but on schedule for October deadline
4		4	
5		5	
6		6	
7		7	
8		8	

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 September ~~May~~ 2025	Group Director of Estates & Facilities	Group Head of Sustainability	31 May 2025	Completed

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

Group Audit Committee Upward Report

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2 September 2025*
Item Number	*12.3*

Group Audit Committee Upward Report of the meeting held on 25th July 2025

Accountable Director	*Neil Herbert, Audit Committee Chair*
Presented by	*Neil Herbert, Audit Committee Chair*
Author(s)	*Jayne Warner, Director of Corporate Affairs*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the upward report*

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

This assurance Committee meets quarterly and takes scheduled reports according to an established work programme, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2025/26 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG).

Internal Audit

The Committee received the Internal Audit Summary Internal Controls Assurance Report for both organisations. The Committee recognised the ongoing delays that were being experienced in finalising some of the internal audit reviews and the publication of the final reports. There was recognition that there had been delays both in turnaround and providing management responses. The Committee discussed where in the process delays were being identified and agreed that the Director of Corporate Affairs and the lead from Internal Audit would agree actions at their next weekly catch up meeting to improve the tracking and ensure the appropriate escalations to get the reviews to completion.

The Committee noted that 4 Internal Audit reports had been issued in respect of ULTH and 1 report for LCHS since the most recent Committee meeting all with reasonable assurance.

The Internal Audit Provider highlighted a persistent issue with the clearance of audit recommendations. It was recognised that this position was much improved from the

historical position but sought assurance that there would be no further slippage. The Trusts would work with the Internal Audit Provider to ensure that the portal was updated with all evidence where actions had been cleared and in some areas targeted follow up work would take place to confirm that actions had been addressed.

External Audit

The Committee were advised that a lessons learned exercise was underway in respect of the year end annual accounts and annual report process.

Local Counter Fraud Progress Report

The Committee received a joint progress report in respect of Counter Fraud. The Committee were alerted to the new criminal offence of the failure to prevent fraud. The Committee received the Local Counter Fraud Specialist Annual Report for ULTH and LCHS.

Compliance Report

The Committee received the quarterly compliance report. The Committee were advised that a reduction in the level of overseas nurse recruitment had resulted in lower occupancy in respect of Progress housing and exposure to liability around minimum utilisation rates linked to the historic contract. The Committee were advised that actions continued to push occupancy and address the issue along with discussions with the supplier.

The Committee were alerted to ongoing work to ensure IR35 compliance and ensuring all approvals were captured.

The Committee were also advised of work to understand a spike in the level of expired medicines and work was ongoing with the Chief Pharmacist to understand any issues and take action.

Board Assurance Framework

The Committee considered the revised Group Board Assurance Framework. The Committee were satisfied that the framework supported the organisations in describing the risks to the achievement of the Group objectives. The Assurance Committee Chairs were able to offer assurance that the framework was being utilised in all Committees and met the Committee needs. The Committee recognised that the framework continued to be reviewed and developed.

The Committee approved the Group Board Assurance Framework Policy which supported the work done on the revised framework.

Risk Report

The Committee noted that the Risk Register Confirm and Challenge Group terms of reference had been revised

Policies

The Committee noted that there had been a continued lack of significant progress in reducing the level of overdue policies. The Committee remained concerned that there was insufficient visibility of the risk exposure faced by the organisations in respect of this. Recognising that this had been escalated to the Board on previous occasions. The Committee proposed a number of actions for consideration including the inclusion within executive objectives, improved reporting and external benchmarking and the use of AI.

The Committee asked that the discussion was escalated to the Group CEO and through the upward report to Group Board.

The Committee approved the Fit and Proper Person Policy and the Standards of Business Conduct Policy.

Corporate Governance Manual

The Committee agreed that the revised Corporate Governance Manuals for both organisations would be circulated for review by Committee members. Subject to agreement outside the meeting these documents would then be considered at the September Trust board meeting for approval.

Revised Corporate Governance Manual (ULTH and LCHS)

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*2 September 2025*
Item Number	*12.4*

Revised Corporate Governance Manual – ULTH and LCHS

Accountable Director	*Jayne Warner, Group Director of Corporate Affairs*
Presented by	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Jayne Warner, Group Director of Corporate Affairs*
Recommendations/ Decision Required	*The Group Board is asked to:* • *Approve for publication the updated Corporate Governance Manuals for ULTH and LCHS;*

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

The Corporate Governance Manual provides the regulatory and business framework for the Trust.

The manual was last considered by the Board in 2023 and has now been updated to align the governance arrangements across the two organisations in line with latest best practice and to reflect the Group Operating Model. Each organisation will have it's own version of the manual published on the website.

The procurement team have reviewed the manual so that all elements align to latest procurement regulations.

The documents have been reviewed by members of the Audit Committee ahead of submission to Trust Board.

Group Board Action Required

The Group Board is asked to:

- Approve for publication the updated Corporate Governance Manuals for ULTH and LCHS;

CORPORATE GOVERNANCE MANUAL

Document Information

Trust Policy Number	:	ULH-CORPORATE-SO01
Version	:	July 2025
Status	:	For approval by board
Issued by	:	Director of Corporate Affairs
Issued date	:	
Approved by	:	
Date of approval	:	
Date of review	:	July 2025

Change Control

Previous Versions	:	
Changes	:	Changes to reflect the move to group
Modifications	:	
Deletions	:	
Date of Issue	:	
Review Date	:	
Reference Documents	:	
Relevant Legislation	:	Code of Governance for NHS Provider Trusts / Accountable Officer Memorandum
Relevant Standards	:	

FOREWORD

The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive regulatory and business framework for the Trust.

All directors, and all members of staff, should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfill the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

Failure to comply with any part of standing orders is a disciplinary matter, which could result in dismissal. Non-compliance may also constitute a criminal offence of fraud in which case the matter will be reported to the Trust's local counter fraud specialist in accordance with the Counter Fraud Bribery and Corruption Policy. Where evidence of fraud, corruption or bribery offences is identified, this may also result in referral for prosecution which could lead to the imposition of criminal sanctions.

STANDING ORDERS

1.   INTRODUCTION

1.1   Statutory Framework

The United Lincolnshire Teaching Hospitals NHS Trust (the Trust) is a statutory body which came into existence on 20th April 2000 under The United Lincolnshire Hospitals NHS Trust (Establishment) Order 2000 No 410, (the Establishment Order) and The United Lincolnshire Hospitals NHS Trust (Establishment) Amendment Order 2001 No 154. and The United Lincolnshire Hospitals NHS Trust (Establishment) Amendment Order 2024 No 951

The principal places of business of the Trust are Lincoln County Hospital, Lincoln; Pilgrim Hospital, Boston; Grantham and District Hospital, Grantham and Louth Hospital, Louth.

NHS Trusts are governed by Acts of Parliament, mainly the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 2012 and the Health and Care Act 2022 and the functions of the Trust are conferred by this legislation.

As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

The Trust has a duty to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals. The board must also comply with the standard for members of NHS Board and CCG Governing Bodies in England 2012.

The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2   NHS Framework

In addition to the statutory requirements the Secretary of State through the Department of Health and Social Care, NHS England, issues further directions and guidance. These are normally issued under cover of a circular or letter.

The NHS Code of Conduct & Accountability requires that, among other things, boards draw up a schedule of decisions reserved to the board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior officers (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The NHS Code of Conduct & Accountability makes various requirements concerning possible conflicts of interest of board directors.

The Freedom of Information Act sets out the requirements for public access to information about the Trust's business.

1.3   Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in the Scheme of Delegation and Reservation and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

1.4   NHS Board Governance

NHS trust boards must put in place and maintain good corporate governance arrangements, integrated across the organisation and all aspects of governance. This will encompass corporate, financial, clinical, information and research governance. Integrated governance will better enable the board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2.   THE TRUST BOARD

2.1 Corporate role of the Board

All business shall be conducted in the name of the Trust*.

All funds received in trust shall be held in the name of the Trust as corporate trustee.

The powers of the Trust established under statute shall be exercised by the board meeting in public session except as otherwise provided for in Standing Order No.3.

The board has resolved that certain powers and decisions may only be exercised by the board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

*As part of the formation of the Lincolnshire Community & Hospitals NHS Group (LCHG), a joint group board and joint board committees have been established. Under the group model arrangement, individual boards will be retained in statute, however decision making will take place via this joint working approach.

2.2   Composition of the Membership of the Trust Board

In accordance with the Membership and Procedure Regulations the composition of the board shall be:

The Chair of the Trust (Appointed by NHS England);

Up to 7 non- executive directors (appointed by NHS England);

5 executive directors including:

- the Chief Executive;
- the Chief Finance Officer
- the Chief Nursing Officer
- the Chief Medical Officer
- The Chief Integration Officer / Deputy Chief Executive

The following officers will attend the board meetings in a non-voting capacity unless the board resolves that they should not attend:

- Chief People Officer
- Chief Operating Officer
- Chief Clinical Governance Officer
- Chief Estates and Facilities Officer
- Director of Corporate Affairs

2.3 Appointment of Chair and Directors of the Trust

The Chair and Directors of the Trust - are appointed by NHSE on behalf of the Secretary of State. The appointment and tenure of office of the Chair and Directors are set out in the Membership and Procedure Regulations.

2.5 Terms of Office of the Chair and Directors

The regulations setting out the period of tenure of office of the Chair and directors and for the termination or suspension of office of the Chair and directors are contained in regulation 7 and regulations 8 and 9 of the Membership and Procedure Regulations, respectively.

2.6 Appointment and Powers of Vice-Chair

Subject to Standing Order below, the Chair and directors of the Trust may appoint one of their numbers, who is not also an executive director, to be Vice-Chair, for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.

Any director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and directors may thereupon appoint another director as Vice-Chair in accordance with the provisions of Standing Orders

Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

2.7 Joint Directors

Where more than one person is appointed jointly to a post mentioned in regulation 2 of the Membership and Procedure Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.

2.8 Role of Directors

The board will function as a corporate decision-making body, executive and Non-executive directors will be full and equal directors. Their role as directors of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives and other such requirements as determined by NHS England.

The division of responsibilities between the Chair and the Chief Executive is outlined in **Appendix A.**

(3) Chief Finance Officer

The Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its directors and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4)   **Non-Executive Directors**

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as directors of or when chairing a committee of the Trust which has delegated powers.

(5)   **Chair**

The Chair shall be responsible for the operation of the board and chair all board meetings when present. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with NHS England over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work closely with the Chief Executive and shall ensure that key and appropriate issues are discussed by the board in a timely manner with all the necessary information and advice being made available to the board to inform the debate and ultimate resolutions.

The division of responsibilities between the Chair and Chief Executive is outlined in **Appendix A.**

2.9   Lead Roles for Board Directors

The Chair and Chief Executive will ensure that the designation of lead roles or appointments of Board Directors as required by the Department of Health and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a lead board director with responsibilities for infection control or safeguarding etc.). The schedule of lead roles will be reviewed and / or approved periodically by the board.

3.   MEETINGS OF THE TRUST BOARD

3.1   Admission of public and the press

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board resolving as follows:

A body may by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings') wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings; and where such a resolution is passed, this Act shall not require the meeting to be open to the public during proceedings to which the resolution applied. (Public Bodies (Admission to meetings) Act 1960.

The Chair shall give such directions as they thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.2   Calling meetings

Ordinary meetings of the board shall be held at regular intervals at such times and places as the board may determine.

The Chair of the Trust may call a meeting of the board at any time.

One third or more directors of the board may request a meeting in writing. If the chair refuses, or fails, to call a meeting within seven days of a request being presented, the directors signing the request may forthwith call a meeting.

3.3   Notice of Meetings and the Business to be transacted

Before each meeting of the board a notice specifying the business proposed to be transacted shall be delivered to every director, so as to be available to them at least three clear days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf.

Want of service of such a notice on any director shall not affect the validity of a meeting.

In the case of a meeting called by directors in default of the Chair calling the meeting, the notice shall be signed by those directors.

No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

Before each meeting of the board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

3.4   Chair of meeting

At any meeting of the Trust Board the chair, if present, shall preside. If the chair is absent from the meeting, the vice-chair (if the board has appointed one), if present, shall preside.

If the chair and vice-chair are absent, such director (who is not also an Executive Director of the Trust) as the directors present shall choose shall preside.

3.5   Chair's ruling

The decision of the Chair of the meeting on questions of order, relevancy and regularity and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.6   Quorum

No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and directors (including at least one director who is also an executive director of the and one non- executive director) is present.

An Officer in attendance for an Executive Director but without written acting up status may not count towards the quorum.

If the Chair or director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.7   Voting

Every question at a meeting shall be determined by a majority of the votes of directors present and voting on the question. In the case of an equal vote, the person presiding (i.e.: the Chair of the meeting) shall have a second, and casting vote.

All questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

If at least one third of the directors present so request, the voting on any question may be recorded so as to show how each director present voted or did not vote (except when conducted by paper ballot).

If a director so requests, their vote shall be recorded by name.

In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

An Officer who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

An Officer attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.8   Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

3.9   Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

3.10   Annual Public Meeting

The trust will publicise and hold an annual public meeting on or before 30th September in every year in accordance with the NHS Trusts (Public meeting) Regulations 1991 (SI 1991) 482.

3.11   Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- that two thirds of the board directors are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive directors vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.12 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the directors of the board are present (including at least one executive director of the Trust and one non-executive director) and that at least two-thirds of those directors present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust board's minutes.

(ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and directors of the Trust.

(iii) No formal business may be transacted while Standing Orders are suspended.

(iv) Every decision to suspend standing orders shall be reported to the Audit Committee.

4. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

4.1 Delegation of Functions to Committees, Officers or other bodies

Subject to regulation 17 and 18 of the Membership and Procedure Regulations, the board may make arrangements for the exercise, on behalf of the board, of any of its functions by a committee, or sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

Regulation allows for the functions of NHS trusts to be carried out jointly with any other NHS body or other NHS trust, or any other third party.

4.2 Emergency Powers

The powers which the board has reserved to itself within these Standing Orders may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and Chairm shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

4.3 Unavailability of Chair/ Vice Chair

In addition to the statutory power of the vice chair, if the chair is unavailable for whatever reason to transact the business of the Trust expressly or impliedly delegated to the chair, then, if so requested by the Chief Executive, the vice chair shall be empowered to act in the chair's place and to exercise all the powers and duties of the chair until the chair is again available.

If the vice chair is unavailable for whatever reason to transact the business of the Trust expressly or impliedly delegated to the vice chair, then if so requested by the chief executive in relation to any particular matter, any non-executive director shall be empowered to act in the vice chairs place and exercise all the powers and duties of the vice chair in relation to that matter.

4.4 Delegation to Committees

The board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the board.

The powers of such committees shall be limited to those set out in their terms of reference.

4.5 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust.

The Chief Executive shall prepare a Scheme of Delegation identifying his proposals which shall be considered and approved by the board.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the board of the Chief Finance Officer to provide information and advise the board in accordance with statutory or Department of Health and Social Care requirements. Outside these statutory requirements the roles of the Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

The arrangements made by the board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

4.6 Non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and justification for non-compliance and the circumstances shall be reported to the next formal meeting of the board for action or ratification. All directors of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive and Chair as soon as possible.

5. TRUST COMMITTEES

5.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health, the Trust Board may appoint committees or sub-committees or joint committees of the Trust.

The Trust shall determine the membership and terms of reference of committees and shall receive and consider reports from such committees.

5.2 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term 'Chair' is to be read as a reference to the Chair of other committee as the context permits, and the term 'member' is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

5.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions as the board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.4 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish reporting groups they may not delegate executive powers to the group unless expressly authorised by the Trust Board.

5.5 Approval of Appointments to Committees

The board shall approve the appointments to each of the committees which it has formally constituted. Where the board determines, and regulations permit, that persons, who are neither directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the board as defined by the Secretary of State. The board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.6 Appointments for Statutory functions

Where the board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

5.7 Committees established by the Trust Board

The committees established by the Board are as follows:

- Remuneration Committee
- Audit and Risk Committee
- Quality Committee
- Finance and Performance Committee
- People Committee
- Integration Committee

6. RELATIONSHIP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Trust Board will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2   Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

-       the Standards of Business Conduct and Declarations of Interest Policy for United Lincolnshire Teaching Hospitals NHS Trust staff;

-       the staff Disciplinary and Appeals Procedures adopted by the Trust

-       The Counter Fraud, Bribery and Corruption Policy

6.3   Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4   Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with guidance and requirements issued by or on behalf of the Secretary of State for Health.

7.   DUTIES AND OBLIGATIONS OF BOARD DIRECTORS AND UNDER THESE STANDING ORDERS

7.1   Declaration of Interests

All Board members and staff of the Trust are required to comply with the Standards of Business Conduct and Declarations of Interest Policy. If Board directors have any doubt about the relevance of an interest they should discuss it with the chair or the Director of Corporate Affairs.

7.2   Recording of Interests in Trust Board minutes

At the time Board directors' interests are declared, or updated, they should be recorded in the Trust Board minutes.

7.3   Publication of declared interests in Annual Report

Board directors' declarations of interests will be published in the Trust's annual report.

7.4   Conflicts of interest which arise during the course of a meeting

At the start of every Board meeting there will be an agenda item which invites Directors to declare whether they have any interests which might be relevant to any items of business on the agenda. Directors should declare all such interests whether

or not they have already declared them for the register. If a conflict of interest is established, the Board director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.5 Register of Interests

The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board members.

The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.6 Exclusion of Chairand Directors in proceedings of the Board

Subject to the following provisions of this Standing Order, if the Chair or a director of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed.

The Trust Board may exclude the Chair or a director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest, direct or indirect, is under consideration.

Any remuneration, compensation or allowance payable to the Chair or a Director by virtue of Schedule 5 of the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

This Standing Order applies to a committee as it applies to the Trust and applies to a member of any such committee (whether or not he/she is also a member of the Trust) as it applies to a director of the Trust.

7.7 Canvassing of and Recommendations by Directors in Relation to Appointments

Canvassing of directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

Directors of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.8 Relatives of Directors or Officers

Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any director or

the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

The Chair and every director and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

On appointment, directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive or a nominated Officer by him / her in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of by the Chief Executive, and Chair or named deputy, and shall be attested by them.

8.3 Register of Sealing

The Chief Executive shall keep a register in which he / she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document. The register shall be reported to the Audit Committee.

8.4 Use of Seal – General guide

The Seal shall be affixed in the following general circumstances;

• All contracts for the purchase / lease of land and / or building
• All contracts for capital works exceeding £250,000

This list is not exhaustive and further advice regarding the affixation of the Seal should be gained from the Director of Corporate Affairs or Chief Finance Officer.

8.5 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

In the case of contracts for goods, works and services relating to non-pay expenditure officers should refer to Standing Financial Instructions.

9 SCHEME OF RESERVATION AND DELEGATION OF POWERS

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
SO 2.9 (1)	THE BOARD	**General Enabling Provision** The board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers. General matters reserved 1. To ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. To appoint, appraise and remunerate senior executives and hold them to account; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
SO 2.9 (1)	THE BOARD	*Regulations and Control* 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.2 5. Approve a scheme of delegation of powers from the Board to committees.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		6. Require and receive the declaration of Board directors' interests that may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property. 15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6. 17. Discipline directors of the Board or employees who are in breach of statutory requirements or SOs. 18. Agree a schedule setting out the division of responsibilities of the Chair and Chief Executive (Appendix A refers).
SO 2.9 (1)	THE BOARD	**Appointments/ Dismissal** 1. Appoint the Vice Chair of the Board. 2. Appoint and dismiss committees (and individual directors) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary to the Board. 6. Approve proposals of the Remuneration Committee regarding appropriate remuneration and terms of service for the Chief Executive and other Executive Directors.
SO 2.9 (1)	THE BOARD	***Strategy, Plans and Budgets***

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		1. Define the strategic aims and objectives of the Trust / Group. 2. Approve proposals for ensuring quality and clinical governance in services provided by the Trust / Group, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment in excess of £1,000,000 5. Approve budgets. 6. Approve annually the proposed organisational development proposals for the Trust / Group. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3 year period or the period of the contract if longer. 11. Approve individual compensation payments. 12. Approve proposals for action on litigation against or on behalf of the Trust. 13. Review use of NHS Resolution risk pooling schemes (LPST/CNST/RPST).
SO 2.9 (1)	THE BOARD	**Policy Determination** *1.* Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
SO 2.9 (1)	THE BOARD	**Audit** 1 Approve the appointment (and where necessary dismissal) of External Auditors on the advice of the Audit Panel. 2. Receive the annual management letter from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 3. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
SO 2.9 (1)	THE BOARD	**Annual Reports and Accounts** 1. Receive and and approve the Trust's Annual Report and Annual Accounts. 2. Receive and approve the Annual Report and Accounts for funds held on trust.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
SO 2.9 (1)	THE BOARD	**Monitoring** 1. Receive such reports as the board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust and wider group by means of the provision to the board as the board may require from directors, committees, and officers of the Trust as set out in management policy statements. 3. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the board. 4. Receive reports from Chief Finance Officer on financial performance against budget and annual plan. 5. Receive reports from Chief Finance Officer on actual and forecast income from contracts.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 11.1.1 and SO 4.8	AUDIT COMMITTEE	The committee will: 1. Advise the board on internal and external audit services; 2. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; 3. Monitor compliance with Standing Orders and Standing Financial Instructions; 4. Review schedules of losses and compensations and making recommendations to the board. 5. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the board. 6. Review the annual financial statements prior to submission to the board. 7. Other duties as set out within the Audit Committee Handbook and its Terms of Reference.

SFI 20.1.1 and SO 4.8	REMUNERATION AND TERMS OF SERVICE COMMITTEE	The committee will:
		
		1. Decide on the appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff. Aspects to include:
		  • Salary (including any performance-related elements/bonuses);
		  • Provisions for other benefits, including pensions and cars;
		  • Arrangements for termination of employment and other contractual terms; advise on and oversee appropriate contractual arrangements for such staff;
		2. Proper calculation and scrutiny of any termination payments taking account of such national guidance as is appropriate.
		The Committee shall report in writing to the board the basis for its recommendations.

SO 4.8	QUALITY COMMITTEE	The core duties of the Committee are as follows:

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		- Ensure that there are robust processes in place for the effective management of clinical governance, quality and risk. - Ensure that there are effective structures in place to support clinical governance and that these structures operate effectively and that action is taken to address areas of concern. - Through the receipt of upward reports from the reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the Quality Committee. - Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboards monthly with exception reporting as the norm. - Use outcome measures to demonstrate continuous improvement. - Consider the control and mitigation of quality related risks and provide assurance to the Group Board that such risks are being effectively controlled and managed in line with the risk appetite statement. Whilst the committee's remit covers all of the Group's services, the committee has a specific oversight role in relation to the quality & safety of United Lincolnshire Teaching Hospitals Trust's maternity services (reference: Ockenden). - Review and provide assurance on those strategic objectives within the Group Board Assurance Frameworks, identified as the responsibility of the committee seeking where necessary further action. - Provide assurance to the Board that all legal and regulatory requirements relating to quality are met, including directives, regulations, national standards, policies, reports, reviews and best practice. - Review & challenge the annual Quality Accounts ensuring they are a balanced and accurate reflection of both Trusts position. - Approve and monitor the annual clinical audit plans. - Monitor the implementation of agreed action plans in relation to all major internal reviews and all external reviews within the remit of the Quality Committee. - Ensure that there is sufficient time on the agenda to allow for strategic discussion items on areas of responsibility of the committee and to include horizon scanning on the current and future environment.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SO 4.8	FINANCE & PERFORMANCE COMMITTEE	The core duties of the Committee are as follows: • Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly. • Approve the business planning timetable. • Seek assurance that the trusts and wider group have in place robust and effective operational and financial planning arrangements and delivery plans. • Review, challenge and monitor in-year financial and operational performance. • Consider the control and mitigation of finance & operational performance and related risks and provide assurance to the Group Board that such risks are being effectively controlled and managed. • Provide oversight of and receive assurance on delivery of agreed Cost Improvement Plans and associated efficiency and productivity programmes. • Provide oversight of and receive assurance on procurement processes and performance. • Review estates & facilities compliance including health & safety requirements and compliance with the Premises Assurance Model (PAM). • Provide oversight of and receive assurance in respect of compliance with the Data Security Protection Toolkit. • Provide assurance to the Board that all legal and regulatory requirements relating to finance, operational, estates compliance and data security are met, including directives, regulations, national standards (including constitutional standards), policies, reports, reviews and best practice. • Review and provide assurance to the Group Board on those strategic objectives within the Group Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance and actions where necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
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SO 4.8	PEOPLE COMMITTEE	The core duties of the Committee are as follows: • Ensure that there are robust processes in place for the effective management of people and organisational development. • Ensure that there are effective structures in place to support people and OD and that these structures operate effectively and that action is taken to address areas of concern. • Through the receipt of upward reports from the reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the People Committee. • Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly • Consider the control and mitigation of workforce related risks and provide assurance to the Board that such risks are being effectively controlled and managed • Provide assurance to the Board that all legal and regulatory requirements relating to the workforce are met, including directives, regulations, national standards, policies, reports, reviews and best practice • Review and provide assurance through the Integrated Improvement Plan and Performance Review Meeting reporting, on those strategic objectives within the Group Board Assurance Framework, identified as the responsibility of the committee seeking, where necessary, further action.
SO 4.8	INTEGRATION COMMITTEE	The committee will: • Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly with exception reporting as the norm.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		- Through the receipt of upward reports from relevant reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the Integration Committee. - Consider progress with and risks to delivery of the group's integration agenda & objectives and provide assurance to the Group Board that such risks are being effectively controlled and managed and / or escalate such risks to ensure timely and appropriate mitigating actions are put in place. Where appropriate, the committee may seek to request deep dives are undertaken to identify the required improvement and actions. - Receive assurance that all appropriate actions are being taken to ensure full participation in population partnership initiatives and programmes of change and, in turn provide assurance to the Board on the robustness of delivery plans. This will include the receipt of plans for the continued development of Community Primary Partnership(s) over time supporting both Place and group strategies and seeking assurance on the robustness of plans to increase the range and scope of the Community primary partnership(s), anchor partners work and the group's role within them. - Seek assurance on the adequacy of plans to realise the group's ambition of addressing the wider determinants of health and health inequalities. - Seek assurance for the operational performance and delivery of Out of Hospital Services delivering on Integrated Care. - Ensure that proposed changes to services are being made on the basis of strong clinical evidence and best practice. - Seek assurance in respect of delivery of the group's digital agenda and objectives including development of the 'Vision for Information'. - Review and seek assurance on delivery of the estates strategy, estates rationalisation & space management and sustainability & the Green Plan (including Net Zero) programmes of work. - Ensure that key enablers to the delivery of the integration agenda are properly considered as part of the agreement of the group integration plan and programmes of work and that these plans and programmes of work are appropriately aligned to the longer term strategy, vision and values for the group. - Review and provide assurance to the Group Board on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		and actions where necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions.
SO 4.8	CHARITABLE FUNDS COMMITTEE	The committee will: • administer those charitable funds received by the Trust in accordance with any statutory or other legal requirements or best practice required by the Charities Commission. • advise the board in relation to the discharge of the Trust's duties with respect to the above.

REF	DELEGATED TO	DUTIES DELEGATED
7	CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
9	CHIEF EXECUTIVE AND CHIEF FINANCE OFFICER	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the board.
10	CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
12 & 13	CHIEF EXECUTIVE	Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers: • have a clear view of their objectives and the means to assess achievements in relation to those objectives

REF	DELEGATED TO	DUTIES DELEGATED
		• be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
12	CHAIR	Implement requirements of corporate governance.
13	CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office (NAO).
15	CHIEF FINANCE OFFICER	Operational responsibility for effective and sound financial management and information.
15	CHIEF EXECUTIVE	Primary duty to see that the Chief Finance Officer discharges the above function.
16	CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
18	CHIEF EXECUTIVE AND CHIEF FINANCE OFFICER	Responsible for ensuring appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
19	CHIEF EXECUTIVE	Where the Board or Chair is doing something that might infringe probity or regularity, responsible for setting this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary NHS England and the Department of Health.
20	CHIEF EXECUTIVE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform NHS England and the Department of Health. In such cases, and in those described in paragraph 24, the Chief Executive should as a member of the board vote against the course of action rather than merely abstain from voting.

1.3.1.7	BOARD	Approve the procedure for declarations of hospitality and sponsorship.
1.3.1.8	BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
1.31.9 & 1.3.2.2	ALL BOARD MEMBERS	Subscribe to the NHS Code of Conduct & Accountability and the Nolan Principles.
1.3.2.4	BOARD	Board directors share corporate responsibility for all decisions of the board.
1.3.2.4	CHAIR AND NON EXECUTIVE DIRECTORS	Chair and non-executive directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.
1.3.2.4	BOARD	The board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. To ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. To appoint, appraise and remunerate senior executives; 4. To ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
1.3.24	BOARD	It is the board's duty to: 1. Act within statutory financial and other constraints; 2. Be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;

		4. Establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. Establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the committee, the limit to their powers, and the arrangements for reporting back to the main Board.
1.3.2.5	CHAIR	1. Provide leadership to the board; 2. Enable all board members to make a full contribution to the board's affairs and ensure that the board acts as a unitary team; 3. Ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. Ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. Lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. Appoint Non-Executive Board members to an Audit Committee and other vommittees of the main Board; 7. Advise the Secretary of State on the performance of Non-Executive Board members.
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chairand Non-Executive members of the board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum. The division of responsibilities between the Chair and Chief Executive are set out in Appendix A.
1.3.2.6	NON-EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by NHS Englandto bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	CHAIR AND DIRECTORS	Completion of their entry on the Trust's Register of Interests and prompt declaration of conflicts of interest which may arise during the course of their duties for the Trust.

1.3.2.9	BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chair
3.1	CHAIR	Call meetings of the board.
3.9	CHAIR	Chair all board meetings and associated responsibilities.
3.10	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIR	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to be notified of every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders.
4.1	BOARD	Formal delegation of powers to committees, sub-committees or joint committees and approval of their constitution and terms of reference.
5.2	CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	THE BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.
7.4	ALL STAFF	Comply with the Department of Health's "Standards of Business Conduct for NHS Staff" and Trust policy.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

* Nominated officers and the areas for which they are responsible will be incorporated into the Trust's Scheme of Delegation document.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	CHIEF FINANCE OFFICER	Approval of all financial procedures.
10.1.4	CHIEF FINANCE OFFICER	Advice on interpretation or application of Standing Financial Instructions.
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.
10.2.4	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.4	CHIEF EXECUTIVE & CHIEF FINANCE OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.5	CHIEF EXECUTIVE	To ensure all board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.6	CHIEF FINANCE OFFICER	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action. b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented. c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff. e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.7	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
10.2.8	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
11.1.2	CHAIR	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	CHIEF FINANCE OFFICER	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	CHIEF FINANCE OFFICER	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
11.4	AUDIT COMMITTEE	Ensure cost-effective External Audit.
11.5	CHIEF FINANCE OFFICER	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	CHIEF ESTATES & FACILITIES OFFICER	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	CHIEF EXECUTIVE	Compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
13.1.2 & 13.1.3	CHIEF FINANCE OFFICER	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
13.1.6	CHIEF FINANCE OFFICER	Ensure adequate training is delivered on an ongoing basis to budget holders.
13.3.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
13.4.1	CHIEF FINANCE OFFICER	Devise and maintain systems of budgetary control.
13.4.2	BUDGET HOLDERS	Ensure that

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
13.4.3	BUDGET HOLDERS	Identify and implement cost improvements and income generation activities in line with the Annual plan
13.6.1	CHIEF EXECUTIVE/ CHIEF FINANCE OFFICER	Submit monitoring returns
14.1	CHIEF FINANCE OFFICER	Preparation of annual accounts and reports.
15.1	CHIEF FINANCE OFFICER	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
16.	CHIEF FINANCE OFFICER	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform Chief Finance Officer of money due from transactions which they initiate/deal with.
17.	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.3	CHIEF EXECUTIVE	Waive formal tendering procedures.
17.5.3	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
17.5.5	CHIEF FINANCE OFFICER	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the Chief Executive.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders.
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations dispatched.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.6.4	CHIEF EXECUTIVE AND CHIEF FINANCE OFFICER	Assess for value for money and fair price in circumstances where one bid is received against a tender.
17.6.6	CHIEF EXECUTIVE	Consideration and authorisation, as appropriate, of a tender which commits expenditure in excess of that which has been allocated by the Trust.
17.6.8	CHIEF ESTATES AND FACILITIES OFFICER	Will appoint a manager to maintain a list of approved firms.
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	Responsibility to ensure they, or their nominated deputy, award tenders in accordance with Trust procedures.
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	Board	Approval of all PFI proposals
17.11	CHIEF EXECUTIVE	Nomination of an officer to oversee and manage each contract on behalf of the Trust.
17.12	CHIEF EXECUTIVE	Nomination of officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
17.15	CHIEF EXECUTIVE	Ensure that best value for money can be demonstrated for all services provided on an in-house basis.
17.15.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	CHIEF EXECUTIVE	Ensure that the Trust enters into suitable contracts with service commissioners for the provision of NHS services
18.3	CHIEF EXECUTIVE	Ensure that regular reports are provided to the board detailing actual and forecast income from contracts
20.1.1	BOARD	Establish a Remuneration & Terms of Service Committee

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.1.2	REMUNERATION COMMITTEE	Advise the board on and make recommendations on the remuneration and terms of service of the Chief Executive, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
20.1.3	REMUNERATION COMMITTEE	Report in writing to the board its advice about remuneration and terms of service of directors and senior employees.
20.1.4	BOARD	Approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
20.10.1 and 20.10.2	CHIEF FINANCE OFFICER	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 10.4.2).
20.10.3	NOMINATED MANAGERS*	Submit time records in line with timetable. Complete time records and other notifications in required form. Submit termination forms in prescribed form and on time.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.10.5	CHIEF FINANCE OFFICER	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
20.5	NOMINATED MANAGER*	Ensure that all employees are issued with a Contract of Employment in a form approved by the board and which complies with employment legislation; and deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
21.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
21.2.1	REQUISITIONER*	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
21.2.2	CHIEF FINANCE OFFICER	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	CHIEF FINANCE OFFICER	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
21.2.4	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to the Chief Finance Officer to support the need for a prepayment.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
21.2.4	CHIEF FINANCE OFFICER	Approve proposed prepayment arrangements.
21.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform Chief Finance Officer if problems are encountered).
21.2.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
21.2.6	MANAGERS AND OFFICERS	Ensure compliance in full with the guidance and limits specified by the Chief Finance Officer.
21.2.7	CHIEF EXECUTIVE CHIEF FINANCE OFFICER	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
22.1.1	CHIEF FINANCE OFFICER	Advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.
22.1.2	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive and Chief Finance Officer.)
22.1.3	CHIEF FINANCE OFFICER	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	CHIEF EXECUTIVE OR CHIEF FINANCE OFFICER	Be on an authorising panel comprising one other member for short term borrowing approval.
22.2.2	CHIEF FINANCE OFFICER	Advise the board on investments and report, periodically, on performance of same.
22.2.3	CHIEF FINANCE OFFICER	Prepare detailed procedural instructions on the operation of investments held.
23	CHIEF FINANCE OFFICER	Ensure that board members are aware of the Financial Framework and ensure compliance.
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
24.1.2	CHIEF FINANCE OFFICER	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
24.1.4	CHIEF FINANCE OFFICER	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	CHIEF FINANCE OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	CHIEF FINANCE OFFICER	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
24.2.1	CHIEF FINANCE OFFICER	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
24.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
24.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from Chief Finance Officer).
24.3.5	CHIEF FINANCE OFFICER	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	CHIEF FINANCE OFFICER	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
24.4.2	CHIEF FINANCE OFFICER	Approval of fixed asset control procedures.
24.4.4	BOARD MEMBERS AND ALL SENIOR STAFF	Responsible for security of Trust assets including notifying discrepancies to Chief Finance Officer , and reporting losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to Chief Finance Officer responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.2	CHIEF FINANCE OFFICER	Responsible for systems of control over stores and receipt of goods.
25.2	CHIEF PHARMACIST	Responsible for controls of pharmaceutical stocks
25.2	CHIEF ESTATES AND FACILITIES OFFICER	Responsible for control of stocks of fuel oil and coal.
25.2	NOMINATED OFFICERS*	Security arrangements and custody of keys.
25.2	CHIEF FINANCE OFFICER	Set out procedures and systems to regulate the stores.
25.2	CHIEF FINANCE OFFICER	Agree stocktaking arrangements.
25.2	CHIEF FINANCE OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
25.2	CHIEF FINANCE OFFICER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
25.2	NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to Chief Finance Officer evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
26.1.1	CHIEF FINANCE OFFICER	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	CHIEF FINANCE OFFICER	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
26.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and Chief Finance Officer .
26.2.2	CHIEF FINANCE OFFICER	Where a criminal offence is suspected, Chief Finance Officer must inform the police if theft or arson is involved. In cases of fraud and corruption Chief Finance Officer must inform the relevant LCFS and Regional Team in line with SoS directions.
26.2.2	CHIEF FINANCE OFFICER	Notify External Audit of all prima facie or actual acts of fraud.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
26.2.3	CHIEF FINANCE OFFICER	Notify board and External Auditor of losses caused, theft, arson, neglect of duty or gross carelessness (unless trivial).
26.2.4	AUDIT COMMITTEE	Approve write off of losses (within limits delegated by Department of Health).
26.2.6	CHIEF FINANCE OFFICER	Consider whether any insurance claim can be made.
26.2.7	CHIEF FINANCE OFFICER	Maintain losses and special payments register.
27.1	CHIEF FINANCE OFFICER	Responsible for accuracy and security of computerised financial data.
27.1	CHIEF FINANCE OFFICER	Be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
27.1.3	DIRECTOR OF CORPORATE AFFAIRS	Publish and maintain a Freedom of Information Publication Scheme.
27.2.1	RELEVANT OFFICERS	Send proposals for general computer systems to Chief Finance Officer.
27.3	CHIEF FINANCE OFFICER	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek adequate assurances from the provider that appropriate controls are in operation.
27.4	CHIEF FINANCE OFFICER / CHIEF INTEGRATION OFFICER	Ensure that risks to the Trust from the use of IT are identified and considered and that disaster recovery plans are in place.
27.5	CHIEF FINANCE OFFICER	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) Chief Finance Officer and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
28.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
28.3	CHIEF FINANCE OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
28.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
29.1	CHIEF FINANCE OFFICER	Ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
30	CHIEF FINANCE OFFICER	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
32	CHIEF EXECUTIVE	Retention of document procedures in accordance with HSC 1999/053.
33.1	CHIEF EXECUTIVE	Risk management programme.
33.1	BOARD & ALL COMMITTEES	Approve and monitor risk management programme.
33.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	CHIEF FINANCE OFFICER	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed. |
| 33.4 | CHIEF FINANCE OFFICER | Ensure documented procedures cover management of claims and payments below the deductible. |

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

10.1.1   The Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2   These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State for Health under the provisions of Section 99 (3), 97 (A) (4) and (7) and 97 (AA) of the National Health Service Act 1977 for the regulation of the conduct of the Trust in relation to all financial matters. The Code of Accountability requires that the Trust shall give, and may vary or revoke Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code.

These Standing Financial Instructions shall have effect as if incorporated in the Standing Orders (SOs)

All directors and all members of staff should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfil the dual role of protecting the Trust's interests and protecting the staff from any possible accusation that they have acted improperly.

10.1.3   These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer.

10.1.4   Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Finance Officer must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5   The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

10.1.6   Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.

10.2   Responsibilities and delegation

10.2.1   **The Trust Board**

The Board exercises financial supervision and control by:

(a)   formulating the financial strategy and agreeing the long term financial model;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out within the Scheme of Delegation. All other powers have been delegated to such other committees as the Trust has established.

10.2.3 **The Chief Executive and Chief Finance Officer**

The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.4 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.5 **The Chief Finance Officer**

The Chief Finance Officer is responsible for:

(a) ensuring that the Standing Financial Instructions are maintained and regularly reviewed.

(b) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(c) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(d) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

(e) the provision of financial advice to other members of the Board and employees;

(f) the design, implementation and supervision of systems of internal financial control;

(g)   the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.6   **Board Members and All Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a)   the security of the property of the Trust;

(b)   avoiding loss;

(c)   exercising economy and efficiency in the use of resources;

(d)   conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.7   **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

10.2.8   For any and all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

11.   AUDIT

11.1   Audit Committee

11.1.1   In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference (based on those contained in the latest NHS Audit Committee Handbook), which will provide an independent and objective view of internal control by:

(a)   overseeing Internal and External Audit services;

(b)   reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c)   review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d)   monitoring compliance with Standing Orders and Standing Financial Instructions;

(e)   reviewing schedules of losses and compensations and making recommendations to   the Board;

(f)   Reviewing the arrangements in place to support the Board Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

11.1.2   Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally the Chief Finance Officer may be instructed to refer the matter to the Department of Health and Social Care. Matters pertaining to fraud, bribery and/or corruption must be reported to the Local Counter Fraud Specialist (LCFS) for investigation in accordance with the Trust's Local Counter Fraud, Bribery and Corruption Policy and Response Plan.

11.1.3   The Minutes of Audit Committee meetings shall be formally recorded and an upward report submitted to the Board.

11.2   Chief Finance Officer

11.2.1   It is the responsibility of the Chief Finance Officer to ensure an adequate Internal Audit service is provided. The Audit Committee shall be advised of the selection process and appointment when / if an Internal Audit service provider is changed.

11.2.2   The Chief Finance Officer is responsible for:

(a)   ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b)   ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c)   deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d)   ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee [and the Board]. The report must cover:

(i)   a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;
(ii)   major internal financial control weaknesses discovered;
(iii)   progress on the implementation of internal audit recommendations;
(iv)   progress against plan over the previous year;
(v)   strategic audit plan covering the coming three years;
(vi)   a detailed plan for the coming year.

11.2.2   The Chief Finance Officer or designated auditors and LCFS are entitled (without necessarily giving prior notice) to require and receive:

(a)   access to all records, documents and correspondence and data relating to any financial or other relevant transactions, including documents of a confidential nature;

(b)   access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c)   the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d)   explanations concerning any matter under investigation.

11.2.3   The Trust's Chief Executive and Chief Finance Officer are responsible for ensuring that access rights are given to NHS Counter Fraud Authority (NHSCFA) where necessary

for the prevention, detection and investigation of cases of fraud, bribery and corruption, in accordance with NHSCFA Provider Standards.

11.3   Role of Internal Audit

11.3.1   Internal Audit will review, appraise and report upon:

(a)   the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b)   the adequacy and application of financial and other related management controls;

(c)   the suitability of financial and other related management data;

(d)   the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i)   fraud and other offences;
(ii)   waste, extravagance, inefficient administration;
(iii)   poor value for money or other causes.

(e)   Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care.

11.3.2   Whenever any matter arises which involves, or is thought to involve, fraud, bribery or corruption, the matter must be reported to the LCFS, in accordance with the Trust's Local Counter Fraud, Bribery and Corruption Policy and Response Plan. All other irregularities, or suspected irregularities, concerning cash, stores, or other property of the Trust, or the exercise of any function of a pecuniary nature, must be notified to the Chief Finance Officer immediately.

11.3.3   The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

11.3.4   The Chief Internal Auditor shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.3.5   Internal Audit terms of reference shall have effect as if incorporated within these Standing Financial Instructions. The terms of reference cover the scope of internal audit work, authority and independence, management responsibilities, co-ordination of assurance work, reporting and key outputs and the operational responsibilities.

11.4   External Audit

11.4.1   The External Auditor is appointed and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor.

11.5   Fraud Bribery and Corruption

11.5.1   In line with their responsibilities, the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with the NHS Standard contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority standards.

11.5.2   The Chief Finance Officer is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

11.5.3   The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the Trust as specified in the NHS Counter Fraud Authority (NHSCFA) Counter Fraud Standards.

11.5.4   The LCFS shall report to the Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority (NHSCFA) in accordance with the NHS Counter Fraud Authority Counter Fraud Standards, the NHS Counter Fraud manual and the NHSCFA's Investigation Case File Toolkit.

11.5.6   If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the Chief Finance Officer to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHSCFA.

11.5.7   The LCFS will at least annually provide a written report to the Audit Committee on anti-fraud, bribery and corruption work within the Trust.

11.5.8   The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the Chief Finance Officer and outcomes fed back to the Audit Committee.

11.5.9   The Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption concerns and internally publicise this, together with the NHSCFA's national fraud and corruption reporting line and online referral form.

11.5.10   The Trust will report annually on how it has met the standards set by the NHS Counter Fraud Authority in relation to anti-fraud, bribery and corruption work and the Chief Finance Officer shall sign-off the annual self-review and authorise its submission to the NHS Counter Fraud Authority.
           The Chief Finance Officer shall sign-off qualitative assessments (in years when this assessment is required) and submit it to the relevant authority.

11.6   Security Management

11.6.1   In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2   The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3   The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Chief Estates and Facilities Officer and the appointed Local Security Management Specialist (LSMS).

12.   RESOURCE LIMIT CONTROL

Not applicable to NHS Trusts.

13.   BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

13.1   Preparation and Approval of Plans and Budgets

13.1.1   The Chief Executive will prepare annually, a statement of strategic direction for approval by the Board of Directors.

13.1.2   The Chief Executive will submit to the Board of Directors an annual business plan (the "Annual Plan") which takes into account financial targets and forecast limits of available resources. The annual plan will contain:

(a)   a statement of the significant assumptions on which the plan is based;

(b)   details of major changes in workload, delivery of services or resources required to achieve the plan.

In preparing the Annual Plan the Trust should ensure:

(a)   financial performance measures have been defined and will be monitored;

(b)   reasonable targets have been identified for these measures;

(c)   a robust system is in place for managing performance against the targets;

(d)   reporting lines are in place to ensure overall performance is managed;

(e)   arrangements are in place to manage/respond to adverse performance.

13.1.3   Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit a financial plan and associated income & expenditure budget to the Board for approval. The plan will contain:

(a)   a statement of any significant assumptions on which the plan is based and an assessment as to whether they are realistic;

(b)   details of major changes in workload, delivery of services or resources required to achieve the plan.

The budget will:

(a) be in accordance with the aims and objectives set out in the Annual Plan and long term financial model;

(b) accord with activity and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available income;

(e) identify potential risks.

13.1.4 The Chief Finance Officer shall monitor financial performance against budget and Annual Plan, periodically review them, and report regularly to the Board.

13.1.5 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled and financial performance against budgets to be monitored.

13.1.6 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

13.1.7 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage budgets successfully.

13.2 Budgetary Delegation

13.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities.

This will be achieved through the approval by the Chief Executive of the Executive Devolution Policy setting out Delegation of authority and decision-making power to Corporate Directorates and Divisions, This policy will provide for differential levels of delegated authority dependent upon the Performance of the Directorate or Division.

13.2.2 Subject to any specific provisions arising from a particular set of circumstances, Budgets shall be delegated as far as possible to the lowest level consistent with effective operational management.

13.2.3 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

13.2.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

13.2.5 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer.

13.2.6 All Business Cases will be approved in accordance with the authority set out in Investment Appraisal Framework and Scheme of Reservation and Delegation of Powers to the Board.

13.3 Budgetary Control and Reporting

13.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. All managers whom the Trust may empower to engage staff or otherwise incur expenditure, collect or generate income, shall comply with the requirements of those systems.

The Chief Finance Officer shall also be responsible for providing budgetary information and advice to enable the Chief Executive and other operational managers to carry out their budgetary responsibilities and issue to all relevant staff, rules and procedures governing the operation of Budgets.

13.3.2 The Chief Finance Officer is responsible for presenting financial reports to the Board giving details of underlying performance, financial efficiency, liquidity and achievement of plan, as well as details of the overall financial risk ratings score.

(a) Monthly financial reports in a form approved by the Board will contain as a minimum:

(i) income and expenditure to date showing trends and forecast year-end position;
(ii) progress against the efficiency / savings programme
(iii) summary cash flow and balance sheet including a forecast year-end position;
(iv) details of new cash borrowings in month and cumulative debt levels
(v) movements in working capital;
(vi) External Financial Limit (EFL) target and performance against Capital Resource Limit (CRL)
(vii) capital project spend and projected outturn against plan;
(viii) explanations of any material variances from plan;
(ix) details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer' view of whether such actions are sufficient to correct the situation;
(x) monitoring of management action to correct variances;
(xi) Performance against risk assurance metrics

13.3.3 The Chief Finance Officer is responsible for the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

13.3.4 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of a member of the Executive Team;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

(d) No temporary employees are appointed which would lead to an overspend on the delegated budget without approval of the Chief Executive.

(e) The systems of budgetary control established by the Chief Finance Officer are complied with fully.

(f) cost improvements, productivity, efficiency and income generation initiatives are identified and implemented in accordance with the requirements of the Annual Plan

13.3.5 The Chief Executive may delegate the responsibility for identifying and implementing cost improvements and income generation initiatives to Divisions and Directorates in accordance with the requirements of the Annual Plan and its delivery.

13.3.6 The Chief Finance Officer shall devise and maintain adequate systems to ensure that the Trust can identify, implement and monitor opportunities for schemes to be included within cost improvement and income generating programmes.

13.4 Capital Expenditure

13.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. All capital procurement shall be carried out in accordance with the Tendering and Contract Procedures. (The particular applications relating to capital are contained in SFI 24).

13.5 Monitoring Returns

13.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation in line with the agreed timescales.

13.6 Value for Money

13.6.1 The Chief Executive in conjunction with the Chief Finance Officer shall be responsible for the efficient and effective use of the total financial resources available to the Trust and ensure that good value for money is achieved.

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Chief Finance Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards;

(b) prepare and submit annual financial returns and accounts to the Department of Health and Social Care in accordance with the national timetable and published requirements;

14.2 The Trust's annual accounts must be audited by the Trust's external auditor as appointed by the Audit Panel and thereafter adopted by the Trust Board.

14.3 The Trust will publish an annual report, in accordance with the national timetable. The document will comply with the relevant Department of Health and Social Care guidance including that contained in the Department of Health Group Accounting Manual.

14.4 The Audited Annual Report and Accounts must be presented to a public meeting and made available to the public.

15. BANK ACCOUNTS

15.1 General

15.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ directions and best practice advice issued by the Department of Health and Social Care and Treasury. In line with 'Cash Management in the NHS' Trusts should minimise the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

The Board of Directors shall approve the banking, working capital and investment arrangements including a review of the Trust's Treasury Management Policy on an annual basis.

15.2   **Bank Accounts**

15.2.1   The Chief Finance Officer is responsible for:

(a)   the operation Government Banking Service (GBS) and other bank accounts held by the Trust, Working Capital Facilities and the appropriate investment of the Trust's cash.

(b)   establishing separate bank accounts for the Trust's non-exchequer funds;

(c)   ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d)   reporting to the Board all instances where bank accounts may become or have become overdrawn (together with remedial action taken);

(e)   ensuring the Board of Directors is notified of changes to the Trust's borrowing facilities; and

(f)   monitoring compliance with Department of Health and Social Care or any other relevant guidance on the level of cleared funds.

15.3   **Banking Procedures**

15.3.1   The Chief Finance Officer will prepare detailed instructions on the operation of all Trust bank accounts, investments and borrowings which must include:

(a)   the conditions under which each bank and GBS account is to be operated, including the limit to be applied to any overdraft

(b)   a panel of officers with delegated authority to sign cheques or authorise payments drawn on the Trust's accounts and the number of signatories required on each authority to pay.

(c)   those authorised to invest monies; and

(d)   any records which must be maintained in respect of the above.

15.3.2   The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

15.3.3   All funds shall be held in accounts in the name of the Trust. No members of staff other than those designated by the Chief Executive and the Chief Finance Officer shall open any bank or building society account in the name of the Trust. Any employee aware of the existence of such an account shall report the matter to the Chief Finance Officer.

15.3.4   Where an agreement is entered into with any other body for payment to be made on behalf of the Trust from bank accounts maintained in the name of the Trust or other body, or by Electronic Funds Transfer (BACS), the Chief Finance Officer shall ensure that satisfactory security regulations of the Trust/other body relating to bank accounts exist and are observed. This will be specified in an agreement with the appropriate body.

15.4   **Investments**

15.4.1 The Chief Finance Officer is responsible for arrangements for the investment of surplus cash with the National Loans fund ensuring:

  (a) a competitive rate of return within a minimal risk profile;
  (b) the availability of cash to meet operational requirements;

15.4.2 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

15.4.3 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

15.5 Tendering and Review

15.5.1 The Chief Finance Officer will review any commercial banking arrangements of the Trust at five yearly intervals to ensure they reflect best practice and represent best value for money.

15.5.2 Competitive tenders shall be sought and the results reported to the Board. This review is not necessary for the operation of Government Banking Services accounts required by the Department of Health and Social Care.

16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1 Income Systems

16.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

16.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

16.1.3
16.1.4 The Trust may carry on activities for the purpose of making additional income available in and/or to better carry out the Trust's principal purpose subject to any restrictions contained in the Regulatory Framework.

16.1.5 Disposal of materials and items surplus to requirements shall be dealt with in accordance with relevant financial procedure notes – see overlap with SFI 26.1.

16.2 Fees and Charges

16.2.1 The Trust shall follow the Department of Health and Social Care's advice in setting prices for NHS service agreements. The charges will be in line with National Tariff or locally agreed where tariff is not applicable.

16.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

Where sponsorship income is considered the guidance in the Trust's 'Standards of Business Conduct and Declarations of Interest Policy shall be followed.

16.2.3   All employees must inform the Chief Finance Officer promptly of money due from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings, overseas patients and other transactions.

16.2.4   In relation to Income Generation Schemes, the Chief Finance Officer shall ensure that all costs and revenues attributed to each scheme can be identified.

16.3   Debt Recovery

16.3.1   The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts including detailed procedures for the issuing of credit notes and write-off of debts after all reasonable steps have been taken to secure payment.

16.3.2   Income not received should be dealt with in accordance with losses procedures and reported to the Audit Committee.

16.3.3   The Chief Finance Officer is responsible for ensuring that systems are in place to prevent salary and other overpayments. Where overpayments occur, recovery should be initiated as per the Trust's debt recover procedure.

16.4   Security of Cash, Cheques and other Negotiable Instruments

16.4.1   The Chief Finance Officer is responsible for:

(a)   approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b)   ordering and securely controlling any such stationery;

(c)   the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d)   prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

16.4.2   Official money shall not under any circumstances be used for the encashment of private cheques or for the granting of personal loans of any kind.

16.4.3   All cheques, postal orders, cash receipts shall be banked intact to the credit of the Trust's Main Account or, if appropriate, the Trust's Charitable fund bank account. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

16.4.4   The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16.4.5   All unused cheques and other orders shall be subject to the same security precautions as are applied to cash.

16.4.6   Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned shall be reported immediately to the Chief Finance Officer and dealt with in accordance with the agreed procedure for reporting losses.

17.   PROCUREMENT AND CONTRACTING PROCEDURE

17.1   Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.12 Suspension of Standing Orders is applied).

Procurement by External Agents

Any External Agent used by the Trust shall be appointed in accordance with these SFI's.

Where the Trust uses External Agents to act on its behalf in relation to any procurement and the Trust is the named "Contracting Authority" then the Procurement Team must ensure that they carry out the procurement exercise in accordance with these SFI's.

No External Agent shall make any decision on whether to award a Contract or who a Contract should be awarded to.

Where the Trust uses External Agents to act on its behalf in relation to any procurement the External Agents must declare any conflict of interest that may arise to the Procurement Team prior to commencing work on any Tender.

Where the Procurement Team considers that such a conflict of interest is significant and cannot be effectively addressed, consideration should be given to whether it is appropriate for the External Agent to undertake the work on behalf of the Trust

17.2   UK Regulations Governing Public Procurement

The Procurement Act including the current financial thresholds prescribed for advertising and awarding all forms of contracts shall have effect as if incorporated in these SFIs.

17.3   Roles and Accountability

The Chief Finance Officer is responsible for ensuring policies and procedures are in place for the control of all procurement activity carried out within the Trust.

17.4.1   Procurement Overview

(i)   Procurement is categorized into 4 ranges of expenditure, explained below. Unless specifically exempted below the Board shall ensure that competitive offers are invited for:

- the supply of goods, materials and manufactured articles;
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care);
- for the design, construction and maintenance of building and engineering works, including construction and maintenance of grounds and gardens;
- disposals.

(ii)   Through the Trust's Finance System purchase orders are automatically generated for catalogue items where pricing has been competitively contracted or benchmarked against approved suppliers to ensure best value.

(iii)   For all goods and services Trust Standing Orders and UK legislation dictates the different purchasing thresholds and the process route of purchasing.

Relevant Contracts Overview

All relevant contracts must comply with the SFI's

A relevant contract is any arrangement made by, or on behalf of the Trust for the supply of goods, services or works.

This includes arrangements for:

- The purchase, hire or leasing of goods and equipment
- The delivery of services
- The delivery of works and associated services
- Use of agency staff
- Any Consultancy services
- Consignment Stock Agreements and Loan Kit Agreements
- Any lease, hire or credit arrangement
- Concession and Income contracts
- Call Off and/or Pricing Agreements via approved Frameworks

A contract is a legally binding agreement required for all goods, services or works entered into by a nominated representative of the Trust. A contract can be formed through verbal or, written means or via the exchange of monies.

Procurement Pipeline and Contracts Register

The Trusts Procurement Team, in conjunction with Divisions are required to publish Procurement Pipelines, Planned Procurement and Market Engagement Notices on the Governments Central Digital Platform detailing the contracts for goods, services and works, which it expects to procure in the coming financial year.

Divisions shall ensure that all contracts that need to be procured over are notified to the Procurement Team and are registered on the Procurement Teams forward plan so any notices that are required are published in accordance with the regulations.

The Procurement Team will maintain a register of any contracts that have been procured in accordance with these SFI's.

Defining the Contract Value

When contracting goods, services or works, a genuine assessment of the whole life value of the contract or framework agreement must be undertaken e.g. a 4 year estimated value.

If the project can be demonstrated as truly, innovative and an estimate cannot be provided, approval on what value to publish must be obtained from the Deputy Director of Procurement before commencing a competitive tendering process.

The Trust shall make the best use of its purchasing power by aggregating opportunities wherever possible both internally and where possible via collaborations with other Trusts.

Contracts for goods, services or works shall not be disaggregated in an attempt to avoid the application of these SFI's or to avoid complying with the Regulations.

For Concession contracts, the value of the contract shall be the total turnover of the concessionaire generated over the duration of the contract, in consideration for the goods, services or works that are the object of the Concession contract.

The value of an Income Contracts is the gross income generated by the Trust as a result of the rights granted, or goods, services or works supplied by the Trust.

Information Governance

Where any Provider (commercial or other) will or might be given access (storage, support and maintenance etc.) to any personal data (Staff/ patients), the Division must comply with the Trusts Data Protection policies and obligations.

The Division must follow the Trusts Information Security and Data Protection/ IG Policies, in particular regarding contracting with data processors and sharing data, and consider IG requirements at all stages of the procurement process.

This includes ensuring IG requirements are adequately covered in the tender phase, carrying out a Data Protection Impact Assessment (DPIA) in consultation with the Information Governance Team, and ensuring sufficient clauses are included in any agreement (prior to any go live).

The provider must meet minimum standards/ expectation in relation to IG and Data Security and if they do not the Trust may not be able to contract with them.

ICT Related Contracts

The Group Director of Digital Services or nominated officer must be consulted regarding the procurement of ICT related goods or services such as ICT consumables, hardware, software/systems or website development or any other ICT service prior to the commencement of any procurement activity.

Contracting Rules based on value

Contracts valued up to £10,000

Where the estimated value of a proposed contract does not exceed £10,000 (Ex Vat) For spend below £10,000 (excluding VAT) no formal procurement exercise is required, but value for money must still be demonstrated. (Do we need to mention here that the Procurement Team do not need to involved?)

(v)	Contracts Value from £10,000 up to £25,000 (How are we going to capture info for notice requirements and are we still happy with this value or do we want to increase it?)

☐ Where spend is between £10,000 - £25,000 and the payee is NHS Supply Chain (NHSSC) no formal procurement process is required and orders can be placed direct with NHSSC.
(vi)☐	For non NHS Supply Chain spend between £10,000- £25,000 (excluding VAT) Procurement should be undertaken through one of the routes outlined below:
a.	Proportionate Procurement, for example, a best value Request for Quote process comparing price and quality,
☐ A requirement to seek at least three written quotations from suitable suppliers. Wherever possible a minimum of one of the quotations must be sought from a Local Business.
b.•	A Further competition under a compliant Procurement framework agreement – if there is a competitive market and /or the potential for future growth in spend.

c. Three quotes – for a one-off purchase but in a competitive market a price only quote process can be undertaken

d.   Less than three quotes – where a competitive market is not established, or demand in the market limits procurement options, one to three quotes will be accepted on the basis there is evidence of attempts to seek quotes and this is document on a procurement record.

e.•   Direct award – where only one provider can deliver the requirement, or for a unique requirement (value for money must still be demonstrated). A short Contract Award Report is required to demonstrate justifiable direct award.

f. Contract variation under an existing contract – providing the contract variation is no more than 10% of the original contract value or for technical or economic reasons, the variation is no more than 50% of the original contract value. Contract variations higher than these thresholds will require a new procurement process.

See SFI 17.9 for further details.

   Contracts Value for Goods and Service contracts above £25,000 to Current Threshold £139,688, Service Contract covered under Light Touch Regime above £25,000 to Current Threshold £589,148 and Works above £25,000 to £500,000.

(vii)   For spend above £25,000 (excluding VAT) but below the current tender thresholds within PCR2015, or £100,000 for services described in Schedule 3 of PCR 2015, or £500,000 for works as described in PCR2015

Procurement must be engagedlead on all procurement activity at these value and to undertake one of the following processes

• Proportionate Procurement Exercise in the open market – where a price and quality are evaluatedi. on is required, then a proportionate tendering approach to test the market. should be undertaken by the Procurement Team.

• Where appropriate a restricted exercise where price and quality are evaluated to test the market.

a.

• Mini-competition through a compliant framework agreement.

b.

• Where an approved third party framework has an option to compliantly direct award on a non-competitive basis the Procurement Team must have a written justification for the selection of the provider(s) and this must be contained within the Contract Award Report.

c. Direct award under a compliant framework agreement

d.   Contract variation under an existing contract – providing the contract variation is no more than 10% of the original contract value or for technical or economic reasons, the variation is no more than 50% of the original contract value. Contract variations higher than these thresholds are not permitted and will require a new procurement. Contract variations which result in a total value contract above procurement thresholds are not permitted, and will require a compliant procurement under the Public
Contract Regulations 2015

e.   In exceptional circumstances, a single tender waiver may be required In very exceptional circumstances a direct award is permitted– where only one provider can legitimately deliver the requirement, or for a unique requirement. (value for money must still be demonstrated). Where this process is undertaken a Contract Waiver form should be completed in advance of the requirement.

Works Contracts valued above £500,000 to Current Threshold £5,372,609

Procurement must lead all procurement activity at these values and undertake one of the following processes:

- Undertake a tender where a minimum of **three** submissions should be sought from suitable suppliers. Wherever possible a minimum of one tender must be sought from a Local Business.
- Undertake a mini-competition in-accordance with an approved framework terms, conditions and processed.
- Where an approved third party framework has an option to compliantly direct award on a non-competitive basis the Procurement Team must have a written justification for the selection of the provider(s) and this must be contained within the Contract Award Report.

All contracts valued above UK tender threshold

For all spend above the current UK tender threshold limit the Procurement Team must lead on this activity and undertake one of the following processes:

- A compliant procurement process in line with the associated procedures detailed within the Regulations

- Undertake a mini-competition in-accordance with an approved framework terms, conditions and processed.
- Where an approved third party framework has an option to compliantly direct award on a non-competitive basis the Procurement Team must have a written justification for the selection of the provider(s) and this must be contained within the Contract Award Report
- In exceptional circumstances, a compliant direct award under section 41, 42 or 43 of the Regulations. The Procurement Team will need to ensure that all appropriate transparency notices have been completed in accordance with Section 44 Regulations

(iv) .

17.4.2

17.4.3 **Exceptions and instances where a procurement process need not be applied**

(a) where the estimated expenditure or income does not, or is not reasonably expected to, exceed **£10,000**
(b) ;

(b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in SFI No. 26;

(d)

17.4.4   Waivers to SFIs

Waivers to the SFIs may be permitted when the SFIs cannot be practicality applied, and the award meets one of the following circumstances:

 (a)   in very exceptional circumstances where formal procurement procedures would not be practicable and the circumstances are detailed in an appropriate Trust record.

 (b)   where the timescale genuinely precludes competitive procurement but failure to plan the work properly would not be regarded as a justification for a single tender;

 (c)   where the Trust area able to demonstrate that only one specialist firm is able to meet the requirement

 (d)   when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

 (e)   there is a clear benefit to be gained from maintaining continuity with an earlier project or compatibility with existing equipment / service. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive procurement;

 (f)   for building and engineering construction works and maintenance where there is either a direct legal enforcement of safety the consequence of which would result in the closure of the Trusts services and/or prosecution of the Trust and it's officials or a specified National or Local Health economy imperative where failure to deliver could place patients safety at risk.

Only the Group Chief Finance Officer (or nominated deputy) has the authority to waive the SFI's.

Waivers must be obtained in advance of the procurement action as a waiver cannot be authorised retrospectively unless in an emergency situation.

Waivers **must not** be used to avoid the requirements of the SFI's to go to competition due to lack of time to procure. Procurement projects should be planned well in advance.

Waivers for goods & services contracts can only allowed up to the value, **£138,760 inc. VAT**, **£663,540 inc. VAT** for contracts under the Light Touch Regime **£5,336,937 inc. VAT** for works contracts.

Waivers must be documented with a unique reference number and on the Trust approved Waiver Form

Where it is decided that a formal procurement process is not possible and should be waived, the reason for the waiver should be documented on the

approved Trust Waiver Form with a unique reference, endorsed by the Procurement Team, then authorised by the Group Chief Finance Officer.

All waivers are to be reported to the Audit and Risk Committee on a quarterly basis, or more frequent if requested by the Committee.

17.4.5

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17.5 Tendering Procedure for Goods, Materials, Services and Disposals including non NHS provided health care.

17.5.1 **Invitation to tender**

(i) All invitations to tender shall be issued via the appropriate e procurement/sourcing portal in use within the Trust. (Where the Trust has engaged with an External Agent the tender shall be run on their e-procurement portal)

(i)

(ii) All invitations to tender shall state that no tender will be accepted unless it has been submitted via the appropriate e procurement/sourcing portal adhering to all the required terms of the invitation to tender but specifically the requested time and date of return.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Terms and Conditions of Contract as are applicable. Any contract that is not to be let under these terms must be referred to the Deputy Director of Procurement for approval prior to any contractual agreement.

(iv) Every tender for building or engineering works will be procured under a relevant form of contract specific to the required such as NEC, JCT etc.

17.5.2 **Receipt and safe custody of tenders**

The Procurement Team will be responsible for the electronic receipt, and safe custody of tenders received within the e-procurement system until the time for the electronic seal to be opened.

17.5.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the electronic vault will be opened by the procurement project lead

(ii) Every tender received shall be marked with the date of opening automatically by the e-procurement software and will maintain a full auditable record of the opening process.

(iii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, shall be addressed in accordance with the conditions set out in the invitation to tender document and regulations.

(iv) Appropriately detailed electronic notes shall be kept in the contract file to detail any matters such as action taken in respect of late tenders, non-compliant bids or any other matters relevant to tender receipt and opening.

17.5.4 **Admissibility**

(i) Tenders submitted but not received until after the due time and date (at which point the electronic vault is locked), may be considered only if confirmation of submission is received from the e-sourcing portal. The Deputy Director of Procurement will decide whether there are exceptional circumstances e.g. System failure on the part of the Portal having been uploaded in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders In addition to this it will also only be considered if the evaluation process of the other tenders has not commenced.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential,

(iv) Where only one tender is sought and / or received, it must be demonstrated that the price to be paid is fair and reasonable and will ensure value for money for the Trust. This will be recorded in the appropriate documentation namely the contract award report.

17.5.5 **Acceptance of formal tenders (See overlap with SFI No. 17.6)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender. All such questions must be raised and responded to via the e procurement system to maintain audit trails and transparency.

In accordance with the Procurement Act section 19 the evaluation criteria for tenders will be developed using the most advantageous tender (MAT) model that will ensure a wide range of criteria is considered rather than just the cost.

It is accepted that the lowest price does not always represent the best value for money. Other factors affecting the success of a project may include (without limitation):

(a) Qualitative elements of the bidders proposal including social value;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be documented in the contract award report,.

Criteria taken into account in selecting a successful tenderer must be clearly recorded and documented in the invitation to tender/quote.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Finance Officer

(iv)   The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded; or

(b) that best value for money was achieved.

(v)   All tenders should, subject to compliance with the provisions of the Freedom of Information Act 2000, be treated as confidential and should be retained fo the following periodsr:

Tender Documentation

In accordance with section 98 of the regulations tender documentation must be kept until the end of the period of three years beginning with the day on which the contract is entered into or, if the contract is awarded but not entered into, awarded.

Contract Documentation

(a) 6 years after contract completion where executed under hand

(b) 12 years after contract completion where executed under seal

(vi) All tenders should be assessed for embedded derivatives and embedded leases utilising a standard checklist. Any proposed tender award which indicates the existence of either should be notified to the Assistant Chief Finance Officer – Financial Services, prior to award.

17.6   Contract Award Process and Documentation

These levels of authorisation may be varied or changed only with the express agreement of the Trust Board.

Providing all the conditions and circumstances set out in these SFI's have been fully complied with, formal authorisation for the awarding of a contract must be obtained.

Depending on the contract value and process undertaken the documentation requirements are as follows:

*   On completion of an above Threshold Procurement a formal Contract Award Recommendation Report will be required in accordance with the regulations.

*   On completion of a below Threshold Procurement a short form Contract Award Report will be required.

These reports will be authorised as a minimum by the following staff depending on the contract value :

	Total Contract Award Value				
	<£25,000	<£100,000	<£250,000	<£1m	£1m+
Divisional Lead	X	X	X	X	X
Head of Category	X	X	X	X	X
Divisional Head of Finance	X	X	X	X	X
Deputy Director of Procurement		X	X	X	X

			X	X	X
Group Chief Finance Officer			X	X	X
Chief Executive Officer				X	X
Finance and Performance Committee					X
Trust Board					X

Where Divisions and projects require additional member of staff to sign off the Contract Award this will be agreed with the relevant Head of Category.

17.7   Signing of Commercial Procurement Contracts/ Agreements (External Document)

17.7.1   The signing of the commercial agreements must only be undertaken by the following Trust Staff and within the identified value limits

< £100,000 – Deputy Director of Procurement
£100,000 – £250,000 Group Chief Finance Officer
>£250,000 – Chief Executive Officer or where the agreement requires two signatories Chief Executive Officer and Group Chief Finance Officer

Works and other associated construction contract specified in section XX

< £100,000 – Deputy Director of Procurement
£100,000 – £250,000 Group Chief Finance Officer
>£250,000 – Group Director of Estates and Facilities or where the agreement requires two signatories Group Director of Estates and Group Chief Finance Officer

As part of utilising Procurement Frameworks there will be the requirement to sign off access agreements and other associated paperwork before commencing any procurement exercise. These documents must authorised by either the Deputy Director of Procurement or Head of Category.

17.8   **Private Finance and leasing for capital procurement (see overlap with SFI No. 24)**

17.8.1   When the Board proposes, or is required, to use finance provided by the private sector (PFI) the following should apply:

(a)   The Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b)   Where the sum exceeds delegated limits, a business case must be referred to the appropriate department or agency for approval or treated as per current guidelines.

(c)   The proposal must be specifically agreed by the Board of the Trust.

(d)   The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.8.2   Where it is proposed that leasing be considered in preference to capital procurement then the following should apply:

(a)   The selection of a contract / finance company shall be on the basis of a competitive process;

(b)   All proposals to enter into a leasing agreement shall be referred to the Chief Finance Officer before acceptance of any offer;

(c)   The Chief Finance Officer shall ensure that the proposal demonstrates best value for money; and

(d)   The proposal shall be agreed in writing by the Chief Finance Officer prior to acceptance of any offer to the lease.

In the case of property leases the relevant NHS guidance shall be followed and procurement rules do not apply.

17.9   Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a)   The Trust's Standing Orders and Standing Financial Instructions;

(b)   UK Procurement Regulations and other statutory provisions;

(c)   any relevant directions issued by Treasury, the Department of Health or other Statutory Body.

(d)   such of the NHS Standard Contract Conditions as are applicable.

(e)   contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f)   Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis of the Procurement.

(g)

17.10   Personnel and Temporary Staff Contracts (see overlap with SFI Nos. 20.6, 20.9, 21.2.3)

The Chief Executive shall nominate officers with delegated authority to design and operate a process for engaging with and enter into contracts of employment, regarding staff,.

17.11

17.12   Disposals (See overlap with SFI No 26)

Competitive Procurement procedures shall not apply to the disposal of:

(a)   any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

<ol type="a" start="2">
obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed on a periodic basis;
items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

17.13   In-house Services

17.13.1   The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by. undertaking a procurement process in accordance with those specified above.

17.13.2   In all cases where the Board determines that in-house services should be reviewed the following groups shall be set up:

(a)   Specification group, comprising the Chief Executive or nominated officer/s and specialist/s.

(b)   In-house bid group, comprising a nominee of the Chief Executive and technical support.

(c)   Evaluation team, comprising normally a specialist officer, a member of the Procurement Team and Chief Finance Officer or nominated representative. For services having a likely annual expenditure exceeding £ 1,000,000, a non-officer member should be a member of the evaluation team.

17.13.3   All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house bid group may participate in the evaluation.

17.13.4   The evaluation team shall make recommendations to the Board.

17.13.5   The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

17.14   Applicability of SFIs to Procurement using funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased by the United Lincolnshire Hospitals Trust Charity.

17.15   Contract Administration

17.15.1

Termination of Contract(s)

Inline with standard NHS Terms and Conditions the provision for the termination of a contract must be included within the terms and conditions of the contract. Where appropriate the termination for convenience clause should be selected.

The Contract Management Head of Category must be consulted and give their approval where a contract is to be terminated by exercising the termination for convenience clause.

The Deputy Director of Procurement must be consulted if the performance of a contract as resulted in a breach of contract and consideration has been given to termination of the contract.

Only the Deputy Director of Procurement has the authority to agree to the early termination of a contract due to a single or multiple breach/s and the subsequent Termination Notice but be signed by them or their nominated deputy.

Contract Modification.

All Contract modifications must be carried out within the scope of the original Contract.

All Contract modifications must be carried out in accordance with section 74-77 of the regulations.

Any Contract modification that material affects or changes the scope of the original contract potential may not be permitted under the regulations so prior approval must be sought by the relevant Head of Category before entering into any contractual discussions.

If a material change is approved by the Head of Category, then the necessary notices must be published in accordance with the regulations.

A new procurement is required in the case of a material change where one or more of the following conditions are met:

- increase or decrease the term of the contract by more than 10 per cent of the maximum term provided for on award,
    -
- materially change the scope of the contract
    -
- materially change the economic balance of the contract in favour of the supplier.

- the modification would not itself increase or decrease the estimated value of the contract by more than:

- in the case of a contract for goods or services, 10 per cent;

- in the case of a contract for works, 15 per cent,

All contract modifications must be in writing and signed by both the Trust and the provider except where different provisions are made within the contract documentation.

The value of each modification must be assessed and all necessary approvals sought prior to the variation taking place.

Approval for any modification shall be sought in writing in accordance with the authorisation matrix contained at XXXXX.

Contract Extensions

The term of any contract may only be extended where all the following criteria have been met:

Provision for an extension of the term is evidenced by the original contract and any subsequent notices required by the regulations; and

The Provider is currently delivering to an expected standard.

Where the budget provision and the extension is in line with the SFI;s; and

Where the extensions have not been allowed for in the initial Contract Award Report a separate Contract Award Report will be needed before the extension can be approved.

Where the contract still delivers Value For Money

Contract extensions will not be permitted if they take the overall contract value above the value that was advertised in the Contract Notice.

Contracts Novation and Assignment

Transfer, assignment and novation of contracts can only be agreed by the Deputy Director of Procurement (or nominated deputy).

Any novation and assignment must be processed in accordance with the terms and conditions of the contract and must be in writing and signed by both the Trust and the provider except where different provisions are made within the contract documentation

18.   AGREEMENTS FOR PROVISION OF HEALTHCARE SERVICES (see overlap with SFI No. 17.11)

18.1   The Chief Executive, as the Accountable Officer of the Trust, supported by the Chief Finance Officer and Deputy Chief Executive, is responsible for negotiating contracts with commissioners for the provision of services to patients in accordance with national guidance and the Annual Plan.

18.2   All agreements should aim to implement the agreed priorities contained within the NHS Operating Framework and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the provision of reliable information on cost and volume of services;
- existing agreements, to ensure where appropriate they build on existing partnership arrangements;
- the mandated performance indicators;
- existing Joint Investment Plans;
- the need to ensure agreements are based on integrated care pathways; and any model contracts issued by the Department of Health and Social Care.

In carrying out these functions, the Chief Executive should take account the advice of the Chief Finance Officer regarding:

- the National Tariff Payment System and associated guidance (e.g. national activity recording and coding requirements, the National Grouper etc.) and the costing and pricing of services;
- payment terms and conditions;
- amendments to agreements and other NHS patient services arrangements.

All agreements should be underpinned by the NHS standard contract clauses.

18.3   Involving partners and jointly managing risk

The risks involved in joint working will be assessed and articulated within a legally binding contract. Such a contract will be informed by the view of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Finance Officer to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The agreement will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

18.4   Sub-contracting Provision of Services to Non-NHS Providers

Where the Trust makes arrangements for the provision of services by non-NHS providers, it is the Chief Finance Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided. Before making any agreement with non-NHS providers, the Trust should explore fully the scope to make maximum cost-effective use of NHS facilities and ensure all sub-contracting is in accordance with the NHS Standard Contract. This is to ensure that the quality and performance measures reflect the Trust contract with their main commissioners.

18.5   The Chief Finance Officer, on behalf of the Chief Executive, shall be responsible for drawing up and agreeing to the financial details and terms and conditions contained in the legally binding contract entered into by the Trust.

18.6   Agreements should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Agreement prices shall comply with the latest costing guidelines.

18.7   The Chief Finance Officer shall be responsible for establishing arrangements for the identifying, gaining approval for and invoicing of other NHS patient services referrals.

18.8   Reports to Board on contracts

The Chief Finance Officer will ensure that regular reports are provided to the Board detailing actual and forecast income from the contracts. Contract performance will be reported separately by the Deputy Chief Executive.

19.   COMMISSIONING

Not applicable

20.   HUMAN RESOURCES AND PAY

20.1   Remuneration and Terms of Service (see overlap with SO No. 5.7)

20.1.1   In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

20.1.2   The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust and other senior employees including:

   (i)   all aspects of salary (including any performance-related elements/bonuses);

   (ii)   provisions for other benefits, including pensions and cars;

   (iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(a) monitor and evaluate the performance of individual officer members (and other senior employees);

(b) receive assurance from appropriately qualified officers of the trust in regard to appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate;

(c) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments exceeding £50,000 taking account of such national guidance as is appropriate.

   • For any payment less than £50,000 the Executive Team has authority to consider and approve.
   • For any termination payment over £150,000 the payment must gain Board approval.

(d) Special severance payments (those outside normal statutory or contractual requirements) cannot be made without Treasury and Board approval

20.1.3   The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

20.1.4   The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5   The Trust will pay allowances to the Chair and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

20.2   Funded Establishment

20.2.1   The Executive Devolution Policy provides for a degree of earned autonomy to be reflected in the delegation of powers to Directorates and Divisions in varying Establishment. Unless otherwise devolved, the following apply:

- The workforce plans incorporated within the annual budget will form the funded establishment.

- All new posts must be approved through the business planning process.

- The funded establishment of any department may not be varied in any way which causes expenditure to exceed the authorised annual budget without the prior written approval of the Chief Finance Officer or nominated deputy.

20.2.2   The authority to fill a funded post on the establishment with permanent or fixed term staff sits with the budget holder except when the Trust is operating under special measures when this authority may be rescinded.

20.2.5   The authority each budget manager is attributed in relation to all pay and non-pay decisions is set out within the Executive Devolution Policy (See SFI No. 13.3.1 and 21.2)

20.3   Staff Appointments

20.3.1   No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

(a)   authorised to do so by the Chief Executive;

(b)   within the limit of their approved budget and funded establishment or as set out within the Executive Devolution Policy.

20.3.2   The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

20.3.3   Any monies due to employees as a result of all employments with the Trust howsoever arising shall be paid through the Trust payroll.

20.4   Variation to existing job plans

20.4.1   Only the Clinical Director or Business Manager of the relevant Clinical Business Unit can authorise variations to existing job plans within the agreed budget.

20.5   Authorisation of overtime and additional sessions

20.5.1   The budget holder is responsible for authorising overtime and additional sessions.

20.5.2   Overtime and additional sessions must be authorised prior to being worked. In exceptional circumstances where documentation or electronic systems are not authorised prior to the work being undertaken, these must be completed as soon as possible.

20.6   Authority to engage bank and agency staff, Self-employed or Third Party Workers

20.6.1   Within delegated budget:

(a) The budget holder holds the responsibility to authorise the booking of bank and agency staff or self-employed or Third Party Workers

Outside of delegated budget:

(b) The booking of bank and agency personnel or self-employed or Third Party Workers outside of budget must be agreed in advance with the appropriate Executive Director in consultation with the Chief Finance Officer.

20.6.2   All bookings of bank or agency staff must be made through the agreed process, variations to this can only be made with the express authority of the Chief Finance Officer.

20.7   Leave Policy

20.7.1   The Director of Human Resources is responsible for agreement and publication of Leave Policy, to cover Annual, Maternity, Paternity and other Special Leave categories.

20.7.2   The Director of Human Resources is responsible for agreement and implementation of a Policy to support Career Breaks.

20.8   Redundancy

20.8.1   All staff redundancies must be authorised by the Chief Finance Officer.

20.9   Engagement of Workers off Payroll – (see overlap with SFI No 21.2.3)

20.9.1   The Chief Finance Officer shall issue detailed guidance setting out responsibilities and required actions for managers engaging workers 'off-payroll'.

20.9.2   Only in exceptional cases should a worker be engaged and not paid through the Trust payroll.

20.9.3   Prior to engagement, the tax status of the 'worker' must be determined. To facilitate this, the engaging manager must complete an online IR35 assessment which prior to engagement must be reviewed and agreed by a nominated officer within the Finance Directorate.

20.9.4

20.9.5   Appropriate arrangements shall be in place to ensure that income tax deductions and national insurance contributions for both the Trust and worker are properly made and paid to HM Revenue & Customs in line with current legal and regulatory requirements.

20.9.6   NHSE payment Caps may not be exceeded without the express agreement of the appropriate Executive Director;

20.10   Processing Payroll

20.10.1   The Chief Finance Officer is responsible for:

(a)   specifying timetables for submission of properly authorised time records and other notifications;

(b)   the final determination of pay and allowances;

(c)   making payment on agreed dates;

(d)   agreeing method of payment.

20.10.2   The Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) procedures for payment by cheque, bank direct credit (including BACS), or cash to employees and officers;

(h) procedures for the recall of bank direct credits (including BACS) and stopping of cheques;

(i) Pay advances and their recovery;

(j) maintenance of regular and independent reconciliation of pay control accounts;

(k) separation of duties of preparing records;

(l) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

20.10.3   The Budget Holder has delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) submitting appointment forms and change forms in the prescribed form, immediately upon knowing the effective date of an employee's appointment or change in circumstances;

(c) completing time records and other notifications in accordance with the Chief Finance Officer' instructions and in the form prescribed by the Chief Finance Officer;

(d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

20.10.4   Individual employees are responsible for:

(a) Keeping accurate time records

(b) Submitting time records and claims for reimbursement of overtime, enhancements and extra duties to line management for authorisation each month or where required more frequently in accordance with published timetables

(c)　Submitting claims for reimbursement of travel and other expenses within 3 months of being incurred. Claims outside this period must be authorised by the Chief Finance Officer or nominated Deputy.

(d)　Checking their pay each month and immediately notifying Payroll of any identified error for correction in the following pay period.

20.10.5　Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

20.10.6　All timesheet, pay records and other pay notifications shall be certified and submitted in accordance with the instructions of the Chief Finance Officer. A list of designated authorising Officers shall be maintained, detailing the limits of authorisation and shall contain specimen signatures.

20.10.7　The Chief Finance Officer shall determine the dates on which the payment of salaries, wages, expenses, allowances, termination or compensation payments, and any other form of remuneration are to be made, having regard to the general rule that it is undesirable to make payments in advance, except in special circumstances.

20.10.8　The Chief Finance Officer will publish a salary overpayments and advances policy detailing the Trust approach to and process for recovery of overpayments and circumstances under which an advance of salary may be made.

20.11　Contracts of Employment

20.11.1　It is the responsibility of the Director of Human Resources for:

(a)　ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b)　dealing with variations to, or termination of, contracts of employment in accordance with the requirements of Standing Orders and Standing Financial Instructions

21.　NON-PAY EXPENDITURE

21.1　Delegation of Authority

21.1.1　The Board will approve the level of non-pay expenditure on an annual basis and the Chief Finance Officer will determine the level of delegation to budget managers.

21.1.2　The Chief Finance Officer will set out:

(a)　the list of managers who are authorised to place requisitions for the supply of goods and services;

(c)　the maximum level of each requisition and the system for authorisation above that level.

The list of managers and limits of financial authority will be set out within the Trust authorisation matrix hierarchy. This defines the actions individuals have delegated authority to carry out on behalf of the Trust. The authority will be restricted in most cases to a limited range of budget areas for which the manager is responsible. The

matrix incorporates delegated authority in relation to Human Resources (e.g. recruitment), Procurement / Invoice authorisation, Admin rights, budget amendments and Charitable Fund requests.

21.1.3   No contract in respect of the supply of revenue or capital goods and/or services may be authorised other than by approved budget managers in conjunction with advice from Procurement or Estates services or exceptionally by the Chief Executive. The approved manager shall not authorise a contract in respect of a budget for which they are not accountable.

21.1.4   The Chief Finance Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

21.2   Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with SFI No. 17)

21.2.1   **Requisitioning**

The requisitioner in specifying the item to be supplied (or the service to be performed) shall always engage with Procurement Services to obtain the best value for money for the Trust.

21.2.2   It should be the duty of the Associate Director of Procurement to exercise general supervision over all purchases, except for drugs and pharmaceutical supplies. After making reasonable efforts to resolve conflicts, and having due regard to materiality, he shall inform the Chief Finance Officer of any requisition which appears to be in conflict with the Trust's Standing Orders and Standing Financial Instructions. In the case of drugs and pharmaceutical supplies this duty falls to the Chief Pharmacist.

21.2.3   Where services are required from an individual, consideration should be given to the nature of the role to be undertaken to ensure that the contract will be a contract FOR services (non-pay) and not a contract OF service (pay). It is the responsibility of the Budget Manager to ensure that when making an appointment or agreement for services that the individual is paid appropriately in accordance with the relevant tax regime. This also applies where services are offered by ex-employees or individuals supplying through their own personal service companies: it is the nature of the role which determines the appropriate pay or non-pay arrangement and advice of the Procurement team should be sought where necessary.
The relevant Finance Manager must be consulted when engaging with a PSC for the provision of personal services to ensure IR35 tax legislation is consistently applied. (see overlap with SFI 20.9)

21.2.4   **System of Payment and Payment Verification**

The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

21.2.5   The Chief Finance Officer will:

(a)   advise the Board regarding the setting of thresholds for each route to procurement ; and, once   approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b)   prepare procedural instructions and guidance for governing the procurement of non-pay goods and services within agreed authorisation limits.

(c)   be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Trust employees (including specimens of their signatures where appropriate) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(d) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.6 below.

21.2.6 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. The Chief Finance Officer will provide a list of suppliers or services where payment in advance is permitted. Any situations not covered will require explicit authorisation from the Chief Finance Officer. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages.

(b) The appropriate budget holder must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

21.2.7 **Official orders**

All goods, services or works will unless otherwise exempted be ordered on an official order and contractors shall be notified that they should not accept orders unless in an official form. The only exceptions to raising an official order shall be for:

(a)   cases of emergency or urgent necessity where a confirmation order number should be used.;

(b)   those specific approved goods and services for which a non-stock requisition is not required (as advised by the Head of Procurement on the 'Official exemption list).

(c)   those purchases made with a procurement card or by petty cash in accordance with the relevant approved procedure.

Official Orders must:

(a)   be uniquely numbered;
(b)   be in a form approved by the Chief Finance Officer;
(c)   state the Trust's terms and conditions of trade;
(d)   only be issued to, and used by, those duly authorised by the Chief Executive.
(e)   Confirmation order numbers shall be issued only by an Officer designated by the Chief Executive and used only in cases of emergency or urgent necessity. These shall be confirmed by an official order issued as soon as possible and ideally the next working day. The order should be clearly marked "Confirmation Order".

Orders / requisitions shall only be raised (or electronically processed) by Officers so authorised by the Chief Executive.
Lists of authorised Officers shall be maintained detailing the limits of authorisation within the Trust authorisation matrix (SFI 21.1.2).

21.2.8   **Purchasing Cards**

(a)   All purchase cards are issued subject to the appropriate budget holder completing a business case of need, and authorisation by the Associate Director of Procurement.

(b)   The card must be utilised according to the procedures documented in the Purchase Card Manual.

(c)   Purchase card transactions and relevant backing information will be subject to audit by finance to ensure it is appropriately completed and stored.

(d)   Illicit use of the purchase card for inappropriate or personal spend will result in disciplinary action and referral to the local counter fraud specialist where applicable.

21.2.9   **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a)   all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b)   contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c)   where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with the Trust's "Standards of Business Conduct and Declarations of Interest Policy");

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f) all goods, services, or works (unless specifically exempted by the Chief Finance Officer – SFI 21.2.7) are ordered on an official order;

(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase (indemnity forms should be completed for all trial/loan and free issue equipment); All trials or loans must be authorised in advance through the relevant governance structure.

(i) changes to the list of employees and officers authorised to commit resources and certify invoices are notified to the Chief Finance Officer;

(j) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(k) petty cash records are maintained in a form as determined by the Chief Finance Officer.

21.2.10 No Officer shall place a requisition, purchase from petty cash, by procurement card or require an official order to be raised with an individual to whom they are related or with any person or organisation with whom they hold a financial interest or from whom they are likely to receive any payment, gift or other consideration, without first making a disclosure. of the circumstances in writing to the Chief Executive and receiving his written authority to proceed. A copy of an authority so given must be lodged with the Chief Finance Officer.
Related Party disclosure should be made in accordance with the Trust Standards of Business Conduct and Declarations of Interest policy.

21.2.11 The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the high level principles described within Health Building Note 00-08. The evaluation of the efficiency and effectiveness of these contracts shall be the responsibility of the Chief Estates and Facilities Officer.

22. EXTERNAL BORROWING

22.1.1   The Chief Finance Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The Chief Finance Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

22.1.2   The Chief Finance Officer shall be responsible for ensuring that the best value is obtained in securing loan finance and other sources of external funding and shall prepare detailed procedural instructions concerning applications for loans and overdrafts and on the form or records to be maintained.

22.1.3

22.1.4   Borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health and Social Care.

22.1.5   Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Finance Officer. The Board must be made aware of all short term borrowings at the next Board meeting.

22.1.6   All long term borrowings must be agreed by the Trust Board. Loan documentation must be authorised by the Chief Executive and Chief Finance Officer.

22.1.7   All long term borrowing must be consistent with the plans outlined in the current financial plan as reported to the Department of Health and Social Care and be approved by the Trust Board.

22.1.8   The Chief Finance Officer is responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Trust to fulfill the requirement to maintain adequate cash balances. The Board of Directors will receive details of the Trust's performance from the Chief Finance Officer.

23.   FINANCIAL FRAMEWORK

23.1.1   The Chief Finance Officer should ensure that members of the Board are aware of the NHS Financial Regime. The Chief Finance Officer should also ensure that the direction and guidance issued as part of the NHS Financial Regime is followed by the Trust.

24.   CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

24.1   Capital Investment

24.1.1   The Chief Executive:

(a)   shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b)   is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to budget;

(c)   shall ensure that the capital investment is not undertaken without confirmation of Commissioner support (where appropriate) and the availability of resources to finance all revenue consequences, including VAT and capital charges.

24.1.2   For every capital expenditure proposal the Chief Executive shall ensure:

(a)   that a business case (in line with current Department of Health and Social Care guidance and the Trusts Investment Appraisal Framework is produced setting out:

(i)   an option appraisal of potential financial and non-financial benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii)   the involvement of appropriate Trust personnel and external agencies;

(iii)   appropriate project management and control arrangements;

(b)   that the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.

(c)   that advice is taken and acted upon to minimise the VAT and other taxes payable;

24.1.3   For capital schemes where the contracts stipulate stage payments, the Chief Finance Officer will issue procedures for their management.

24.1.4   The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue and Customs guidance.

24.1.5   The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure. This as a minimum shall include reporting to the Board on:

(a) an individual scheme / project

(b) the source and level of funding, and

(c) the expenditure incurred against the annual plan profile

24.1.6   The approval of a capital programme shall not constitute approval for the initiation of expenditure on any individual scheme, because it is also necessary to undertake the mandatory procurement processes of the Trust.

The Chief Executive shall issue to the manager responsible for any scheme:

(a)   specific authority to commit expenditure;

(b)   authority to proceed to tender (see overlap with SFI No. 17.6);

(c)   approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with current Department of Health and Social Care guidance and the Trust's Standing Orders.

24.1.7   The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

24.1.8   The Chief Finance Officer shall issue procedures for the use of capital receipts from the sale of assets and will ensure that the Trust's financial plans incorporate any expected capital receipts.

24.1.9   The Board of Directors will approve details of the Capital Expenditure Programme as part of the Annual Plan.

24.1.10   The Board of Directors will approve the acquisition / disposal of land and property.

          24.1.11

24.1.11   The classification and recording of capital expenditure should be in accordance with the requirements laid down in the Department of Health Group Accounting Manual.

24.2   Private Finance and leases (see overlap with SFI No. 17.8)

24.2.1   The Trust should consider market-testing against Private Finance Initiative Funding (PFI) and / or leasing agreements when considering a large capital procurement.

24.3   Asset Registers

24.3.1   The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted on a rolling basis every two years.

24.3.2   Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be sufficient to meet requirements set out within International Financial Reporting Standards and other requirements as stipulated in the Department of Health Group Accounting Manual.

24.3.3   Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

    (a)   properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

    (b)   stores, requisitions and salary records for own materials and labour including appropriate overheads;

    (c)   lease agreements in respect of assets held under a finance lease and capitalised.

24.3.4   Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

24.3.5   The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

24.3.6   The value of each asset shall be depreciated using methods and rates as specified in the Trust's accounting policies and indexed / revalued annually as appropriate.

24.3.7   The Chief Finance Officer shall calculate and make dividend payments in accordance with instructions issued by the Department of Health.

24.4   Security of Assets

24.4.1   The overall control of non-current assets is the responsibility of the Chief Executive.

24.4.2   Asset control procedures (including fixed assets, cash, cheques, negotiable instruments, and donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a)   recording managerial responsibility for each asset;

(b)   identification of additions and disposals;

(c)   identification of all repairs and maintenance expenses;

(d)   physical security of assets;

(e)   periodic verification of the existence of, condition of, and title to, assets recorded;

(f)   identification and reporting of all costs associated with the retention of an asset;

(g)   reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

24.4.3   All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer who may also undertake such other independent checks as considered necessary.

24.4.4   Whilst each employee and officer has a responsibility for the security of property of the Trust; it is the responsibility of board members and senior employees in all disciplines to apply such appropriate routine security checks and practices in relation to Trust and NHS property as may reasonable or as otherwise specified by the board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

24.4.5   Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses – see SFI 26.2.

24.4.6   Where practical, assets should be marked as Trust property.

24.4.7   Employees unless specifically authorised by the Chief Executive shall not use Trust assets for personal use.

24.4.8   The up-to-date maintenance and annual checking of asset records shall be the responsibility of designated departmental managers or Budget Holders for all items for which the initial purchase or replacement is within their delegated responsibilities.

24.4.9   Registers shall be maintained to record all controlled items issued to individuals, and where practicable, receipts shall be obtained.

24.4.10   Records shall also be maintained and receipts obtained for:

- equipment on loan to patients; and
- all contents of furnished lettings.

25.   STORES AND RECEIPT OF GOODS

25.1   General position

25.1.1   Stocks are those goods normally utilised in day-to-day activity but which, at any point in time, have not yet been consumed (excluding capital assets). They are usually held in controlled stores and within departments.

Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a)   kept to a minimum level commensurate with delivery and cost effective purchasing;

(b)   subjected to annual stock take;

(c)   valued at the lower of cost and net realisable value except where otherwise determined by the Trust's accounting policies.

25.2   Control of Stores, Stocktaking, condemnations and disposal

25.2.1

Subject to the requirements of the Chief Finance Officer for the systems in use, overall responsibility for the control of stores shall be delegated to an Officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel to a designated estates manager.

25.2.2   The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

25.2.3   The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
All stock records shall be in such form, and shall comply with such systems of control, as the Chief Finance Officer shall approve.

25.2.4   Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one Officer other than the storekeeper and his staff. The stocktaking records shall be numerically controlled and signed by the Officers undertaking the check. Any surplus or deficiencies revealed on stocktaking shall be reported to the Chief Finance Officer immediately.

25.2.5   Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

25.2.6   The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No 26 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

25.3   Goods supplied by NHS Supply Chain

25.3.1   For goods supplied via NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note and report

discrepancies to avoid overpayment where such discrepancies cannot be resolved via the Procurement Team.

26. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

26.1 Disposals and Condemnations

26.1.1 **Procedures**

The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

26.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine the estimated market value of the item, taking account of professional advice where appropriate. Advice should be sought from the Deputy Director of Procurement as to the most appropriate disposal process (for example: auctions < £5,000 market value or quotation / tender > £5,000).
(see overlap with SFI 17.14)

26.2 Losses and Special Payments

26.2.1 **Procedures**

The Chief Finance Officer must prepare procedural instructions on the recording, approval of and accounting for losses, and special payments.

26.2.2 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Finance Officer or confidentially inform an officer charged with responsibility for responding to concerns involving loss or potential fraud. This officer will then appropriately inform the Chief Finance Officer.
The loss must be recorded by the Officer on Datix (risk management system) and a Datix reference number obtained.

26.2.3 Where a criminal offence is suspected, the Chief Finance Officer must have in place provision to immediately inform the police.
In cases of theft or arson the Chief Finance Officer must immediately inform the police.
In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the Local Counter Fraud Specialist (LCFS).

26.2.4 The Chief Finance Officer must ensure arrangements are in place to notify the Audit committee of all suspected frauds.

26.2.5 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Chief Finance Officer must ensure the following are notified:-

(a) the Board of Directors; and
(b) the External Auditor

26.2.6 The Audit Committee shall approve the writing-off of losses and special payments

26.2.7 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

26.2.8   The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

26.2.9   No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

26.2.10   All losses and special payments must be reported to the Audit Committee on a quarterly basis.

26.2.11   The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations. This should include:

(a)   when a bankruptcy, liquidation or receivership is discovered, all payments should be ceased pending confirmation of the bankruptcy, etc. As a matter of urgency, a statement must be prepared listing the amounts due to and from the Trust.

(b)   ensuring that any payments due by the Trust are made to the correct person.

(c)   ensuring that any claim by the Trust is properly lodged with the correct party and without delay.

27.   INFORMATION TECHNOLOGY

27.1   Responsibilities and duties of the Chief Finance Officer

27.1.1   The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a)   devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and any subsequent legislation;

(b)   ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c)   ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d)   ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

27.1.2   The Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

27.1.3   The Chief Finance Officer shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

27.2   Contracts for Computer Services with other health bodies or outside agencies

The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

27.3   Risk Assessment

The Deputy Chief Executive shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans and vulnerability to cyber-security attack.

27.4   Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Deputy Chief Executive shall need to be satisfied that:

(a)   systems acquisition, development and maintenance are in line with corporate policies such as the Integrated Digital Care Strategy;

(b)   data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c)   Chief Finance Officer staff have access to such data;

(d)   such computer audit reviews as are considered necessary are being carried out.

27.5   Acquisition and Disposal of Computer Systems
The Chief Finance Officer will devise procedures which ensure that orders for the acquisition of computer hardware, software and services (other than consumables) are placed in accordance with the Integrated Digital Care strategy.

27.6   The Chief Finance Officer will ensure that separate control procedures are put in place for computer systems. This procedure will include:
- the acquisition and disposal of IT, systems and equipment;
- the decommissioning of systems containing confidential data; and in accordance with any guidance issued by the Information Commissioner and the Department of Health and Social Care.

28.   PATIENTS' PROPERTY

28.1   The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of terminal or deceased patients in hospital.

28.2   The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

-    notices and information booklets;

- hospital admission documentation and property records;
- the advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

28.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

28.4 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

28.5 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

28.6 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

29. FUNDS HELD ON TRUST

29.1 Corporate Trustee

(1) Standing Order No. 2 outlines the Trust's responsibilities as corporate trustee for the management of funds it holds on trust, along with SFI 4.8.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Chief Finance Officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

29.2 Accountability to Charity Commission and Secretary of State for Health and Social Care

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for health and Social Care for all Exchequer funds.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

29.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as applicable these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Chief Finance Officer shall ensure that all staff are made aware of the Trust Standards of Business Conduct and Declarations of Interest policy. This policy deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

31. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Trusts

32. RETENTION OF RECORDS

32.1 All NHS records are public records under the terms of the Public Records Act 1958 Section 3 (1) – (2). The Chief Executive and senior managers of the Trust are personally accountable for records management within the organisation.

32.2 The Trust will follow the latest guidance Records Management Code of Practice for Health and Social Care 2016") issued by NHS Digital. The Records Management Code sets out the minimum length of time for the retention of particular.

32.3 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Trust policy.
Records held in archives shall be capable of retrieval by authorised persons.

32.4 Records held in accordance with latest guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.
Day to day responsibility for decisions to destroy records following achievement of the retention date, and maintenance of the destruction register, is the responsibility of the Records Manager taking into account the provisions of the Records Management Code. The Records Manager is accountable to the SIRO and Chief Executive for decisions taken.

33. RISK MANAGEMENT AND INSURANCE

33.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Board.
A Board Assurance Framework shall be in place to enable the monitoring of risk.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b)   engendering among all levels of staff a positive attitude towards the control of risk;

c)   management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d)   contingency plans to offset the impact of adverse events;

e)   audit arrangements including; Internal Audit, clinical audit, health and safety review;

f)   decision on and a clear indication of which risks shall be insured through arrangements with either the Risk Pooling Schemes administered by NHS Resolution or commercial insurance. ;

g)   arrangements to review the Risk Management programme.

h)   appropriate levels of external accreditation.

These matters shall be defined in more detail in the Risk Management Strategy or Policy. The existence, integration and evaluation of the above elements will support statements and conclusions within the Annual Governance Statement (AGS).

33.2   **Insurance: Risk Pooling Schemes administered by NHS Resolution**

The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

33.3   **Insurance arrangements with commercial insurers**

33.3.1   The Trust may not enter into insurance arrangements with commercial insurers except:

(1)   for the purpose of **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2)   where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3)   where **income generation activities** take place, income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Finance Officer should consult NHS Resolution.

(4)   for the purposes of insuring Directors and Officers against any liability arising in their appointment,

(5)   where, in the opinion of the Board of Directors, the level of cover afforded through the NHS Resolution Scheme in the event of significant or total loss of a facility would be insufficient to enable the re-provision of a safe and appropriate level of care to service users.

33.4   Arrangements to be followed by the Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'excess'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below 'excess' levels.

CORPORATE GOVERNANCE MANUAL

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FOREWORD

The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive regulatory and business framework for the Trust.

All directors, and all members of staff, should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfill the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

Failure to comply with any part of standing orders is a disciplinary matter, which could result in dismissal. Non-compliance may also constitute a criminal offence of fraud in which case the matter will be reported to the Trust's local counter fraud specialist in accordance with the Counter Fraud Bribery and Corruption Policy. Where evidence of fraud, corruption or bribery offences is identified, this may also result in referral for prosecution which could lead to the imposition of criminal sanctions.

STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The Lincolnshire Community Health Services NHS Trust (the Trust) is a statutory body which came into existence on 1 April 2011 under The Lincolnshire Community Health Services NHS Trust (Establishment) Order 2011, (Establishment Order).

(1) The principal place of business of the Trust is Beech House, Witham Park, Waterside South, Lincoln, LN5 7JH.

NHS Trusts are governed by Acts of Parliament, mainly the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 2012 and the Health and Care Act 2022 and the functions of the Trust are conferred by this legislation.

As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

The Trust has a duty to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals. The board must also comply with the standard for members of NHS Board and CCG Governing Bodies in England 2012.

The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

In addition to the statutory requirements the Secretary of State through the Department of Health and Social Care, NHS England, issues further directions and guidance. These are normally issued under cover of a circular or letter.

The NHS Code of Conduct & Accountability requires that, among other things, boards draw up a schedule of decisions reserved to the board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior officers (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The NHS Code of Conduct & Accountability makes various requirements concerning possible conflicts of interest of board directors.

The Freedom of Information Act sets out the requirements for public access to information about the Trust's business.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in the Scheme of Delegation and Reservation and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

1.4 NHS Board Governance

NHS trust boards must put in place and maintain good corporate governance arrangements, integrated across the organisation and all aspects of governance. This will encompass corporate, financial, clinical, information and research governance. Integrated governance will better enable the board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. THE TRUST BOARD

2.1 Corporate role of the Board

All business shall be conducted in the name of the Trust*.

All funds received in trust shall be held in the name of the Trust as corporate trustee.

The powers of the Trust established under statute shall be exercised by the board meeting in public session except as otherwise provided for in Standing Order No.3.

The board has resolved that certain powers and decisions may only be exercised by the board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

*As part of the formation of the Lincolnshire Community & Hospitals NHS Group (LCHG), a joint group board and joint board committees have been established. Under the group model arrangement, individual boards will be retained in statute, however decision making will take place via this joint working approach.

2.2 Composition of the Membership of the Trust Board

In accordance with the Membership and Procedure Regulations the composition of the board shall be:

The Chair of the Trust (Appointed by NHS England);

Up to 7 non- executive directors (appointed by NHS England);

5 executive directors including:

- the Chief Executive;
- the Chief Finance Officer
- the Chief Nursing Officer
- the Chief Medical Officer
- The Chief Integration Officer / Deputy Chief Executive

The following officers will attend the board meetings in a non-voting capacity unless the board resolves that they should not attend:

- Chief People Officer
- Chief Operating Officer
- Chief Clinical Governance Officer
- Chief Estates and Facilities Officer
- Director of Corporate Affairs

2.3   Appointment of Chair and Directors of the Trust

The Chair and Directors of the Trust - are appointed by NHSE on behalf of the Secretary of State.   The appointment and tenure of office of the Chair and Directors are set out in the Membership and Procedure Regulations.

2.5   Terms of Office of the Chair and Directors

The regulations setting out the period of tenure of office of the Chair and directors and for the termination or suspension of office of the Chair and directors are contained in regulation 7 and regulations 8 and 9 of the Membership and Procedure Regulations, respectively.

2.6   Appointment and Powers of Vice-Chair

Subject to Standing Order below, the Chair and directors of the Trust may appoint one of their numbers, who is not also an executive director, to be Vice-Chair, for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.

Any director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and directors may thereupon appoint another director as Vice-Chair in accordance with the provisions of Standing Orders

Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

2.7   Joint Directors

Where more than one person is appointed jointly to a post mentioned in regulation 2 of the Membership and Procedure Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.

2.8   Role of Directors

The board will function as a corporate decision-making body, executive and Non-executive directors will be full and equal directors. Their role as directors of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1)   Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2)   Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives and other such requirements as determined by NHS England.

The division of responsibilities between the Chair and the Chief Executive is outlined in **Appendix A.**

(3)   Chief Finance Officer

The Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its directors and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4)   **Non-Executive Directors**

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as directors of or when chairing a committee of the Trust which has delegated powers.

(5)   **Chair**

The Chair shall be responsible for the operation of the board and chair all board meetings when present. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with NHS England over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work closely with the Chief Executive and shall ensure that key and appropriate issues are discussed by the board in a timely manner with all the necessary information and advice being made available to the board to inform the debate and ultimate resolutions.

The division of responsibilities between the Chair and Chief Executive is outlined in **Appendix A.**

2.9   Lead Roles for Board Directors

The Chair and Chief Executive will ensure that the designation of lead roles or appointments of Board Directors as required by the Department of Health and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a lead board director with responsibilities for infection control or safeguarding etc.). The schedule of lead roles will be reviewed and / or approved periodically by the board.

3.   MEETINGS OF THE TRUST BOARD

3.1   Admission of public and the press

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board resolving as follows:

A body may by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings') wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings; and where such a resolution is passed, this Act shall not require the meeting to be open to the public during proceedings to which the resolution applied. (Public Bodies (Admission to meetings) Act 1960.

The Chair shall give such directions as they thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.2   Calling meetings

Ordinary meetings of the board shall be held at regular intervals at such times and places as the board may determine.

The Chair of the Trust may call a meeting of the board at any time.

One third or more directors of the board may request a meeting in writing. If the chair refuses, or fails, to call a meeting within seven days of a request being presented, the directors signing the request may forthwith call a meeting.

3.3   Notice of Meetings and the Business to be transacted

Before each meeting of the board a notice specifying the business proposed to be transacted shall be delivered to every director, so as to be available to them at least three clear days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf.

Want of service of such a notice on any director shall not affect the validity of a meeting.

In the case of a meeting called by directors in default of the Chair calling the meeting, the notice shall be signed by those directors.

No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

Before each meeting of the board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

3.4   Chair of meeting

At any meeting of the Trust Board the chair, if present, shall preside. If the chair is absent from the meeting, the vice-chair (if the board has appointed one), if present, shall preside.

If the chair and vice-chair are absent, such director (who is not also an Executive Director of the Trust) as the directors present shall choose shall preside.

3.5   Chair's ruling

The decision of the Chair of the meeting on questions of order, relevancy and regularity and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.6   Quorum

No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and directors (including at least one director who is also an executive director of the and one non- executive director) is present.

An Officer in attendance for an Executive Director but without written acting up status may not count towards the quorum.

If the Chair or director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.7 Voting

Every question at a meeting shall be determined by a majority of the votes of directors present and voting on the question. In the case of an equal vote, the person presiding (i.e.: the Chair of the meeting) shall have a second, and casting vote.

All questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

If at least one third of the directors present so request, the voting on any question may be recorded so as to show how each director present voted or did not vote (except when conducted by paper ballot).

If a director so requests, their vote shall be recorded by name.

In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

An Officer who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

An Officer attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.8 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

3.9 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

3.10 Annual Public Meeting

The trust will publicise and hold an annual public meeting on or before 30th September in every year in accordance with the NHS Trusts (Public meeting) Regulations 1991 (SI 1991) 482.

3.11 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- that two thirds of the board directors are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive directors vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.12 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the directors of the board are present (including at least one executive director of the Trust and one non-executive director) and that at least two-thirds of those directors present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust board's minutes.

(ii)   A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and directors of the Trust.

(iii)   No formal business may be transacted while Standing Orders are suspended.

(iv)   Every decision to suspend standing orders shall be reported to the Audit Committee.

4.   ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

4.1 Delegation of Functions to Committees, Officers or other bodies

Subject to regulation 17 and 18 of the Membership and Procedure Regulations, the board may make arrangements for the exercise, on behalf of the board, of any of its functions by a committee, or sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

Regulation allows for the functions of NHS trusts to be carried out jointly with any other NHS body or other NHS trust, or any other third party.

4.2 Emergency Powers

The powers which the board has reserved to itself within these Standing Orders may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and Chairm shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

4.3 Unavailability of Chair/ Vice Chair

In addition to the statutory power of the vice chair, if the chair is unavailable for whatever reason to transact the business of the Trust expressly or impliedly delegated to the chair, then, if so requested by the Chief Executive, the vice chair shall be empowered to act in the chair's place and to exercise all the powers and duties of the chair until the chair is again available.

If the vice chair is unavailable for whatever reason to transact the business of the Trust expressly or impliedly delegated to the vice chair, then if so requested by the chief executive in relation to any particular matter, any non-executive director shall be empowered to act in the vice chairs place and exercise all the powers and duties of the vice chair in relation to that matter.

4.4 Delegation to Committees

The board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the board.

The powers of such committees shall be limited to those set out in their terms of reference.

4.5 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust.

The Chief Executive shall prepare a Scheme of Delegation identifying his proposals which shall be considered and approved by the board.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the board of the Chief Finance Officer to provide information and advise the board in accordance with statutory or Department of Health and Social Care requirements. Outside these statutory requirements the roles of the Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

The arrangements made by the board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

4.6 Non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and justification for non-compliance and the circumstances shall be reported to the next formal meeting of the board for action or ratification. All directors of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive and Chair as soon as possible.

5. TRUST COMMITTEES

5.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health, the Trust Board may appoint committees or sub-committees or joint committees of the Trust.

The Trust shall determine the membership and terms of reference of committees and shall receive and consider reports from such committees.

5.2   Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term 'Chair' is to be read as a reference to the Chair of other committee as the context permits, and the term 'member' is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

5.3   Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions as the board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.4   Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish reporting groups they may not delegate executive powers to the group unless expressly authorised by the Trust Board.

5.5   Approval of Appointments to Committees

The board shall approve the appointments to each of the committees which it has formally constituted. Where the board determines, and regulations permit, that persons, who are neither directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the board as defined by the Secretary of State. The board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.6   Appointments for Statutory functions

Where the board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

5.7   Committees established by the Trust Board

The committees established by the Board are as follows:

- Remuneration Committee
- Audit and Risk Committee
- Quality Committee
- Finance and Performance Committee
- People Committee
- Integration Committee

6.   RELATIONSHIP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1   Policy statements: general principles

The Trust Board will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2   Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

-     the Standards of Business Conduct and Declarations of Interest Policy for Lincolnshire Community Health Services NHS Trust staff;

-     the staff Disciplinary and Appeals Procedures adopted by the Trust

-     The Counter Fraud, Bribery and Corruption Policy

6.3   Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4   Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with guidance and requirements issued by or on behalf of the Secretary of State for Health.

7.   DUTIES AND OBLIGATIONS OF BOARD DIRECTORS AND UNDER THESE STANDING ORDERS

7.1   Declaration of Interests

All Board members and staff of the Trust are required to comply with the Standards of Business Conduct and Declarations of Interest Policy. If Board directors have any doubt about the relevance of an interest they should discuss it with the chair or the Director of Corporate Affairs.

7.2   Recording of Interests in Trust Board minutes

At the time Board directors' interests are declared, or updated, they should be recorded in the Trust Board minutes.

7.3   Publication of declared interests in Annual Report

Board directors' declarations of interests will be published in the Trust's annual report.

7.4   Conflicts of interest which arise during the course of a meeting

At the start of every Board meeting there will be an agenda item which invites Directors to declare whether they have any interests which might be relevant to any items of business on the agenda. Directors should declare all such interests whether

or not they have already declared them for the register. If a conflict of interest is established, the Board director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.5   Register of Interests

The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board members.

The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.6   Exclusion of Chairand Directors in proceedings of the Board

Subject to the following provisions of this Standing Order, if the Chair or a director of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed.

The Trust Board may exclude the Chair or a director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest, direct or indirect, is under consideration.

Any remuneration, compensation or allowance payable to the Chair or a Director by virtue of Schedule 5 of the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

This Standing Order applies to a committee as it applies to the Trust and applies to a member of any such committee (whether or not he/she is also a member of the Trust) as it applies to a director of the Trust.

7.7   Canvassing of and Recommendations by Directors in Relation to Appointments

Canvassing of directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

Directors of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.8   Relatives of Directors or Officers

Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any director or

the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

The Chair and every director and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

On appointment, directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive or a nominated Officer by him / her in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of by the Chief Executive, and Chair or named deputy, and shall be attested by them.

8.3 Register of Sealing

The Chief Executive shall keep a register in which he / she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document. The register shall be reported to the Audit Committee.

8.4 Use of Seal – General guide

The Seal shall be affixed in the following general circumstances;

• All contracts for the purchase / lease of land and / or building
• All contracts for capital works exceeding £250,000

This list is not exhaustive and further advice regarding the affixation of the Seal should be gained from the Director of Corporate Affairs or Chief Finance Officer.

8.5 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

In the case of contracts for goods, works and services relating to non-pay expenditure officers should refer to Standing Financial Instructions.

9 SCHEME OF RESERVATION AND DELEGATION OF POWERS

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
SO 2.9 (1)	THE BOARD	**General Enabling Provision** The board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers. General matters reserved 1. To ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. To appoint, appraise and remunerate senior executives and hold them to account; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
SO 2.9 (1)	THE BOARD	*Regulations and Control* 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.2 5. Approve a scheme of delegation of powers from the Board to committees**.**

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		6. Require and receive the declaration of Board directors' interests that may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property. 15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6. 17. Discipline directors of the Board or employees who are in breach of statutory requirements or SOs. 18. Agree a schedule setting out the division of responsibilities of the Chair and Chief Executive (Appendix A refers).
SO 2.9 (1)	THE BOARD	**Appointments/ Dismissal** 1. Appoint the Vice Chair of the Board. 2. Appoint and dismiss committees (and individual directors) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary to the Board. 6. Approve proposals of the Remuneration Committee regarding appropriate remuneration and terms of service for the Chief Executive and other Executive Directors.
SO 2.9 (1)	THE BOARD	***Strategy, Plans and Budgets***

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		1. Define the strategic aims and objectives of the Trust / Group. 2. Approve proposals for ensuring quality and clinical governance in services provided by the Trust / Group, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment in excess of £1,000,000 5. Approve budgets. 6. Approve annually the proposed organisational development proposals for the Trust / Group. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3 year period or the period of the contract if longer. 11. Approve individual compensation payments. 12. Approve proposals for action on litigation against or on behalf of the Trust. 13. Review use of NHS Resolution risk pooling schemes (LPST/CNST/RPST).
SO 2.9 (1)	THE BOARD	**Policy Determination** *1.* Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
SO 2.9 (1)	THE BOARD	**Audit** 1 Approve the appointment (and where necessary dismissal) of External Auditors on the advice of the Audit Panel. 2. Receive the annual management letter from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 3. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
SO 2.9 (1)	THE BOARD	**Annual Reports and Accounts** 1. Receive and and approve the Trust's Annual Report and Annual Accounts. 2. Receive and approve the Annual Report and Accounts for funds held on trust.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
SO 2.9 (1)	THE BOARD	**Monitoring** 1. Receive such reports as the board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust and wider group by means of the provision to the board as the board may require from directors, committees, and officers of the Trust as set out in management policy statements. 3. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the board. 4. Receive reports from Chief Finance Officer on financial performance against budget and annual plan. 5. Receive reports from Chief Finance Officer on actual and forecast income from contracts.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 11.1.1 and SO 4.8	AUDIT COMMITTEE	The committee will: 1. Advise the board on internal and external audit services; 2. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; 3. Monitor compliance with Standing Orders and Standing Financial Instructions; 4. Review schedules of losses and compensations and making recommendations to the board. 5. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the board. 6. Review the annual financial statements prior to submission to the board. 7. Other duties as set out within the Audit Committee Handbook and its Terms of Reference.
SFI 20.1.1 and SO 4.8	REMUNERATION AND TERMS OF SERVICE COMMITTEE	The committee will: 1. Decide on the appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff. Aspects to include: • Salary (including any performance-related elements/bonuses); • Provisions for other benefits, including pensions and cars; • Arrangements for termination of employment and other contractual terms; advise on and oversee appropriate contractual arrangements for such staff; 2. Proper calculation and scrutiny of any termination payments taking account of such national guidance as is appropriate. The Committee shall report in writing to the board the basis for its recommendations.
SO 4.8	QUALITY COMMITTEE	The core duties of the Committee are as follows:

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		- Ensure that there are robust processes in place for the effective management of clinical governance, quality and risk. - Ensure that there are effective structures in place to support clinical governance and that these structures operate effectively and that action is taken to address areas of concern. - Through the receipt of upward reports from the reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the Quality Committee. - Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboards monthly with exception reporting as the norm. - Use outcome measures to demonstrate continuous improvement. - Consider the control and mitigation of quality related risks and provide assurance to the Group Board that such risks are being effectively controlled and managed in line with the risk appetite statement. Whilst the committee's remit covers all of the Group's services, the committee has a specific oversight role in relation to the quality & safety of United Lincolnshire Teaching Hospitals Trust's maternity services (reference: Ockenden). - Review and provide assurance on those strategic objectives within the Group Board Assurance Frameworks, identified as the responsibility of the committee seeking where necessary further action. - Provide assurance to the Board that all legal and regulatory requirements relating to quality are met, including directives, regulations, national standards, policies, reports, reviews and best practice. - Review & challenge the annual Quality Accounts ensuring they are a balanced and accurate reflection of both Trusts position. - Approve and monitor the annual clinical audit plans. - Monitor the implementation of agreed action plans in relation to all major internal reviews and all external reviews within the remit of the Quality Committee. - Ensure that there is sufficient time on the agenda to allow for strategic discussion items on areas of responsibility of the committee and to include horizon scanning on the current and future environment.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SO 4.8	FINANCE & PERFORMANCE COMMITTEE	The core duties of the Committee are as follows: • Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly. • Approve the business planning timetable. • Seek assurance that the trusts and wider group have in place robust and effective operational and financial planning arrangements and delivery plans. • Review, challenge and monitor in-year financial and operational performance. • Consider the control and mitigation of finance & operational performance and related risks and provide assurance to the Group Board that such risks are being effectively controlled and managed. • Provide oversight of and receive assurance on delivery of agreed Cost Improvement Plans and associated efficiency and productivity programmes. • Provide oversight of and receive assurance on procurement processes and performance. • Review estates & facilities compliance including health & safety requirements and compliance with the Premises Assurance Model (PAM). • Provide oversight of and receive assurance in respect of compliance with the Data Security Protection Toolkit. • Provide assurance to the Board that all legal and regulatory requirements relating to finance, operational, estates compliance and data security are met, including directives, regulations, national standards (including constitutional standards), policies, reports, reviews and best practice. • Review and provide assurance to the Group Board on those strategic objectives within the Group Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance and actions where necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		n
SO 4.8	<mark>PEOPLE COMMITTEE</mark>	The core duties of the Committee are as follows: • Ensure that there are robust processes in place for the effective management of people and organisational development. • Ensure that there are effective structures in place to support people and OD and that these structures operate effectively and that action is taken to address areas of concern. • Through the receipt of upward reports from the reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the People Committee. • Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly • Consider the control and mitigation of workforce related risks and provide assurance to the Board that such risks are being effectively controlled and managed • Provide assurance to the Board that all legal and regulatory requirements relating to the workforce are met, including directives, regulations, national standards, policies, reports, reviews and best practice • Review and provide assurance through the Integrated Improvement Plan and Performance Review Meeting reporting, on those strategic objectives within the Group Board Assurance Framework, identified as the responsibility of the committee seeking, where necessary, further action.
SO 4.8	INTEGRATION COMMITTEE	The committee will: • Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly with exception reporting as the norm.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		- Through the receipt of upward reports from relevant reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the Integration Committee. - Consider progress with and risks to delivery of the group's integration agenda & objectives and provide assurance to the Group Board that such risks are being effectively controlled and managed and / or escalate such risks to ensure timely and appropriate mitigating actions are put in place. Where appropriate, the committee may seek to request deep dives are undertaken to identify the required improvement and actions. - Receive assurance that all appropriate actions are being taken to ensure full participation in population partnership initiatives and programmes of change and, in turn provide assurance to the Board on the robustness of delivery plans. This will include the receipt of plans for the continued development of Community Primary Partnership(s) over time supporting both Place and group strategies and seeking assurance on the robustness of plans to increase the range and scope of the Community primary partnership(s), anchor partners work and the group's role within them. - Seek assurance on the adequacy of plans to realise the group's ambition of addressing the wider determinants of health and health inequalities. - Seek assurance for the operational performance and delivery of Out of Hospital Services delivering on Integrated Care. - Ensure that proposed changes to services are being made on the basis of strong clinical evidence and best practice. - Seek assurance in respect of delivery of the group's digital agenda and objectives including development of the 'Vision for Information'. - Review and seek assurance on delivery of the estates strategy, estates rationalisation & space management and sustainability & the Green Plan (including Net Zero) programmes of work. - Ensure that key enablers to the delivery of the integration agenda are properly considered as part of the agreement of the group integration plan and programmes of work and that these plans and programmes of work are appropriately aligned to the longer term strategy, vision and values for the group. - Review and provide assurance to the Group Board on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		and actions where necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions.
SO 4.8	CHARITABLE FUNDS COMMITTEE	The committee will: • administer those charitable funds received by the Trust in accordance with any statutory or other legal requirements or best practice required by the Charities Commission. • advise the board in relation to the discharge of the Trust's duties with respect to the above.

REF	DELEGATED TO	DUTIES DELEGATED
7	CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
9	CHIEF EXECUTIVE AND CHIEF FINANCE OFFICER	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the board.
10	CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
12 & 13	CHIEF EXECUTIVE	Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers: • have a clear view of their objectives and the means to assess achievements in relation to those objectives

REF	DELEGATED TO	DUTIES DELEGATED
		• be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
12	CHAIR	Implement requirements of corporate governance.
13	CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office (NAO).
15	CHIEF FINANCE OFFICER	Operational responsibility for effective and sound financial management and information.
15	CHIEF EXECUTIVE	Primary duty to see that the Chief Finance Officer discharges the above function.
16	CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
18	CHIEF EXECUTIVE AND CHIEF FINANCE OFFICER	Responsible for ensuring appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
19	CHIEF EXECUTIVE	Where the Board or Chair is doing something that might infringe probity or regularity, responsible for setting this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary NHS England and the Department of Health.
20	CHIEF EXECUTIVE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform NHS England and the Department of Health. In such cases, and in those described in paragraph 24, the Chief Executive should as a member of the board vote against the course of action rather than merely abstain from voting.

1.3.1.7	BOARD	Approve the procedure for declarations of hospitality and sponsorship.
1.3.1.8	BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
1.31.9 & 1.3.2.2	ALL BOARD MEMBERS	Subscribe to the NHS Code of Conduct & Accountability and the Nolan Principles.
1.3.2.4	BOARD	Board directors share corporate responsibility for all decisions of the board.
1.3.2.4	CHAIR AND NON EXECUTIVE DIRECTORS	Chair and non-executive directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.
1.3.2.4	BOARD	The board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. To ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. To appoint, appraise and remunerate senior executives; 4. To ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
1.3.24	BOARD	It is the board's duty to: 1. Act within statutory financial and other constraints; 2. Be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;

		4. Establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. Establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the committee, the limit to their powers, and the arrangements for reporting back to the main Board.
1.3.2.5	CHAIR	1. Provide leadership to the board; 2. Enable all board members to make a full contribution to the board's affairs and ensure that the board acts as a unitary team; 3. Ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. Ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. Lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. Appoint Non-Executive Board members to an Audit Committee and other vommittees of the main Board; 7. Advise the Secretary of State on the performance of Non-Executive Board members.
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chairand Non-Executive members of the board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum. The division of responsibilities between the Chair and Chief Executive are set out in Appendix A.
1.3.2.6	NON-EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by NHS Englandto bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	CHAIR AND DIRECTORS	Completion of their entry on the Trust's Register of Interests and prompt declaration of conflicts of interest which may arise during the course of their duties for the Trust.

1.3.2.9	BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chair
3.1	CHAIR	Call meetings of the board.
3.9	CHAIR	Chair all board meetings and associated responsibilities.
3.10	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIR	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to be notified of every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders.
4.1	BOARD	Formal delegation of powers to committees, sub-committees or joint committees and approval of their constitution and terms of reference.
5.2	CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	THE BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.
7.4	ALL STAFF	Comply with the Department of Health's "Standards of Business Conduct for NHS Staff" and Trust policy.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

* Nominated officers and the areas for which they are responsible will be incorporated into the Trust's Scheme of Delegation document.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	CHIEF FINANCE OFFICER	Approval of all financial procedures.
10.1.4	CHIEF FINANCE OFFICER	Advice on interpretation or application of Standing Financial Instructions.
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.
10.2.4	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.4	CHIEF EXECUTIVE & CHIEF FINANCE OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.5	CHIEF EXECUTIVE	To ensure all board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.6	CHIEF FINANCE OFFICER	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action. b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented. c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff. e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.7	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
10.2.8	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
11.1.2	CHAIR	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	CHIEF FINANCE OFFICER	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	CHIEF FINANCE OFFICER	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
11.4	AUDIT COMMITTEE	Ensure cost-effective External Audit.
11.5	CHIEF FINANCE OFFICER	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	CHIEF ESTATES & FACILITIES OFFICER	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	CHIEF EXECUTIVE	Compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
13.1.2 & 13.1.3	CHIEF FINANCE OFFICER	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
13.1.6	CHIEF FINANCE OFFICER	Ensure adequate training is delivered on an ongoing basis to budget holders.
13.3.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
13.4.1	CHIEF FINANCE OFFICER	Devise and maintain systems of budgetary control.
13.4.2	BUDGET HOLDERS	Ensure that

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
13.4.3	BUDGET HOLDERS	Identify and implement cost improvements and income generation activities in line with the Annual plan
13.6.1	CHIEF EXECUTIVE/ CHIEF FINANCE OFFICER	Submit monitoring returns
14.1	CHIEF FINANCE OFFICER	Preparation of annual accounts and reports.
15.1	CHIEF FINANCE OFFICER	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
16.	CHIEF FINANCE OFFICER	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform Chief Finance Officer of money due from transactions which they initiate/deal with.
17.	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.3	CHIEF EXECUTIVE	Waive formal tendering procedures.
17.5.3	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
17.5.5	CHIEF FINANCE OFFICER	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the Chief Executive.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders.
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations dispatched.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.6.4	CHIEF EXECUTIVE AND CHIEF FINANCE OFFICER	Assess for value for money and fair price in circumstances where one bid is received against a tender.
17.6.6	CHIEF EXECUTIVE	Consideration and authorisation, as appropriate, of a tender which commits expenditure in excess of that which has been allocated by the Trust.
17.6.8	CHIEF ESTATES AND FACILITIES OFFICER	Will appoint a manager to maintain a list of approved firms.
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	Responsibility to ensure they, or their nominated deputy, award tenders in accordance with Trust procedures.
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	Board	Approval of all PFI proposals
17.11	CHIEF EXECUTIVE	Nomination of an officer to oversee and manage each contract on behalf of the Trust.
17.12	CHIEF EXECUTIVE	Nomination of officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
17.15	CHIEF EXECUTIVE	Ensure that best value for money can be demonstrated for all services provided on an in-house basis.
17.15.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	CHIEF EXECUTIVE	Ensure that the Trust enters into suitable contracts with service commissioners for the provision of NHS services
18.3	CHIEF EXECUTIVE	Ensure that regular reports are provided to the board detailing actual and forecast income from contracts
20.1.1	BOARD	Establish a Remuneration & Terms of Service Committee

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.1.2	REMUNERATION COMMITTEE	Advise the board on and make recommendations on the remuneration and terms of service of the Chief Executive, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
20.1.3	REMUNERATION COMMITTEE	Report in writing to the board its advice about remuneration and terms of service of directors and senior employees.
20.1.4	BOARD	Approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
20.10.1 and 20.10.2	CHIEF FINANCE OFFICER	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 10.4.2).
20.10.3	NOMINATED MANAGERS*	Submit time records in line with timetable. Complete time records and other notifications in required form. Submit termination forms in prescribed form and on time.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.10.5	CHIEF FINANCE OFFICER	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
20.5	NOMINATED MANAGER*	Ensure that all employees are issued with a Contract of Employment in a form approved by the board and which complies with employment legislation; and deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
21.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
21.2.1	REQUISITIONER*	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
21.2.2	CHIEF FINANCE OFFICER	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	CHIEF FINANCE OFFICER	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
21.2.4	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to the Chief Finance Officer to support the need for a prepayment.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
21.2.4	CHIEF FINANCE OFFICER	Approve proposed prepayment arrangements.
21.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform Chief Finance Officer if problems are encountered).
21.2.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
21.2.6	MANAGERS AND OFFICERS	Ensure compliance in full with the guidance and limits specified by the Chief Finance Officer.
21.2.7	CHIEF EXECUTIVE CHIEF FINANCE OFFICER	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
22.1.1	CHIEF FINANCE OFFICER	Advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.
22.1.2	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive and Chief Finance Officer.)
22.1.3	CHIEF FINANCE OFFICER	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	CHIEF EXECUTIVE OR CHIEF FINANCE OFFICER	Be on an authorising panel comprising one other member for short term borrowing approval.
22.2.2	CHIEF FINANCE OFFICER	Advise the board on investments and report, periodically, on performance of same.
22.2.3	CHIEF FINANCE OFFICER	Prepare detailed procedural instructions on the operation of investments held.
23	CHIEF FINANCE OFFICER	Ensure that board members are aware of the Financial Framework and ensure compliance.
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
24.1.2	CHIEF FINANCE OFFICER	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
24.1.4	CHIEF FINANCE OFFICER	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	CHIEF FINANCE OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	CHIEF FINANCE OFFICER	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
24.2.1	CHIEF FINANCE OFFICER	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
24.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
24.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from Chief Finance Officer).
24.3.5	CHIEF FINANCE OFFICER	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	CHIEF FINANCE OFFICER	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
24.4.2	CHIEF FINANCE OFFICER	Approval of fixed asset control procedures.
24.4.4	BOARD MEMBERS AND ALL SENIOR STAFF	Responsible for security of Trust assets including notifying discrepancies to Chief Finance Officer , and reporting losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to Chief Finance Officer responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.2	CHIEF FINANCE OFFICER	Responsible for systems of control over stores and receipt of goods.
25.2	CHIEF PHARMACIST	Responsible for controls of pharmaceutical stocks
25.2	CHIEF ESTATES AND FACILITIES OFFICER	Responsible for control of stocks of fuel oil and coal.
25.2	NOMINATED OFFICERS*	Security arrangements and custody of keys.
25.2	CHIEF FINANCE OFFICER	Set out procedures and systems to regulate the stores.
25.2	CHIEF FINANCE OFFICER	Agree stocktaking arrangements.
25.2	CHIEF FINANCE OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
25.2	CHIEF FINANCE OFFICER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
25.2	NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to Chief Finance Officer evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
26.1.1	CHIEF FINANCE OFFICER	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	CHIEF FINANCE OFFICER	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
26.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and Chief Finance Officer .
26.2.2	CHIEF FINANCE OFFICER	Where a criminal offence is suspected, Chief Finance Officer must inform the police if theft or arson is involved. In cases of fraud and corruption Chief Finance Officer must inform the relevant LCFS and Regional Team in line with SoS directions.
26.2.2	CHIEF FINANCE OFFICER	Notify External Audit of all prima facie or actual acts of fraud.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
26.2.3	CHIEF FINANCE OFFICER	Notify board and External Auditor of losses caused, theft, arson, neglect of duty or gross carelessness (unless trivial).
26.2.4	AUDIT COMMITTEE	Approve write off of losses (within limits delegated by Department of Health).
26.2.6	CHIEF FINANCE OFFICER	Consider whether any insurance claim can be made.
26.2.7	CHIEF FINANCE OFFICER	Maintain losses and special payments register.
27.1	CHIEF FINANCE OFFICER	Responsible for accuracy and security of computerised financial data.
27.1	CHIEF FINANCE OFFICER	Be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
27.1.3	DIRECTOR OF CORPORATE AFFAIRS	Publish and maintain a Freedom of Information Publication Scheme.
27.2.1	RELEVANT OFFICERS	Send proposals for general computer systems to Chief Finance Officer.
27.3	CHIEF FINANCE OFFICER	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek adequate assurances from the provider that appropriate controls are in operation.
27.4	CHIEF FINANCE OFFICER / CHIEF INTEGRATION OFFICER	Ensure that risks to the Trust from the use of IT are identified and considered and that disaster recovery plans are in place.
27.5	CHIEF FINANCE OFFICER	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) Chief Finance Officer and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
28.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
28.3	CHIEF FINANCE OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
28.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
29.1	CHIEF FINANCE OFFICER	Ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
30	CHIEF FINANCE OFFICER	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
32	CHIEF EXECUTIVE	Retention of document procedures in accordance with HSC 1999/053.
33.1	CHIEF EXECUTIVE	Risk management programme.
33.1	BOARD & ALL COMMITTEES	Approve and monitor risk management programme.
33.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	CHIEF FINANCE OFFICER	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
33.4	CHIEF FINANCE OFFICER	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

10.1.1 The Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State for Health under the provisions of Section 99 (3), 97 (A) (4) and (7) and 97 (AA) of the National Health Service Act 1977 for the regulation of the conduct of the Trust in relation to all financial matters. The Code of Accountability requires that the Trust shall give, and may vary or revoke Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code.

These Standing Financial Instructions shall have effect as if incorporated in the Standing Orders (SOs)

All directors and all members of staff should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfil the dual role of protecting the Trust's interests and protecting the staff from any possible accusation that they have acted improperly.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Finance Officer must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

10.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.

10.2 Responsibilities and delegation

10.2.1 **The Trust Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy and agreeing the long term financial model;

(b)   requiring the submission and approval of budgets within approved allocations/overall income;

(c)   defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d)   defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.2   The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out within the Scheme of Delegation. All other powers have been delegated to such other committees as the Trust has established.

10.2.3   **The Chief Executive and Chief Finance Officer**

The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources.   The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.4   It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.5   **The Chief Finance Officer**

The Chief Finance Officer is responsible for:

(a) ensuring that the Standing Financial Instructions are maintained and regularly reviewed.

(b) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(c)   maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(d)   ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

(e)   the provision of financial advice to other members of the Board and employees;

(f)   the design, implementation and supervision of systems of internal financial control;

(g) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.6 **Board Members and All Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.7 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

10.2.8 For any and all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

11.   AUDIT

11.1   Audit Committee

11.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference (based on those contained in the latest NHS Audit Committee Handbook), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board;

(f) Reviewing the arrangements in place to support the Board Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

11.1.2   Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally the Chief Finance Officer may be instructed to refer the matter to the Department of Health and Social Care. Matters pertaining to fraud, bribery and/or corruption must be reported to the Local Counter Fraud Specialist (LCFS) for investigation in accordance with the Trust's Local Counter Fraud, Bribery and Corruption Policy and Response Plan.

11.1.3   The Minutes of Audit Committee meetings shall be formally recorded and an upward report submitted to the Board.

11.2   Chief Finance Officer

11.2.1   It is the responsibility of the Chief Finance Officer to ensure an adequate Internal Audit service is provided. The Audit Committee shall be advised of the selection process and appointment when / if an Internal Audit service provider is changed.

11.2.2   The Chief Finance Officer is responsible for:

(a)   ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b)   ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c)   deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d)   ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee [and the Board]. The report must cover:

(i)   a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;
(ii)   major internal financial control weaknesses discovered;
(iii)   progress on the implementation of internal audit recommendations;
(iv)   progress against plan over the previous year;
(v)   strategic audit plan covering the coming three years;
(vi)   a detailed plan for the coming year.

11.2.2   The Chief Finance Officer or designated auditors and LCFS are entitled (without necessarily giving prior notice) to require and receive:

(a)   access to all records, documents and correspondence and data relating to any financial or other relevant transactions, including documents of a confidential nature;

(b)   access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c)   the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d)   explanations concerning any matter under investigation.

11.2.3   The Trust's Chief Executive and Chief Finance Officer are responsible for ensuring that access rights are given to NHS Counter Fraud Authority (NHSCFA) where necessary

for the prevention, detection and investigation of cases of fraud, bribery and corruption, in accordance with NHSCFA Provider Standards.

11.3   Role of Internal Audit

11.3.1   Internal Audit will review, appraise and report upon:

(a)   the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b)   the adequacy and application of financial and other related management controls;

(c)   the suitability of financial and other related management data;

(d)   the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i)   fraud and other offences;
(ii)   waste, extravagance, inefficient administration;
(iii)   poor value for money or other causes.

(e)   Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care.

11.3.2   Whenever any matter arises which involves, or is thought to involve, fraud, bribery or corruption, the matter must be reported to the LCFS, in accordance with the Trust's Local Counter Fraud, Bribery and Corruption Policy and Response Plan. All other irregularities, or suspected irregularities, concerning cash, stores, or other property of the Trust, or the exercise of any function of a pecuniary nature, must be notified to the Chief Finance Officer immediately.

11.3.3   The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

11.3.4   The Chief Internal Auditor shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.3.5   Internal Audit terms of reference shall have effect as if incorporated within these Standing Financial Instructions. The terms of reference cover the scope of internal audit work, authority and independence, management responsibilities, co-ordination of assurance work, reporting and key outputs and the operational responsibilities.

11.4   External Audit

11.4.1   The External Auditor is appointed and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor.

11.5   Fraud Bribery and Corruption

11.5.1   In line with their responsibilities, the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with the NHS Standard contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority standards.

11.5.2   The Chief Finance Officer is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

11.5.3   The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the Trust as specified in the NHS Counter Fraud Authority (NHSCFA) Counter Fraud Standards.

11.5.4   The LCFS shall report to the Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority (NHSCFA) in accordance with the NHS Counter Fraud Authority Counter Fraud Standards, the NHS Counter Fraud manual and the NHSCFA's Investigation Case File Toolkit.

11.5.6   If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the Chief Finance Officer to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHSCFA.

11.5.7   The LCFS will at least annually provide a written report to the Audit Committee on anti-fraud, bribery and corruption work within the Trust.

11.5.8   The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the Chief Finance Officer and outcomes fed back to the Audit Committee.

11.5.9   The Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption concerns and internally publicise this, together with the NHSCFA's national fraud and corruption reporting line and online referral form.

11.5.10   The Trust will report annually on how it has met the standards set by the NHS Counter Fraud Authority in relation to anti-fraud, bribery and corruption work and the Chief Finance Officer shall sign-off the annual self-review and authorise its submission to the NHS Counter Fraud Authority.
          The Chief Finance Officer shall sign-off qualitative assessments (in years when this assessment is required) and submit it to the relevant authority.

11.6   Security Management

11.6.1   In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2   The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3   The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Chief Estates and Facilities Officer and the appointed Local Security Management Specialist (LSMS).

12.   RESOURCE LIMIT CONTROL

Not applicable to NHS Trusts.

13.   BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

13.1   Preparation and Approval of Plans and Budgets

13.1.1   The Chief Executive will prepare annually, a statement of strategic direction for approval by the Board of Directors.

13.1.2   The Chief Executive will submit to the Board of Directors an annual business plan (the "Annual Plan") which takes into account financial targets and forecast limits of available resources. The annual plan will contain:

(a)   a statement of the significant assumptions on which the plan is based;

(b)   details of major changes in workload, delivery of services or resources required to achieve the plan.

In preparing the Annual Plan the Trust should ensure:

(a)   financial performance measures have been defined and will be monitored;

(b)   reasonable targets have been identified for these measures;

(c)   a robust system is in place for managing performance against the targets;

(d)   reporting lines are in place to ensure overall performance is managed;

(e)   arrangements are in place to manage/respond to adverse performance.

13.1.3   Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit a financial plan and associated income & expenditure budget to the Board for approval. The plan will contain:

(a)   a statement of any significant assumptions on which the plan is based and an assessment as to whether they are realistic;

(b)   details of major changes in workload, delivery of services or resources required to achieve the plan.

The budget will:

(a)   be in accordance with the aims and objectives set out in the Annual Plan and long term financial model;

(b)   accord with activity and manpower plans;

(c)   be produced following discussion with appropriate budget holders;

(d)   be prepared within the limits of available income;

(e)   identify potential risks.

13.1.4   The Chief Finance Officer shall monitor financial performance against budget and Annual Plan, periodically review them, and report regularly to the Board.

13.1.5   All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled and financial performance against budgets to be monitored.

13.1.6   All budget holders will sign up to their allocated budgets at the commencement of each financial year.

13.1.7   The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage budgets successfully.

13.2   Budgetary Delegation

13.2.1   The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities.

This will be achieved through the approval by the Chief Executive of the Executive Devolution Policy setting out Delegation of authority and decision-making power to Corporate Directorates and Divisions, This policy will provide for differential levels of delegated authority dependent upon the Performance of the Directorate or Division.

13.2.2   Subject to any specific provisions arising from a particular set of circumstances, Budgets shall be delegated as far as possible to the lowest level consistent with effective operational management.

13.2.3   The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

13.2.4   Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

13.2.5   Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer.

13.2.6   All Business Cases will be approved in accordance with the authority set out in Investment Appraisal Framework and Scheme of Reservation and Delegation of Powers to the Board.

13.3   Budgetary Control and Reporting

13.3.1   The Chief Finance Officer will devise and maintain systems of budgetary control. All managers whom the Trust may empower to engage staff or otherwise incur expenditure, collect or generate income, shall comply with the requirements of those systems.

The Chief Finance Officer shall also be responsible for providing budgetary information and advice to enable the Chief Executive and other operational managers to carry out their budgetary responsibilities and issue to all relevant staff, rules and procedures governing the operation of Budgets.

13.3.2   The Chief Finance Officer is responsible for presenting financial reports to the Board giving details of underlying performance, financial efficiency, liquidity and achievement of plan, as well as details of the overall financial risk ratings score.

(a)   Monthly financial reports in a form approved by the Board will contain as a minimum:

(i)   income and expenditure to date showing trends and forecast year-end position;
(ii)   progress against the efficiency / savings programme
(iii)   summary cash flow and balance sheet including a forecast year-end position;
(iv)   details of new cash borrowings in month and cumulative debt levels
(v)   movements in working capital;
(vi)   External Financial Limit (EFL) target and performance against Capital Resource Limit (CRL)
(vii)   capital project spend and projected outturn against plan;
(viii) explanations of any material variances from plan;
(ix)   details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer' view of whether such actions are sufficient to correct the situation;
(x)   monitoring of management action to correct variances;
(xi)   Performance against risk assurance metrics

13.3.3   The Chief Finance Officer is responsible for the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

13.3.4   Each Budget Holder is responsible for ensuring that:

(a)   any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of a member of the Executive Team;

(b)   the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c)   no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

(d)   No temporary employees are appointed which would lead to an overspend on the delegated budget without approval of the Chief Executive.

(e)   The systems of budgetary control established by the Chief Finance Officer are complied with fully.

(f)   cost improvements, productivity, efficiency and income generation initiatives are identified and implemented in accordance with the requirements of the Annual Plan

13.3.5   The Chief Executive may delegate the responsibility for identifying and implementing cost improvements and income generation initiatives to Divisions and Directorates in accordance with the requirements of the Annual Plan and its delivery.

13.3.6 The Chief Finance Officer shall devise and maintain adequate systems to ensure that the Trust can identify, implement and monitor opportunities for schemes to be included within cost improvement and income generating programmes.

13.4 Capital Expenditure

13.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. All capital procurement shall be carried out in accordance with the Tendering and Contract Procedures. (The particular applications relating to capital are contained in SFI 24).

13.5 Monitoring Returns

13.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation in line with the agreed timescales.

13.6 Value for Money

13.6.1 The Chief Executive in conjunction with the Chief Finance Officer shall be responsible for the efficient and effective use of the total financial resources available to the Trust and ensure that good value for money is achieved.

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Chief Finance Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards;

(b) prepare and submit annual financial returns and accounts to the Department of Health and Social Care in accordance with the national timetable and published requirements;

14.2 The Trust's annual accounts must be audited by the Trust's external auditor as appointed by the Audit Panel and thereafter adopted by the Trust Board.

14.3 The Trust will publish an annual report, in accordance with the national timetable. The document will comply with the relevant Department of Health and Social Care guidance including that contained in the Department of Health Group Accounting Manual.

14.4 The Audited Annual Report and Accounts must be presented to a public meeting and made available to the public.

15. BANK ACCOUNTS

15.1 General

15.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ directions and best practice advice issued by the Department of Health and Social Care and Treasury. In line with 'Cash Management in the NHS' Trusts should minimise the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

The Board of Directors shall approve the banking, working capital and investment arrangements including a review of the Trust's Treasury Management Policy on an annual basis.

15.2   Bank Accounts

15.2.1   The Chief Finance Officer is responsible for:

(a)   the operation Government Banking Service (GBS) and other bank accounts held by the Trust, Working Capital Facilities and the appropriate investment of the Trust's cash.

(b)   establishing separate bank accounts for the Trust's non-exchequer funds;

(c)   ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d)   reporting to the Board all instances where bank accounts may become or have become overdrawn (together with remedial action taken);

(e)   ensuring the Board of Directors is notified of changes to the Trust's borrowing facilities; and

(f)   monitoring compliance with Department of Health and Social Care or any other relevant guidance on the level of cleared funds.

15.3   Banking Procedures

15.3.1   The Chief Finance Officer will prepare detailed instructions on the operation of all Trust bank accounts, investments and borrowings which must include:

(a)   the conditions under which each bank and GBS account is to be operated, including the limit to be applied to any overdraft

(b)   a panel of officers with delegated authority to sign cheques or authorise payments drawn on the Trust's accounts and the number of signatories required on each authority to pay.

(c)   those authorised to invest monies; and

(d)   any records which must be maintained in respect of the above.

15.3.2   The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

15.3.3   All funds shall be held in accounts in the name of the Trust. No members of staff other than those designated by the Chief Executive and the Chief Finance Officer shall open any bank or building society account in the name of the Trust. Any employee aware of the existence of such an account shall report the matter to the Chief Finance Officer.

15.3.4   Where an agreement is entered into with any other body for payment to be made on behalf of the Trust from bank accounts maintained in the name of the Trust or other body, or by Electronic Funds Transfer (BACS), the Chief Finance Officer shall ensure that satisfactory security regulations of the Trust/other body relating to bank accounts exist and are observed. This will be specified in an agreement with the appropriate body.

15.4   Investments

15.4.1   The Chief Finance Officer is responsible for arrangements for the investment of surplus cash with the National Loans fund ensuring:

(a) a competitive rate of return within a minimal risk profile;
(b) the availability of cash to meet operational requirements;

15.4.2   The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

15.4.3   The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

15.5   Tendering and Review

15.5.1   The Chief Finance Officer will review any commercial banking arrangements of the Trust at five yearly intervals to ensure they reflect best practice and represent best value for money.

15.5.2   Competitive tenders shall be sought and the results reported to the Board. This review is not necessary for the operation of Government Banking Services accounts required by the Department of Health and Social Care.

16.   INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1   Income Systems

16.1.1   The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

16.1.2   The Chief Finance Officer is also responsible for the prompt banking of all monies received.

16.1.3
16.1.4   The Trust may carry on activities for the purpose of making additional income available in and/or to better carry out the Trust's principal purpose subject to any restrictions contained in the Regulatory Framework.

16.1.5   Disposal of materials and items surplus to requirements shall be dealt with in accordance with relevant financial procedure notes – see overlap with SFI 26.1.

16.2   Fees and Charges

16.2.1   The Trust shall follow the Department of Health and Social Care's advice in setting prices for NHS service agreements. The charges will be in line with National Tariff or locally agreed where tariff is not applicable.

16.2.2   The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

Where sponsorship income is considered the guidance in the Trust's 'Standards of Business Conduct and Declarations of Interest Policy shall be followed.

16.2.3 All employees must inform the Chief Finance Officer promptly of money due from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings, overseas patients and other transactions.

16.2.4 In relation to Income Generation Schemes, the Chief Finance Officer shall ensure that all costs and revenues attributed to each scheme can be identified.

16.3 Debt Recovery

16.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts including detailed procedures for the issuing of credit notes and write-off of debts after all reasonable steps have been taken to secure payment.

16.3.2 Income not received should be dealt with in accordance with losses procedures and reported to the Audit Committee.

16.3.3 The Chief Finance Officer is responsible for ensuring that systems are in place to prevent salary and other overpayments. Where overpayments occur, recovery should be initiated as per the Trust's debt recover procedure.

16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

16.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or for the granting of personal loans of any kind.

16.4.3 All cheques, postal orders, cash receipts shall be banked intact to the credit of the Trust's Main Account or, if appropriate, the Trust's Charitable fund bank account. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

16.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16.4.5 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash.

16.4.6 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned shall be reported immediately to the Chief Finance Officer and dealt with in accordance with the agreed procedure for reporting losses.

17. PROCUREMENT AND CONTRACTING PROCEDURE

17.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.12 Suspension of Standing Orders is applied).

Procurement by External Agents

Any External Agent used by the Trust shall be appointed in accordance with these SFI's.

Where the Trust uses External Agents to act on its behalf in relation to any procurement and the Trust is the named "Contracting Authority" then the Procurement Team must ensure that they carry out the procurement exercise in accordance with these SFI's.

No External Agent shall make any decision on whether to award a Contract or who a Contract should be awarded to.

Where the Trust uses External Agents to act on its behalf in relation to any procurement the External Agents must declare any conflict of interest that may arise to the Procurement Team prior to commencing work on any Tender.

Where the Procurement Team considers that such a conflict of interest is significant and cannot be effectively addressed, consideration should be given to whether it is appropriate for the External Agent to undertake the work on behalf of the Trust

17.2   UK Regulations Governing Public Procurement

The Procurement Act including the current financial thresholds prescribed for advertising and awarding all forms of contracts shall have effect as if incorporated in these SFIs.

17.3   Roles and Accountability

The Chief Finance Officer is responsible for ensuring policies and procedures are in place for the control of all procurement activity carried out within the Trust.

17.4.1   Procurement Overview

(i)   Procurement is categorized into 4 ranges of expenditure, explained below. Unless specifically exempted below the Board shall ensure that competitive offers are invited for:

- the supply of goods, materials and manufactured articles;
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care);
- for the design, construction and maintenance of building and engineering works, including construction and maintenance of grounds and gardens;
- disposals.

(ii)   Through the Trust's Finance System purchase orders are automatically generated for catalogue items where pricing has been competitively contracted or benchmarked against approved suppliers to ensure best value.

(iii)   For all goods and services Trust Standing Orders and UK legislation dictates the different purchasing thresholds and the process route of purchasing.

Relevant Contracts Overview

All relevant contracts must comply with the SFI's

A relevant contract is any arrangement made by, or on behalf of the Trust for the supply of goods, services or works.

This includes arrangements for:

- The purchase, hire or leasing of goods and equipment
- The delivery of services
- The delivery of works and associated services
- Use of agency staff
- Any Consultancy services
- Consignment Stock Agreements and Loan Kit Agreements
- Any lease, hire or credit arrangement
- Concession and Income contracts
- Call Off and/or Pricing Agreements via approved Frameworks

A contract is a legally binding agreement required for all goods, services or works entered into by a nominated representative of the Trust. A contract can be formed through verbal or, written means or via the exchange of monies.

Procurement Pipeline and Contracts Register

The Trusts Procurement Team, in conjunction with Divisions are required to publish Procurement Pipelines, Planned Procurement and Market Engagement Notices on the Governments Central Digital Platform detailing the contracts for goods, services and works, which it expects to procure in the coming financial year.

Divisions shall ensure that all contracts that need to be procured over are notified to the Procurement Team and are registered on the Procurement Teams forward plan so any notices that are required are published in accordance with the regulations.

The Procurement Team will maintain a register of any contracts that have been procured in accordance with these SFI's.

Defining the Contract Value

When contracting goods, services or works, a genuine assessment of the whole life value of the contract or framework agreement must be undertaken e.g. a 4 year estimated value.

If the project can be demonstrated as truly, innovative and an estimate cannot be provided, approval on what value to publish must be obtained from the Deputy Director of Procurement before commencing a competitive tendering process.

The Trust shall make the best use of its purchasing power by aggregating opportunities wherever possible both internally and where possible via collaborations with other Trusts.

Contracts for goods, services or works shall not be disaggregated in an attempt to avoid the application of these SFI's or to avoid complying with the Regulations.

For Concession contracts, the value of the contract shall be the total turnover of the concessionaire generated over the duration of the contract, in consideration for the goods, services or works that are the object of the Concession contract.

The value of an Income Contracts is the gross income generated by the Trust as a result of the rights granted, or goods, services or works supplied by the Trust.

Information Governance

Where any Provider (commercial or other) will or might be given access (storage, support and maintenance etc.) to any personal data (Staff/ patients), the Division must comply with the Trusts Data Protection policies and obligations.

The Division must follow the Trusts Information Security and Data Protection/ IG Policies, in particular regarding contracting with data processors and sharing data, and consider IG requirements at all stages of the procurement process.

This includes ensuring IG requirements are adequately covered in the tender phase, carrying out a Data Protection Impact Assessment (DPIA) in consultation with the Information Governance Team, and ensuring sufficient clauses are included in any agreement (prior to any go live).

The provider must meet minimum standards/ expectation in relation to IG and Data Security and if they do not the Trust may not be able to contract with them.

ICT Related Contracts

The Group Director of Digital Services or nominated officer must be consulted regarding the procurement of ICT related goods or services such as ICT consumables, hardware, software/systems or website development or any other ICT service prior to the commencement of any procurement activity.

Contracting Rules based on value

Contracts valued up to £10,000

Where the estimated value of a proposed contract does not exceed £10,000 (Ex Vat) For spend below £10,000 (excluding VAT) no formal procurement exercise is required, but value for money must still be demonstrated. (Do we need to mention here that the Procurement Team do not need to involved?)

(v)   Contracts Value from £10,000 up to £25,000 (How are we going to capture info for notice requirements and are we still happy with this value or do we want to increase it?)

☐Where spend is between £10,000 - £25,000 and the payee is NHS Supply Chain (NHSSC) no formal procurement process is required and orders can be placed direct with NHSSC.
(vi)☐   For non NHS Supply Chain spend between £10,000- £25,000 (excluding VAT) Procurement should be undertaken through one of the routes outlined below:
a.   Proportionate Procurement, for example, a best value Request for Quote process comparing price and quality,
☐A requirement to seek at least three written quotations from suitable suppliers. Wherever possible a minimum of one of the quotations must be sought from a Local Business.
b.•   A Further competition under a compliant Procurement framework agreement – if there is a competitive market and /or the potential for future growth in spend.

c. Three quotes – for a one-off purchase but in a competitive market a price only quote process can be undertaken

d.　　　Less than three quotes – where a competitive market is not established, or demand in the market limits procurement options, one to three quotes will be accepted on the basis there is evidence of attempts to seek quotes and this is document on a procurement record.

e. •　　　Direct award – where only one provider can deliver the requirement, or for a unique requirement (value for money must still be demonstrated). A short Contract Award Report is required to demonstrate justifiable direct award.

f. Contract variation under an existing contract – providing the contract variation is no more than 10% of the original contract value or for technical or economic reasons, the variation is no more than 50% of the original contract value. Contract variations higher than these thresholds will require a new procurement process.

See SFI 17.9 for further details.

   Contracts Value for Goods and Service contracts above £25,000 to Current Threshold £139,688, Service Contract covered under Light Touch Regime above £25,000 to Current Threshold £589,148 and Works above £25,000 to £500,000.

(vii)　　　For spend above £25,000 (excluding VAT) but below the current tender thresholds within PCR2015, or £100,000 for services described in Schedule 3 of PCR 2015, or £500,000 for works as described in PCR2015

Procurement must be engagedlead on all procurement activity at these value and to undertake one of the following processes

• Proportionate Procurement Exercise in the open market – where a price and quality are evaluatedi. on is required, then a proportionate tendering approach to test the market. should be undertaken by the Procurement Team.
• Where appropriate a restricted exercise where price and quality are evaluated to test the market.
a.
• Mini-competition through a compliant framework agreement.
b.
• Where an approved third party framework has an option to compliantly direct award on a non-competitive basis the Procurement Team must have a written justification for the selection of the provider(s) and this must be contained within the Contract Award Report.

c. Direct award under a compliant framework agreement

d.　　　Contract variation under an existing contract – providing the contract variation is no more than 10% of the original contract value or for technical or economic reasons, the variation is no more than 50% of the original contract value. Contract variations higher than these thresholds are not permitted and will require a new procurement. Contract variations which result in a total value contract above procurement thresholds are not permitted, and will require a compliant procurement under the Public
Contract Regulations 2015

e.　　　In exceptional circumstances, a single tender waiver may be required In very exceptional circumstances a direct award is permitted– where only one provider can legitimately deliver the requirement, or for a unique requirement. (value for money must still be demonstrated). Where this process is undertaken a Contract Waiver form should be completed in advance of the requirement.

Works Contracts valued above £500,000 to Current Threshold £5,372,609

Procurement must lead all procurement activity at these values and undertake one of the following processes:

- Undertake a tender where a minimum of **three** submissions should be sought from suitable suppliers. Wherever possible a minimum of one tender must be sought from a Local Business.
- Undertake a mini-competition in-accordance with an approved framework terms, conditions and processed.
- Where an approved third party framework has an option to compliantly direct award on a non-competitive basis the Procurement Team must have a written justification for the selection of the provider(s) and this must be contained within the Contract Award Report.

All contracts valued above UK tender threshold

> For all spend above the current UK tender threshold limit the Procurement Team must lead on this activity and undertake one of the following processes:

- A compliant procurement process in line with the associated procedures detailed within the Regulations

- Undertake a mini-competition in-accordance with an approved framework terms, conditions and processed.
- Where an approved third party framework has an option to compliantly direct award on a non-competitive basis the Procurement Team must have a written justification for the selection of the provider(s) and this must be contained within the Contract Award Report
- In exceptional circumstances, a compliant direct award under section 41, 42 or 43 of the Regulations. The Procurement Team will need to ensure that all appropriate transparency notices have been completed in accordance with Section 44 Regulations

(iv) .

17.4.2

17.4.3 **Exceptions and instances where a procurement process need not be applied**

(a) where the estimated expenditure or income does not, or is not reasonably expected to, exceed **£10,000**

(b) ;

(b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in SFI No. 26;

(d)

17.4.4   Waivers to SFIs

Waivers to the SFIs may be permitted when the SFIs cannot be practicality applied, and the award meets one of the following circumstances:

(a)   in very exceptional circumstances where formal procurement procedures would not be practicable and the circumstances are detailed in an appropriate Trust record.

(b)   where the timescale genuinely precludes competitive procurement but failure to plan the work properly would not be regarded as a justification for a single tender;

(c)   where the Trust area able to demonstrate that only one specialist firm is able to meet the requirement

(d)   when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(e)   there is a clear benefit to be gained from maintaining continuity with an earlier project or compatibility with existing equipment / service. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive procurement;

(f)   for building and engineering construction works and maintenance where there is either a direct legal enforcement of safety the consequence of which would result in the closure of the Trusts services and/or prosecution of the Trust and it's officials or a specified National or Local Health economy imperative where failure to deliver could place patients safety at risk.

Only the Group Chief Finance Officer (or nominated deputy) has the authority to waive the SFI's.

Waivers must be obtained in advance of the procurement action as a waiver cannot be authorised retrospectively unless in an emergency situation.

Waivers **must not** be used to avoid the requirements of the SFI's to go to competition due to lack of time to procure. Procurement projects should be planned well in advance.

Waivers for goods & services contracts can only allowed up to the value, **£138,760 inc. VAT**, **£663,540 inc. VAT** for contracts under the Light Touch Regime **£5,336,937 inc. VAT** for works contracts.

Waivers must be documented with a unique reference number and on the Trust approved Waiver Form

Where it is decided that a formal procurement process is not possible and should be waived, the reason for the waiver should be documented on the

approved Trust Waiver Form with a unique reference, endorsed by the Procurement Team, then authorised by the Group Chief Finance Officer.

All waivers are to be reported to the Audit and Risk Committee on a quarterly basis, or more frequent if requested by the Committee.

17.4.5

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17.5   Tendering Procedure for Goods, Materials, Services and Disposals including non NHS provided health care.

17.5.1   **Invitation to tender**

(i)   All invitations to tender shall be issued via the appropriate e procurement/sourcing portal in use within the Trust. (Where the Trust has engaged with an External Agent the tender shall be run on their e-procurement portal)

(i)

(ii)   All invitations to tender shall state that no tender will be accepted unless it has been submitted via the appropriate e procurement/sourcing portal adhering to all the required terms of the invitation to tender but specifically the requested time and date of return.

(iii)   Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Terms and Conditions of Contract as are applicable. Any contract that is not to be let under these terms must be referred to the Deputy Director of Procurement for approval prior to any contractual agreement.

(iv)   Every tender for building or engineering works will be procured under a relevant form of contract specific to the required such as NEC, JCT etc.

17.5.2   **Receipt and safe custody of tenders**

The Procurement Team will be responsible for the electronic receipt, and safe custody of tenders received within the e-procurement system until the time for the electronic seal to be opened.

17.5.3   **Opening tenders and Register of tenders**

(i)   As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the electronic vault will be opened by the procurement project lead

(ii)   Every tender received shall be marked with the date of opening automatically by the e-procurement software and will maintain a full auditable record of the opening process.

(iii)   Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, shall be addressed in accordance with the conditions set out in the invitation to tender document and regulations.

(iv)   Appropriately detailed electronic notes shall be kept in the contract file to detail any matters such as action taken in respect of late tenders, non-compliant bids or any other matters relevant to tender receipt and opening.

17.5.4   **Admissibility**

(i)   Tenders submitted but not received until after the due time and date (at which point the electronic vault is locked), may be considered only if confirmation of submission is received from the e-sourcing portal. The Deputy Director of Procurement will decide whether there are exceptional circumstances e.g. System failure on the part of the Portal having been uploaded in good time but delayed through no fault of the tenderer.

(ii)   Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders In addition to this it will also only be considered if the evaluation process of the other tenders has not commenced.

(iii)   While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential,

(iv)   Where only one tender is sought and / or received, it must be demonstrated that the price to be paid is fair and reasonable and will ensure value for money for the Trust. This will be recorded in the appropriate documentation namely the contract award report.

17.5.5   **Acceptance of formal tenders (See overlap with SFI No. 17.6)**

(i)   Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender. All such questions must be raised and responded to via the e procurement system to maintain audit trails and transparency.

In accordance with the Procurement Act section 19 the evaluation criteria for tenders will be developed using the most advantageous tender (MAT) model that will ensure a wide range of criteria is considered rather than just the cost.

It is accepted that the lowest price does not always represent the best value for money.   Other factors affecting the success of a project may include (without limitation):

(a) Qualitative elements of the bidders proposal including social value;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be documented in the contract award report,.

Criteria taken into account in selecting a successful tenderer must be clearly recorded and documented in the invitation to tender/quote.

(iii)   No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Finance Officer

(iv)   The use of these procedures must demonstrate that the award of the contract was:

  (a) not in excess of the going market rate / price current at the time the contract was awarded; or

  (b) that best value for money was achieved.

(v)   All tenders should, subject to compliance with the provisions of the Freedom of Information Act 2000, be treated as confidential and should be retained fo the following periodsr:

Tender Documentation

In accordance with section 98 of the regulations tender documentation must be kept until the end of the period of three years beginning with the day on which the contract is entered into or, if the contract is awarded but not entered into, awarded.

Contract Documentation

  (a) 6 years after contract completion where executed under hand
  (b) 12 years after contract completion where executed under seal

(vi) All tenders should be assessed for embedded derivatives and embedded leases utilising a standard checklist. Any proposed tender award which indicates the existence of either should be notified to the Assistant Chief Finance Officer – Financial Services, prior to award.

17.6   Contract Award Process and Documentation

These levels of authorisation may be varied or changed only with the express agreement of the Trust Board.

Providing all the conditions and circumstances set out in these SFI's have been fully complied with, formal authorisation for the awarding of a contract must be obtained.

Depending on the contract value and process undertaken the documentation requirements are as follows:

- On completion of an above Threshold Procurement a formal Contract Award Recommendation Report will be required in accordance with the regulations.

- On completion of a below Threshold Procurement a short form Contract Award Report will be required.

These reports will be authorised as a minimum by the following staff depending on the contract value :

	Total Contract Award Value				
	<£25,000	<£100,000	<£250,000	<£1m	£1m+
Divisional Lead	X	X	X	X	X
Head of Category	X	X	X	X	X
Divisional Head of Finance	X	X	X	X	X
Deputy Director of Procurement		X	X	X	X

			X	X	X
Group Chief Finance Officer			X	X	X
Chief Executive Officer				X	X
Finance and Performance Committee					X
Trust Board					X

Where Divisions and projects require additional member of staff to sign off the Contract Award this will be agreed with the relevant Head of Category.

17.7   Signing of Commercial Procurement Contracts/ Agreements (External Document)

17.7.1   The signing of the commercial agreements must only be undertaken by the following Trust Staff and within the identified value limits

< £100,000 – Deputy Director of Procurement
 £100,000 – £250,000 Group Chief Finance Officer
>£250,000 – Chief Executive Officer or where the agreement requires two signatories Chief Executive Officer and Group Chief Finance Officer

Works and other associated construction contract specified in section XX

< £100,000 – Deputy Director of Procurement
 £100,000 – £250,000 Group Chief Finance Officer
>£250,000 – Group Director of Estates and Facilities or where the agreement requires two signatories Group Director of Estates and Group Chief Finance Officer

As part of utilising Procurement Frameworks there will be the requirement to sign off access agreements and other associated paperwork before commencing any procurement exercise. These documents must authorised by either the Deputy Director of Procurement or Head of Category.

17.8   Private Finance and leasing for capital procurement (see overlap with SFI No. 24)

17.8.1   When the Board proposes, or is required, to use finance provided by the private sector (PFI) the following should apply:

(a)   The Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b)   Where the sum exceeds delegated limits, a business case must be referred to the appropriate department or agency for approval or treated as per current guidelines.

(c)   The proposal must be specifically agreed by the Board of the Trust.

(d)   The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.8.2 Where it is proposed that leasing be considered in preference to capital procurement then the following should apply:

(a) The selection of a contract / finance company shall be on the basis of a competitive process;

(b) All proposals to enter into a leasing agreement shall be referred to the Chief Finance Officer before acceptance of any offer;

(c) The Chief Finance Officer shall ensure that the proposal demonstrates best value for money; and

(d) The proposal shall be agreed in writing by the Chief Finance Officer prior to acceptance of any offer to the lease.

In the case of property leases the relevant NHS guidance shall be followed and procurement rules do not apply.

17.9 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) UK Procurement Regulations and other statutory provisions;

(c) any relevant directions issued by Treasury, the Department of Health or other Statutory Body.

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis of the Procurement.

(g)

17.10 Personnel and Temporary Staff Contracts (see overlap with SFI Nos. 20.6, 20.9, 21.2.3)

The Chief Executive shall nominate officers with delegated authority to design and operate a process for engaging with and enter into contracts of employment, regarding staff,.

17.11

17.12 Disposals (See overlap with SFI No 26)

Competitive Procurement procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

17.13 In-house Services

17.13.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by. undertaking a procurement process in accordance with those specified above.

17.13.2 In all cases where the Board determines that in-house services should be reviewed the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist/s.

(b) In-house bid group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a member of the Procurement Team and Chief Finance Officer or nominated representative. For services having a likely annual expenditure exceeding £ 1,000,000, a non-officer member should be a member of the evaluation team.

17.13.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house bid group may participate in the evaluation.

17.13.4 The evaluation team shall make recommendations to the Board.

17.13.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

17.14 Applicability of SFIs to Procurement using funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased by the Lincolnshire NHS Charity.

17.15 Contract Administration

17.15.1

Termination of Contract(s)

Inline with standard NHS Terms and Conditions the provision for the termination of a contract must be included within the terms and conditions of the contract. Where appropriate the termination for convenience clause should be selected.

The Contract Management Head of Category must be consulted and give their approval where a contract is to be terminated by exercising the termination for convenience clause.

The Deputy Director of Procurement must be consulted if the performance of a contract as resulted in a breach of contract and consideration has been given to termination of the contract.

Only the Deputy Director of Procurement has the authority to agree to the early termination of a contract due to a single or multiple breach/s and the subsequent Termination Notice but be signed by them or their nominated deputy.

Contract Modification.

All Contract modifications must be carried out within the scope of the original Contract.

All Contract modifications must be carried out in accordance with section 74-77 of the regulations.

Any Contract modification that material affects or changes the scope of the original contract potential may not be permitted under the regulations so prior approval must be sought by the relevant Head of Category before entering into any contractual discussions.

If a material change is approved by the Head of Category, then the necessary notices must be published in accordance with the regulations.

A new procurement is required in the case of a material change where one or more of the following conditions are met:

- increase or decrease the term of the contract by more than 10 per cent of the maximum term provided for on award,
    -
- materially change the scope of the contract
    -
- materially change the economic balance of the contract in favour of the supplier.

- the modification would not itself increase or decrease the estimated value of the contract by more than:

- in the case of a contract for goods or services, 10 per cent;

- in the case of a contract for works, 15 per cent,

All contract modifications must be in writing and signed by both the Trust and the provider except where different provisions are made within the contract documentation.

The value of each modification must be assessed and all necessary approvals sought prior to the variation taking place.

Approval for any modification shall be sought in writing in accordance with the authorisation matrix contained at XXXXX.

Contract Extensions

The term of any contract may only be extended where all the following criteria have been met:

Provision for an extension of the term is evidenced by the original contract and any subsequent notices required by the regulations; and

The Provider is currently delivering to an expected standard.

Where the budget provision and the extension is in line with the SFI;s; and

Where the extensions have not been allowed for in the initial Contract Award Report a separate Contract Award Report will be needed before the extension can be approved.

Where the contract still delivers Value For Money

Contract extensions will not be permitted if they take the overall contract value above the value that was advertised in the Contract Notice.

Contracts Novation and Assignment

Transfer, assignment and novation of contracts can only be agreed by the Deputy Director of Procurement (or nominated deputy).

Any novation and assignment must be processed in accordance with the terms and conditions of the contract and must be in writing and signed by both the Trust and the provider except where different provisions are made within the contract documentation

18. AGREEMENTS FOR PROVISION OF HEALTHCARE SERVICES (see overlap with SFI No. 17.11)

18.1 The Chief Executive, as the Accountable Officer of the Trust, supported by the Chief Finance Officer and Deputy Chief Executive, is responsible for negotiating contracts with commissioners for the provision of services to patients in accordance with national guidance and the Annual Plan.

18.2 All agreements should aim to implement the agreed priorities contained within the NHS Operating Framework and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the provision of reliable information on cost and volume of services;
- existing agreements, to ensure where appropriate they build on existing partnership arrangements;
- the mandated performance indicators;
- existing Joint Investment Plans;
- the need to ensure agreements are based on integrated care pathways; and any model contracts issued by the Department of Health and Social Care.

In carrying out these functions, the Chief Executive should take account the advice of the Chief Finance Officer regarding:

- the National Tariff Payment System and associated guidance (e.g. national activity recording and coding requirements, the National Grouper etc.) and the costing and pricing of services;
- payment terms and conditions;
- amendments to agreements and other NHS patient services arrangements.

All agreements should be underpinned by the NHS standard contract clauses.

18.3   Involving partners and jointly managing risk

The risks involved in joint working will be assessed and articulated within a legally binding contract. Such a contract will be informed by the view of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Finance Officer to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The agreement will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

18.4   Sub-contracting Provision of Services to Non-NHS Providers

Where the Trust makes arrangements for the provision of services by non-NHS providers, it is the Chief Finance Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided. Before making any agreement with non-NHS providers, the Trust should explore fully the scope to make maximum cost-effective use of NHS facilities and ensure all sub-contracting is in accordance with the NHS Standard Contract. This is to ensure that the quality and performance measures reflect the Trust contract with their main commissioners.

18.5   The Chief Finance Officer, on behalf of the Chief Executive, shall be responsible for drawing up and agreeing to the financial details and terms and conditions contained in the legally binding contract entered into by the Trust.

18.6   Agreements should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Agreement prices shall comply with the latest costing guidelines.

18.7   The Chief Finance Officer shall be responsible for establishing arrangements for the identifying, gaining approval for and invoicing of other NHS patient services referrals.

18.8   Reports to Board on contracts

The Chief Finance Officer will ensure that regular reports are provided to the Board detailing actual and forecast income from the contracts. Contract performance will be reported separately by the Deputy Chief Executive.

19.   COMMISSIONING

Not applicable

20.   HUMAN RESOURCES AND PAY

20.1   Remuneration and Terms of Service (see overlap with SO No. 5.7)

20.1.1   In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

20.1.2   The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust and other senior employees including:

   (i) all aspects of salary (including any performance-related elements/bonuses);

   (ii) provisions for other benefits, including pensions and cars;

   (iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(a) monitor and evaluate the performance of individual officer members (and other senior employees);

(b) receive assurance from appropriately qualified officers of the trust in regard to appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate;

(c) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments exceeding £50,000 taking account of such national guidance as is appropriate.

   • For any payment less than £50,000 the Executive Team has authority to consider and approve.
   • For any termination payment over £150,000 the payment must gain Board approval.

(d) Special severance payments (those outside normal statutory or contractual requirements) cannot be made without Treasury and Board approval

20.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

20.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5 The Trust will pay allowances to the Chair and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

20.2   Funded Establishment

20.2.1 The Executive Devolution Policy provides for a degree of earned autonomy to be reflected in the delegation of powers to Directorates and Divisions in varying Establishment. Unless otherwise devolved, the following apply:

- The workforce plans incorporated within the annual budget will form the funded establishment.

- All new posts must be approved through the business planning process.

- The funded establishment of any department may not be varied in any way which causes expenditure to exceed the authorised annual budget without the prior written approval of the Chief Finance Officer or nominated deputy.

20.2.2   The authority to fill a funded post on the establishment with permanent or fixed term staff sits with the budget holder except when the Trust is operating under special measures when this authority may be rescinded.

20.2.5   The authority each budget manager is attributed in relation to all pay and non-pay decisions is set out within the Executive Devolution Policy (See SFI No. 13.3.1 and 21.2)

20.3   Staff Appointments

20.3.1   No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

(a)   authorised to do so by the Chief Executive;

(b)   within the limit of their approved budget and funded establishment or as set out within the Executive Devolution Policy.

20.3.2   The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

20.3.3   Any monies due to employees as a result of all employments with the Trust howsoever arising shall be paid through the Trust payroll.

20.4   Variation to existing job plans

20.4.1   Only the Clinical Director or Business Manager of the relevant Clinical Business Unit can authorise variations to existing job plans within the agreed budget.

20.5   Authorisation of overtime and additional sessions

20.5.1   The budget holder is responsible for authorising overtime and additional sessions.

20.5.2   Overtime and additional sessions must be authorised prior to being worked. In exceptional circumstances where documentation or electronic systems are not authorised prior to the work being undertaken, these must be completed as soon as possible.

20.6   Authority to engage bank and agency staff, Self-employed or Third Party Workers

20.6.1   Within delegated budget:

(a) The budget holder holds the responsibility to authorise the booking of bank and agency staff or self-employed or Third Party Workers

Outside of delegated budget:

(b) The booking of bank and agency personnel or self-employed or Third Party Workers outside of budget must be agreed in advance with the appropriate Executive Director in consultation with the Chief Finance Officer.

20.6.2   All bookings of bank or agency staff must be made through the agreed process, variations to this can only be made with the express authority of the Chief Finance Officer.

20.7   Leave Policy

20.7.1   The Director of Human Resources is responsible for agreement and publication of Leave Policy, to cover Annual, Maternity, Paternity and other Special Leave categories.

20.7.2   The Director of Human Resources is responsible for agreement and implementation of a Policy to support Career Breaks.

20.8   Redundancy

20.8.1   All staff redundancies must be authorised by the Chief Finance Officer.

20.9   Engagement of Workers off Payroll – (see overlap with SFI No 21.2.3)

20.9.1   The Chief Finance Officer shall issue detailed guidance setting out responsibilities and required actions for managers engaging workers 'off-payroll'.

20.9.2   Only in exceptional cases should a worker be engaged and not paid through the Trust payroll.

20.9.3   Prior to engagement, the tax status of the 'worker' must be determined. To facilitate this, the engaging manager must complete an online IR35 assessment which prior to engagement must be reviewed and agreed by a nominated officer within the Finance Directorate.

20.9.4

20.9.5   Appropriate arrangements shall be in place to ensure that income tax deductions and national insurance contributions for both the Trust and worker are properly made and paid to HM Revenue & Customs in line with current legal and regulatory requirements.

20.9.6   NHSE payment Caps may not be exceeded without the express agreement of the appropriate Executive Director;

20.10   Processing Payroll

20.10.1   The Chief Finance Officer is responsible for:

(a)   specifying timetables for submission of properly authorised time records and other notifications;

(b)   the final determination of pay and allowances;

(c)   making payment on agreed dates;

(d)   agreeing method of payment.

20.10.2   The Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) procedures for payment by cheque, bank direct credit (including BACS), or cash to employees and officers;

(h) procedures for the recall of bank direct credits (including BACS) and stopping of cheques;

(i) Pay advances and their recovery;

(j) maintenance of regular and independent reconciliation of pay control accounts;

(k) separation of duties of preparing records;

(l) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

20.10.3   The Budget Holder has delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) submitting appointment forms and change forms in the prescribed form, immediately upon knowing the effective date of an employee's appointment or change in circumstances;

(c) completing time records and other notifications in accordance with the Chief Finance Officer' instructions and in the form prescribed by the Chief Finance Officer;

(d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

20.10.4   Individual employees are responsible for:

(a) Keeping accurate time records

(b)   Submitting time records and claims for reimbursement of overtime, enhancements and extra duties to line management for authorisation each month or where required more frequently in accordance with published timetables

(c)   Submitting claims for reimbursement of travel and other expenses within 3 months of being incurred. Claims outside this period must be authorised by the Chief Finance Officer or nominated Deputy.

(d)   Checking their pay each month and immediately notifying Payroll of any identified error for correction in the following pay period.

20.10.5   Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

20.10.6   All timesheet, pay records and other pay notifications shall be certified and submitted in accordance with the instructions of the Chief Finance Officer. A list of designated authorising Officers shall be maintained, detailing the limits of authorisation and shall contain specimen signatures.

20.10.7   The Chief Finance Officer shall determine the dates on which the payment of salaries, wages, expenses, allowances, termination or compensation payments, and any other form of remuneration are to be made, having regard to the general rule that it is undesirable to make payments in advance, except in special circumstances.

20.10.8   The Chief Finance Officer will publish a salary overpayments and advances policy detailing the Trust approach to and process for recovery of overpayments and circumstances under which an advance of salary may be made.

20.11   Contracts of Employment

20.11.1   It is the responsibility of the Director of Human Resources for:

(a)   ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b)   dealing with variations to, or termination of, contracts of employment in accordance with the requirements of Standing Orders and Standing Financial Instructions

21.   NON-PAY EXPENDITURE

21.1   Delegation of Authority

21.1.1   The Board will approve the level of non-pay expenditure on an annual basis and the Chief Finance Officer will determine the level of delegation to budget managers.

21.1.2   The Chief Finance Officer will set out:

(a)   the list of managers who are authorised to place requisitions for the supply of goods and services;

(c)   the maximum level of each requisition and the system for authorisation above that level.

The list of managers and limits of financial authority will be set out within the Trust authorisation matrix hierarchy. This defines the actions individuals have delegated authority to carry out on behalf of the Trust. The authority will be restricted in most cases to a limited range of budget areas for which the manager is responsible. The

matrix incorporates delegated authority in relation to Human Resources (e.g. recruitment), Procurement / Invoice authorisation, Admin rights, budget amendments and Charitable Fund requests.

21.1.3   No contract in respect of the supply of revenue or capital goods and/or services may be authorised other than by approved budget managers in conjunction with advice from Procurement or Estates services or exceptionally by the Chief Executive. The approved manager shall not authorise a contract in respect of a budget for which they are not accountable.

21.1.4   The Chief Finance Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

21.2   Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with SFI No. 17)

21.2.1   **Requisitioning**

The requisitioner in specifying the item to be supplied (or the service to be performed) shall always engage with Procurement Services to obtain the best value for money for the Trust.

21.2.2   It should be the duty of the Associate Director of Procurement to exercise general supervision over all purchases, except for drugs and pharmaceutical supplies. After making reasonable efforts to resolve conflicts, and having due regard to materiality, he shall inform the Chief Finance Officer of any requisition which appears to be in conflict with the Trust's Standing Orders and Standing Financial Instructions. In the case of drugs and pharmaceutical supplies this duty falls to the Chief Pharmacist.

21.2.3   Where services are required from an individual, consideration should be given to the nature of the role to be undertaken to ensure that the contract will be a contract FOR services (non-pay) and not a contract OF service (pay). It is the responsibility of the Budget Manager to ensure that when making an appointment or agreement for services that the individual is paid appropriately in accordance with the relevant tax regime. This also applies where services are offered by ex-employees or individuals supplying through their own personal service companies: it is the nature of the role which determines the appropriate pay or non-pay arrangement and advice of the Procurement team should be sought where necessary.
The relevant Finance Manager must be consulted when engaging with a PSC for the provision of personal services to ensure IR35 tax legislation is consistently applied. (see overlap with SFI 20.9)

21.2.4   **System of Payment and Payment Verification**

The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

21.2.5   The Chief Finance Officer will:

(a)   advise the Board regarding the setting of thresholds for each route to procurement ; and, once   approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b)   prepare procedural instructions and guidance for governing the procurement of non-pay goods and services within agreed authorisation limits.

(c)   be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i)   A list of Trust employees (including specimens of their signatures where appropriate) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(d)   be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.6 below.

21.2.6   **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. The Chief Finance Officer will provide a list of suppliers or services where payment in advance is permitted. Any situations not covered will require explicit authorisation from the Chief Finance Officer. In such instances:

(a)   Prepayments are only permitted where the financial advantages outweigh the disadvantages.

(b)   The appropriate budget holder must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c)   The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

21.2.7   **Official orders**

All goods, services or works will unless otherwise exempted be ordered on an official order and contractors shall be notified that they should not accept orders unless in an official form. The only exceptions to raising an official order shall be for:

(a)   cases of emergency or urgent necessity where a confirmation order number should be used.;

(b)   those specific approved goods and services for which a non-stock requisition is not required (as advised by the Head of Procurement on the 'Official exemption list).

(c)   those purchases made with a procurement card or by petty cash in accordance with the relevant approved procedure.

Official Orders must:

(a)   be uniquely numbered;
(b)   be in a form approved by the Chief Finance Officer;
(c)   state the Trust's terms and conditions of trade;
(d)   only be issued to, and used by, those duly authorised by the Chief Executive.
(e)   Confirmation order numbers shall be issued only by an Officer designated by the Chief Executive and used only in cases of emergency or urgent necessity. These shall be confirmed by an official order issued as soon as possible and ideally the next working day. The order should be clearly marked "Confirmation Order".

Orders / requisitions shall only be raised (or electronically processed) by Officers so authorised by the Chief Executive.
Lists of authorised Officers shall be maintained detailing the limits of authorisation within the Trust authorisation matrix (SFI 21.1.2).

21.2.8   **Purchasing Cards**

(a)   All purchase cards are issued subject to the appropriate budget holder completing a business case of need, and authorisation by the Associate Director of Procurement.

(b)   The card must be utilised according to the procedures documented in the Purchase Card Manual.

(c)   Purchase card transactions and relevant backing information will be subject to audit by finance to ensure it is appropriately completed and stored.

(d)   Illicit use of the purchase card for inappropriate or personal spend will result in disciplinary action and referral to the local counter fraud specialist where applicable.

21.2.9   **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a)   all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b)   contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c)   where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

(d)   no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

   (i)   isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

   (ii)   conventional hospitality, such as lunches in the course of working visits;

   (This provision needs to be read in conjunction with the Trust's "Standards of Business Conduct and Declarations of Interest Policy");

(e)   no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f)   all goods, services, or works (unless specifically exempted by the Chief Finance Officer – SFI 21.2.7) are ordered on an official order;

(g)   orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h)   goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase (indemnity forms should be completed for all trial/loan and free issue equipment); All trials or loans must be authorised in advance through the relevant governance structure.

(i)   changes to the list of employees and officers authorised to commit resources and certify invoices are notified to the Chief Finance Officer;

(j)   purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(k)   petty cash records are maintained in a form as determined by the Chief Finance Officer.

21.2.10   No Officer shall place a requisition, purchase from petty cash, by procurement card or require an official order to be raised with an individual to whom they are related or with any person or organisation with whom they hold a financial interest or from whom they are likely to receive any payment, gift or other consideration, without first making a disclosure. of the circumstances in writing to the Chief Executive and receiving his written authority to proceed. A copy of an authority so given must be lodged with the Chief Finance Officer.
Related Party disclosure should be made in accordance with the Trust Standards of Business Conduct and Declarations of Interest policy.

21.2.11   The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the high level principles described within Health Building Note 00-08. The evaluation of the efficiency and effectiveness of these contracts shall be the responsibility of the Chief Estates and Facilities Officer.

22.   EXTERNAL BORROWING

22.1.1   The Chief Finance Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The Chief Finance Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

22.1.2   The Chief Finance Officer shall be responsible for ensuring that the best value is obtained in securing loan finance and other sources of external funding and shall prepare detailed procedural instructions concerning applications for loans and overdrafts and on the form or records to be maintained.

22.1.3

22.1.4   Borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health and Social Care.

22.1.5   Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Finance Officer. The Board must be made aware of all short term borrowings at the next Board meeting.

22.1.6   All long term borrowings must be agreed by the Trust Board. Loan documentation must be authorised by the Chief Executive and Chief Finance Officer.

22.1.7   All long term borrowing must be consistent with the plans outlined in the current financial plan as reported to the Department of Health and Social Care and be approved by the Trust Board.

22.1.8   The Chief Finance Officer is responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Trust to fulfill the requirement to maintain adequate cash balances. The Board of Directors will receive details of the Trust's performance from the Chief Finance Officer.

23.   FINANCIAL FRAMEWORK

23.1.1   The Chief Finance Officer should ensure that members of the Board are aware of the NHS Financial Regime. The Chief Finance Officer should also ensure that the direction and guidance issued as part of the NHS Financial Regime is followed by the Trust.

24.   CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

24.1   Capital Investment

24.1.1   The Chief Executive:

(a)   shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b)   is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to budget;

(c)   shall ensure that the capital investment is not undertaken without confirmation of Commissioner support (where appropriate) and the availability of resources to finance all revenue consequences, including VAT and capital charges.

24.1.2   For every capital expenditure proposal the Chief Executive shall ensure:

(a)   that a business case (in line with current Department of Health and Social Care guidance and the Trusts Investment Appraisal Framework is produced setting out:

(i)   an option appraisal of potential financial and non-financial benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii)   the involvement of appropriate Trust personnel and external agencies;

(iii) appropriate project management and control arrangements;

(b)   that the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.

(c)   that advice is taken and acted upon to minimise the VAT and other taxes payable;

24.1.3   For capital schemes where the contracts stipulate stage payments, the Chief Finance Officer will issue procedures for their management.

24.1.4   The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue and Customs guidance.

24.1.5   The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure. This as a minimum shall include reporting to the Board on:

(a) an individual scheme / project

(b) the source and level of funding, and

(c) the expenditure incurred against the annual plan profile

24.1.6   The approval of a capital programme shall not constitute approval for the initiation of expenditure on any individual scheme, because it is also necessary to undertake the mandatory procurement processes of the Trust.

The Chief Executive shall issue to the manager responsible for any scheme:

(a)   specific authority to commit expenditure;

(b)   authority to proceed to tender (see overlap with SFI No. 17.6);

(c)   approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with current Department of Health and Social Care guidance and the Trust's Standing Orders.

24.1.7   The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

24.1.8 The Chief Finance Officer shall issue procedures for the use of capital receipts from the sale of assets and will ensure that the Trust's financial plans incorporate any expected capital receipts.

24.1.9 The Board of Directors will approve details of the Capital Expenditure Programme as part of the Annual Plan.

24.1.10 The Board of Directors will approve the acquisition / disposal of land and property.

24.1.11

24.1.11 The classification and recording of capital expenditure should be in accordance with the requirements laid down in the Department of Health Group Accounting Manual.

24.2 Private Finance and leases (see overlap with SFI No. 17.8)

24.2.1 The Trust should consider market-testing against Private Finance Initiative Funding (PFI) and / or leasing agreements when considering a large capital procurement.

24.3 Asset Registers

24.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted on a rolling basis every two years.

24.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be sufficient to meet requirements set out within International Financial Reporting Standards and other requirements as stipulated in the Department of Health Group Accounting Manual.

24.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and salary records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

24.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

24.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

24.3.6 The value of each asset shall be depreciated using methods and rates as specified in the Trust's accounting policies and indexed / revalued annually as appropriate.

24.3.7 The Chief Finance Officer shall calculate and make dividend payments in accordance with instructions issued by the Department of Health.

24.4 Security of Assets

24.4.1 The overall control of non-current assets is the responsibility of the Chief Executive.

24.4.2 Asset control procedures (including fixed assets, cash, cheques, negotiable instruments, and donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

24.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer who may also undertake such other independent checks as considered necessary.

24.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust; it is the responsibility of board members and senior employees in all disciplines to apply such appropriate routine security checks and practices in relation to Trust and NHS property as may reasonable or as otherwise specified by the board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

24.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses – see SFI 26.2.

24.4.6 Where practical, assets should be marked as Trust property.

24.4.7 Employees unless specifically authorised by the Chief Executive shall not use Trust assets for personal use.

24.4.8 The up-to-date maintenance and annual checking of asset records shall be the responsibility of designated departmental managers or Budget Holders for all items for which the initial purchase or replacement is within their delegated responsibilities.

24.4.9 Registers shall be maintained to record all controlled items issued to individuals, and where practicable, receipts shall be obtained.

24.4.10 Records shall also be maintained and receipts obtained for:

- equipment on loan to patients; and
- all contents of furnished lettings.

25.   STORES AND RECEIPT OF GOODS

25.1 General position

25.1.1   Stocks are those goods normally utilised in day-to-day activity but which, at any point in time, have not yet been consumed (excluding capital assets). They are usually held in controlled stores and within departments.

Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a)   kept to a minimum level commensurate with delivery and cost effective purchasing;

(b)   subjected to annual stock take;

(c)   valued at the lower of cost and net realisable value except where otherwise determined by the Trust's accounting policies.

25.2   Control of Stores, Stocktaking, condemnations and disposal

25.2.1

Subject to the requirements of the Chief Finance Officer for the systems in use, overall responsibility for the control of stores shall be delegated to an Officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel to a designated estates manager.

25.2.2   The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

25.2.3   The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
All stock records shall be in such form, and shall comply with such systems of control, as the Chief Finance Officer shall approve.

25.2.4   Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one Officer other than the storekeeper and his staff. The stocktaking records shall be numerically controlled and signed by the Officers undertaking the check. Any surplus or deficiencies revealed on stocktaking shall be reported to the Chief Finance Officer immediately.

25.2.5   Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

25.2.6   The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No 26 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

25.3   Goods supplied by NHS Supply Chain

25.3.1   For goods supplied via NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note and report

discrepancies to avoid overpayment where such discrepancies cannot be resolved via the Procurement Team.

26. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

26.1 Disposals and Condemnations

26.1.1 Procedures

The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

26.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine the estimated market value of the item, taking account of professional advice where appropriate. Advice should be sought from the Deputy Director of Procurement as to the most appropriate disposal process (for example: auctions < £5,000 market value or quotation / tender > £5,000).
(see overlap with SFI 17.14)

26.2 Losses and Special Payments

26.2.1 Procedures

The Chief Finance Officer must prepare procedural instructions on the recording, approval of and accounting for losses, and special payments.

26.2.2 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Finance Officer or confidentially inform an officer charged with responsibility for responding to concerns involving loss or potential fraud. This officer will then appropriately inform the Chief Finance Officer.
The loss must be recorded by the Officer on Datix (risk management system) and a Datix reference number obtained.

26.2.3 Where a criminal offence is suspected, the Chief Finance Officer must have in place provision to immediately inform the police.
In cases of theft or arson the Chief Finance Officer must immediately inform the police.
In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the Local Counter Fraud Specialist (LCFS).

26.2.4 The Chief Finance Officer must ensure arrangements are in place to notify the Audit committee of all suspected frauds.

26.2.5 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Chief Finance Officer must ensure the following are notified:-

(a)   the Board of Directors; and
(b)   the External Auditor

26.2.6 The Audit Committee shall approve the writing-off of losses and special payments

26.2.7 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

26.2.8   The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

26.2.9   No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

26.2.10 All losses and special payments must be reported to the Audit Committee on a quarterly basis.

26.2.11 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations. This should include:

   (a)   when a bankruptcy, liquidation or receivership is discovered, all payments should be ceased pending confirmation of the bankruptcy, etc. As a matter of urgency, a statement must be prepared listing the amounts due to and from the Trust.

   (b)   ensuring that any payments due by the Trust are made to the correct person.

   (c)   ensuring that any claim by the Trust is properly lodged with the correct party and without delay.

27.   INFORMATION TECHNOLOGY

27.1   Responsibilities and duties of the Chief Finance Officer

27.1.1   The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

   (a)   devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and any subsequent legislation;

   (b)   ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

   (c)   ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

   (d)   ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

27.1.2   The Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

27.1.3   The Chief Finance Officer shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

27.2   Contracts for Computer Services with other health bodies or outside agencies

The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

27.3   Risk Assessment

The Deputy Chief Executive shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans and vulnerability to cyber-security attack.

27.4   Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Deputy Chief Executive shall need to be satisfied that:

(a)   systems acquisition, development and maintenance are in line with corporate policies such as the Integrated Digital Care Strategy;

(b)   data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c)   Chief Finance Officer staff have access to such data;

(d)   such computer audit reviews as are considered necessary are being carried out.

27.5   Acquisition and Disposal of Computer Systems
The Chief Finance Officer will devise procedures which ensure that orders for the acquisition of computer hardware, software and services (other than consumables) are placed in accordance with the Integrated Digital Care strategy.

27.6   The Chief Finance Officer will ensure that separate control procedures are put in place for computer systems. This procedure will include:
- the acquisition and disposal of IT, systems and equipment;
- the decommissioning of systems containing confidential data; and in accordance with any guidance issued by the Information Commissioner and the Department of Health and Social Care.

28.   PATIENTS' PROPERTY

28.1   The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of terminal or deceased patients in hospital.

28.2   The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

-    notices and information booklets;

- hospital admission documentation and property records;
- the advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

28.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

28.4 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

28.5 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

28.6 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

29. FUNDS HELD ON TRUST

29.1 Corporate Trustee

(1) Standing Order No. 2 outlines the Trust's responsibilities as corporate trustee for the management of funds it holds on trust, along with SFI 4.8.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Chief Finance Officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

29.2 Accountability to Charity Commission and Secretary of State for Health and Social Care

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for health and Social Care for all Exchequer funds.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

29.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as applicable these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Chief Finance Officer shall ensure that all staff are made aware of the Trust Standards of Business Conduct and Declarations of Interest policy. This policy deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

31. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Trusts

32. RETENTION OF RECORDS

32.1 All NHS records are public records under the terms of the Public Records Act 1958 Section 3 (1) – (2). The Chief Executive and senior managers of the Trust are personally accountable for records management within the organisation.

32.2 The Trust will follow the latest guidance Records Management Code of Practice for Health and Social Care 2016") issued by NHS Digital. The Records Management Code sets out the minimum length of time for the retention of particular.

32.3 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Trust policy.
Records held in archives shall be capable of retrieval by authorised persons.

32.4 Records held in accordance with latest guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.
Day to day responsibility for decisions to destroy records following achievement of the retention date, and maintenance of the destruction register, is the responsibility of the Records Manager taking into account the provisions of the Records Management Code. The Records Manager is accountable to the SIRO and Chief Executive for decisions taken.

33. RISK MANAGEMENT AND INSURANCE

33.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Board.
A Board Assurance Framework shall be in place to enable the monitoring of risk.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) decision on and a clear indication of which risks shall be insured through arrangements with either the Risk Pooling Schemes administered by NHS Resolution or commercial insurance. ;

g) arrangements to review the Risk Management programme.

h) appropriate levels of external accreditation.

These matters shall be defined in more detail in the Risk Management Strategy or Policy. The existence, integration and evaluation of the above elements will support statements and conclusions within the Annual Governance Statement (AGS).

33.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

33.3 Insurance arrangements with commercial insurers

33.3.1 The Trust may not enter into insurance arrangements with commercial insurers except:

(1) for the purpose of **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place, income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Finance Officer should consult NHS Resolution.

(4) for the purposes of insuring Directors and Officers against any liability arising in their appointment,

(5) where, in the opinion of the Board of Directors, the level of cover afforded through the NHS Resolution Scheme in the event of significant or total loss of a facility would be insufficient to enable the re-provision of a safe and appropriate level of care to service users.

33.4 **Arrangements to be followed by the Board in agreeing Insurance cover**

(1) Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'excess'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below 'excess' levels.

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			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		