Bundle LCHG Board Meeting in Public Session 4 November 2025

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

1 Introduction, Welcome and Chair's Opening Remarks
Group Chair

2 Apologies for Absence
Group Chair

3 Public Questions
Group Chair

3.1 Ward Accreditation
Group Chief Nurse

3.2 Patient/Staff Story
Group Chief Nurse

3.3 Celebrating Group Success

4 Declarations of Interest
Group Chair

5 Minutes of the meeting held on 2nd September 2025
Group Chair
Item 5 DRAFT Public Board Minutes Sept 25

5.1 Matters arising from the previous meeting/action log
Group Chair
Item 5.1 Public Board Action log Sept 2025

6 Group Chief Executive Report to the Board
Group Chief Executive
Item 6 Group CEO update Public Board - November 2025 -FINAL

6.1 Group Model Workstream Progress Briefing
Group Chief Executive
Item 6.1 Font sheet Group Development Plan
Item 6.1 Work Programme as at 141025

6.2 Winter Plan
Group Chief Operating Officer
Item 6.2 Item 6.2 Front Sheet Winter Plan 25-26
Item 6.2 LCHG Winter Ready 2025-26 plan v3

7.2 BREAK

8 Strategic Aim 1 - Patients

8.1 Assurance and Risk Report from the Quality Committee
Chair, Quality Committee
Item 8.1 Quality Committee Assurance Upward Report September 2025
Item 8.1 September Appendix 1 LCHS IPC Annual Report 24 25
Item 8.1 Quality Committee Assurance Upward Report October 2025

8.2 Finance Briefing
Group Chief Finance Officer
Item 8.2 Trust Board - Finance Briefing M6

8.3 Assurance and Risk Report from the Finance and Performance Committee
Chair, Finance and Performance Committee
Item 8.3 Finance Committee Assurance Upward Report September 2025
Item 8.3 Finance Committee Assurance Upward Report October 2025dc

9 Strategic Aim 2 - People

9.1 Assurance and Risk Report from the People Committee
Chair, People Committee
2024/25 Freedom to Speak Up Guardian Annual Report
- Item 9.1 People Committee Assurance Upward Report September 2025 v1
- Item 9.1 People Committee Assurance Upward Report October 2025
- Item 9.1 FTSU Annual Report 2024-25

9.2 Resident Doctors 10 Point Plan
Group Chief Medical Officer
- Item 9.2 Resident Doctors 10 Point Plan - November 2025 Group Board Paper
- Item 9.2 Appendix A - PRN02140 Getting the basics right for resident doctors - letter to trusts
- Item 9.2 Appendix B - PRN02140 10 Point Plan to improve resident doctors' working lives
- Item 9.2 Appendix C - Resident Doctors 10 Point Plan - Action Plan Update late October 2025

10 Strategic Aim 3 - Population

10.1 Assurance and Risk Report from the Integration Committee
Chair, Integration Committee
- Item 10.1 Integration Committee Assurance Upward Report September 2025
- Item 10.1 Appendix A Lincs Neighbourhood health board TOR-DF_v7
- Item 10.1 Appendix B 10.5 EPR approval letter
- Item 10.1 Appendix B 10.5 202500527-United Lincolnshire Hospitals NHS Trust - EPRIB FBC Approval Letter
- Item 10.1 Integration Committee Assurance Upward Report October 2025
- Item 10.1 Oct IC planning update update_v3
- Item 10.1 Oct Appendix A Planning Framework Update Slides_IC_FPC_Oct 25
- Item 10.1 Oct Appendix B Example pack LCHG Medicine Care Group

11 Integrated Performance Reports
Group Chief Officers
- Item 11 ULTH Front Sheet Trust Board - IPR
- Item 11 ULTH IPR Trust Board October 2025 V3_
- item 11 Front Sheet - Integrated Performance Report (September Data)
- Item 11 LCHG Integrated Performance Report_Sep
- Item 11 Group Board Performance Dashboard

11.1 Strategy Delivery Q1 Assurance Report
Group Chief Integration Officer
- Item 11.1 Q1 Strategy delivery update Trust Board November 2025 _v6

11.2 National Oversight Framework Report
Group Chief Integration Officer
- Item 11.2 2025-11-04 NHS Oversight Framework summary for Board

12 Risk and Assurance

12.1 Group Risk Management Report
Group Chief Clinical Governance Officer
- Item 12.1 Front Sheet Risk Report
- Item 12.1 Appendix A- LCHS Group Board High or Very High - November 2025
- Item 12.1 Appendix B-ULTH Group Board High or Very High Risks November 2025

12.2 Board Assurance Framework
Group Director of Corporate Affairs
- Item 12.2 BAF Group Board Front Sheet Nov 2025
- Item 12.2 LCHG Group BAF as at October 24.10.25

12.3 Assurance and Risk Report from the Audit Committee and 2024/25 Annual Report
Deputy Group Chair

Item 12.3 Audit Committee Upward Report October 2025

Item12.3 Appendix Audit Committee Annual Report 2024-25

12.4 Board Forward Planner
Group Director of Corporate Affairs
For information

Item 12.4 Board Forward Planner

13 Any Other Notified Items of Urgent Business

14 The next meeting will be held on 6th January 2026
EXCLUSION OF THE PUBLIC
In accordance with Standing Order 3.1 and Section 1(2) of the Public Bodies (Admission to Meeting) Act 1960: To resolve that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

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

Minutes of the Joint Public Board Meeting

Held on 2 September 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
Professor Karen Dunderdale, Group Chief Executive
Mr Daren Fradgley, Group Chief Integration Officer
Professor Colin Farquharson, Group Chief Medical Officer
Mr Paul Antunes Goncalves, Group Chief Finance Officer

Non-Voting Members:
Mrs Kathryn Helley, Group Chief Clinical Governance Officer
Ms Caroline Landon, Group Chief Operating Officer
Mrs Jayne Warner, Group Director of Corporate Affairs
Mrs Sarah Buik, Associate Non-Executive Director
Mr Ian Orrell, Associate Non-Executive Director

In attendance:
Mrs Karen Willey, Deputy Trust Board Secretary, ULTH
Mrs Rachel Lane, Board Administration, LCHS (minutes)
Mr David Purdy, Deputy Director of Estates and Facilities
Mr Nico Batinica, Deputy Group Chief People Officer
Mr Nicholas Mulholland, Deputy Group Chief Nurse
Ms Holly Watson, Community Team Lead, Butterfly Hospice, LCHS – Item 7
Dr Julia Schofield, Consultant Dermatologist, ULTH – Item 7.1

Apologies:
Mrs Rebecca Brown, Deputy Chair/Non-Executive Director
Mrs Vicki Wells, Non-Executive Director
Miss Claire Low, Group Chief People Officer
Mrs Nerea Odongo, Group Chief Nurse
Mr Mike Parkhill, Group Estates and Facilities Officer

Items 7 and 7.1 were taken ahead of item 6

Sho464/25	**Item 1 Introduction** The Group Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream.
465/25	**Item 2 Public Questions** **Q1 Received from Vi King** Please can I ask why people are not being sent to Grantham for fracture clinic appointments. I understand that for the first one which is classed as trauma are sent to the other sites but follow up appointments should be done at Grantham. This is what I keep getting told each time I raise it. Clinics are getting cancelled at Grantham which is not fair on patients.
466/25	I have been raising these concerns since 2023, and I keep getting promised and reassured that this has been sorted and that there will be more activity at Grantham.
467/25	Please can I ask that these promises and reassurances are sorted once and for all so that patients can have their fracture clinic appointments at Grantham.
468/25	The Group Chief Operating Officer responded by thanking Mrs King for the question and explained that the trauma provision at Grantham Hospital had been reviewed to increase access for all residents in Lincolnshire.
469/25	The pathway had been changed some months ago to allow patients, where clinically appropriate and geographically possible, to have their first appointment at Grantham if they wished, meaning that any patient wanting to be seen at Grantham for the entirety of their pathway could do so. However there had been some challenges in respect of covering the clinics, whereby usually there would be three Consultant teams delivering trauma and this had been reduced to two for some time, due to long term absence, therefore the activity had been reduced.
470/25	The Chief Operating Officer was pleased to advise that this issue had now been resolved and within the next month the consultant gap would be filled with activity returning to full service provision.
471/25	The Group Chief Operating Officer apologised for any inconvenience caused to any patients due to the reduction in service and offered to discuss this situation with any colleagues or residents if that would be helpful.
471/25	**Item 3 Apologies for Absence** Apologies for absence were received from Mrs Rebecca Brown, Non-executive Director/Deputy Group Chair, Mr Ian Orrell, Associate Non-executive Director, Mrs Vicki Wells, Non-executive Director, Miss Claire Low, Group Chief People Officer, Mr Mike Parkhill, Group Chief Estates and Facilities Officer, Mrs Nerea Odongo, Group Chief Nurse.

472/25	The Group Chair took this opportunity to thank Professor Duncan French for his membership of the Board which had recently ceased, as a representative from the University of Lincoln. The Group Chair had been grateful to the University for allowing Professor French's time and indeed to Professor French who had offered the Board significant input, been challenging on business and had built good relationships. A replacement Board member from the University of Lincoln was in the process of being confirmed.
473/25	**Item 4 Declarations of Interest** There were no additional Declarations of Interest made.
474/25	**Item 5 Minutes of the meetings held on 1 July 2025** The minutes of the meeting held on Tuesday 1 July 2025 were approved as an accurate record.
475/25 476/25	**Item 5.1 Matters Arising from the previous meeting/log** The Board reviewed the action log and in relation to item 451/25, it was acknowledged that the Audit Committee had completed a review of the Board Assurance Framework. The Board agreed the item would be closed. The Group Chair also drew attention to minute number 386/25 which indicated a gap in maternity services, and requested this be added to the action log with an appropriate timeline. **Action: Group Director of Corporate Affairs, September 2025** The Board: • **Received the action log**
477/25 478/25	**Item 6 Group Chief Executive's Report to the Board** The Group Chief Executive presented the report to the Board and explained that five days of Industrial Action from Resident Doctors had been undertaken during July, and any disruption had been mitigated across the Group, along with monitoring of the national situation. The Group Chief Executive took the opportunity to pay tribute to colleagues for all the planning that had been undertaken in preparing for the latest action and for ensuring patients had remained safe during this time. There had been a strong response across the Lincolnshire system to this. Several national papers had been published during July, the first of which had been the NHS 10 Year Health Plan which focussed on three fundamental shifts: from hospital to community, from analogue to digital and from sickness to prevention.

479/25	The Lincolnshire system was engaging with the priorities within the plan, particularly in relation to digital transformation, workforce empowerment and financial sustainability, as part of the strategic planning and operational delivery.
480/25	Eight working groups had been established to support the delivery of the 10 Year Health Plan. Following an expression of interest, the Group Chief Executive had been invited to be part of the Oversight, Foundation Trust Licensing and Integrated Health Organisations working group and other CEOs in Lincolnshire had joined other working groups.
481/25	In July, the Department of Health and Social Care published the findings of an independent review into the roles of Physician Associates (PA) and Anaesthesia Associates (AA), which provided an opportunity to reset and clarify the scope and supervision of those roles, with immediate changes including revised job titles and deployment guidance. The Group Chief Executive advised that the Group was committed to supporting the implementation of the recommendations for the small number of PAs employed.
482/25	Also during July, an independent review of patient safety across health and care was published by Dr Penny Dash, Chair of NHS England. This review highlighted the need for a more coherent and strategic approach to patient safety across health and care, setting out nine key recommendations to streamline governance, strengthen accountability, and embed quality improvement, placing greater emphasis on leadership, digital innovation, and meaningful engagement. The Group Chief Executive advised that these were being considered and taken forward within LCHG.
483/254	NHS England had published the 2025/26 Winter Plan in July, which outlined actions to strengthen resilience and improve performance across urgent and emergency care services. The Lincolnshire system was developing robust winter plans to address the key priorities, which would be locally stress-tested and in place ahead of winter pressures. An extra-ordinary Board meeting had been arranged to approve the Winter Plan at the end of September, to comply with national submission deadlines.
484/25	Following the consolidation of Integrated Care Boards, it had now been formally agreed that Lincolnshire ICB would become part of a cluster arrangement with Derby and Derbyshire ICB and Nottingham and Nottinghamshire ICB. Work was ongoing to develop the structures for this cluster; the Chair had very recently been announced as Dr Kathy McLean, OBE. Dr Gerry McSorley Chair of Lincolnshire ICB would be retiring as planned at the end of September. The Group Chief Executive expressed a view that this would be sad loss to the County and colleagues across Lincolnshire. Dr McSorley's leadership across the County had been outstanding, and his wise words and commitment would be missed. The Group Chief Executive wished Dr McSorley well for the future. A formal announcement of the Accountable Officer was expected soon.
485/25	In terms of finance, the Group Chief Executive described the current situation and explained that teams were working on recovery actions for all areas and mitigations. Month four had remained on plan and technical efficiencies had been

	brought forward, all elements of this had been reviewed by the Finance and Performance Committee.
486/25	The Group Chief Executive informed Board members that all Executives had received their appraisal during the summer months and Fit and Proper Persons requirements continued to be met.
488/25	Following the signing of the contract with Nervecentre in June, the Initiation Stage of the Electronic Patient Record (EPR) Programme commenced on 14 July 2025. This short phase was designed, via a series of workshops involving staff, to produce a high-level plan for the programme, which would be the blueprint for the detailed Implementation Stage, in which each of the modules would be designed and built. The excellent level of attendance at the workshops had demonstrated staff commitment and excitement that the EPR Programme had moved from planning into an active stage.
489/25	The Group Chief Executive described an experience of a recent visit to the under construction, 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 would offer modern, accessible spaces for patients while significantly enhancing the working environment for staff.
490/25	Following submission of the annual review by the Endoscopy Service at ULTH, the Trust had received confirmation that all required Joint Advisory Group (JAG) accreditation standards had been met and been renewed for a further year. The Group Chief Executive commented that this significant achievement was testament to the consistent high standards of care, professionalism and dedication demonstrated by every member of the team. Achieving and maintaining JAG accreditation reflected a deep commitment to quality, safety, and continuous improvement in patient care.
491/25	As part of the annual reporting process for the National Neonatal Audit Programme (NNAP), the Neonatal Service at Lincoln County Hospital had 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%. The Group Chief Executive took the opportunity to congratulate the team for their unwavering commitment to clinical excellence, early intervention, and the highest standards of neonatal care.
492/25	The Group Chief Executive was also pleased to inform the Board that the Group had hosted a visit to Lincoln County Hospital on 1st August 2025 from NHS England Chief Executive, Sir Jim Mackey. The visit had included a tour of the urgent and emergency care pathways and provided teams with the opportunity to showcase the good work they were doing to support the residents of Lincolnshire. An opportunity had also been provided for partners to demonstrate joined up working and a sense of community.
493/25	The Group Chair added thanks to Board colleagues for navigating through the recent industrial action as safely as possible. The national and regional activity the Board was required to respond to as set out within the report was acknowledged.

	The Group Chair also took the opportunity to congratulate the Group Chief Executive for being selected to be part of the working groups for the 10 Year Health Plan.
494/25	The Board also noted the public consultation on the relocation of orthopaedics and the Group Chair added that it would be important to obtain the views of patients which would enhance experiences.
495/25	The Group Chair acknowledged the accolades received from achieving the JAG accreditation and maternity and neonatal services which was extremely positive.
496/25	The Group Chair also thanked Sir Jim Mackey for spending time visiting the Lincoln County Hospital site and to colleagues who showcased an excellent programme of activity.
497/25	The Group Chair wished to formally offer thanks and well wishes to Dr Gerry McSorley on his retirement, and acknowledged that he had been a great advocate, friend and critical friend to the Group in the spirit of enhancing levels of care and developing partnership arrangements. The Board: • **Received the report and noted the significant assurance provided**
498/25	**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.
499/25	The Group Chief Executive advised of progress made in respect of three areas of focus advising that the revised Integrated Performance Report would be seen during the next round of Committee reporting, along with the new style reporting templates, which would filter up to the Board at the November meeting. In respect of policies, action was being taken by the Group Chief Executive with the support of colleagues to realign processes to clinical risks being held across the Group and updates on that work would be provided to Committees of the Board. The Board: • **Received the report and noted the issues requiring further action**
500/25	**Item 7 Patient/Staff Story** The Group Deputy Chief Nurse welcomed the Community Team Leader (CTL) from Butterfly Hospice to the meeting and explained that Butterfly Hospice at Boston was a shared partnership provision located in Boston.
501/25	A recording was shared with the Board in which Mark and Lisa described their daughter Ella's story, who had been cared for at the Butterfly Hospice, following the diagnosis of a brain tumour. Ella had sadly passed away at 20 years old.

502/25	Mark and Lisa described the personalised care Ella has received during her nine day stay at the Hospice where the team had supported a range of visits and celebrations for Ella to enhance her end-of-life experience.
503/25	Mark and Lisa also described how welcoming the staff had been when they arrived at the Hospice and how well they had been treated throughout Ella's stay.
504/25	The CTL offered that Ella's journey had demonstrated learning for the Hospice, in relation to caring for younger patients, who had younger groups of friends, ensuring that nothing was out of bounds when it came to Hospice Care and anything could be accommodated reaching the realms of what others may feel was impossible to achieve. The CTL added that this also demonstrated the importance of system partnership working across the whole of Lincolnshire and the impact this had on patients.
505/25	Within the video the Chief Executive of the Butterfly Hospice outlined that a plan was in place to further enhance the service of Hospice care for guests and their families, by offering overnight stay accommodation from a dedicated three bed lodge situated within the Hospice car park, enabling families to be close to their loved ones during difficult times.
506/25	The Group Chair thanked Mark and Lisa for sharing Ella's story with the Board and hoped that they could see the lessons that had been learned from Ella's stay at the Hospice, and that staff members would continue to provide similar care for other families.
507/25	The Group Chair also thanked the Community Team Lead for attending the meeting. The Community Team Leader took the opportunity to thank Ella's parents for allowing her to build a relationship with them over the course of recent months whilst acknowledging that something positive had come from this desperately sad time.
508/25	The Group Chief Executive thanked Mark and Lisa for sharing their humbling story and informed those present that of a recent meeting with the team at Butterfly Hospice and had been impressed by the calm and serene environment. It was pleasing to hear of the team talking about guests at the Hospice rather than patients. The Group Chief Executive added that it was good to see that the staff had acted on the lessons that had been learned from Ella's stay.
509/25	The Group Chief Integration Officer was planning to visit the Hospice soon and commented on the statement the Community Team Lead made within the video of working within the realms of what most people thought was impossible and felt this this was an excellent comment which the team should be applauded for and should be the forefront of what a care model looked like. The Group Chief Integration Officer was proud of the work the team were doing and reflected that this should be replicated across many other pathways.
510/25	The Group Chair commented on the statement from Lisa that Ella had experienced a good nine days in the Hospice and expressed a view that this demonstrated what was trying to be achieved for guests at the Hospice. The

	Group Chair also took the opportunity to thank the Chief Executive of the Butterfly Hospice for all the work they did and for building the new facilities which would support the work being undertaken clinically. The Board: • **Received the Patient/Staff Story**
511/25	**Item 7.1 Celebrating Group Success** The Group Chair welcomed Dr Schofield, Consultant Dermatologist to the meeting who provided the Board with a comprehensive presentation, describing the award-winning Lincolnshire dermatology service, which treated over 36,000 patients a year across the County. The service specialised in skin conditions, skin cancer surgery and inflammatory skin disorders.
512/25	Dr Schofield described the challenges faced by the service, and an innovative piece of collaborative work between ULTH, Lincolnshire ICB and a private provider, DMC Healthcare which had significantly reduced waiting times and improved the quality of life of patients.
513/25	This piece of work had won numerous national accolades and had also been shortlisted for an upcoming award; this work had helped make ULTH the best performing acute trust in the country for dermatology services.
514/25	The Group Chair thanked Dr Schofield for the balanced presentation.
515/25	Mrs Buik asked about recruitment which was an issue affecting capacity and asked if there was any solution to that or if there was anything that could be done differently. Dr Schofield explained that dermatology was a popular specialty and was oversubscribed in terms of training numbers. Most individuals wished to work in major Teaching Centres, and it was explained that a Consultant had recently been appointed to a position in house, with a view that the growing your own was an important approach, however this took a lot of time in terms of support. Dr Schofield expressed a view that extended role practitioners could be developed, however noted that the real area of focus for the service should be artificial intelligence (AI) which could see many benefits for the residents of Lincolnshire.
516/25	The Group Chief Integration Officer thanked Dr Schofield for the presentation and offered to meet to discuss the potential use of AI and future working with the Primary Care Networks.
517/25	The Group Chief Executive said that the dermatology service appeared to be ripe for the left shift hybrid approach which was described within the NHS 10 Year Health Plan and expressed a view that there was potential for the way in which this service could be delivered in the future, to have significant impacts for the residents of Lincolnshire.
518/25	The Group Chief Medical Officer offered that one key area to this would be working in collaboration within community and primary care settings and establishing a key base would be important. The Group Chief Medical Officer

	would be happy to provide guidance in terms of national experience needed to liaise with clinical leadership across the services.
519/25	The Group Chair thanked Dr Schofield for attending the meeting and added that the further ways of working as described were aligned to the work of the Group Strategy. The Board: • **Received the presentation**
	Item 8 Strategic Aim 1 Patients
520/25	**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 July and August 2025 and the reports were taken as read with no formal escalations made to the Board from either meeting.
521/25	The Committee had received 2024/25 Annual Reports for Clinical Audit, Infection Prevention and Control, Safeguarding and Complaints for both elements of the Group. Mr Connolly advised that these had been scrutinised by the Committee and were recommended for approval by the Board.
522/25	Two areas of focus at the meetings had been in relation to Infection, Prevention and Control and the continued challenges associated with that area and antimicrobial prescribing were recognised with a focussed discussion due to be taken at the next Committee meeting in relation to this to strengthen oversight.
523/25	An upward report had been received from the maternity and neonatal group which provided continued assurance however there were several CNST standards which remained a risk in terms of the organisations ability to achieve year seven.
524/25	For CNST standard four, the neonatal medical workforce met the recommendations however nursing did not. A plan was in place with compliance expected by 2027. This remained on the risk register.
525/25	CNST standard five, the midwifery workforce remained below birth rate plus requirements with a current shortfall of around 12 whole time equivalents (WTE) and there was a business case in progress through local processes.
526/25	CNST standard seven was formally escalated to the Board which was in relation to the Maternity Voices Partnership, currently resource gaps were being identified, and mitigations were in place however assurance was being sought on forward looking commissioning.
527/25	CNST standard eight had a continued risk relating to compliance regarding some training, particularly in relation to consultant anaesthetists. There was a mitigation plan in place and work was underway to ensure staff and roster alignment.

528/25	CNST standard nine, progress with the maternity and neonatal staff culture plan was identified within the assurance plan which was available within the Board paper pack.
529/25	For CNST standard ten, there were two qualifying cases so far during 2025/26 and duty of candour had been completed scoring 100%.
530/25	The Group Chair acknowledged the updates surrounding the CNST standards and commented that the teams were undertaking good work to address these and were putting mitigations in place where required.
531/25	The Group Chief Clinical Governance Officer offered that in relation to 2024/25 Clinical Audit Annual Report both LCHS and ULTH had met the requirements to take part in all national audits applicable to each organisation and LCHS had been subject to an internal audit of clinical audit processes which had demonstrated reasonable assurance which was positive. Work was now being undertaken collectively to review the management of audit across the Group moving forward.
532/25	In relation to the 2024/25 Complaints Annual Reports, the Group Chief Clinical Governance Officer also offered that Board members would see that complaint numbers continued to increase, however across the Group response times were being adhered to in most cases.
533/25	In response to Mr Connolly's point regarding Infection Prevention and Control, the Group Chief Medical Officer advised that some detailed work had been underway for some time now and the team were preparing for a focussed review.
534/25	The Group Chief Medical Officer also referred to a letter from Donna Ockenden and Duncan Barton noting that work was underway to prepare for any information that may be requested as part of the Ockenden Review.
535/25	In relation to Birth Rate Plus, the Group Chief Finance Officer advised that the investment case was going through internal governance arrangements which would then feed into discussions with system colleagues as part of the Value Framework review. It was not believed that this would cause any impact on the 2025/26 financial position, however the increase would be modelled into the financial position for 2026/27.
536/25	The Deputy Group Chief Nurse was currently working alongside ICB colleagues looking at pressure ulcers across the county with a view to strengthening system partnership working and working towards a prevention model with Tissue Viability and pressure ulcer management provision across the Group. The Board: • **Received the assurance reports, noting there were no escalations** • **Received the CNST Standard updates and noted the formal escalation of risk relating to CNST Standard Seven** • **Received the 2024/25 Annual Reports as presented**

537/25	**Item 8.2 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 July and August 2025 and the reports were taken as read.
538/25	In relation to operational performance, with the exception of the faster diagnosis standard, ULTH was not delivering against standards however the Committee acknowledged there was sustainable improvement without transformational changes that were part of the overall strategic plan.
539/25	The Committee had received a draft version of the revised Integrated Performance report and good discussion had taken place in relation to how best to receive assurance. This had included national benchmarking data which was helpful in terms of future trajectories and would inform discussions regarding potential escalations.
540/25	The Committee noted there were a small number of patients waiting in relation to the 65 week and 52 week waits and achievement of these was likely to be challenging.
541/25	From a finance perspective, Ms Cechini advised that the Group was reporting on plan however there had been reprofiling of technical efficiencies to support the position and the Committee had been informed of the ability to recover activity in relation to the financial implications of recent industrial action. It was noted that there had been some cost improvement plan (CIP) slippage which required further work.
542/25	Work was underway with the Care Groups to understand why some were not delivering in line with the plan and to identify mitigations.
543/25	A programme of post investment appraisal had also commenced.
544/25	In relation to estates Ms Cecchini explained that ongoing improvement in compliance was being seen and all Authorised Engineers for LCHS had now been appointed and audits were awaiting completion to provide assurance against the community estate. It was also anticipated that by the end of the financial year the Health and Safety Executive would lift the enforcement notices relating to confined spaces. The estates team were reviewing fire safety risks on the risk register with a view to reducing the level of risk, due to work that had progressed over the last few years.
545/25	From an emergency planning perspective, the Committee had received an upward report which provided assurance on arrangements and Business Continuity Plans having been updated.
546/25	An update from the Information Governance Group had informed the Committee that the Data Security Protection Toolkit submission had been made in July and in August an internal audit report on submissions for both LCHS and ULTH had confirmed low risk overall with a high confidence in the veracity of the self-

	competence assessments. The standards had been achieved for LCHS and ULTH had submitted some standards not met, however improvement was expected.
547/25	The Group Chair thanked Ms Cecchini for the comprehensive report and acknowledged the mitigating actions being taken.
548/25	From a finance perspective, the Group Chief Finance Officer offered that for month four there had been a step up in the position and a further step up was expected at month seven. The average deficit in quarter one had been £3.7m and in month four this had improved to £1.2m, however it was acknowledged that there was further work to do on this.
549/25	A further area of focus at the Committee had been in relation to whole time equivalents (WTEs) where good progress had been made over the financial year however the month four WTE had increased by slightly under 50, however there had been a reduction of 141 WTE since the start of the year. The Group Chief Finance Officer advised that month four had been challenging in respect of temporary staffing spend with the key driver being industrial action and utilisation of additional backfill.
550/25	Ms Cecchini offered that a cross referral to the Integration Committee had been made regarding the CIP and transformation changes where there had been concern in respect of oversight, capacity and capability and cultural changes required. The Board: • **Received the assurance report**
551/25	**Item 8.3 Finance Briefing** The Group Chief Finance Officer offered a summary of performance as at month four advising that for 2025/26 the overall position was ahead of plan by £0.1m. The run rate at month four had improved and the same was expected at month seven.
552/25	CIP was ahead of plan by £0.9m which included the bringing forward of non-recurrent actions to support the impact of industrial action, whilst a mitigation plan was developed.
553/25	The Group had subsequently received approval for the EPR scheme and work was progressing.
554/25	£1m of capital funding had also been allocated to the Group recognising the achievement of being amongst the top ten improved in national targets and as a system a further £5m of additional capital resource had been received, relating to being the second most improved system for category two response times.
555/25	The cash position was better than plan by £0.9m which had been supported by additional cash received and a cash working group had been established to ensure all the necessary actions were being taken to maximise the position.

556/25	In terms of revenue, the Group Chief Finance Officer advised of a clear programme of recovery which would be managed via the Planned Care Board, the position was being mitigated, and the delivery of recovery actions would be a key area of focus with weekly reporting to the Executive Leadership Team.
557/25	Workforce controls were moving in the right direction however challenges remained in respect of the workforce plan with temporary staffing being the driver for this.
558/25	The outputs from the Mutually Agreed Resignation Scheme (MARS) would be seen in the coming months.
559/25	The impact on the financial position relating to industrial action had been seen in two ways; there had been an income reduction on planned care due to the volumes of activity that had been stepped down and the increase in temporary workforce to backfill staffing gaps.
560/25	The Group Chair thanked the Group Chief Finance Officer for the comprehensive report and for the assurance provided. The idea of the cash working group was commended, where previous lessons learned would be taken into consideration to maximise opportunities. The Board: • **Received the report and paid due attention to the recommendations made**
	Item 9 Strategic Aim 2 People
561/25	**Item 9.1 Assurance and Risk Report People Committee** Mr Connolly provided the assurances received by the People Committee, at the meetings held during July and August 2025 and the reports were taken as read.
562/25	Several significant reports considered by the People Committee were recommended to the Board in the forthcoming items.
563/25	Mr Connolly advised that the Committee had received the quarterly Freedom to Speak Up Report which highlighted concerns regarding recruitment processes and relationships between staff and managers. An audit was being undertaken, and recruitment training was being observed.
564/25	The Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standard (WDES) Annual Reports for 2024/25 had been considered along with a high-level action plan bringing together all the outputs for both LCHS and ULHT.
565/25	The Ward Establishment Review had also been received by both the People and Quality Committee.

566/25	The Committee had received the Guardian of Safe Working report which highlighted concerns surrounding Resident and Locum Doctors and Executive action was required to explore and resolve this.
567/25	An equality and diversity deep dive had been received and highlighted wider accountability was required to deliver actions; one of which would be taken forward at the next Better Together Forum and the Committee noted that some of the assurance ratings for Objective 2a could move from an amber to green rating, reflecting improved reporting and assurance.
568/25	The Group Chair had been struck by the scale and scope of the Committee from the upward reports.
569/25	The Deputy Group Chief People Officer informed the Board that the ULTH Talent Academy had been recognised in the top 100 Sunday Times apprenticeship employers nationally.
570/25	The Deputy Group Chief People Officer also offered to the Board that a deep dive had been received at the Committee meeting on the Group's health and wellbeing offering where a strong staff story had been received, detailing interventions where there had been an early diagnosis of a health condition.
571/25	With regards to the Guardian of Safe Working report, the Group Chief Executive offered that a letter had been received recently from Sir Jim Mackey and Professor Meghana Pandit, National Medical Director for NHS England regarding getting the basics right for Resident Doctors. The letter included a 10-point plan to improve Resident Doctors' working lives with clear actions to take. The Group Medical Officer was working on this and would liaise with the Group Chief People Officer to provide an update to the Committee. The Deputy Group Chief People Officer informed Board members that a meeting was due to take place with the Guardian of Safe Working, along with the Group Chief Estates and Facilities Officer, with regards to improving rest spaces.
572/25	The Group Chair commented that the detail within the Freedom to Speak Up Guardian report describing issues between staff and managers was disappointing and hoped that work could be undertaken to rectify the issues quickly and efficiently. The Board: • **Received the assurance reports** • **Received the recommendation to upgrade the Board Assurance Framework assurance rating for objective 2a**
573/25	**Item 9.2 Annual Ward Establishment Review** The Deputy Group Chief Nurse presented the report and informed the Board that this was first time the community nursing safer staffing tool had been utilised; the purpose for this was to assist the organisation to map the nursing establishment for community nursing services across all 11 teams. The report was presented for

	information only and no recommendations would be made to the Board until further data sets were run later in the year.
574/25	From a community nursing perspective, the data suggested that the Group was 9 WTE below the standard suggestion, however an element of professional judgement had been applied as the tool did not allow for the identification of skill set or banding and this would be reviewed at the right time. Case management was also a challenging area, and this would be reviewed during October 2025 whilst understanding that any future working model for community nursing may influence the operating model in district nursing. The Deputy Group Chief Nurse offered that there was also work to be done in respect of driving efficiencies across district nursing itself.
575/25	The Group Chair welcomed the review and thanked the Deputy Group Chief Nurse for the report. The Board would support not making any changes based on one data set and the Group Chair commented that it would be helpful to understand the significant variation in benchmarking within the next update to the Board. The Board: • **Received the report and accepted the recommendations**
576/25	**Item 9.3 Responsible Officer Revalidation Report** The Group Chief Medical Officer presented the annual medical revalidation reports for both LCHS and ULHT, noting the variance in the data being presented due to the size of the workforce in each organisation.
577/25	There was recognition of actions having been completed from the previous year's submission and it was noted that the ULTH revalidation policy had been updated and was now fit for purpose.
578/25	The Group Chief Medical Officer assured the Board that across the Group robust systems were in place to comply with NHS England requirements as two designated bodies.
579/25	The Group Chair expressed a view that the ULTH report was one of the best seen in terms of content, the level of insight and assurance provided. The Group Chair took the opportunity to thank colleagues for evidencing the revalidation detail in such a clear manner. The Board: • **Approved the reports for submission to NHS England**
580/25	**Item 9.4 Workforce Race Equality Standard (WRES) Report and Action Plan** The Board received the WRES annual reports for LCHS and ULTH, which demonstrated achievements from the previous year and demonstrated that each Trust had fulfilled its statutory requirements in relation to promoting the workforce race equality agenda and supporting colleagues. The reports focussed on

	engagement with ethnically diverse staff across both Trusts, including celebrating areas of success and outlining future actions for improvement.
581/25	The Group Chair had found the data trend table useful and one of the best data sets, this provided a different perspective on some of the challenges across the Group. The Board: • **Received and approved the 2024/25 WRES Annual Reports**
582/25	**Item 9.5 Workforce Disability Equality Standard (WDES) Report and Action Plan** The Deputy Group Chief People Officer presented the WDES reports and action plan to the Board explaining that this demonstrated achievements from 2024/25 and showed that both ULTH and LCHS had fulfilled its statutory requirements.
583/25	The reports focussed on data relating to disability inequality, exploring areas of good practice and disparities that existed for staff with disability or long-term conditions compared to colleagues without a disability or a long-term condition. The action plans presented outlined future actions for improvement in this area.
584/25	The Group Chair requested all Board members ensure that their Electronic Staff Record (ESR) was up to date with their own personal status. **Action: Board members, 4th November 2025** The Board: • **Received and approved the 2024/25 Annual Reports**
	Item 10 Strategic Aim 3 Population
585/25	**Item 10.1 Assurance and Risk Report from the Integration Committee** Mrs Buik provided the assurances received by the Committee at the meetings held in July and August 2025 noting there were no upward escalations to the Board.
586/25	Mrs Buik offered an update to the Board on the escalation from the Finance and Performance Committee, where good discussion had taken place, and three new risks would be considered for inclusion on the risk register.
587/25	Several reports had been received by the Committee relating to Estates and Facilities and space and capital which provided assurance around the capital programme including endoscopy, Pilgrim ED, maternity services, Skegness and Spalding Urgent Treatment Centres and Scotter Ward at John Coupland Hospital, Gainsborough.
588/25	The Space Group was now meeting regularly, and the Committee was receiving several reports. One area of interest related to the strategic projects, notably the EPR and Booking Centre where there were specific requirements. The team was

	continuing to assess potential options, recognising there was no capital funding available at this time.
589/25	The 2025 - 2028 Green Plans had been received and were recommended to the Board for approval.
590/25	The Committee had reflected on the scale of the capital programme, which despite being positive presented some risks and the Executives were asked to review whether appropriate mitigations were in place to ensure there was satisfactory capacity to deliver the programme.
591/25	Several reports were received from the Digital Oversight Group and key strategic project groups. The Committee was alerted to some resource concerns across the EPR project and to mitigate these there had been some good progress made in recruitment and the use of partners to support the work. Significant assurance was also received in relation to benchmarking on the Group's ability to implement digital systems which was positive.
592/25	The Committee had been informed of an ongoing programme to support digital literacy and improve connectivity across the Group, recognising that there was a need to make sure any barriers for staff were removed to allow them to engage with digital programmes.
593/25	In relation to research and innovation, a new five-year strategy had been created for this area focussing on increasing trial recruitment and widening the scope of trials to include non-medical workforce groups and innovation activity. The Committee Chair, Mrs Brown would be taking on the role of a champion in this area to further support the development of the agenda.
594/25	With regards to fragile services, Mrs Buik explained that several services had been identified in conjunction with the Quality Committee and pipeline reports were being received, focussing on the service delivery improvements. The Committee had so far received reports regarding tuberculosis, lymphoedema and children's speech and language therapy and all were at various stages of development, however, would have a focus on changes that would reduce waiting lists, right size the offer for the future and ensure the ongoing move of activity to the community where appropriate.
595/25	Work was continuing on the ICB Operating Model and updates were received by the Committee. As the development of the ICB direction evolved however, it may be pertinent to amend timings and priorities.
596/25	The Committee acknowledged the scale of the transformation programme and where a new risk was being reviewed and would consider any potential issues relating to capacity and change management, ensuring there were appropriate mitigations in place.
597/25	The Committee received updates on three projects being worked on including the booking processes and patient communication supported by PwC, theatre productivity supported by Earnst and Young and intermediate care supported by

	Newton. All projects would continue to report into the Committees as recommendations became available.
598/25	The Alliance Steering Group was also now meeting regularly with upward reports being provided to the Committee. There was good clinical engagement from the Care Groups and collaboration with the Primary Care Network (PCN) Alliance.
599/25	The integrated neighbourhood teamwork was progressing, and draft terms of reference had been received by the Committee for the new board.
600/25	A further new risk considered at the meeting was in relation to the potential for ongoing uncertainty around the system and how this may impact on programmes of work which would be considered by Executive colleagues.
601/25	The Group Chair acknowledged the step change for this Committee in the work that was now being addressed and any potential mitigations that would be required.
602/25	The Group Chief Integration Officer offered that the new Scotter Ward at John Coupland would be ready to receive patients from 22nd September 2025. A report was also being submitted to the next Group Leadership Team meeting on fragile services and a new service coming forward was neurology, which required some urgent attention.
603/25	In relation to the movement of services from the ICB, the Group Chief Integration Officer advised that shared care records was an important area which the Group would be hosting, and the interfaces were critical in terms of residents living on the borders of Lincolnshire.
604/25	The Group Chief Integration Officer also explained that the neighbourhood health model was progressing, and a Neighbourhood Health Board had been established which would have the same equitability as the Urgent and Emergency Care Board and the Planned Care Board for the Lincolnshire footprint. The Board: • **Received the assurance reports**
605/25	**Item 10.2 NHS 10 Year Health Plan Gap Analysis** The Department of Health and Social Care published the 10-Year Health Plan for England in July 2025, and the Group Chief Integration Officer advised that the document focussed on three fundamental shifts: from hospital to community, from analogue to digital and from sickness to prevention.
606/25	The Group Chief Integration Officer explained that the Lincolnshire system was engaging with the plan's priorities, focusing on digital transformation, empowering workforce, financial sustainability and operational delivery.
607/25	The Group Chief Integration Officer presented a comprehensive report on how those areas aligned with the LCHG Strategic Plan 2025-2030, and areas where

	the Group could potentially make the biggest shift and impacts in line with national priorities.
608/25	The Group Chief Integration Officer offered that the Integration Committee was committed to building some planning horizons and this would also dovetail into the five-year Planning Framework recently released.
609/25	The Group Chair expressed a view that this was a good piece of work and a helpful report. The important principle of the Strategy was taking the right approach, and the Board had been clear of its intentions and there was nothing outlined within the 10 Year Health Plan that would encourage the Board to change its direction of travel; reflecting that there were some must do actions outlined within the document.
610/25	The Group Chair reflected that a Board Development Session would be required for the Board to give some thought to planning moving forward and the Group Director of Corporate Affairs was requested to add this item to the forward plan. **Action: Group Director of Corporate Affairs, 4th November 2025** The Board: • **Received the assurance reports**
611/25	**Item 10.3 2025 – 2028 Green Plans – LCHS/ULTH** The Green Plans for 2025 – 2028 for both LCHS and ULTH were presented to the Board. The Plans outlined the Group's approach to sustainability and carbon reduction, with the aim of delivering a Net Zero NHS.
612/25	The Deputy Director of Estates and Facilities described areas of focus in the plans which related to clinical transformation, digital transformation, medicines, travel and transport, estates and facilities, supply chain, procurement and food and nutrition.
613/25	The Group's Director of Estates and Facilities would be the responsible officer for delivery of the Green Plans, and it was noted that progress reports would be submitted to the Integration Committee moving forward. The Board: • **Approved the 2025 – 2028 Green Plans for LCHS and ULTH**
614/25	**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.
615/25	The Group Chief Integration Officer advised that the new style dashboards would be submitted to Committees shortly and that there would be two triangulation points; ensuring that the National Oversight Framework (NOF) metrics were

	included and to work on the gaps in reporting in respect of neighbourhood teams and urgent and emergency care and lost care hours. The Board: • **Received the Integrated Performance Reports noting the moderate assurance**
	Item 12 Risk and Assurance
616/25 617/25 618/25	**Item 12.1 Group Risk Management Report** The Group Chief Clinical Governance Officer presented the risk report to the Board noting that this outlined the current high and very high risks across the Group. The LCHS risk scores had remained static with no changes to the risk scores. From a ULTH perspective there had been a reduction of one risk from the Quality Committee relating to manual prescribing and epilepsy pathways and no changes from the People Committee risk scores. From a Finance and Performance Committee perspective there had been an increase in score for one risk, the 2024/25 CIP risk had been closed and a new risk opened for 2025/26 and there was a new risk in relation to the lack of pharmacy capacity. For the Integration Committee one new risk had been opened relating to the neurology service, which was seen as a fragile service. The Board: • **Accepted the risks as presented noting the significant assurance**
619/25 620/25	**Item 12.2 Board Assurance Framework** The Group Director of Corporate Affairs presented the 2025/26 Board Assurance Framework in its new format as considered by all the Committees during July and was also considered and reviewed for fitness for purpose by the Audit Committee. The People Committee was recommending to the Board that Objective 2a, enable our people to fulfil their potential through training, development and education, increase the assurance rating to green from amber. The Board: • **Accepted the 2025/26 Board Assurance Framework** • **Approved the recommendation to increase the assurance rating of Objective 2a**
621/25 622/25	**Item 12.3 Assurance Report from the Audit Committee** Mr Herbert provided the key highlights from the Audit Committee meeting held in July 2025. Five internal audits reports had been issued across the Group since the previous meeting, all of which had provided reasonable assurance. However, the

	Committee noted ongoing process issues on both sides causing delays in finalising and issuing audit reports.
623/25	The Committee also noted issues relating to the timely clearance of audit recommendations which was impacting on the metrics and whilst the position on overdue actions was much improved the Committee was keen to ensure that this did not slip and felt this required greater ownership by accountable Executives for both the audits and management actions. The Group Director of Corporate Affairs would meet with the Internal Audit provider to discuss and agree improvement actions.
624/25	In respect of the Compliance Report the Committee noted increased costs relating to the underoccupancy of progress housing and a spike in the level of expired medicines. The Committee had been advised of the action being taken in respect of both issues.
625/25	The Board Assurance Framework had been considered following the request from the Board and noted continued development. Actions and timescales areas were better populated, and the Committee Chairs had confirmed that this was being utilised in all Committees and that it was fit for purpose.
626/25	The continued significant lack of progress made against outstanding policies and guidelines was noted by the Committee and it was noted that there was insufficient visibility of the level of risk the Board was exposed to. It had been agreed to again escalate this to the Board and the Group Chief Executive, who had implemented some actions to address this moving forward.
627/25	The Committee had approved several policies; the Group Board Assurance Framework policy, the Fit and Proper Persons Policy and the Standards of Business Conduct Policy. The Committee had also agreed to review and provide comments on the revised corporate governance manual, Standing Orders and Standing Financial Instructions, which was recommended to the Board for approval.
628/25	The Group Director of Corporate Affairs advised that a meeting had been held with Internal Audit lead and some supportive actions had been agreed across the two areas in respect of quicker escalations when responses were not received and the internal auditor would work on the databases to ensure these were up to date, to visually show the position on a monthly basis. The Group Director of Corporate Affairs advised that meetings with the Internal Audit lead would continue fortnightly to ensure that actions remained on track.
629/25	The Group Chief Executive offered to meet with Mr Herbert outside of the meeting to discuss the high-level actions that would be undertaken in relation to policies and guidelines. **Action: Group Chief Executive, 4th November 2025** The Board: • **Received the Assurance Report**

630/25	**Item 12.4 Group Corporate Governance Manual (Standing Orders and Standing Financial Instructions)** The updated Corporate Governance Manual was presented with the Group Director of Corporate Affairs offering that the documents had been updated to align the governance arrangements across the two organisations in line with latest best practice and to reflect the Group Operating Model. The Board: • **Approved the publication of the updated Corporate Governance Manuals for ULTH and LCHS**
631/25	**Item 12.5 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**
632/25	**Item 13 Any Other Notified Items of Urgent Business** No further items were discussed.
633/25	The next scheduled meeting will be held on Tuesday 4th November 2025 via MS Teams live stream.

Voting Members	**6 May 2025**	**1 July 2025**	**2 Sept 2025**									
ULHT/LCHS												
Elaine Baylis	X	X	X									
Rebecca Brown	X	X	A									
Neil Herbert	X	X	X									
Dani Cecchini	X	X	X									
Jim Connolly	A	X	X									
Karen Dunderdale	X	X	X									
Daren Fradgley	X	X	X									
Nerea Odongo	X	X	A									

Colin Farquharson	X	X	X									
Paul Antunes Goncalves	X	X	X									
LCHS												
Gail Shadlock	X											

PUBLIC BOARD IN COMMON ACTION LOG

Agenda item: 5.1

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
1 July 2025	386/25	Assurance Report from Quality Committee	Stocktake to be undertaken to understand the gap analysis in respect of maternity services	Group Chief Medical Officer	06.01.26	
2 September 2025	610/25	NHS 10 year Health Plan Gap Analysis	Board Development Session to be scheduled on planning. To be added to the Forward Plan.	Group Director of Corporate Affairs	04.11.25	Complete
2 September 2025	629/25	Assurance Report from Audit Committee	Group Chief Executive to meet with Audit Committee Chair in respect of high level actions being taken in relation to policies and guidelines	Group Chief Executive	04.11.25	Complete

NHS
Lincolnshire Community and Hospitals NHS Group

Group Chief Executive's Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4th November 2025*
Agenda item number	*6*
Report title	*Group Chief Executives Board Report*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Information*
Accountable Director	*Karen Dunderdale, Group Chief Executive*
Author(s)	*Karen Dunderdale, Group Chief Executive* *Gemma Coupland, Executive Business Manager*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	
Prior approval process, if applicable	*N/A*
Financial implications, if applicable	*N/A*
Action / decision required	*The Board is asked to note the update on the key points from September and October 2025.*

Assurance Rating Key:

Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are uncertain or possibly insufficient*
Red: Limited or No Assurance	*Effective controls are not in place or are insufficient to manage the risk identified and / or appropriate assurances are not available. Immediate action is required to address the gaps, weaknesses or non-compliances identified*

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	*X*
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:	*X*
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:	*X*
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	

System Overview

a) All parts of Lincolnshire health and care system remain busy, and we continue to cope with the ongoing operational pressures.

b) ULTH and LCHS have developed a joint Winter Ready 2025-26 plan which outlines a proactive approach to managing pressures across our acute and community services. The plan focuses on reducing avoidable admissions, enhancing urgent and emergency care pathways and supporting timely discharge through expanded virtual wards and the community base care. The plan is underpinned by data, including scenario modelling which has been stress-tested to ensure resilience across the Lincolnshire System.

   The plan builds on lessons from winter 2024/25 and aligns with NHS England's national and regional expectations to ensure safe, resilient and responsive care for Lincolnshire residents throughout the winter period.

c) The Model Region Blueprint was published on 11 September 2025. This sets out a high-level vision for the future role of NHS regions, as part of the 10 Year Health Plan for England. The blueprint outlines how the seven NHS regions will act as strategic leaders overseeing performance and driving improvements. The blueprint also details the transition arrangements and governance structures supporting implementation, aiming to reduce regulatory burden and foster a more locally empowered NHS operating Model. We are working with the Midlands regional team to understand the impact on us as providers.

d) On 30 September 2025 Lincolnshire ICB as we have known it changed. From 1 October 2025 the three existing NHS ICBs for Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire formed a cluster as part of wide-ranging Government reform of the NHS and healthcare landscape. It has been confirmed that Dr Kathy McLean has been appointed as the Chair designate and Amanda Sullivan as Chief Executive Designate for the clustered ICBs.

e) The first Cluster Quarterly System Review Meeting (QSRM) took place on 1st October, which was chaired by NHSE Midlands Regional Director. The meeting focussed on progress against plans at mid-year, along with the key priorities. This was overall a positive meeting for Lincolnshire.

Group overview

a) The NHS National Oversight Framework was published in September and introduces a new approach to measuring the performance of all NHS trusts**.** The framework assesses providers against 22 metrics across six domains, resulting in a segment rating for each organisation. Under the new framework, ULTH has been placed in Segment 4, while LCHS has been placed in Segment 3.

b) Sir Jim Mackey, NHS England Chief Executive, has written to all NHS trusts to outline the expectations for the second half of 2025/26, following strong progress in financial recovery and service delivery. A number of key priorities were outlined within the letter which the Group is actively addressing.

c) In recognition of the continued development of the Group, amendments have been made to some of the executive portfolios to ensure alignment with strategic priorities and operational effectiveness. As part of these changes, the Communications and Engagement team will now report directly to the Chief Executive, reinforcing the importance of clear, consistent messaging and stakeholder engagement across the Group. Additionally, the medical staffing and rota coordination teams have been realigned to report directly to the Group Chief Medical Officer, ensuring that the responsibility for a more integrated and clinically led approach to medical workforce planning and service delivery.

d) Following the Care Quality Commission (CQC) inspections at Lincoln County Hospital Emergency Department in October 2024, a follow-up visit in July 2025, and an inspection at Pilgrim Hospital, Boston Emergency Department in November 2024, the reports were published on 4 September 2025**.** These CQC reports acknowledge the significant progress made and commended the departments for their dedication to patient care. They also highlighted significant improvements in key areas such as waiting times, leadership, staff training, and infection prevention. While the reports recognised many positive developments, they also noted some areas for improvement.

e) The new Electronic Patient Record (EPR) programme was officially launched at ULTH in September. To support the rollout of the new EPR in the coming years, engagement events were held across all sites, led by key members of the EPR Programme team and representatives from our EPR supplier, Nervecentre. These events successfully engaged over 1,500 colleagues. The next phase of the programme is now underway, focusing on training and knowledge transfer sessions to support both clinical and administrative staff in adopting and embedding the new system.

f) As part of the East Midlands Neuro-Oncology Service, which supports patients across the region with brain tumours, ULTH has been awarded the prestigious Tessa Jowell Centre of Excellence status. This recognition highlights the exceptional standards of treatment, care, and research delivered by our oncology team. The award is granted to a select number of brain tumour centres across the UK, acknowledging their commitment to excellence and continuous improvement in patient outcomes.

g) Following Trust Board approval in September, the business case for the Boston Community Diagnostic Centre (CDC) has now been submitted to NHS England's national panel, and the planning application has been formally submitted. The proposed £24.9 million facility will expand diagnostic capacity across multiple modalities, including X-ray, CT, MRI, and ultrasound. Like our centres in Grantham, Lincoln, and Skegness, this new site also presents opportunities to offer clinical space to other community-based services.

h) ULTH has officially launched the Neonatal Home Phototherapy Service which is a significant step in our commitment in providing high quality, patient-centred care for newborns and their families. This innovative service enables clinically stable newborns with mild to moderate jaundice to receive phototherapy treatment in their homes, reducing the need for prolonged hospital stays. By offering safe, convenient, and less disruptive care, the service enhances the overall family experience while maintaining clinical effectiveness.

i) From 1 October patient visiting hours at acute and community hospitals across LCHG were extended to 11am – 8pm following feedback from staff and patients. These changes reflect the Group's commitments to patient centred care by supporting more consistent and accessible visiting opportunities, which play a key role in the healing and wellbeing of our patients. Arrangements remain unchanged in day case wards, maternity and children's services.

j) LCHG digital teams have worked collaboratively with partners across the Lincolnshire system to support the transition of digital support services for Lincolnshire ICB, primary care and LCHS from Arden and GEM Commissioning Support Unit (AGEM CSU) to an internally hosted model. From the beginning of November, LCHG will welcome 29 experienced colleagues from Lincolnshire ICB, LCHS and primary care services into the digital team. This transition has been underpinned by extensive engagement with system wide colleagues, reflecting a strong commitment to collaborative working. The consolidation marks a significant milestone in our ongoing efforts to enhance the digital experience for colleagues.

k) Following integration of Lincolnshire Urgent Community Response (UCR) and Home Visiting (HV) services, significant improvements have been made in activity levels, responsiveness and operational cohesion. The combined pathway now consistently meets the national 2 hour response standard in over 90% of cases, handling approximately 2,000 visits per month.

l) A new contract, hosted by Lincolnshire County Council, has been established for 35 transitional care beds commissioned across care homes in Lincolnshire. These beds are supported by community therapy teams and primary care. As part of the redesign, 15 beds were decommissioned, with funding re-directed to enhance home-based discharge support (pathway 1 Discharge to Assess). A workforce plan is being delivered and is on track to significantly expand rehabilitation services delivered in patient homes.

m) ULTH has successfully completed its one-year review for the Veteran Aware Accreditation, reaffirming its commitment to delivering personalised, informed, and compassionate care to veterans, serving personnel, reservists, and their families. The Trust continues to meet all eight core standards required for accreditation, demonstrating its sustained dedication to the Armed Forces Covenant.

n) Lincolnshire Community and Hospitals NHS Group annual Staff Awards took place on Friday 10 October, celebrating colleagues from across the Group for their outstanding contributions in patient care, innovation, leadership, and teamwork**.** These awards form a key part of our reward and recognition programme, designed to honour and thank staff for their dedication and impact. This year, the awards received an impressive 1,297 nominations across 13 categories, with 52 individuals and teams shortlisted which is testament to how highly valued our staff are by both colleagues and patient

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Development: Next Phase Delivery Plan Progress Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4th November 2025*
Agenda item number	*6.1*
Report title	*Group Development: Next Phase Delivery Plan Progress Report*
Report Purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Approval*
Accountable Director	*Professor Karen Dunderdale, Group Chief Executive*
Author(s)	*Jayne Warner, Group Director of Corporate Affairs*
Financial implications, if applicable	*None*
Action / decision required	*The Board is asked to:* • *Review progress with the delivery of the group development programme plan and note the issues for escalation*

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

Executive Summary

Background & Introduction

This report is intended to provide a high-level briefing on progress against delivery of the agreed group development programme milestones.

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. In all instances, revised timescales have been included within the plan.

Other issues for escalation:

- work to align the IPR and finalise the group KPIs remains outstanding – a revised timescale has been proposed;
- the number of out of date policies remains a risk for the group. The need for an improvement plan and trajectory to improve compliance in this area has been agreed.
- Review of Communications and Engagement Strategy paused to allow for portfolio review. Revised date proposed January 2025
- Delay of Estates Strategy and estates utilisation linked to finalisation of clinical strategy
- Delay of refresh of partnership strategy for Group linked to delivery capacity

The Board is asked to:

review progress on delivery of the group development programme plan and note the issues for escalation

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 and updating & reissuing of the '*Governance Framework – A Reference Guide for Staff*'	1 April 2025 & Ongoing	Comms cascade undertaken through GLT roadshows. Visual representation of Operating Model uploaded to the Group Intranet. *Governance Framework – A Reference Guide for Staff* updated – date of issue TBC	

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]	**Performance Management & Accountability Framework:** 31 January 2025 **(draft outline)** 28 February 2025 **(socialise)** 3 March 2025 **(approval)** 1 April 2025 **(implementation)** 30 June 2025 **(embedded)** **Final Metrics / Alignment of IPR:** 31 August 2025	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.	
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)**	**Complete** Revised suite of upward report and report templates and report writing guidance developed and published.	

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. Feedback to Board planned in Nov 25	

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	
Agree the group risk appetite and ensure this is appropriately referenced within the BAF for each strategic objective	18 March 2025 **(Group Board workshop)**	**Complete:** Group risk appetite agreed by the Group Board and incorporated within the BAF	
Review and standardise the risk register and approach to risk management and risk reporting across the group including the management of Datix	31 December 2024	**Complete:** A new joint Risk Policy was launched on 1 December 2024. Whilst two separate risk registers remain in place there is considered to be a consistent approach to risk management across the group, however, scope being drafted for NHS Provider to review & test the approach. Routine testing of the effectiveness of these arrangements will continue to be undertaken as part of the annual internal audit review of risk management which informs the Annual Governance Statement and as part of the planned Well Led Assessment Risk Register – Confirm & Challenge Group terms of reference and membership refreshed to ensure executive input	
Alignment of Group Meeting Cycle			
Once the work to design and align the board, committee, sub-group and other key trust meetings is complete, develop and update annually a single group meeting schedule (ensuring alignment with the Accountability & Performance Management Framework and performance review meetings)	31 January 2025	**Complete:** Meeting cycle in place. PRMs to be added	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Document Control & Policy Approvals			
Agree and implement a harmonised and strengthened approach to document control and policy approvals for the group	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. The move to a single Intranet will enable policies to be 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	
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 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 (including the Division of Responsibilities Schedule), Standing Financial Instructions and Scheme of Delegation approved by the board on 2 September 2025	
Review and update relevant policies, documentation and templates to reflect the move to group and the group brand	As above	As above	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Group Working Agreements			
Review and update the Group Partnership Agreement to reflect the agreed changes to the operating model including the leadership and governance & decision-making arrangements, once finalised and agreed	2 September 2025	This action cannot be completed until other work stream actions are complete	
Review and update the Group Workforce Sharing Agreement to reflect the agreed arrangements for broader staff / staff groups from each trust, as required, to work across the group: such arrangements to maintain the existing employment relationship whilst avoiding the need for honorary contracts or secondment agreements	2 September 2025	As above	
Review and update the Group Information & Data Sharing Agreement to reflect changes to the operation of the group and any changes to the requirements for sharing information & data	2 September 2025	As above	

Work Stream 4: Communications & Engagement

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Group Strategy & Group Visual ID / Brand			
Develop and promote the Group Communications & Engagement Strategy	2 September 2025	Strategy drafted. GLT and Group Board approval originally scheduled for July 2025 but delayed. Review of approach with CEO	
Develop the Group visual ID / brand ensuring adherence to the NHS Identity Guidelines specifically in respect of partnership branding	21 April 2025	**Complete:** Group visual ID / brand approved and rolled-out on 21 April 2025	
Develop guidelines and supporting suite of templates for the use of the Group visual ID / brand (how and when it should be used including in respect of signage, document design, correspondence etc.)	As above	**Complete:** Guidelines and templates developed and implemented	
Roll-out / socialise the Group visual ID / brand & supporting guidelines	As above	As above	
Internal & External Communication & Engagement Channels			
Merge the external facing social media platforms (e.g. Linked-In, Instagram, Facebook) currently in use within the two trusts to create combined Group social media platforms. **NB.** X (formerly known as Twitter) to remain separate as not possible to merge	31 March 2025	Confirmation received from relevant social media platforms that due to Meta rules this proposal is not feasible. Action to be closed and removed from the plan	N/A
Merge the staff closed Facebook group	28 February 2025 **(consideration by GLT)** 8 April 2025 **(enacted)**	**Complete:** Proposal considered by GLT in February 2025 and agreed that the Facebook group would not be merged but that each organisation's page could be viewed by staff from the other. This has now been enacted	
Merge the internal communication & engagement channels (e.g. weekly e-newsletter, team brief / communications cascade) to include the use of the Group visual ID / brand once agreed. **NB.** Group Chief Executive's weekly email already in use across the group	31 January 2025 **(original timescale)** 1 April 2025 **(revised timescale)**	**Complete:** Communication channels have been merged – 'Group Bulletin' was the final one and become one newsletter on 23 April 2025	
Develop and implement a communication & engagement toolkit aimed at ensuring wider awareness of service changes & developments across the group	31 March 2025	**Complete:** Toolkit developed in conjunction with the Patient Experience Team. Communication & Engagement Team working with the Improvement & Integration Team to embed the toolkit in to use as part of the service change process	
Continue the ongoing comms on all aspects of group development and benefits realisation as changes occur including the development of FAQs for staff on changes to 'how things work across the group'. **NB.** Case studies and group wide log of engagement activities being maintained including learning from staff listening events	Ongoing	Ongoing	

Work Stream 4: Communications & Engagement cont'd

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Group Intranet & Internet			
Create and roll-out a group Intranet (including the migration of ULTH to nhs.net). **[Note:** All staff across the group to have access to the group Intranet from 1 April 2024. Full migration to nhs.net to take up to a year]	30 June 2025	**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 has been discussed several times with staff side at Policy Committee. This is scheduled for further discussion on 29th October and it is anticipated will then be ratified. 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 newly developed "LCHG Way" and LCHG leadership development programme was launched at Better Together Forum on 1st October 2025, with wider opportunity for 'bookings' becoming available in quarter 3.	
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 - ambition and scope has changed since the decision to move in full the AGEM service (exc. LPFT) to LCHG. This will support a more ambitious approach supporting integration between Acute, Community and Primary Care.	31 March 2025 **(Implementation Plan)** 31 July 2025 **(Hand Over of Domain)** 1 Nov 2025 **(AGEM transition)** 31 Jan 2026 **(plan)** **Following stabilisation of AGEM service to LCHG**	**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 new plan agreed due to focus on full novation of AGEM Digital services for LCHS, ICB and primary care (GP IT) but 1st Nov. • Due to significant expansion of scope, the work to integrate the digital services will continue over a 12-18 month period, post AGEM transition. A programme plan will be developed. • The move from AGEM on 1st November will	

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 - **Scope expanded to align novation of service for ICB and Primary Care (GP IT)**	24 January 2025 **(Finalised Plan)** 1 November 2025 **(Full Service Migration – some things may take longer)** 1 November + 12/18 months – **(integration and optimisation of service)**	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 • 30 wte colleagues from AGEM due to TUPE to ULTH from 1st November. • Group consultation process due to complete 17th October. • LCHS AGEM Digital service due to partially transfer to in LCHG in house provision on 20th November. • Full AGEM transfer on track to complete 1st November.	
• 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 Linked to AGEM transition – team brand to be LCHG Digital Services, with associated new uniforms and logos being created.	Rating change to green
• 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	**Rating change to green**

Work Stream 8: Estates & Facilities

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Estates Strategy, Service Developments & Transformation			
Develop the Estates Strategy in support of delivery of the agreed group strategic aims & objectives, planned service developments & transformation projects and in support of reducing health inequalities:	31 March 2025 **(commencement of work to develop the strategy)** 2 September 2025 **(board approval)**	Underway although completion dependent on finalisation of the clinical service strategy and also likely to be impacted by the decision on the future model for the provision of EFM services – *see next action. Approval not expected until 31 March 2026*	
• consider & evaluate the different models for the provision of EFM services across the group to include the option of a wholly owned subsidiary model and present the findings and recommendations for approval to the Group Leadership Team and Trust Board	30 September 2025	Assessment of options undertaken and currently being evaluated. Further guidance awaited from NHSE on legal requirements in respect of wholly owned subsidiary option. Date for approval of agreed option to be confirmed	
• undertake an estates rationalisation review with a focus on decompressing the acute site and agile working and present the findings and recommendations to the Group Leadership Team and Trust Board. This work to be undertaken in line with "left shift" proposals	30 June 2025	Underway: external support to undertake the review being sourced at an estimated cost of £22.5k. Procurement process commenced. Work to be progressed in the 2025/26 financial year 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 New procurement exercise to commence Q4 for the whole estate, funding required as expected cost of circa £250,000 One Space Manager in place, however further internal resources are required, issues remain with under utilisation and behaviour. New process for booking open space implemented. Future GLT sessions planned on space and space management	
• continue the programme of ward refurbishments, as funding is available	Ongoing	No funding currently available – programme to be reviewed in new financial year	
• undertake a review of all leases and licences across the group	30 June 2025	**Complete & ongoing:** All LCHS leases now obtained. New MOTO being negotiated with NHSPS which will	

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 Facilities (Housekeeping) Cultural Review completed Scope for wider review being finalised.	
• 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. Complete: Safety Groups in place, Group Health & Safety Committee in place	
• 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 Completed	
• 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	

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 Complete: CIR risks added to the risk register.	
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) Update: Audit has started.	
• 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 Update: asset validation exercise to be implemented, also will be picked up as part of the PPM review.	
• carry out a review of PPM across the group to improve compliance and productivity	31 March 2026	External audit support required. Update: Audit has started.	

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	

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 September 2025 30 December 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 Team capacity continues to be impacted by the ongoing staff consultation process, which has required significant time and attention from key personnel. In parallel, there has been an increasing need to reprioritise workload to support the commencement of the annual planning round, identification of CIP opportunities and the co-creation of Integrated Neighbourhood Teams (INTs).This shift in focus reflects our strategic commitment to place-based care and collaborative service design. While this has temporarily constrained delivery capacity in some areas, it is enabling the organisation to lay the foundations for more integrated partnership strategy. This is being updated to reflect our key developments such as setting up of Integrated Neighbourhood Partnership Board.	

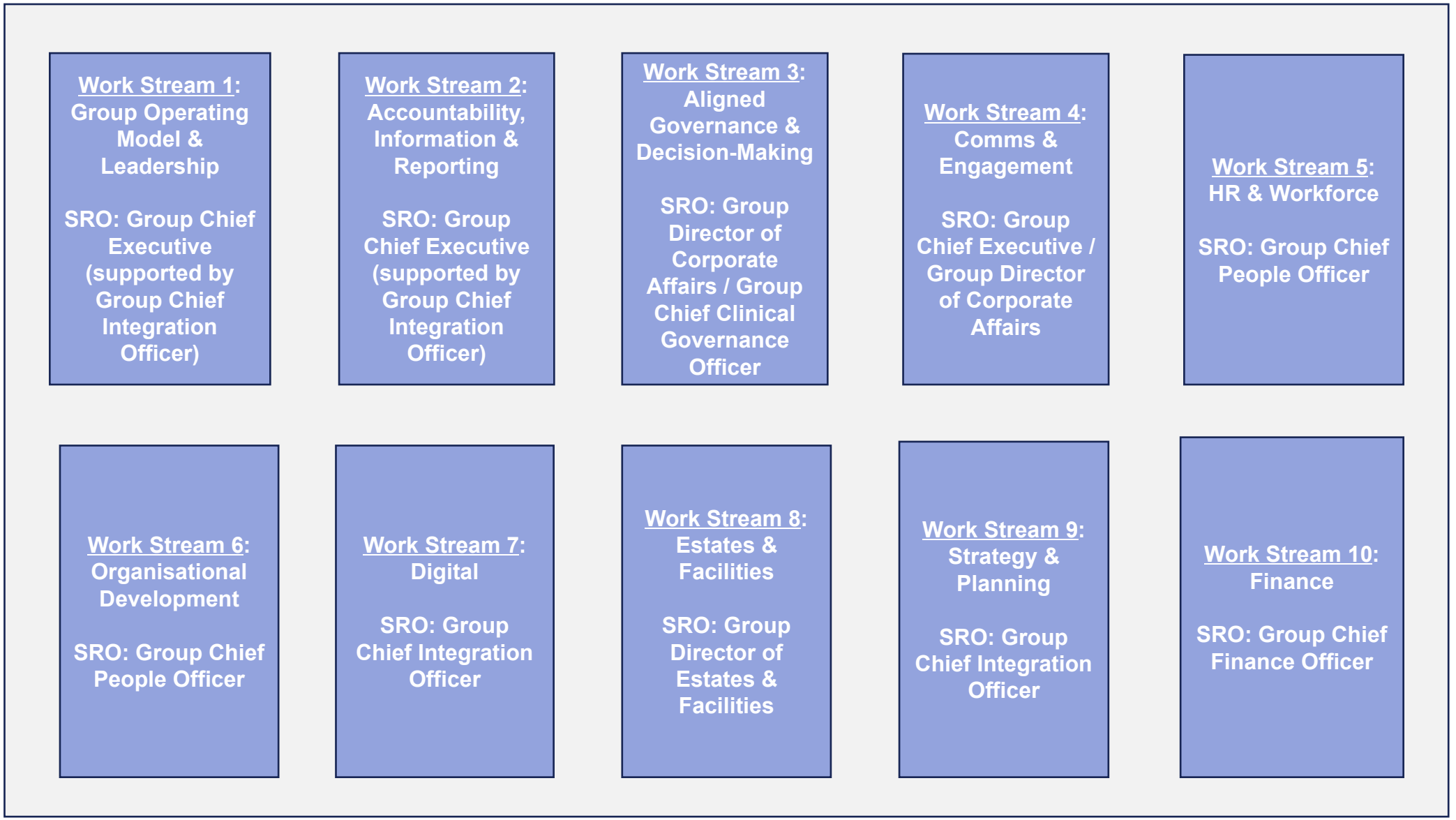
Work Stream 10: Finance

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 This work is behind schedule, going through governance in November (GLT, FPC).	
Harmonise the financial planning & budget setting processes across the group	31 January 2025	Completed 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	Completed 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)**	Completed 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	Completed 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	

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 Board	25 July 2025 **(Audit Committee)** 2 September 2025 **(Group Board approval)**	Updated Standing Financial Instructions and Scheme of Delegation & Powers Reserved for the Board approved by the group board on 2 September 2025	
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	**Completed**. 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	

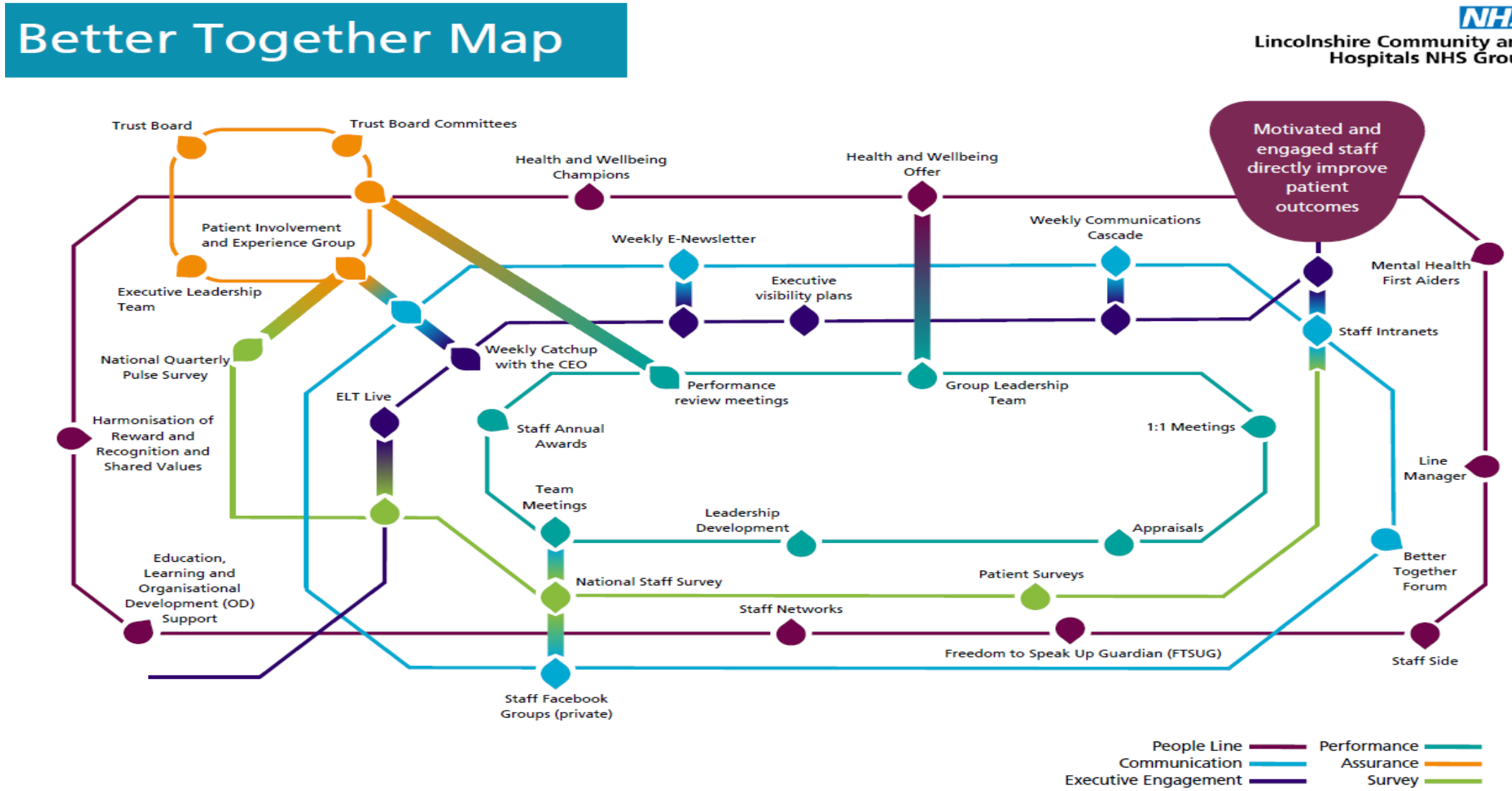
Appendix A: Group Development Programme: Work Streams & SROs



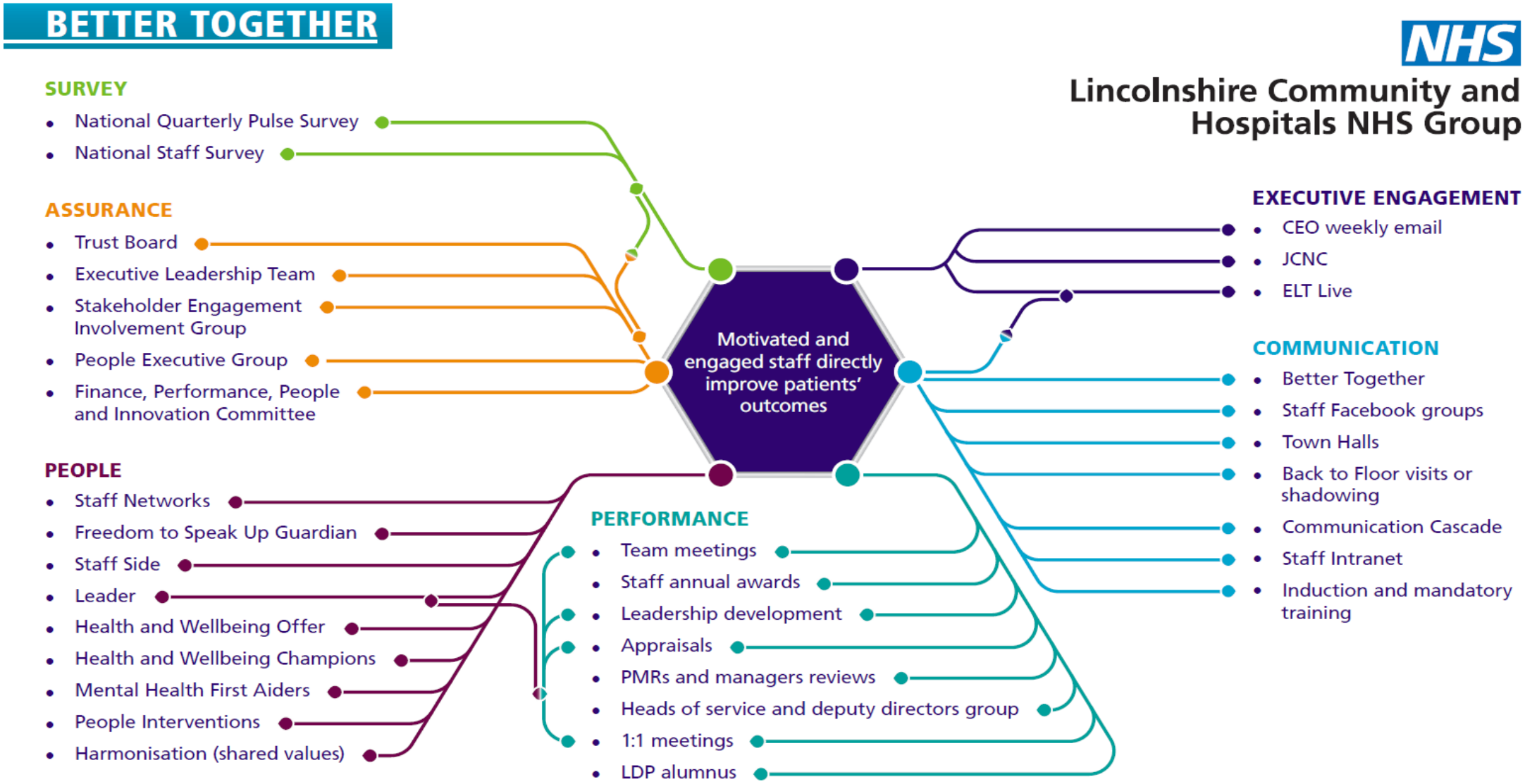
Appendix B: Group Development Programme Delivery RAG Rating

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

Appendix C: Staff Engagement 'Tube Map'



Appendix C: Staff Engagement 'Tube Map'



NHS
Lincolnshire Community and Hospitals NHS Group

Winter Plan 2025 - 2026 (Winter Ready)

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4th November 2025*
Agenda item number	*6.2*
Report title	*Winter Plan 2025 - 2026*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Information*
Accountable Director	*Caroline Landon, Group Chief Operating Officer*
Author(s)	*Lee Taylor, Deputy Group Chief Operating Officer/Winter Director* *Rebecca Maxwell, Strategy Manager*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Reasonable Assurance*
Prior approval process, if applicable	
Financial implications, if applicable	
Action / decision required	*The Board is asked to note the Winter Plan 2025-2026*

Assurance Rating Key:

Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are uncertain or possibly insufficient*
Red: Limited or No Assurance	*Effective controls are not in place or are insufficient to manage the risk identified and / or appropriate assurances are not available. Immediate action is required to address the gaps, weaknesses or non-compliances identified*

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	

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	
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	
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	*x*

NHS
Lincolnshire Community and Hospitals NHS Group

Winter ready

2025-2026

Minimising admissions
Maximising community care

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

Forward

We are pleased to present the first winter plan for Lincolnshire Community and Hospitals NHS Group; which is the first joint plan between United Lincolnshire Teaching Hospitals and Lincolnshire Community Health Service NHS Trusts. This marks a significant step forward in our shared commitment to delivering a unified and resilient approach to managing winter pressures across both acute and community services.

By aligning our efforts, we are better positioned to maximise the use of community pathways, reduce avoidable attendances, and alleviate pressure on our acute services. Our plan is designed to reduce unplanned service attendances, optimise utilisation of our community urgent and emergency care (UEC) services, and ensure timely, safe discharge to improve patient flow.

As we prepare for winter 2025/26, we are guided by the expectations set out by NHS England. These expectations focus on system resilience, patient safety, and service continuity during periods of peak demand. This briefing outlines the key asks from NHS England, both nationally and from the Midlands Region, with a particular emphasis on UEC services. It is intended to support strategic planning, operational readiness, and collaborative delivery across providers and Integrated Care Boards (ICBs), embedding lessons from previous winters and ensuring we are equipped to respond effectively to varying levels of pressure.

Together, we are confident that this joint approach will strengthen our Groups ability to deliver safe, effective care throughout the winter period.



Karen Dunderdale
Group Chief Executive Officer

Introduction

The winter season traditionally represents a period of heightened demand and system-wide pressure across the NHS in England. In Lincolnshire, as in many health and care systems in recent years, emergency department attendances surge as respiratory viruses (notably influenza, RSV and norovirus) rise sharply from November into January. Hospital bed occupancy consistently peaks well above safe thresholds often exceeding 90 percent with discharge delays and delayed transfers of care compounding pressures across acute, urgent and community services.

Despite the efforts of frontline staff, patients frequently experience extended waits including corridor care and ambulance handover delays extending beyond NHS targets while large numbers of medically fit patients remain in hospital due to limited community capacity, These challenges have been particularly acute during winter surges in Lincolnshire, such as December 2023–January 2024, when bed occupancy exceeded national averages and unsupported discharges led to increased readmissions.

Covering the period from 1st October 2025 to 31st March 2026, this plan is underpinned by:

- Data-driven assurance, including scenario modelling that has been stress-tested to ensure system readiness
- Robust governance, with a clear structure to ensure accountability, oversight, and timely delivery

This year the LCHG Winter Ready plan aims to respond to the following areas of risk:

1. Responding to the complexity of patients attending with respiratory illness and the management of multiple pathways
2. Managing and adapting to the anticipated increased levels of demand for unplanned and emergency services alongside or planned elective services
3. Challenges faced by our partners which impact upon the number of patients within our hospitals with no criteria to reside
4. Continuing to care for our workforce during periods of significant demand

National ask

NHS England has set out clear expectations for Winter 2025/26, requiring all providers to produce individual Winter Plans. These plans must demonstrate how each organisation will maintain resilience, protect patient safety, and safeguard staff wellbeing through the most challenging months of the year. A key requirement is the appointment of a designated Winter Director at provider level, with responsibility for leading and coordinating the local winter response and ensuring clear accountability to Boards.

Regional

For 2025/26, NHS England Midlands Region has outlined specific expectations for NHS Boards and Integrated Care Boards (ICBs). These are focused on four priority areas:

1. Embedding learning from winter 2024/25.
2. Mitigating the impact of wider system changes on patient flow and service delivery.
3. Ensuring leadership capacity, including the appointment of Winter Directors.
4. Providing Boards with assurance regarding delivery risks and impact.

Urgent and Emergency Care

The Urgent and Emergency Care (UEC) Delivery Plan 2025/26 forms a cornerstone of national resilience planning. It seeks to align immediate winter readiness with longer-term transformation ambitions, ensuring that operational delivery supports national improvement goals. All winter plans are expected to contribute towards the following outcomes:

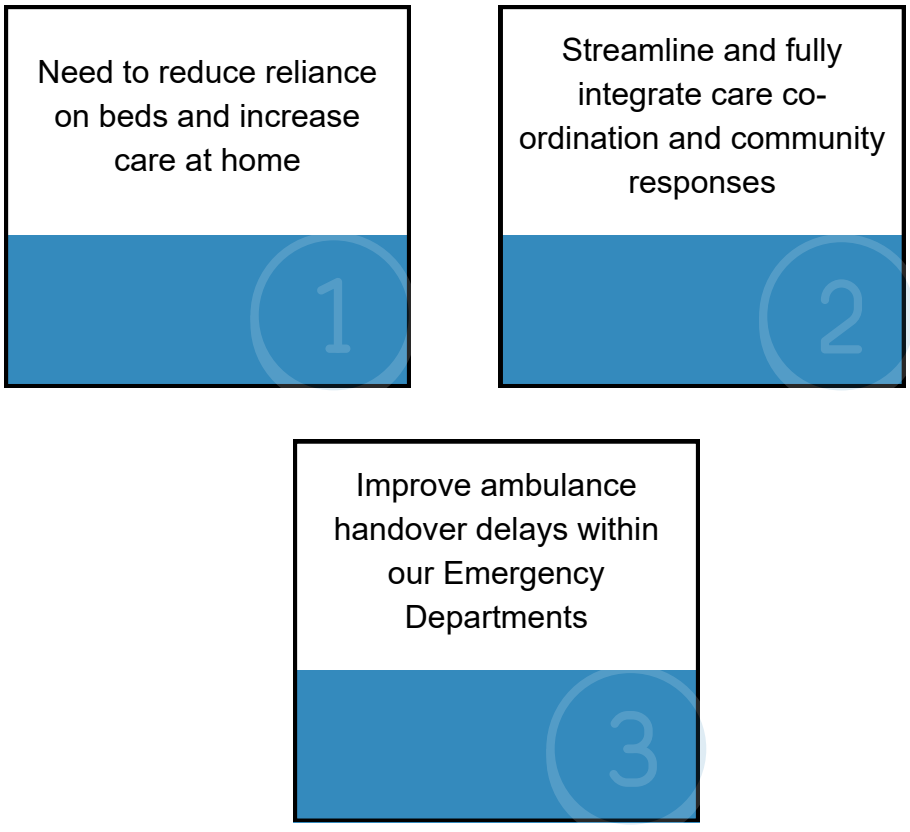
- Ambulance Response: Reduce average Category 2 response times to 30 minutes.
- Emergency Department Flow: Ensure that 78% of patients are seen, treated, admitted, or discharged within 4 hours.
- Handover Delays: Limit ambulance handovers to a maximum of 45 minutes.
- Mental Health: Eliminate waits of more than 24 hours in Emergency Departments for access to mental health beds.



Reflection on winter 2024/25

The 2024/2025 winter period demonstrated strong operational resilience and collaborative working across health and care partners. Flow out of hospitals was consistently maintained across all discharge pathways, supported by effective coordination between EMAS and Emergency Departments, which enabled timely handovers. The introduction of weekend discharge doctors proved beneficial in sustaining discharge rates during peak periods. Surge beds were successfully used to pilot a frailty short stay model, with partners expressing support for the development of a permanent frailty ward.The system was widely recognised as having worked “very well” together, with opportunities identified to expand the confirm and challenge approach to strengthen governance. Discharge processes were streamlined through reduced reliance on forms and phone calls, underpinned by increased trust between services. The two-day post-discharge pharmacy review received positive feedback for its role in supporting safe transitions of care. Performance improvements were evident, with the system achieving the 78% four-hour target in March and reducing the number of patients waiting over 12 hours in emergency departments. Ambulance response times for Category 2 calls were maintained, and elective activity continued throughout the winter period, ensuring continuity of planned care.

What we learnt



Preparing for winter 2025/26

LCHG has taken a structured and proactive approach to preparing for Winter 2025/26, building on the lessons learned during 2024/25 and ensuring alignment with national and regional requirements. Planning activity has been underway since April, with a clear governance framework to provide assurance that our services are resilient, safe, and ready to meet seasonal pressures.

Timelines and Planning Process

Preparation began in April with the finalisation of operational plan assumptions, including demand and capacity modelling for the winter period. In May, learning from Winter 2024/25 was reviewed at the Urgent and Emergency Care Partnership Board, while June saw the submission of responses to NHS England Midlands' Key Lines of Enquiry (KLOEs). System-wide engagement intensified in July, with attendance at the NHS England Midlands Winter Webinar, a dedicated winter planning session, and a system leadership meeting led by the ICB Medical Director, Chief Nurse, and Deputy Director for System Delivery to agree key priorities.

In August, a draft Winter Plan was submitted to NHS England Midlands, followed by regional stress-testing in September. During this period, Trust Boards reviewed final drafts and provided assurance through Board discussions and the submission of Board Assurance Statements in line with national requirements. This process ensured that the Lincolnshire System Winter Plan was thoroughly developed, tested, and signed off ahead of the October deadline.

Governance and Oversight

As part of the national and regional requirements, NHS England has asked all providers to plan against three scenarios: baseline, moderate, and extreme pressure. LCHG has responded by developing a comprehensive system-wide plan, covering both acute and community services. This includes alignment with national priorities such as early and equitable vaccination rollout, strengthened discharge pathways, and enhanced workforce resilience.

Foundations for winter

This winter, our strategic focus is on enabling patients to access care closer to home, within community settings, and to avoid hospital admissions wherever clinically appropriate. Our approach is underpinned by four key pillars that guide our preparedness and response:



Leading with purpose

Visible, accountable leadership guiding our Group through winter pressures

7



Caring for our people and patients

Supporting staff wellbeing and protecting patients with safe, compassionate care

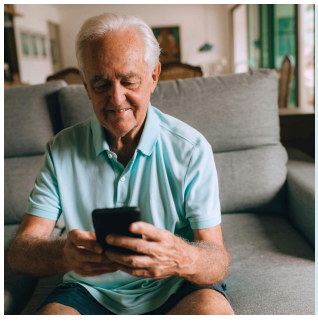
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Prepared and responsive services

Flexible, well-planned services ready to meet rising winter demand

12



Communication that connects

Clear, consistent message keeping staff, patients and communities informed

20



Leading with purpose

Effective leadership is fundamental to delivering safe, high-quality care during periods of heightened demand. This winter, our approach will be defined by visible, accountable, and collaborative leadership at every level of the Group. We recognise that winter pressures require not only operational grip but also clarity of direction and consistent communication to maintain confidence among our staff, patients, and partners.

Our leadership model for winter 2025–26 will operate with three core principles: **visibility, responsiveness, and shared accountability**. Senior leaders will maintain a strong presence across sites, providing assurance and support where pressures are greatest. Local leadership teams will have clear decision-making authority, enabling rapid escalation and timely interventions when patient flow is at risk. Escalation routes will be simplified, ensuring that information flows seamlessly from ward to board and across system partners.

This year, we are strengthening leadership coordination through an integrated **Winter Oversight Cell**, bringing together senior representatives from all providers, local authorities, and system partners. This group will oversee delivery of the plan, monitor performance against key indicators, and act decisively when system resilience is challenged. At an operational level, each care group and service line will adopt daily huddles and structured situation reports to maintain real-time oversight and ensure staff are supported to act quickly and safely.

Our commitment to purposeful leadership extends beyond operational control. Leaders will champion staff wellbeing, model compassionate behaviours, and foster an environment where concerns can be raised and resolved promptly. Through this proactive and connected leadership approach, we aim to maintain safe, effective services for patients while supporting our workforce throughout the winter period.

This winter, leadership across LCHG will be strengthened through new processes that ensure visibility, accountability, and proactive management of system pressures. Alongside our established site meetings, we will introduce a daily Gold Call, bringing senior leaders together to review system pressures, monitor infection prevention and control, and take rapid action to address emerging risks. This will complement existing governance arrangements and provide a single forum for oversight of patient flow, capacity, and escalation.

In addition, a new Full Capacity Protocol (FCP) will be implemented across all sites. This will work in tandem with the national Operational Pressures Escalation Levels (OPEL) framework, providing a structured and consistent approach to managing capacity pressures when services are under strain. The protocol sets out clear actions for escalation, patient flow management, and system coordination, ensuring safe care while protecting the resilience of front-line services.

Leadership this winter will also focus on visible presence and decision-making transparency. Senior leaders will be more consistently present across clinical and operational environments, providing support, listening to staff feedback, and ensuring that decisions made at system level are clearly communicated to frontline teams. This will help bridge the gap between operational reality and strategic oversight, ensuring that local pressures and innovative solutions are heard and acted upon quickly.

To strengthen assurance, the Winter Oversight Cell will continue to operate, supported by real-time data flows on activity, flow, and workforce resilience. By combining these insights with daily leadership forums, we can act swiftly on any emerging risks and maintain a coordinated response across the system.

Through these arrangements, LCHG will ensure that leadership this winter is not only about oversight but also about being visible, accountable, and responsive to the needs of staff and patients.

We will...

- Implement a daily Gold Call to monitor pressures, IPC risks and site resilience in real time
- Apply our newly reviewed Full Capacity Protocol alongside the OPEL framework to support safe and consistent decision-making



Caring for our people and patients

Our staff and patients are at the heart of everything we do. This winter, we recognise the pressures that seasonal demand creates and remain committed to keeping care, compassion, and safety central to our approach. The resilience of our services depends on the dedication of our workforce, and we acknowledge both the demands this places on staff and the vulnerability of patients during this time, particularly those at risk from respiratory illness and cold-related conditions.

To protect our people and communities, we are prioritising a vaccination programme for influenza, COVID-19, and RSV. Flexible delivery models, including workplace clinics and mobile teams, will support uptake among staff and patients, helping to reduce infection, safeguard continuity, and protect those most at risk.

Staff wellbeing remains a priority. This winter we will strengthen access to wellbeing resources, psychological support, and welfare facilities, alongside rostering that promotes rest and recovery. Managers will continue to encourage open dialogue, ensuring colleagues feel supported and valued.

Patient Safety

Keeping patients safe is our top priority this winter. We will closely monitor any risks or incidents through our Patient Safety Response Panel, which brings together experts to make sure concerns are picked up and acted on quickly. When things do go wrong, we will use the national Patient Safety Incident Response Framework (PSIRF) to look carefully at what happened, support patients, families, and staff, and make sure lessons are learned. We will collect and share learning from incidents during the winter so that services can improve and become stronger, helping us provide safer care for everyone.

Infection Prevention and Control

Infection prevention and control (IPC) is central to patient safety during the winter months, when seasonal viruses place added strain on services. We will continue to monitor local and national data to identify emerging outbreaks and respond quickly through clear escalation processes.

To manage confirmed outbreaks, we have pre-identified cohort wards at Lincoln County Hospital (Neudstadt Welton) and Pilgrim Hospital Boston (Ward 1). Additional cohort areas are in place across the Group to provide further capacity if required. This approach gives us flexibility and resilience to protect patients and staff.



Predictive modelling, using historic outcomes and local data, has helped us forecast likely patterns of bed closures and infection surges. Current projections suggest adult cases of influenza and RSV will peak in December and January, with paediatric respiratory illness expected from late October.

By combining active surveillance, designated cohort facilities and predictive modelling, we will minimise the risks of infection and maintain safe, effective services throughout the winter period.

Staff wellbeing

Winter brings added pressures for our workforce, and supporting staff wellbeing is essential to maintaining safe, high-quality care. This year, we are strengthening our wellbeing offer through **proactive promotion, accessible support, and responsive action**.

Staff will have access to psychological support, peer networks, and welfare facilities, alongside targeted communications to promote rest, hydration, and safe working practices. Managers will be supported to recognise and respond to signs of fatigue and stress, with flexible options in place to help staff access wellbeing services when needed.

We will use data such as sickness absence and staff feedback to identify hotspots and target additional support to teams under the greatest pressure. By protecting staff health and wellbeing, we aim to sustain resilience, reduce winter pressures, and ensure our workforce can continue to provide compassionate care to patients.



Vaccinations

Vaccination remains one of the most effective ways to protect staff and patients during winter. This year, we are aiming to increase staff uptake by five percentage points compared to last year, putting Lincolnshire above the national average and strengthening our resilience.

Our campaign will launch with a high-profile event supported by senior leaders, followed by a myth-busting programme with multilingual materials and online Q&A sessions. Staff will have more options to access vaccines, including pre-booked clinics, roving vaccinators, and peer-to-peer delivery. We will also target areas with historically lower uptake, using absence and vaccination data to guide our approach.

By making vaccination accessible and inclusive, we aim to protect our workforce, reduce seasonal illness, and ensure safe, reliable services for patients this winter.



Prepared and responsive services

Winter brings significant and often unpredictable demand across our health and care system. To respond effectively, we must ensure that services are both well-prepared and able to adapt quickly to changing pressures. This year, we are taking a proactive approach to planning, ensuring that capacity, flow, and escalation measures are in place to keep patients safe and services resilient.

Our planning has been informed by detailed demand and capacity modelling, using learning from previous years and local data to anticipate peaks in pressure. We are increasing flexibility across services, with actions such as expanding virtual ward capacity, strengthening urgent community response teams, and improving patient flow through earlier discharge planning and closer collaboration with social care partners. These measures will help reduce delays, free up hospital beds, and ensure patients receive the right care in the right setting.

Escalation protocols are in place to allow rapid response when services are under strain. These include predefined trigger points, coordinated actions across system partners, and the ability to redeploy resources quickly where they are needed most. By combining robust preparation with responsive action, we will maintain safe, effective care and strengthen the resilience of our system throughout the winter period.

Emergency Departments

Our priority is to minimise the time patients spend waiting in our Emergency Departments and to avoid unnecessary overnight admissions wherever possible. We are committed to supporting more people to be assessed, treated, and safely discharged on the same day. For those who do require a hospital stay, we will make prompt, safe decisions about the care and setting that best meet their needs, helping to keep patient flow steady and Emergency Departments ready for the next person who needs urgent care.

We are also taking steps to limit the spread of infections during the winter months. Visiting restrictions will only be introduced when absolutely necessary to protect patients, staff, and visitors, particularly during outbreaks of flu, norovirus, COVID-19, or other seasonal illnesses. These measures are vital to safeguarding vulnerable patients and ensuring our staff remain well and available to provide care.



One Front Door

This winter, we are piloting a new “one front door” streaming process to ensure patients are seen in the right place, first time. By bringing together our Emergency Department and Urgent Treatment Centre at the front door, we will be able to direct patients more quickly to the most appropriate care, reducing unnecessary waits in ED and improving patient experience.

Depending on clinical need, patients may be streamed directly to Same Day Emergency Care (SDEC) services, speciality assessment areas, their own GP, community services, or one of our new Community Diagnostic Centres. This approach aims to ease pressure on the Emergency Department while ensuring patients receive safe, timely, and effective care in the setting best suited to their needs.

Same Day Emergency Care (SDEC)

Our Same Day Emergency Care (SDEC) services are a key part of our strategy to improve patient care, reduce delays, and prevent unnecessary hospital admissions this winter. We are committed to expanding and enhancing SDECs so that more patients are treated in the most appropriate setting, more quickly.

To achieve this, we are introducing longer opening hours within our SDEC units across our sites, increasing capacity to see more patients, improving diagnostic turnaround times, and streamlining referral and streaming processes so that patients can be directed immediately to SDEC when clinically appropriate. This will help reduce waiting times, improve patient flow, relieve pressure on the Emergency Departments and ensure patients get care in the right setting.

SDEC services are able to treat many urgent medical conditions without admitting patients overnight. Examples include:

- skin infections such as cellulitis
- chest infections / lower respiratory tract infections
- anaemia and abnormal blood test results
- acute headaches or migraines
- flare ups of chronic conditions (for example asthma, COPD)
- low-risk chest pain (not cardiac)
- acute uncontrolled diabetes or hypertension
- other acute but stable conditions amenable to rapid assessment and investigation.



We will ensure that SDEC services are visible and accessible: patients arriving via the Emergency Department, from GP referrals, or via our front-door streaming pilot can be streamed into SDEC where appropriate. We will also align diagnostics, specialty assessment, and treatment so as many patients as possible can go home safely the same day.

Paediatric support

Supporting children and young people is a central focus of our Winter Ready plan. We know that paediatric services face unique pressures during the colder months, particularly with the seasonal rise in respiratory illness such as bronchiolitis, RSV, influenza and other viral infections. These conditions often result in large numbers of children presenting to urgent and emergency care, placing pressure on both front-door services and inpatient paediatric wards.

To strengthen our response, we are introducing dedicated paediatric doctors across our UEC services, including Emergency Departments and Urgent Treatment Centres. Having paediatric specialists available at the front door will allow children to be assessed and treated more quickly, ensuring timely clinical decisions and reducing the need for unnecessary admissions. Earlier access to specialist expertise will mean more children can be discharged safely home with appropriate advice and support, easing pressure on acute wards and improving patient flow across the wider system.



Paediatric Assessment Units

Alongside our Paediatric support as part of our Winter Ready plan, we are establishing new Paediatric Assessment Units at both Lincoln County Hospital and Pilgrim Hospital Boston. These units will provide ring-fenced beds for children who require further acute assessment or treatment, but do not necessarily need to stay in hospital overnight. By offering a dedicated space for observation and short-term care, the units will help avoid unnecessary admissions, reduce demand on paediatric inpatient wards, and ensure that families experience a more streamlined and child-focused pathway.

Together, these measures will allow us to deliver more timely, effective, and family-centred care for children and young people.

Frailty Assessment Unit

Ward 7A at Pilgrim Hospital will function as the Frailty Assessment Unit (FAU), providing short-stay admissions with a maximum length of stay of 72 hours. This model is designed to prevent deconditioning and delirium, reduce hospital mortality, and support timely discharge. Patients will be admitted directly from the Frailty Same Day Emergency Care (SDEC) service and the Emergency Department (ED), following assessment by the Front Door Frailty Team.

All patients will receive specialist frailty care, including reviews by Geriatricians or Frailty Advanced Clinical Practitioners (ACPs), with a strong emphasis on early discharge planning and optimising patient flow. The unit will be staffed by a multidisciplinary team comprising consultants, nurses, therapists, doctors, and ward clerks, who will work collaboratively to deliver care and facilitate discharge.

Pharmacy First

This winter, patients attending Lincoln Urgent Treatment Centre (UTC) with certain common conditions will benefit from a new Pharmacy First pilot, offering quicker and more convenient access to treatment. Instead of waiting to be seen at the UTC, eligible patients can be referred directly to a participating community pharmacy for a same-day consultation.

The service covers seven common conditions:

- Sinusitis
- Sore throat
- Earache
- Infected insect bite
- Impetigo (skin infection)
- Shingles
- Uncomplicated urinary tract infections (women aged 16–64)

Community pharmacists are highly trained healthcare professionals, able to provide expert advice, treatment, and, where appropriate, prescribe medicines for these conditions. Consultations take place in private rooms within the pharmacy, with same-day access to treatment where clinically appropriate.

By working in partnership with local pharmacies, the scheme aims to reduce waiting times, improve convenience for patients, and free up UTC and urgent care capacity for people with more complex health needs. This ensures that patients receive the right care, in the right place, at the right time, while easing pressure on frontline services during the winter period.

Planned Care



A central focus this winter will be reducing the number of day case procedures that convert into unplanned overnight stays. By maximising the use of day case pathways, we can safeguard capacity, shorten recovery times, and maintain flow through our hospitals. To achieve this, we will strengthen operational oversight and introduce daily elective briefings. These briefings will provide site teams with a clear picture of the next day's planned activity, enabling them to proactively manage capacity, anticipate risks, and ensure resources are in place to avoid unnecessary admissions.

Alongside this, we will continue to drive down waiting lists and improve Referral to Treatment (RTT) performance. Through careful scheduling, ring-fencing of elective capacity where possible, and close monitoring of long waiters, we will ensure that patients waiting the longest are prioritised for care. The use of additional theatre sessions, weekend operating, and targeted outpatient clinics will further support reductions in waiting times. These actions will build on the stability achieved in 2024/25, reinforcing our commitment to sustained elective recovery.

Operational and clinical leaders will monitor elective activity in real time through enhanced reporting, enabling swift escalation where elective pathways are at risk. By embedding this approach into daily site management, we can protect elective activity from being displaced by winter pressures and maintain access for patients requiring planned procedures.

Through these measures, LCHG aims to sustain elective performance, continue to reduce waiting lists, improve RTT compliance, and provide assurance to patients awaiting treatment, while building on the resilience and learning established during Winter 2024/25.

Discharge to Assess

The Discharge to Assess (D2A) model ensures patients who are medically fit leave hospital promptly, with assessments carried out in the community rather than on the ward. This enables people to recover at home, reduces risks of deconditioning and infection, and frees up beds for those needing urgent or specialist care.

Delivered by Lincolnshire Community Health Services NHS Trust in partnership with Lincolnshire County Council, the service operates county-wide, seven days a week (8am–8pm). Multidisciplinary teams; including therapists, pharmacy staff, and support workers provide personalised rehabilitation, equipment, and social support, helping patients to regain independence.

This winter, capacity will be expanded through reinvestment from reduced Transitional Care Bed use. This will allow more patients to be supported to return home safely and quickly, easing pressure on acute wards while improving recovery outcomes in the community.



Virtual Wards

The Virtual Ward is a key component of the frailty care pathway, designed to provide hospital-level care to patients in their own homes. It enables safe and effective monitoring and treatment for individuals who are medically stable but still require clinical oversight, allowing them to recover in a familiar environment while remaining under the care of a multidisciplinary team. During the winter period, when acute services face increased demand, the Virtual Ward plays a vital role in relieving pressure on inpatient beds. It facilitates early discharge from hospital wards, including the Frailty Assessment Unit, by ensuring patients continue to receive appropriate care and support at home. This approach not only improves patient experience and outcomes but also helps maintain flow through acute services.

To maximise its impact during winter, occupancy of our Virtual Wards will be maintained at 100%, with flexible use of beds across specialties to meet fluctuating demand. This dynamic model supports system resilience, reduces avoidable admissions, and ensures that acute hospital capacity is prioritised for those with the most urgent needs.

IV Therapy

As part of our commitment to providing patient-centred care and reducing unnecessary hospital admissions, LCHG will expand the delivery of Outpatient Parenteral Antimicrobial Therapy (OPAT) and wider IV Therapy services in the community this winter. This approach enables patients who require intravenous antibiotics to be treated safely at home or in community clinics, avoiding hospital admission where inpatient care is not clinically required.

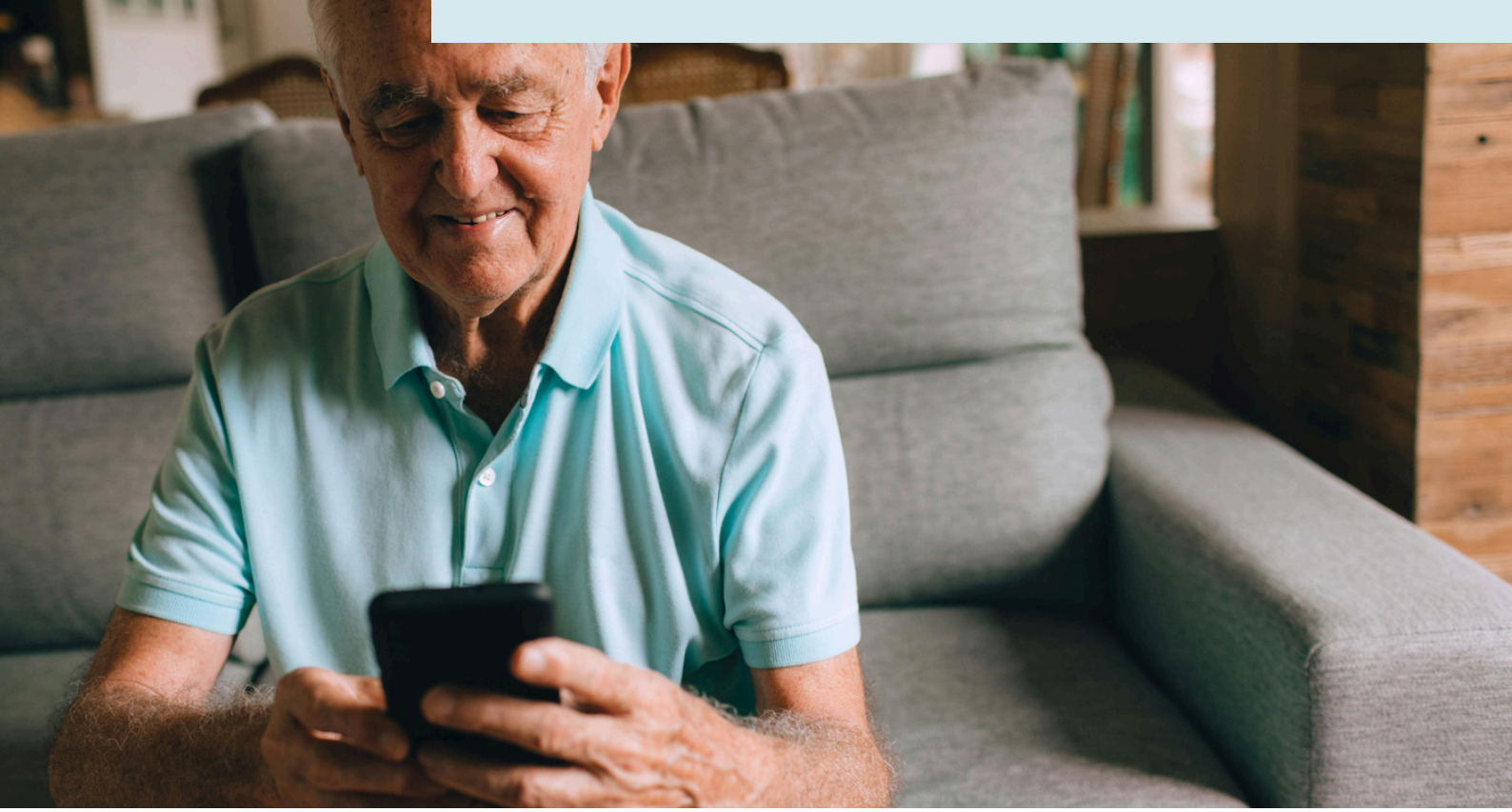
This model of care is particularly effective for patients with infections requiring prolonged IV therapy who are otherwise stable and do not need continuous inpatient monitoring. By supporting treatment closer to home, we can enhance patient comfort and independence, while also protecting acute capacity for those with more complex needs.

Benefits of expanding OPAT/IV Therapy include:

- Avoidance of admission: Patients can remain at home, reducing exposure to hospital-acquired infections and disruption to daily life.
- Improved patient experience: Care in familiar surroundings supports independence, particularly for those with mobility issues or caring responsibilities.
- Optimised bed capacity: Treating suitable patients in the community frees hospital beds for those requiring urgent or specialist care, which is critical during winter.
- Cost-effective care: OPAT is proven to reduce the cost of treatment per patient episode while maintaining safe clinical outcomes.
- Targeted support: Services will focus on patients most at risk of hospitalisation due to infection, including older adults, people with chronic respiratory conditions, and those who are immunocompromised.

We will...

- Implement a joint streaming model between ED and UTCs the direct patients to the most appropriate setting
- We will protect our elective capacity during winter, minimising disruption to planned pathways
- We will increase the use of virtual wards to support safe discharge and care at home



Communication that connects

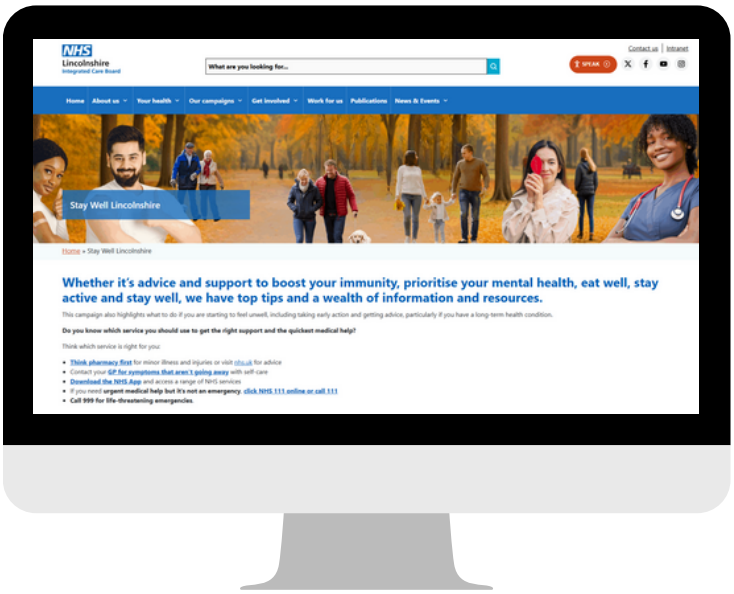
Clear, consistent communication is essential to keeping our people and communities informed, engaged, and prepared for the challenges of winter. This year, we are strengthening how we communicate across the system to ensure staff, patients, and partners receive timely information that supports safe care and confident decision-making.

For our workforce, we will provide regular updates through briefings, digital channels, and team huddles, ensuring colleagues understand pressures, escalation levels, and the actions required of them. These communications will also focus on wellbeing and recognition, reinforcing that staff are supported and valued throughout the winter period.

For our patients and communities, we will run targeted campaigns to promote vaccination uptake, appropriate use of NHS services, and practical advice on staying well during cold weather. Messages will be delivered through trusted partners, community networks, and local media to maximise reach and impact.

By connecting our communication efforts across organisations, we will present a single, consistent voice that builds trust and confidence. This coordinated approach will help manage demand, support staff resilience, and ensure the public remain informed and empowered throughout the winter.

Staff communication will be delivered through regular briefings, intranet updates, daily huddles, and wellbeing campaigns, ensuring colleagues are kept up to date on system pressures, escalation levels, and support available to them. Leaders will continue to be visible and accessible, reinforcing a culture of openness and support.



Public communication will be anchored by the Stay Well Lincolnshire campaign. This county-wide initiative provides simple and practical advice on staying well during winter, encouraging vaccination uptake, signposting people to the right service at the right time, and promoting self-care where appropriate. The campaign will use infographics, digital content, community networks, and local media to ensure messages are clear, accessible, and inclusive.

The communications plan will also include targeted messaging during periods of heightened pressure, such as infection outbreaks or escalation under OPEL, to ensure both staff and communities understand the actions being taken and how they can help. Materials will be available in multiple formats and languages to ensure accessibility across Lincolnshire's diverse communities.

Through this approach, LCHG aims to reduce avoidable demand on urgent services, improve vaccination uptake, support staff wellbeing, and keep the public informed and engaged throughout the winter period.

We will...

- Deliver clear and consistent communication with staff, patients and communities throughout winter
- Provide targets, timely messaging during periods of high pressure, ensuring people know what to expect and how to access the right care

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

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Quality Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*8.1*

Quality Committee Upward Report of the meeting held on 16 September 2025

Accountable Director	*Nerea Odongo, Group Chief Nurse*
Presented by	*Jim Connolly, Non-*
Author(s)	
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the [insert] Committee;* • *consider the matters which the committee wish to escalate to the Group Board and note and agree the action required*

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	
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	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	4 November 2025
Report from:	Quality Committee
Report from meeting held on:	16 September 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Quality Committee at its meeting held on 16 September 2025 including assurances received and those matters which the committee wish to escalate to the Group Board.

2.0 Matters considered by the committee

2.1 The committee received and considered the following reports on which assurance was received:

Assurances in respect of Objective 1a(i):

a) Patient Safety Group Upward Report
b) High Profile Cases
c) Children and Young People Oversight Group Upward Report
d) Quarterly Ventilation Safety Group Progress Report

The Committee noted positive progress with Central Alert System and Field Safety Notices with the remaining alert relating to bed rails which was being considered to determine how compliance could be gained.

The outcome of the national Never Event consultation was awaited with the recognition that these were not conducive to the Patient Safety Incident Response Framework and therefore changes were expected as a result.

Martha's rule was noted to have been launched with the Committee recognising the roll out of this across the Group, ensuring that this was supported by capacity and could be delivered in line with the framework. The Committee would receive a further update at the next meeting.

The LCHS Infection Prevention and Control (IPC) Annual Report was received by the Committee and commended to the Board **(appended)**. The overall IPC position was noted in respect of the level of detail now being presented to the Committee, enabling assurance to be gained in this area,

particularly through the action plans in place. The Committee also received the CQC IPC letter, noting the content.

Assurances in respect of Objective 1a(ii):

a) Patient Experience and Involvement Group Upward Report
b) Safeguarding and Vulnerabilities Oversight Group Upward Report including Children in Care Update

The Committee received, through the Patient Experience and Involvement Group Upward report, assurance in respect of objective 1a(ii) however it was noted that a gap in assurance remained in respect of mixed sex accommodation. Executive action would be taken in respect of the management of the process and a further update offered to the Committee through the upward report.

There was recognition of the need for the triangulation of data from a patient experience perspective with other areas of the Group such as complaints. The Committee noted the national direction of travel in respect of Health Watch and noted the changes that may be seen.

Section 42 reports continued to be received, primarily due to pressure ulcers, for LCHS with work continuing to support staff in the community. Increases in domestic homicide reviews were noted, with national increased being seen, with the Group up to date in respect of related actions.

Challenges continued to be noted in respect of Oliver McGowan training, which was captured within the risk register, with the delivery of the training noted to be a system issue. There was recognition of the need for further engagement from medical staff to attend the training.

The Committee was pleased to note the achievement of permanent funding in respect of looked after children which would enable the recruitment of staff into the service, however the Committee recognised that the funding did not allow for the service to be delivered to the level required.

Improvements were noted in respect of paediatric cardiology, which the Committee had been monitoring for some time. There was recognition of the change in oversight, moving from NHS England to the ICB, in response to the improvements made.

The Committee received the ventilation report, which had been an area of focus, noting the risks linked to the aged infrastructure for ULTH. The Estates and Facilities team was managing the associated risks and undertaking the appropriate due diligence and full space management and protocols were in place.

Assurances in respect of Objective 1a(iii):

a) Clinical Effectiveness Group Upward Report

The Committee received the report from the group noting the ongoing oversight of clinical audit with a focus on the Intensive Care National Audit & Research Centre (ICNARC) where there had been higher than expected unit acquired infection. It was recognised that the Committee would be holding a focus IPC discussion at the October meeting.

There was recognition of improvements with Structured Judgement Reviews when support was in place with a need for consistency and embedding to ensure this was continually delivered. The HSMR and SHMI were noted as within expected levels

Assurances in respect of other areas:

a) Patient Story
b) Board Assurance Framework
c) Risk Register
d) Policy Position Update
e) Internal Audit Recommendations
f) Committee Performance Dashboard

The Committee received the risk register noting the static position presented for LCHS and whilst the position was static for ULTH, this had been offset by the changes in a number of risks.

Positive movement in the policy position was noted with improved engagement noted from the care groups with local trackers being developed, enabling local oversight of the position.

The Committee received the new format of the performance dashboard which had incorporated the feedback from the previous meeting with the recognition that there was a ned to ensure all dashboard data was aligned.

3.0 Matters on which the committee was not assured and has requested additional information and assurance:

3.1 The committee requested additional information and assurance on the following matters:

a) None

4.0 Matters for reporting / escalation to the Group Board

4.1 The committee agreed the following matters for reporting / escalation to the Group Board:

a) None

5.0 Confirm or challenge of the Board Assurance Framework (BAF):

5.1 The committee considered the areas of the BAF for which it has oversight and has proposed the following change(s):

The committee considered the areas of the BAF for which it has oversight and no changes are proposed.

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- *note the discussions and assurance received by the [insert] Committee;*

Jim Connolly, Non-Executive Director

16 September 2025

NHS
Lincolnshire Community Health Services
NHS Trust

LCHS IPC ANNUAL REPORT 24-25

Caring and building a healthier future for all

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1. Introduction

The prevention and control of healthcare-associated infections is a key patient safety and quality activity and is a corporate function of The Lincolnshire Community Health Services NHS Trust (LCHS) under the administrative direction and responsibility of the Director for Infection Prevention (DIPC).

The overarching goal of the service is to promote safe care that will facilitate the prevention and control of healthcare associated infections in accordance with key legislative requirements (such as the Health and Social Care Act 2008 Code of Practice for Health and Social Care on the Prevention and Control of Infections (Hygiene Code) and related guidelines) and other national, international, and best practice guidelines.

This report provides an overview of the Trusts infection prevention (IP) performance for year 2024/2025.

2. Members of the Infection Prevention Service

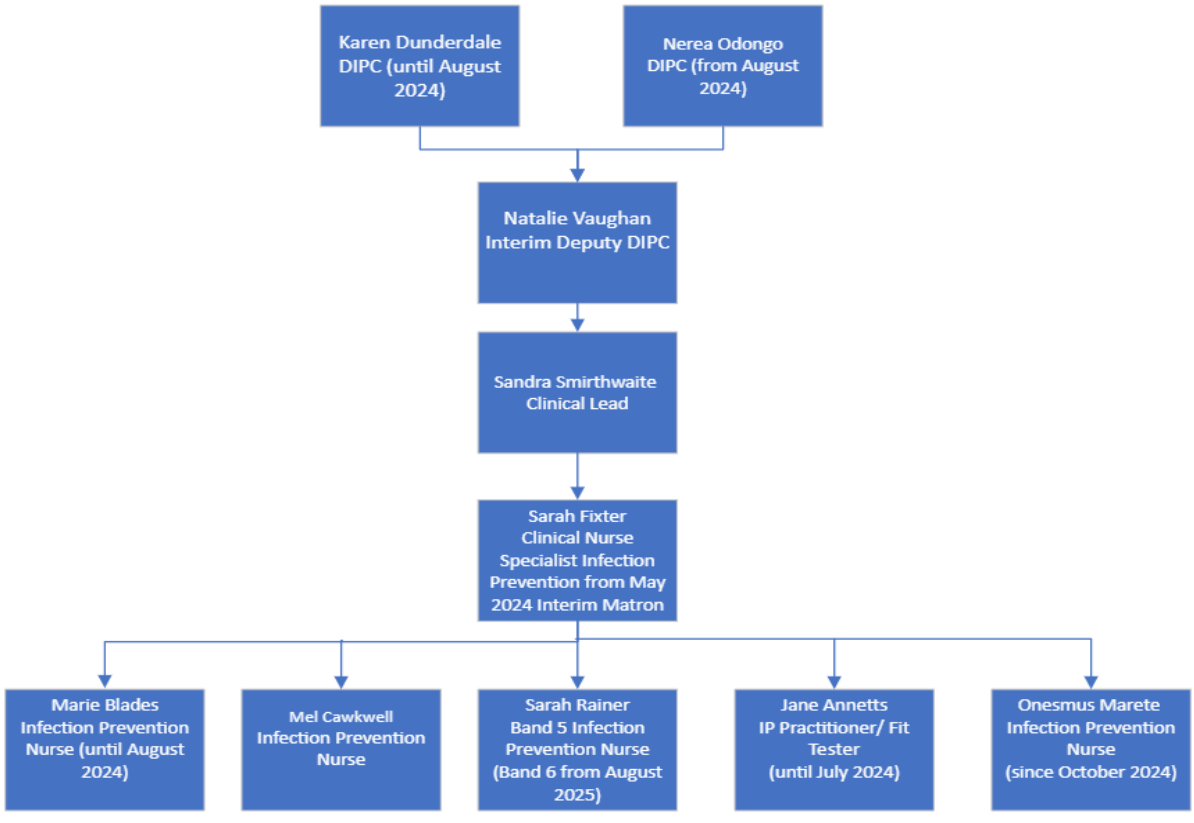


Figure 1. Team Structure

3. 2024/2025 INFECTION PREVENTION ASSURANCE AND GOVERNANCE

Board assurance is achieved through an agreed formal reporting structures to the Board. This includes formal reports to the IP Group and to the organisation's Quality Risk and Assurance Committees.

The IPC Group meets monthly and provides assurance for the prevention and control of HCAI, it also assures the organisation against IPC Key Objectives and the Board Assurance Framework.

The annual work programme was aligned to the required standards set out in these.

IPC key objectives 2024/2025

The following objectives have been approved by the Infection Prevention Group:

Number	Objective
1	**Develop infection prevention and organisational and Divisional 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**

Board Assurance Framework (BAF)

The Trust compliance with the Board Assurance Framework (BAF) was undertaken and actions tracked through the LCHG IP Group meetings.

All areas with exception of criterion 2 and criterion 3 are RAG rated as green.

Criterion 2 – provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections:

This continues with one non- compliant section and a partially compliant section in regard to water and ventilation management. From September 1st, 2024, the Total Facilities Management has been delivered through the LCHS/ULTH Group. The Estates Shared Service no longer have an operational responsibility or accountability for the LCHS estate. The transition continues to find and fill gaps where identified, this being a relatively slow process with the focus being directed to statutory compliance. All processes are still being reviewed at present.

Criterion 3 – ensure appropriate antimicrobial prescribing stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.

This section continues with 3 partially compliant sections and one non-compliant section. This is due to having no dedicated pharmacy technician within the community hospitals recruitment is underway to rectify this. Once this post has been filled work can commence to ensure compliance is obtained.

3.1. Outcomes and achievements of the annual Programme

The annual work programme was achieved for 20204/20205.

This year we continued to develop the LCHS link champion role this development will continue in 2025/26. There are 60 IP Link Champions throughout The Trust, based at various sites and working within various specialities and job roles. The meetings are quarterly full day face to face.

These have been a success with positive feedback on the learning and development opportunities.

The Link Champion programme is intended to provide an additional channel of communication between the IP Team and teams throughout the Trust, allowing up-to-date information to be shared effectively, provide a level of local IP expertise, and give those with a particular interest in IP a chance to play a more active role and develop their knowledge in this speciality.

The LCHS and ULTH IP Team is now working collaboratively as part of LCHG as well as being part of the Lincolnshire System IPC Group, which includes ICB, LPFT, ULHT, LCC, UKHSA, and the private sector. This group looks at working proactively together for the benefit of Lincolnshire patients. This has been especially beneficial on workstreams that benefit the whole of LCHG, e.g. the gloves off campaign, High Consequence Infectious Disease (HCID) preparations and interpreting national guidance changes, e.g., Mpox guidance ensuring that as a Lincolnshire system we are all working collaboratively and ensuring that guidance is the same across the whole system.

The IP Team embraced system working both within Lincolnshire and the wider midlands teams. The focus has been to ensure that guidance and working practice is standardised across the whole system and wider collaborative working.

ULTH Health and Safety Team now have a fit tester that is dedicated to fit testing staff within the community trust.

The IP Team work clinically on request of the service leads with staff that require individualised supervision, the link champions to offer them any support they require, the hospital, specialist and community teams to offer advice on best practice and problem solve any queries that apply to their service. This enables the establishment of good working relationships with all services.

Whilst working clinically the team has also focused on patient experience starting with hand hygiene and patient isolation experience.

The IP Team has worked closely with the Learning and Development Team to ensure that the induction and mandatory training is in line with current guidance.

3.2. Reducing avoidable infections

Policies and guidelines that serve to inform staff in the requirements to manage a patient with infections are current and have continued to be reviewed and revised in line with The Health and Social Care Act (2008) Code of Practice on

the prevention and control of infections and related guidance and the National Infection Prevention and Control Manual for England.

The IP Team manage outbreaks of infection and advise on adjustments to practices such as the use of ventilation, environmental decontamination, providing oversight and advice for water purity, refurbishment works, patient and staff testing/ screening/ isolation processes.

3.2.1. Surveillance

Surveillance for key alert organisms has been maintained during 2024/2025.

The Web V IP Module continues to be instrumental in alerting the IP team to any infections ensuring patients are isolated promptly and receiving any treatment in a timely manner. The implementation of PSIRF has provided robust assurance around investigation.

3.2.1A. Respiratory

The IP team is working with the Lincolnshire wide IP team to ensure that precautions are stepped up and down as local and national prevalence changes.

3.2.1B. Clostridiodes difficile infection

The number of *Clostridioides difficile* related infections involving patients who received care from the Trust for this reporting period is seven toxin positive cases. Five of these were proactively identified on admission, the other two patients were identified has having previous long term antibiotic use, no lapses in care or prescribing noted for these patients whilst an inpatient in LCHS. All patients were cared for as per guidance.

Zero outbreaks of *Clostridioides difficile* or evidence of cross infection has been identified for this period and no cases were classed as a serious incidence.

3.2.1C. E coli

The Trust can demonstrate exceptional performance in relation to cases of *Escherichia coli* blood stream infections during this reporting period. The total identified cases for the Trust for this period was zero. The totals for the last eight years have remained stable at zero.

3.2.1D. MRSA

The Trust achieved zero avoidable Meticillin resistant *Staphylococcus aureus* blood stream infections for this reporting period. This is the 10th year in succession where the Trust has achieved zero cases.

3.2.1E. MSSA

The numbers of cases of Meticillin sensitive *Staphylococcus aureus* blood stream infections continue to be zero for the year. Strategies such as peripheral line monitoring, good hand hygiene, effective wound care and antimicrobial stewardship have remained the key influencing factors resulting in the maintenance of zero cases.

3.2.1F. Outbreaks of infection

Through the year LCHS had a total of two outbreaks one Norovirus and one COVID-19 both were managed as per guidance.

The outbreaks and periods of increased surveillance were managed in line with best practice recommendations with reporting, mitigation and monitoring overseen by the IP Team working in partnership with ULTH IP team.

3.2.1G. Carbapenamase Resistant Enterococcus /CarbaPenamase Resistant organism

The Trust manages patients in line with national CPE/CRO guidance for the community sector.

Zero outbreaks of CRP/CPE or evidence of cross infection has been identified for this period.

3.2.1H. Klebsiella and Pseudomonas blood stream infections

The numbers of Klebsiella and Pseudomonas related blood stream infections was zero for the year.

3.2.1I. Mpox clade I and II

The IP Team have worked in partnership with ULTH and the wider Lincolnshire system to produce a Lincolnshire wide process flowchart to enable safe triage, diagnosis and treatment of patients presenting with suspected Mpox to our UTCs, ED’s and LiSH services.

3.2.1j. Antimicrobial stewardship (AMS)

The AMS stewardship Pharmacist lead has worked closely with the IPC team for world antimicrobial awareness week. This involves putting up posters in clinical areas to highlight the risks of antimicrobial resistance and to encourage best practices among healthcare practitioners and patients.

LCHS AMS lead now works closely with ULTH AMS lead on effective utilisation of antimicrobials. Some of the work that has been carried out jointly include penicillin allergy lanyards which was put in place to support clinical practitioners with decision making around antibiotic options for patients that are allergic to penicillin. Being discussed at present is penicillin allergy de-labelling which is a key initiative to improve antibiotic prescribing and AMS. The aim is to support the identification and removal of penicillin allergy labels in adults who do not have an acute IgE-mediated Type1 hypersensitivity reaction.

LCHS and ULTH now work together to produce a monthly AMS report for IPC group

LCHS AMS lead links in with ULTH AMS lead around education and training opportunities and having a joined-up approach in ensuring that education materials are available to staff in both organisations

LCHS AMS lead working with IUEC and CoHo to review current antimicrobial audit to ensure that they are fit for purpose

LCHS AMS Lead alongside IUEC clinical director and Chief pharmacist are working with ULTH group deputy medical director to find a solution around prescribing of antibiotics by acute trust clinicians for patients who present to UTCs but require specialist input for treatment/management.

3.2.1.K Water Safety

From September 1st, 2024, the Total Facilities Management has been delivered through the LCHS/ULTH Group. The Estates Shared Service no longer have an operational responsibility or accountability for the LCHS estate. The transition continues to find and fill gaps where identified, this being a relatively slow process with the focus being directed to statutory compliance.

Water safety is reported through the Health and Safety Committee, IP Group and now the Water Safety Group. The IP Team are core members of the Water Safety Group and included in any decisions made.

There has been a single identified colonisation of Legionella within an LCHS commercial leased property, this being 63 Monks Road. Following from the release of the ESS from 1st September 2024, action was taken to interpret the data, with remedial measures to TMT, TMV's, increased flushing, localised disinfection and minor pipework changes. This resulted in the eradication of the bacteria in November 2024

There have been positive outlets of Legionella in John Coupland and Skegness Hospitals. These continue to be managed by NHSPS. John Coupland should

evidence great improvement once the old Scotter Ward is transferred to the new ward building, this allowing for the area of colonisation to be decommissioned from the wider system and action implemented to clear any remaining pockets of bacteria. Skegness have two remaining outlets that remain at low count, and we await a decision on the potential disconnection and removal of the basins.

There have been positive outlets of Pseudomonas aeruginosa in Ravendale Clinic. Much the same approach as 63 Monks Road, interpretation of data and targeted remedial intervention was taken. However, this made a limited impact so a review over what clinical activities was made. Due to there being no augmented care being administered at Ravendale, and the likelihood that Pseudomonas aeruginosa would only be eradicated with a full system replacement, permission was granted to remove POU's filters, continue flushing and follow hand hygiene protocols.

A full raft of Water Hygiene Risk Assessments was commissioned in November 2024 and an action plan created. Works to complete the actions is progressing with completion advised to be April 2025.

An Authorising Engineer Audit is also being commissioned in April 2025 to provide oversight for controls and management. Any actions leading from this audit will be actioned accordingly.

3.2.1L. Ventilation

A proposed replacement ventilation system has now been installed by Property Services at John Coupland Hospital and effectively in operation from February 2025.

Plant at Johnson and the three ULHT Hospital sites continues to be serviced and maintained within HTM guidance frequencies. There is no mechanical air handling unit ventilation at the other sites.

4. Cleanliness

The Trust complies with the Hygiene Code criterion 2 that requires that services "provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. Cleaning is undertaken at a minimum in line with the national standards for cleanliness by our contracted services.

The National Standards of Cleanliness audits are now fully incorporated and are carried out in all clinical areas. All areas are displaying the appropriate Commitment to Cleanliness Charter and star ratings.

Cleanliness monitoring has demonstrated some intermittent local variations to attaining the required standards throughout the period resulting from fluctuations in activity, timing of audits completed, and décor. Local remediation/action plans have been implemented where compliance was unattained.

The LCHG estates team oversee the capital work plan and formal contracting/provider meetings provides assurances that those décor and cleaning issues are known and addressed fully. This is monitored through the IP Group.

5. Decontamination

The Decontamination Lead role at LCHG now includes support for LCHS therefore supporting the group model. The Decontamination Lead nurse is currently undertaking site visits with IPC colleagues in order to scope and take forward the wide range of decontamination work and interventions that have been applied at LCHG and maybe required for the group

The embedded quarterly Decontamination Group meetings provide a forum for discussion and resolution of issues, with revised Group Terms of Reference and there is now representation from the group as a whole.

An AE Decontamination to support the wider decontamination risks and initiate a decontamination audit to comply with HTM 01 across the group is yet to be appointed but the process has now started and it is anticipated that this will be resolved soon.

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. Whilst John Coupland Hospital are on a different contract to ULTH, concerns regarding instrument traceability are being addressed after a visit from the Decontamination Lead nurse.

Site visits are planned with the IPC team and Decontamination lead in order to replicate the audit carried out regarding outpatient ventilation. Work will primarily concentrate on ventilation and environmental factors, scoping work to be carried out with regards to Group-wide operating ventilation.

The decontamination of critical and semi-critical ultrasound probes has been raised as a result of some practice observed at LCHS sites and all staff have been trained according to the local SOP’s. The staff undertaking the procedures were ULTH staff, we are now in a process of carrying out a repeat audit to ensure the standardised chemical products and robust decontamination

process are embedded in line with the SOP. Staff have also received education via an online package and follow up face-to-face training.

The decontamination Lead has planned time to support IPC colleagues within the community to provide education and support re the decontamination lead role and will be a resource for colleagues. This will also include Estates and Facilities support for building work and service development.

6. PLACE (Patient Led Assessments of the Care environment)

The official PLACE (Patient Led Assessment of the Care Environment) results were released by NHS England in February 2025 following the assessments that we held in autumn 2024. The results were an improvement in 2023 in the main, and the overall Trust scores are at or within 3% of the national average in all domains. Work is commencing to address any issue that have risen.

PLACE Scores Overview

Criteria	2024 National Average	LCHS	
		2024 Score	2023 Score
Cleanliness	98.31%	97.87%	99.25%
Combined Food	91.32%	90.79%	88.43%
Organisation Food	92.17%	90.05%	89.78%
Ward Food	91.38%	91.87%	86.83%
Privacy, Dignity & Well Being	88.22%	87.24%	88.25%
Condition, Maintenance and Appearance	96.36%	94.81%	95.18%
Dementia	83.66%	84.19%	78.62%
Disability	85.20%	84.40%	78.43%

Criteria	2024 National Average	JCH, Gainsborough		Johnson, Spalding		Louth		Skegness		UTC Boston		UTC Lincoln	
		2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023
Cleanliness	98.31%	98.83%	99.36%	100%	99.79%	95.62%	99.58%	97.30%	98.66%	100%	100%	100%	99.02%
Combined Food	91.32%	90.73%	91.58%	93.73%	88.42%	89.84%	85.47%	89.12%	88.59%	n/a	n/a	n/a	n/a
Organisation Food	*92.17%*	88.83%	89.36%	90.96%	89.36%	88.83%	91.49%	90.96%	89.36%	n/a	n/a	n/a	n/a
Ward Food	*91.38%*	92.86%	93.75%	96.67%	87.50%	90.91%	78.21%	88.10%	87.78%	n/a	n/a	n/a	n/a
Privacy, dignity & wellbeing	88.22%	86.00%	85.71%	94.92%	92.86%	77.33%	76.92%	89.29%	92.11%	89.19%	13.64%	92.11%	66.67%
Condition, maintenance & appearance	96.36%	94.51%	92.86%	99.17%	98.76%	91.67%	91.74%	93.84%	95.56%	84.21%	84.72%	91.27%	94.92%
Dementia	83.66%	84.77%	75.44%	93.86%	86.55%	73.13%	69.40%	84.44%	79.44%	85.19%	31.67%	88.46%	69.57%
Disability	85.20%	84.80%	71.59%	89.10%	84.78%	80.38%	71.74%	83.41%	80.61%	81.63%	30.00%	85.11%	70.27%

7. Clinical Practice

7A CLINICAL VISIBILTY

The IP Team has been clinically visible throughout all services, assisting with the audit process, providing education, responding to any queries, patient placement discussions, advise and support.

7B HAND HYGIENE/ GLOVES OFF CAMPAIGN

The IP Team in conjunction with The World Health Organisation Hand Hygiene Day has delivered hand hygiene education to LCHS staff, visitors, and other external organisations.

As part of the wider LCHG IP team we have promoted the gloves off campaign via social media using informative posters and a quiz. We also cascaded the

information to the teams through the link champion network and as part of the clinical visits conducted by the IP team.

7C LINK CHAMPION NETWORK

A proactive link champion network continues to promote the link between the teams and the IP Team. Across LCHS we have 60 link champions from a range of specialities. Quarterly face to face study days continue to offer learning opportunities. Link champions spend time with the IP team within their own clinical area and actively produce their own notice boards to promote a range of IP topics. The next step is to develop a robust system to ensure the learning is disseminated effectively to their teams.

7D PATIENT INVOLVEMENT

The IP Team is working to involve patients in IP practices to ensure that their knowledge and perspective are considered.

A Service Improvement Plan was implemented to promote hand hygiene with patients prior to their mealtimes. This was developed through feedback from patients about their preferences for hand hygiene using with patient hand hygiene wipes, hand sanitiser or soap and water. Through talking to patients, we established their level of understanding of the way microorganisms can be transferred by contact with hands. The feedback from patients was used to develop an information sheet on the importance of supporting patients to perform effective patient hand hygiene was promoted with staff.

The IP Team spoke to patients, their family and carers to capture their experience of being cared for in isolation, over a 6-month period. This included how it impacted their well-being and staff practices they observed, e.g. hand hygiene and wearing of PPE. The information was collated and disseminated through governance meetings and learning developed by the team leads.

7E STAFF TRAINING

Staff training called OSCE's already embedded within ULTH were adapted for use within LCHS. These include both a video and a competency to be completed by all staff.

The first OSCE utilised was for commode cleaning, which was developed to ensure all staff were aware of how to clean commodes effectively, following the introduction of a monthly commode audit which showed that the commodes needed replacing and that staff cleaning was inconsistent. There was excellent staff compliance with this training and all the commodes were replaced because of the audit findings.

More OSCE's are planned for development in 20205/20206.

7F AUDITS

The IPC programme of audit has continued to monitor and assure IPC practice standards across the Trust. These monthly audits consist of hand hygiene, sharps, isolation, environmental cleanliness, AMR, mattresses and commodes.

All audits are monitored by the IP team and the divisions and reported through the divisional lead reports which are presented through IP Group monthly.

External audits were also completed for hand hygiene and sharps with reports presented to each division and learning implemented. These external audits are carried out 6 monthly and have shown significant improvements. After each audit the findings were disseminated to the divisions to enable learning to take place.

7G COLLABORATIVE WORKING

The IP Team contributed to a Podcast on hand hygiene as part of a joint project for World Health Organisation Hand Hygiene Day with Lincolnshire Partnership Foundation Trust and the Lincolnshire ICB.

Working collaboratively with ULTH, as part of LCHG to ensure a consistent IP message is being heard across the group and learning is shared. This works consists of quality improvement projects, e.g. DRIPP and HCID preparations and the sharing of policies and procedures. Joint working has improved surveillance of infections, when patients are transferred within the Group allowing for seamless, consistent patient care.

7H PSIRF

PSIRF principles have been fully embedded within IP and replace the serious incident framework ensuring:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement.

7I CAMPAIGNS

The IP team continue to promote learning in the clinical areas by visiting clinical teams within their areas of work

Campaigns are used to promote local and national messages and can also be used to deliver targeted training identified from audits or clinical observation by the IP team. These are delivered to the appropriate clinical teams and comprise of interactive sessions, discussions with staff, use of printed materials, quizzes and practical demonstrations.

For example, following on from annual audit findings and clinical visit observation, a campaign promoting mattress and pressure cushion cleaning was delivered which consisted of discussion and a practical demonstration.

National campaigns that the team have promoted include Infection prevention week, WHO Hand Hygiene Day and Antimicrobial Awareness Week. These campaigns raise staff awareness and promote good working relationships.

8. Mandatory Training Infection Prevention

IP training is mandatory for all Trust employed staff. The IP Team has contributed to the development of the training packages that were delivered by the Learning and Development Team.

Compliance figures as of 31st March 2025

Reporting Period	Compliant	Non-compliant	Compliancy%
2024-2025 (L1)	2,274	33	98.57%
(L2)	1,715	129	93.00%

Both compliance percentages continue to exceed the local & national target of 90%.

Both form part of Induction e-learning for new starters. Level 2 is updated annually & Level 1 every three years through the Mandatory Training programme to ensure continued compliance.

Additionally, the IP Team has developed training resources and delivered training for staff in key areas such sharps management, antimicrobial awareness, and hand hygiene.

9. Identified Priorities for 2025/26

To continue to work as a strong Group IP Team working across both ULTH and LCHS, sharing learning.

To continue to be clinically visible to all the teams based in the hospitals, clinics or in the community to offer guidance, advice, and support.

To expand the link champion role further to ensure that knowledge gained at the link champion meetings is disseminated to their teams.

As a key stakeholder within the Lincolnshire system the IP Team will contribute to the development of a standardised system approach to IP practices, continuing the promotion of working relationships and system wide working to ensure that there is one process for Lincolnshire to enable the health of the local population to be maximised.

To continue to strengthen AMS across the trust in conjunction with the medicines management team.

Support the divisional leads to ensure that there is a robust audit programme and reporting process in place, overseen by the divisions in collaboration with the IP team.

To continue to progress the IP BAF to ensure a good level of compliance and working with services to close any gaps.

To work together across LCHG ensuring preparedness for any emerging or re-emerging organisms.

To continue to produce and embed IP OSCE's within LCHS

10. Conclusion

Work will continue within the Group model to promote a strong collaborative ULHT and LCHS IP Team.

The Team will continue to be clinically visible to maintain and continue to build effective working relationships with all services, providing advice and support. This visibility is welcomed, and support positively received.

The link champion network has been successful following engagement with leaders and stakeholders. Meetings are now held as full days quarterly face to face both meetings and workshop style. Work needs to commence to ensure the learning is disseminated through their teams.

The Trust has had low levels of outbreaks/ infections which have resulted in good learning that have been embedded into practice.

The IP team have adapted local IP guidance and practice in response to nationally / regionally changing guidance and contributed to the development of an IP systems approach.

NHS
Lincolnshire Community and Hospitals NHS Group

Quality Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*8.1*

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

Accountable Director	*Nerea Odongo, Group Chief Nurse*
Presented by	*Jim Connolly, Non-Executive Director*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the Quality Committee;* • *consider the matters which the committee wish to escalate to the Group Board and note and agree the action required*

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	
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	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	4 November 2025
Report from:	Quality Committee
Report from meeting held on:	21 October 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Quality Committee at its meeting held on 21 October 2025 including assurances received and those matters which the committee wish to escalate to the Group Board.

2.0 Matters considered by the committee

2.1 The committee received and considered the following reports on which assurance was received:

Assurances in respect of Objective 1a(i):

a) Patient Safety Group Upward Report
b) High Profile Cases
c) Children and Young People Oversight Group Upward Report
d) Maternity and Neonatal Oversight Group Upward Report to inc post implementation review of the BadgerNet Maternity System
e) Focussed discussion – Infection Prevention and Control

The national Never Event consultation was noted to have concluded and the outcome of this was that the definition of never events should be revised. Work was now due to commence with a more detailed paper due to be offered to the Patient Safety Group.

Harms related to paediatric cardiology were noted however it was noted that triangulation was required across reports to confirm the data being offered which was noted to differ.

Claims and inquests were noted as an area being considered through the National Oversight Framework and there was recognition of the benchmarking work that would be completed and reported the following month.

Learning from the process of Patient Safety Incident Investigations was being received by the Committee with a request that the themes and actions also

come to Committee, confirmation was offered that this would be received the following month.

An update in respect of Martha's rule was received with governance issues being addressed and recognition of the clear actions in place to support delivery of this in the EDs. A rollout plan was being developed for the roll out of the Manchester Patient Safety Framework which was being used to develop the safety culture of the Group.

Development of the children and young people dashboard was noted to be continuing to provide the Committee great oversight of areas related to medical staff training and education. Reassurance was sought in respect of support for adopted children due to the meeting being stood down and whilst it was noted that an agreement was in place, further details were required of this.

Work was being undertaken to develop the pathway for paediatrics within UEC and ED to ensure that support was provided to both staff and patients. The autism and epilepsy business cases continued to be a work in progress and it was noted that the epilepsy deep dive would be expanded across all patient groups, not just paediatrics.

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

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

- CNST Standard 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:

    - 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, 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 12.1wte 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 was agreed at CRIG on 29th July with QIA approved 4/08/2025. Awaiting response from ICB Values Framework.
    - Recruitment of newly qualified midwives is underway at LCH. All qualifying students on the PHB site have been offered jobs.
    - *Post-meeting update:* declined at ICB Values Framework, resubmission required by the end of October. Business Case under review to strengthen case. Failure to secure the funding on the second attempt may compromise our ability to evidence continued progress against previously agreed actions reported to Board, due to tight reporting timelines. This presents a material risk to compliance and future positioning.

The Committee noted that a discussion would be required to take place regarding the uplift in the establishment of the 12.1wte should the outcome of the ICB Values Framework decision be that funded would not be granted.

- 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 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**).
  - Note receipt of the quarterly Claim, Complaints and incident Scorecard (Appendix 1.3).

- 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 three cases that qualify for MNSI and one 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 Committee held a focused discussion in respect of Infection Prevention and Control noting the improvements in practice that had been achieved and recognising the focus on the sustainability of good practice whilst strengthening consistency.

Assurances in respect of Objective 1a(ii):

a) Patient Experience and Involvement Group Upward Report

It was recognised that there had been improvement in respect of collaboration and decision making through the outcome of the national cancer survey and actions were being taken as a result of patient feedback in respect of the emergency department environment. This had resulted in charity funding support the service to provide face masks and ear plugs to help patients sleep.

Mixed sex accommodation reporting was being undertaken in a revised process and the Committee noted that, as a result, breaches would appear elevated. A task and finish group had been established to validate the data and ensure feedback was appropriately provided to patients.

Branding for volunteers was being developed, and it was noted that this would be aligned across the Group

Assurances in respect of Objective 1a(iii):

a) Clinical Effectiveness Group Upward Report

The Committee noted the national clinical audits that had been undertaken noting that performance in these was overall positive however there was recognition of the need to strengthen quality assurance of data prior to submission. It was anticipated that this would support greater compliance with the audits being undertaken. Further reporting would include timescales and trajectories for the closure of actions.

The Human Tissue Authority (HTA) actions continued to be progressed with the Committee noting that a single action plan would be developed to ensure clear oversight.

Assurances in respect of other areas:

a) Patient Story
b) Board Assurance Framework 2025/26
c) Risk Register
d) Policy Position Update
e) CQC Inspections to the Group
f) Internal Audit Recommendations
g) Committee Performance Dashboard

The Committee received the risk register noting the static position in for LCHS and ULTH however recognised some movement would be seen the coming month due to closure of the phlebotomy risk for ULTH.

The policy position was noted with the Committee requesting review and completion of updates and RAG ratings for overdue documents with recognition that the position remained unacceptable.

The CQC inspection reports were received for Lincoln and Boston following assessments of urgent and emergency care at both sites and medical care at Boston. It was recognised that there was no must or should do actions identified within the reports however work was being undertaken internally to determine any actions ULTH may wish to take. Verbal feedback was offered to the Committee in respect of the LCHS End of Life pathway assessment.

The performance dashboard was received with no escalation to the Committee with scorings aligned to the National Oversight Framework.

3.0 Matters on which the committee was not assured and has requested additional information and assurance:

3.1 The committee requested additional information and assurance on the following matters:

a) None

4.0 Matters for reporting / escalation to the Group Board

4.1 The committee agreed the following matters for reporting / escalation to the Group Board:

a) None

5.0 Confirm or challenge of the Board Assurance Framework (BAF):

5.1 The committee considered the areas of the BAF for which it has oversight and no changes are proposed.

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- *note the discussions and assurance received by the Quality Committee*

Jim Connolly, Non-Executive Director

21 October 2025

NHS
Lincolnshire Community and Hospitals NHS Group

Finance Briefing M6

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*8.2*
Report title	*Finance Briefing M6*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• Information
Accountable Director	*Paul Antunes Goncalves* *Group Chief Financial Officer*
Author(s)	*Finance Team*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Reasonable assurance*
Prior approval process, if applicable	*Content discussed at Finance and Performance Committee*
Financial implications, if applicable	*None*
Action / 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 internal 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, which has been applied to the Group.* • *Note the forecast risk that is being mitigated through internal and external actions..*

Assurance Rating Key:

Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are uncertain or possibly insufficient*

Red: Limited or No Assurance	*Effective controls are not in place or are insufficient to manage the risk identified and / or appropriate assurances are not available. Immediate action is required to address the gaps, weaknesses or non-compliances identified*

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

Executive Summary

Trust Board is asked to note the following:

- 2025/26 Revenue position M6 YTD (Year to date)

The Group delivered a £14.3m deficit (£0.1m better than planned).

- 2025/26 Capital position M6 YTD

The Group delivered capital expenditure of £15.9m (£15.5m lower than planned).

- 2025/26 CIP position M6 YTD

The Group delivered savings of £24.9m (£0.2m lower than planned).

- M6 Cash position

The Group ended the month with a cash balance of £26.9m (£8m lower than planned).

Lincolnshire Community and Hospitals NHS Group
Trust Board – 4 November 2025
Finance Briefing M6

Executive Summary

The Group have ended the first half of the year in line with plan, delivering a £14.3m deficit. This deficit position was mainly built in quarter 1, with quarter 2 seeing an improvement in our monthly run rate. 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 internal 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. The Group are also working with external parties to support the forecast position, including local system partners and regional colleagues.

Although our financial position is challenging, with circa £14m of risk within the forecast position, the Group are confident that through internal and external actions we will be able to deliver our breakeven year end position.

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, it has been agreed that this will all be utilised within the Group. This will allow for additional capital spend to be made on our front-line services.

The cash position is £8.0m behind plan, with a cash balance at the end of month 6 of £26.9m. 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 6 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)	(14.5)	(14.3)	0.1	(2.5)	(2.3)	0.1	(12.0)	(12.0)	0.0
CIP Delivery	25.1	24.9	(0.2)	2.3	2.6	0.4	22.8	22.3	(0.5)
Capital Spend	31.4	15.9	(15.5)	2.5	1.9	(0.6)	28.9	14.1	(14.8)
Agency Spend	(7.7)	(8.6)	(0.8)	(0.8)	(0.4)	0.4	(6.9)	(8.2)	(1.2)
Cash Balance	34.9	26.9	(8.0)	24.7	18.9	(5.8)	10.2	8.0	(2.2)

Revenue Position

The Group's financial position is a £14.3m deficit after six months, this position is £0.1m better than our planned position. The Group have seen run rate improvements over the second quarter of the year. 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 has a further step up in month 7.

There are three key internal 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. In month 6, ULTH saw a step up in income driven by the productivity improvements in theatres, further improvements are focused in our outpatient care setting. It is forecast that we will fully deliver our activity plan for the year.

2. **Delivery of our efficiency target** – Our efficiency plan is slightly (£0.2m) behind plan, some schemes have not delivered as intended and mitigations are being developed. Additional assurance meetings have taken place with our care groups to develop mitigations and ensure forecast scheme are on track for delivery. 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. We have seen reductions from our MARs scheme with further individuals exiting in October and November depending on notice periods.

The Group are working with external partners to address forecast risks, this includes our ICB regarding winter bed funding and our regional colleagues on items outside of the Groups control.

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. Nationally there has been an announcement of additional industrial action in November.

The forecast position has circa £14m of risk identified mainly due to shortfalls in our efficiency systems, internal and external mitigations are being developed and implemented, and the Group are confident that we will be able to deliver our breakeven year end position.

Capital Position

The Group has the largest ever capital programme of £125.6m 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 6 the Group were £15.5m 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, it has been agreed that this will all be utilised within the Group. This will allow for additional spend to be made to our front-line services. The Group have spoken with regional colleagues, and a cash request is being prepared to support this funding.

NHS
Lincolnshire Community and Hospitals NHS Group

Finance and Performance Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*8.3*

Finance and Performance Committee Upward Report of the meeting held on 18 September 2025

Accountable Director	*Paul Antunes-Goncalves, Group Chief Finance Officer*
Presented by	*Dani Cecchini, Non-Executive Director*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the Finance and Performance Committee;* • *consider the matters which the committee wish to escalate to the Group Board and note and agree the action required*

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	
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	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	4 November 2025
Report from:	Finance and Performance Committee
Report from meeting held on:	18 September 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Finance and Performance Committee at its meeting held on 18 September 2025 including assurances received and those matters which the committee wish to escalate to the Group Board.

2.0 Matters considered by the committee

2.1 The committee received and considered the following reports on which assurance was received:

Assurances in respect of Objective 1c:

a) Finance Report inc CIP, Capital and CRIG
b) Cost Improvement Programme Proposals
c) Procurement Report

The Committee received the finance report noting that the month 5 year to day deficit position was reported at £13.3m for the Group, broadly in line with plan. Work continued to address the financial position with challenges noted in respect of the recent industrial action, delivery of the Cost Improvement Programme (CIP) trajectory and activity.

Activity query notices had been received from the commissioners, and responded to, in respect of planned care performance and pass-through drugs. Medical temporary workforce continued to be an area of focus within the medical workstream.

The position in respect of the Mutually Agreed Resignation Scheme (MARS) was noted with a significant improvement noted in the full year effect position which would support the underlying position.

A deep-dive into the medicine care group has been undertaken, along with an escalation meeting with the Chief Executive to support the care group in improving the position.

Confidence was noted in the delivery of the capital programme an whilst there had been some slippage in year, these were linked to nationally funded schemes and approval processes and timelines.

The CIP proposal paper was noted to include 21 areas of opportunity with a named Senior Responsible Officer (SRO) identified for each. The opportunities would be considered for development of delivery into 2025/26 or 2026/27.

The procurement report continued to offer assurance in respect of the performance of the team with a CIP of £2.5m identified by the team and in the pipeline for delivery. Further areas were also being identified.

Assurances in respect of Objective 1d:

a) Estates and Facilities Update
b) Health and Safety Committee Upward Report

The Estates and Facilities update offered assurance in a number of areas including estates projects, statutory compliance and fire safety. Authorised engineers had been appointed for all disciplines with a number of reports expected in the coming months. Improvements were noted in respect of statutory maintenance and Planned Preventative Maintenance (PPM) with an external review due to be undertaken to support further improvement. As a result of the increased and continued assurance the Committee considered and confirmed the proposal to move the assurance rating from red to amber as reported below.

The Health and Safety Committee upward report was received with the Committee noting the standardisation of fire safety training across the Group and the Group Fire Safety Policy had been approved and would be submitted for publication.

Assurances in respect of other areas:

a) Board Assurance Framework 2025/26
b) Risk Register
c) Information Governance Group including DSPT compliance submission
d) Topical, Legal and Regulatory Update
e) Policy Position
f) Internal Audit Recommendations

The Committee received and noted the risk register position as presented and considered the report from the Information Governance Group which offered the position of the Data Security Protection Toolkit (DSPT) submission. ULTH has submitted ‘approaching standards’ with a supporting improvement plan, which required final sign off by NHSE and LCHS had submitted ‘standards achieved’.

The Committee was pleased to note the improved position in respect of ULTH Subject Access Requests with a significant reduction in the number of overdue requests noted.

The policy position was noted to have improved in month due to the publishing of updated documents alongside the removal of those no longer needed.

The Internal Audit Recommendations were noted with work ongoing with the internal auditors to ensure timely closure of the actions once evidence had been submitted.

3.0 Matters on which the committee was not assured and has requested additional information and assurance:

3.1 The committee requested additional information and assurance on the following matters:

a) Objective 1b – Operational Performance Report and Committee Performance Dashboard

The Committee received the operational performance report noting the position presented and recognised the need for increased reporting from a planned and unplanned care perspective, in addition to clear trajectories for delivery across performance metrics.

Quarterly benchmarking would be developed within a dashboard which would offer the position against peers for key metrics.

The Committee noted the need to have greater oversight of specialty challenges and the plans in place to address these. Changes were noted to the 12-hour target to bring ULTH in line with national recording with the recognition that this would not improve patient experience.

4.0 Matters for reporting / escalation to the Group Board

4.1 The committee agreed the following matters for reporting / escalation to the Group Board:

a) Concern related to operational performance reporting that would be addressed through revised reporting and the inclusion of trajectories against metrics and benchmarking.

5.0 Confirm or challenge of the Board Assurance Framework (BAF):

5.1 The Committee considered the areas of the BAF for which is had oversight and following consideration of the assurances provided against objective 1d

– Provide modern, clean and fit for purpose care settings agreed to recommend to the Board that this be moved from red to amber.

No other changes are proposed.

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the Finance and Performance Committee;
- consider the matters which the committee wish to escalate to the Group Board and note and agree the action required;
- Consider approval of the recommendation of the change of assurance rating for objective 1d from red to amber

Dani Cecchini, Non-Executive Director

18 September 2025

NHS
Lincolnshire Community and Hospitals NHS Group

Finance and Performance Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*8.3*

Finance and Performance Committee Upward Report of the meeting held on 23 October 2025

Accountable Director	*Paul Anutunes-Goncalves, Group Chief Finance Officer*
Presented by	*Dani Cecchini, Non-Executive Director*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the Finance and Performance Committee;*

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	
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	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	4 November 2025
Report from:	Finance and Performance Committee
Report from meeting held on:	23 October 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Finance and Performance Committee at its meeting held on 23 October 2025 including assurances received and those matters which the committee wish to escalate to the Group Board.

2.0 Matters considered by the committee

2.1 The committee received and considered the following reports on which assurance was received:

Assurances in respect of Objective 1b:

a) Operational Performance Report (inc planned care trajectory)

The Committee received the suite of reports offering performance information noting the National Oversight Framework (NOF) report which offered the segments for both ULTH and LCHS which continued to be reported as statutory organisations.

The performance reports were received with the Committee noting the mapping to the NOF, offering clear oversight of the position and areas of focus. Assurance was offered to the Committee through the Planned and Unplanned Care Group upward reports, an area which the Committee had not previously received sufficient assurance in respect of. The new STACK report provided a clear view of the relative operational metrics with recognition that there remained a need for delivery against the trajectory, as well as the year-end position.

The Performance Review Meeting (PRM) upward reports further strengthened assurance and demonstrated the positions for the care groups, the areas of focus and the actions in place where needed to support improvement. The Committee noted, from the report that there were 3 care groups reported 3, 1 amber and 1 in escalation.

Assurances in respect of Objective 1c:

a) Finance Report inc CIP, Capital and CRIG
b) Business Planning Timetable inc planning framework
c) Post Investment Case – Skegness CDC

The Committee noted the year to date deficit of £14.3m which was £0.1m better than planned, however there were variance from the plan relating to delivery of variable income, the costs of industrial action and risks in our Cost Improvement Programme (CIP) delivery.

There was recognition of the step up in productivity anticipated in months 7 & 8, with more patients being seen within existing capacity, this would support an improvement in the financial position. Work continued in respect of theatres and outpatients productivity which are being tracked on a weekly basis to ensure delivery of the variable income in the year to go.

The CIP profile was noted to be a blend of both recurrent (75%) and non-recurrent (25%) with some technical efficiencies brought forward to support the year to date position.

Cash continued to be an area of focus with key challenges being around the phasing of the plan and the timing of efficiency schemes which are being addressed.

Capital programmes continued to be delivered with a recognition that there were some challenges noted in respect of year to date spend and the timeliness of sign off for nationally funded schemes. Mitigations were in place and there was confidence of delivery based on previous track record of the team.

The Committee noted the engagement of the Care Groups in respect of delivering the financial plan with recognition of the challenges within the medicine care group which were being addressed and supported.

The Business Planning report received indicated that NHS England are moving to a 5-year planning process that would include a continuous 2-year operational planning cycle. This approach was welcomed by the Committee noting that this would support our transformational approach.

The post investment case for Skegness CDC which was approved on the basis of being a loss-making business case, supported by national funding, was reviewed and discussed. There was recognition that this case was delivered on time and to budget and evidenced improvements in a number of areas. Learning from this cases will be taken into out Boston CDC proposal.

Assurances in respect of Objective 1d:

a) Estates and Facilities Update and Premises Assurance Model
b) Emergency Planning Group Upward Report inc BCP update

Progress was noted in respect of the Carbon Energy Project with the chosen supplier now mobilising. Development of the estate's strategy was progressing well and would be informed supported by our clinical services strategies.

Work continued in respect of fire safety with improvements noted across the Group and the recent approval of the Group Fire Safety Policy. Authorised Engineers were now in place across the Group and reports were due to be received in the coming months.

The Planned Preventative Maintenance (PPM) audit had commenced which had started to identify some areas of focus. Escalation was noted in respect of recent RIDDOR reportable incidents, and issues with the lifts at Pilgrim Hospital which were being addressed with the maintenance supplier.

The Premises Assurance Model report was received by the Committee with some additional domains being included in the national tool including mortuaries and Helipads, these were known areas to be addressed. In all, this reflected an improvement on previous years.

The Emergency Planning Group upward report offered assurance on the core standards submission with 58 of the 62 standards fully compliant for ULTH and 57 of 58 compliant for LCHS, those standards which were not compliant were noted to be partially compliant.

Business Continuity Plans were noted to be in a positive position with a significant improvement noted for clinical areas. Focus was now shifting to corporate areas to drive further improvement.

Assurances in respect of other areas:

a) Board Assurance Framework 2025/26
b) National Oversight Framework update
c) Risk Register
d) Policy Position
e) Internal Audit Recommendations
f) Stroke Business Case – for information
g) Committee Performance Dashboard
h) PRM Upward Reports
i) Any other business

The Committee considered all elements of performance under objective 1b as reported above.

The risk register was received and the position noted with a request that risks were reviewed and narrative updated to ensure this accurately reflected the risk. The policy position was noted with LCHS remaining static and some positive improvement in ULTH policies.

The Committee was advised that the Procurement Team has been shortlisted for a National award at HCSA - Clinical Procurement in Partnership Award. Recognising the amazing work done on procedure packs which is now being used as an exemplar piece of work and being turned into a case study and shared nationally.

3.0 Matters on which the committee was not assured and has requested additional information and assurance:

3.1 The committee requested additional information and assurance on the following matters:

a) None

4.0 Matters for reporting / escalation to the Group Board

4.1 The committee agreed the following matters for reporting / escalation to the Group Board:

a) None

5.0 Confirm or challenge of the Board Assurance Framework (BAF):

5.1 The committee considered the areas of the BAF for which it has oversight and no changes are proposed.

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the Finance and Performance Committee;

Dani Cecchini, Non-Executive Director

23 October 2025

NHS
Lincolnshire Community and Hospitals NHS Group

People Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*9.1*

People Committee Upward Report of the meeting held on 9 September 2025

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Elaine Baylis, Group Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the People Committee*

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	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	4 November 2025
Report from:	People Committee
Report from meeting held on:	9 September 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the People Committee at its meeting held on 9 September 2025 including assurances received and those matters which the committee wish to escalate to the Group Board.

2.0 Matters considered by the committee

2.1 The committee received and considered the following reports on which assurance was received:

Assurances in respect of Objective 2a:

a) Education Oversight Group Upward Report inc Non-Clinical Education
b) Medical Education Update
c) Safer Staffing Nursing in TB service capacity & demand and B2 to B3 training updates

The Committee noted that statutory and mandatory training compliance was on target and alignment to national packages was continuing. The deep dive undertaken by the Education Oversight Group in respect of statutory and mandatory training has highlighted that medical and dental colleagues and doctors in training compliance rates remained lower than required.

Ongoing concerns were noted in respect of the removal of level 7 apprenticeships however funding would continue for a limited number of advanced clinical practitioner programmes.

The Committee was pleased to note the progress of the band 2 to band 3 uplift programme which remained on trajectory.

Improvements in medical education were noted, particularly within surgery, despite cultural challenges persisting, which were being addressed locally. Recent visits by NHS England had recognised improvements in obstetrics and gynaecology and Health Education England had noted quality improvements within medicine.

The Committee received and noted the assurance provided by the safer staffing report for nursing.

Triangulation of Datix reports was requested to ensure that staffing concerns were not impacting on patient safety. Whilst it was confirmed that these had not been seen in the Committee, it was noted the need to ensure oversight of this with reporting into the Quality Committee to take place.

The Committee was advised that action was being taken in relation to the national 10-point plan for improving resident doctors working lives. The Group Chief People Officer and the Group Chief Medical Officer are joint SRO's and will report through the People Committee for assurance purposes.

Assurances in respect of Objective 2b:

a) Workforce Strategy Group Upward Report inc Committee Performance Dashboard
b) Outputs from quarterly Pulse survey action plan and preparation for National Staff Survey focussed discussion

The increase in vacancy rates in quarter 2 were noted as having increased across the Group, which reflected the implementation of the Vacancy Control Process (VCP) and is expected. Turnover was noted to have reduced and sickness rates were below target, despite an increase for LCHS, with targeted work underway. However further work is required for 'hot spot' areas who are above the sickness targets and additional resource to support the care groups from a HR perspective are currently being recruited for a fixed term period.

The increase in appraisal rates was noted, following the adoption on the appraisal cycle across the Group. Employee relations activity was noted following a number of actions implemented to reduce caseloads and the implementation of the Just and Restorative Culture, with regular case reviews being conducted.

The Committee received the Workforce Hub report noting the ongoing work to support staff through the redeployment cell, impacted by change programmes, capability processes or those requiring reasonable adjustments.

The outputs from the Pulse survey were noted with recognition of the scale of the challenge in respect of improving staff survey responses and strengthening long-term staff engagement. Due to the number of ongoing actions associated with the work the Committee took reasonable assurance from the report.

Assurances in respect of Objective 2c:

a) Culture and Leadership Group Upward Report

b) NHS and System People Plan Update

The Committee noted the continued work of the Culture and Leadership Group where a focused discussion took place in respect of Health and Welbeing and the support in place for staff. The Group was now receiving themes from social media as a standing item to support triangulation of all feedback from staff.

Assurances in respect of Objective 2d:

a) Reward and Recognition Update

The Committee was pleased to note that the Reward and Recognition policy had been updated and aligned across the Group with long service awards now aligned. There had been concerns raised that the alignment of the policy disadvantaged some staff, due to the timing of the awards, resulting in a one off exercise to address this. Post meeting note: the introduction of 20 year long service award has now been introduced to address staff concerns raised.

October would see the launch of values in action in respect of the new behavioural values for the Group, supported by a behavioural framework.

A record number of submissions had been made for the staff awards with the Committee pleased to note the engagement with the awards.

Assurances in respect of other areas:

a) Board Assurance Framework 2025/26
b) Staff story
c) Risk Report
d) Policy Position Update
e) Topical, Legal and Regulatory Update
f) Internal audit Recommendations

The Committee received and noted the risk report with a reduction in risks noted from the previous month.

The policy position was reported to be static however it was anticipated that this would improve with the publication of a number of Group polices recently approved.

3.0 Matters on which the committee was not assured and has requested additional information and assurance:

3.1 The committee requested additional information and assurance on the following matters:

a) Objective 2a - Safer staffing medical

Whilst recognising the improvement in the reporting for safer staffing medical, there remained concerns about the ability to triangulate workforce data with financial and productivity information in order to provide clarity on both establishment figures and use of temporary staff.

The Committee was advised that these issues were under review, and a report would be brought back to the Committee which would offer further triangulation of data between substantive workforce, productivity and the use of temporary staff.

b) Objective 2b - Workforce Hub Report

The Committee was not assurance in respect of the ability to achieve the workforce plan, with reassurance provided to the Committee through the work being undertaken. There was recognition that the Committee had received the data but there was a need to gain grip and control to support the delivery of the financial plan with a request for the Committee to be sighted on the action plans in place to achieve trajectory.

4.0 Matters for reporting / escalation to the Group Board

4.1 The committee agreed the following matters for reporting / escalation to the Group Board:

a) None

5.0 Confirm or challenge of the Board Assurance Framework (BAF):

5.1 The committee considered the areas of the BAF for which it has oversight and has proposed the following change(s):

The committee considered the areas of the BAF for which it has oversight and no changes are proposed.

The committee noted the need to strengthen the controls and gaps in assurance against objective 2a, to ensure the Committee was able to accurately reflect the assurance ratings.

A request was made for consideration to be given to further development of the BAF, to include clear reference to the workforce plan as it was felt that this was not fully reflected.

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the People Committee;

Elaine Baylis, Group Chair

9 September 2025

NHS
Lincolnshire Community and Hospitals NHS Group

People Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*9.1*

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

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Elaine Baylis, Group Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the People Committee*

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	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	4 November 2025
Report from:	People Committee
Report from meeting held on:	14 October 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the People Committee at its meeting held on 9 September 2025 including assurances received and those matters which the committee wish to escalate to the Group Board.

2.0 Matters considered by the committee

2.1 The committee received and considered the following reports on which assurance was received:

Assurances in respect of Objectives 2a:

a) Education Oversight Group Upward Report
b) Safer Staffing Nursing
c) National job profiles for nursing update
d) Safer Staffing Medical inc fragile services

The Committee noted the statutory and mandatory training compliance reported at 95% for LCHS and 92% for ULTH with an increase in compliance for doctors increasing from 20% to 50%.

Continuing professional development continued to see a positive spend and apprenticeship levy utilisation was reported at 119% with a wide variety of apprenticeships underway.

Following a recent nomination to the Greater Lincolnshire 2025 Apprenticeship Awards, the Committee was delighted to be informed that LCHG was awarded the overall winner – employer champion.

The Education Oversight Group was now considering education in the round, including under-graduate, postgraduate and medical education which would enable the Committee to have better oversight.

Some concerns were noted in respect of non-compliance of induction however this was being reviewed further by the group with the next report to include detail of the mitigation of any risks as a result of this.

The safer staffing nursing report continued to demonstrate a level of over establishment with the Committee noting the need for management of communications to staff due to the perceived pressures being experienced.

The Committee noted the work which had commenced in June regarding the nursing profiles update with a local working group established to map any relevant changes. Lessons learned would be taken from the HealthCare Support Worker process and it was anticipated that the review would conclude in May 2026. Reporting would be offered to the Committee on a regular basis.

The safer staffing medical position was noted with the Group not being an outlier for vacancy numbers against model hospital. The fragile services position was received with the Committee noting that shortages of consultants in these services was a national issue. The Committee was informed that actions were taken to ensure that any resulting risks to patient care were mitigated or taken through the quality committee.

Assurances in respect of Objectives 2b:

a) Workforce Strategy Group Upward Report inc Committee Performance Dashboard
b) Freedom to speak Up Annual report **(appended)** and quarter 2 report
c) Sexual Safety Charter

The Committee noted that turnover within LCHS was above target with ULTH reporting as below, this was impacting the workforce trajectories and the assumptions within the workforce plan however this was recognised as a national issue.

Sickness was above target in both organisations resulting in the use of some temporary staffing to address gaps in staffing. Sickness coordinators are currently in the process of been recruited to and these roles will provide intensive support to hot spot areas of sickness absence.

The Committee received and approved the annual Freedom to Speak up Report (appended) noting the ongoing work of the guardians across LCHS and ULTH, with improved engagement noted for LCHS. Ongoing themes of behaviours and relationships were noted.

There was recognition that the new leadership programme would support the guardians by ensuring staff were aware of all routes for speaking up, including line managers, prior to speaking up to the guardians. The Committee noted the need to ensure people felt safe to speak up well and to

the right people in the organisations. The quarter 2 report was also received and noted.

The Committee noted the formal launch of the Sexual Safety Charter on the 29 September with the event well supported by the Executive team which was positively received. Various support was noted to be in place with a firm executive level commitment around the actions, as per the national board assurance framework, would continue to be embedded. Future reporting of this would be offered via the Culture and Leadership Group.

Assurances in respect of Objectives 2c:

a) Culture and Leadership Group Upward Report
b) Equality, Diversity and Inclusion Group Upward Report
c) AAC Recruitment update to inc framework and onboarding enhancements
d) Employee Exclusions

The values and behavior framework was launched on 1 October and was being embedded across the Group, alongside the leadership development programme. There was recognition that triangulation of data would be possible following the launch of the framework.

The use of mediation was noted by the Committee which demonstrated a positive position however the group continued to consider the use and promotion of this. The Committee requested further information be offered, including the staff groups accessing mediation and the number of mediators across the Group.

The Committee received the Equality, Diversity and Inclusion Group upward report and noted the action to review the relevant action plans, following the Board Development Session to ensure that the actions were right for the Group.

The progress for AAC panels was noted, in particular the use of inclusive recruitment questions and identification of mentorship support for successful candidates. Psychometric testing was also being considered in order to support recruitment with further work required to determine if this was a suitable approach.

The Committee noted 4 employee exclusions in ULTH at the end of September with the average time for exclusions now down to 9 weeks, from 19 weeks in July. This demonstrated the process change and improved working relationships with professional bodies. There were no active exclusions reported in LCHS.

Assurances in respect of Objectives 2d:

a) Wellbeing day reward update
b) Staff awards update

The wellbeing day reward update was received with the recognition that this being put in place to address cultural challenges in key metrics including flu vaccinations, staff survey completion, mandatory training and appraisal completion. Following the decision by the Group Leadership Team on the 19 September the incentive was launched on the 1 October at the Better Together event.

The Committee was pleased to note the successful staff awards with 1297 nominations across 13 categories with 52 individuals and teams shortlisted. The event was attended by over 300 people. The Breath Easy Choir had performed at the evening, with one of the award winners being instrumental in the establishment of the choir.

Assurances in respect of other areas:

a) Board Assurance Framework 2025/26
b) Staff story
c) Risk Report
d) Policy Position Update
e) Internal audit Recommendations

The Committee noted the position in respect of the risk register and was pleased to note the positive improvement in respect of policy documents, for ULTH, following the publication of a number of Group policies. Timelines for completion and RAG ratings were offered for the remaining overdue documents.

3.0 Matters on which the committee was not assured and has requested additional information and assurance:

3.1 The committee requested additional information and assurance on the following matters:

Objective 2a-safer staffing medical

It is recognised the report continues to improve in terms of the triangulation of data, however some inaccuracies were identified which raises concerns about the internal validation process.

a) Objective 2b Workforce Hub Report

The Committee noted the continued work of the workforce hub with 41 individuals currently seeking redeployment. The over establishment in the workforce, against the plan for the substantive workforce was noted however there was recognition that this position was income backed as a result of a number of schemes.

Challenges continued to be noted in respect of the Extra Contractual Rate (ECR) for doctors, resulting in the need to utilise temporary workforce to maintain the financial position.

Concern was noted about the deliverability of the plan, given the current position with the Committee requesting that the actions taken/being taken were included in the next report to demonstrate any progress and assurance on the delivery of the trajectory, alongside the forecast position.

4.0 Matters for reporting / escalation to the Group Board

4.1 The committee agreed the following matters for reporting / escalation to the Group Board:

a) None

5.0 Confirm or challenge of the Board Assurance Framework (BAF):

5.1 The committee considered the areas of the BAF for which it has oversight and has proposed the following change(s):

The committee considered the areas of the BAF for which it has oversight and no changes are proposed.

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the People Committee;

Vicki Wells, People Committee Chair

14 October 2025

NHS
Lincolnshire Community and Hospitals NHS Group

Freedom to Speak up Annual Report 2024/25 to People Committee



Caring and building a healthier future for all

Meeting	*People Committee*
Date of meeting	*14 October 2025*
Agenda item number	*8.3*
Report title	*Freedom to Speak up Annual Report 2024/25*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	•
Accountable Director	
Author(s)	
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *[insert details of the level of assurance provided within the report, if applicable]*
Prior approval process, if applicable	*[insert details of where the report has previously been considered and / or any prior approval]*
Financial implications, if applicable	*[insert details of any financial implications arising from the proposals within the report]*
Action / decision required	*The board / committee is asked to:* • *[insert details]*

Assurance Rating Key:

Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are uncertain or possibly insufficient*
Red: Limited or No Assurance	*Effective controls are not in place or are insufficient to manage the risk identified and / or appropriate assurances are not available. Immediate action is required to address the gaps, weaknesses or non-compliances identified*

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	*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	
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 Trust has a responsibility to listen to staff, to be open and responsive to concerns which are raised. This report provides an update on the following:

- Concerns raised with FTSU Guardian
- National and Local Updates
- Actions taken
- Trend Analysis

National Update

Following on from the announcement of the National Guardians office function transferring to NHS E a further a communication went out to all NHS FTSUGs on the 13th August from NHS E advising that Freedom to Speak up and the role of guardians will be incorporated into the NHS Standard Contract for 2026/27 and assurance to the commitment to guardians and the importance of the speak up agenda.

Local Update

This report is compiled of joint data from the group, true comparisons have commenced in Q4 of this period and are demonstrating the effective joint working of the group FTSUG team. Previous reporting was quarterly, this has brought about alignment between both trusts in reporting, triangulation, and executive oversight. As a group it is now evident that as corporate and patient services align and integrate, the guardians can provide a more comprehensive view from a wider range of the workforce. Themes and statistics are being compared and used to assess how the service can be improved, and what learning has taken place.

The FTSUG's have been involved in the well-led review and this has enabled greater understanding of how the group can continue to assess, plan and implement the required changes, to bring about improved information analysis and measure the outcomes. Preparation for the review allowed the formulation of a strengths and weaknesses plan and actions to address.

The co-ordination and planning of a joint Reflection and Planning tool will be incorporated into the FTSUG plans for 2025/26 with both FTSUG's working with the Group board.

2024 NSS results

Staff Survey LCHS

		Historical				
			2021	2022	2023	2024
q20a	Would feel secure raising concerns about unsafe clinical practice		83%	81%	80%	80%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice		73%	69%	67%	66%
q25e	Feel safe to speak up about anything that concerns me in this organisation		74%	75%	73%	70%
q25f	Feel organisation would address any concerns I raised		63%	64%	60%	60%

The overall trend with the speak up questions have plateaued in terms of lack of overall improvement and the small decrease year on year are a concern and have been communicated to the senior leaders of the organisation. A plan is in place to role model speak up principles via the operational delivery group and forge improved speak up responses at team level.

Staff Survey ULTH

		Historical				
			2021	2022	2023	2024
q20a	Would feel secure raising concerns about unsafe clinical practice		65%	64%	65%	65%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice		44%	45%	47%	48%
q25e	Feel safe to speak up about anything that concerns me in this organisation		47%	53%	54%	56%
q25f	Feel organisation would address any concerns I raised		32%	37%	40%	42%

ULHT continues on the upward trajectory for staff feeling safe to speak up about concerns and feel the organisation would address their concerns when nationally it is reported organisations are showing a decrease.

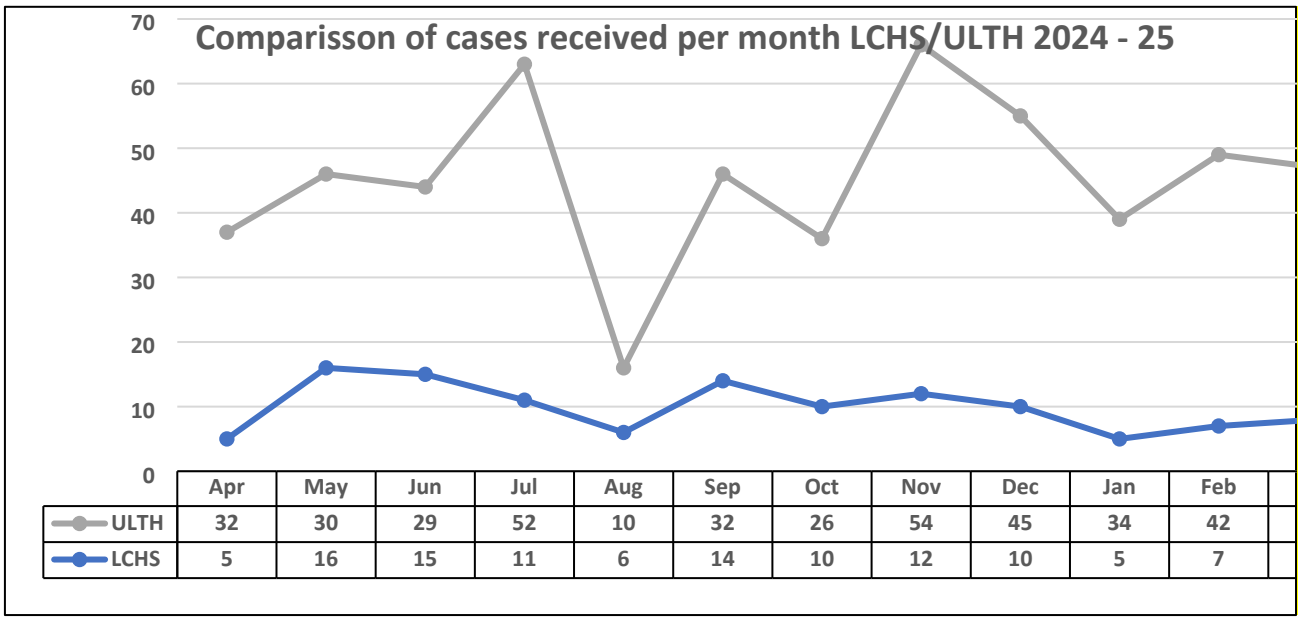
Feeling secure to speak up about unsafe clinical practice has stayed static and the organisation addressing concerns about unsafe clinical practice has slightly increased.

The FTSUG is working with medical staff to encourage them to raise concerns, this is an area which nationally, guardians report, there is a fear of repercussions if they speak up.

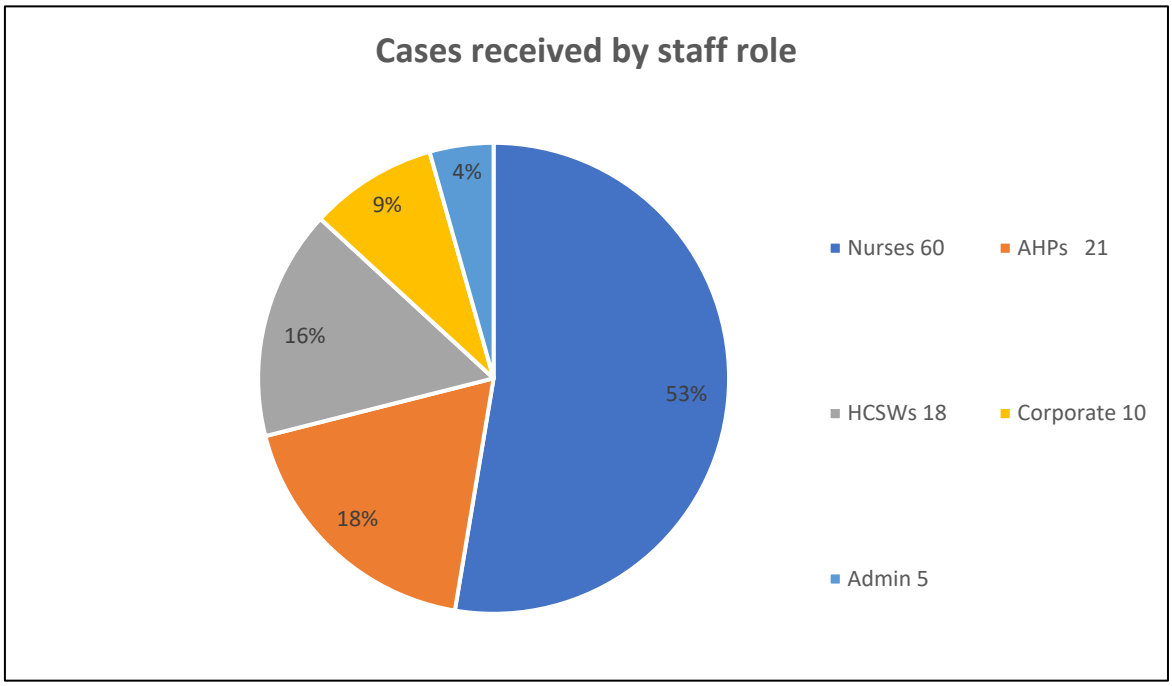
Responses from cases are not always timely, which is being addressed in the group.

Reporting Data 2024/25

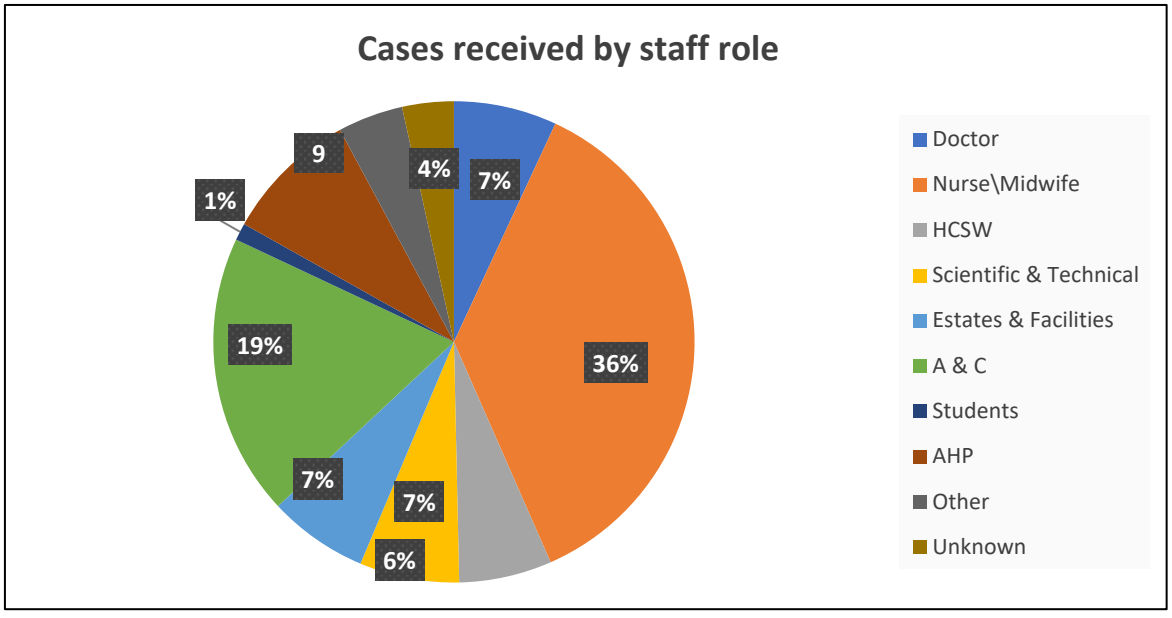
Reporting Period 2024/25	ULHT	LCHS
Number of issues raised	433	114
Number of issues raised anonymously	18	1
Number of issues raised with an element of Patient Safety	45	19
Number of issues raised about systems and processes	35	43
Number of issues raised with an element of worker safety	78	24
Number of issues raised with elements of Bullying/Harassment	50	13
Number of issues raised with elements of Behaviour and Relationships	52	50
Did the reporter describe having suffered detriment from speaking up	7	0
Number of issues raised through Champions (not included in figures raised through FTSUG)	18	0



LCHS



ULTH



Themes of Contact

LCHS

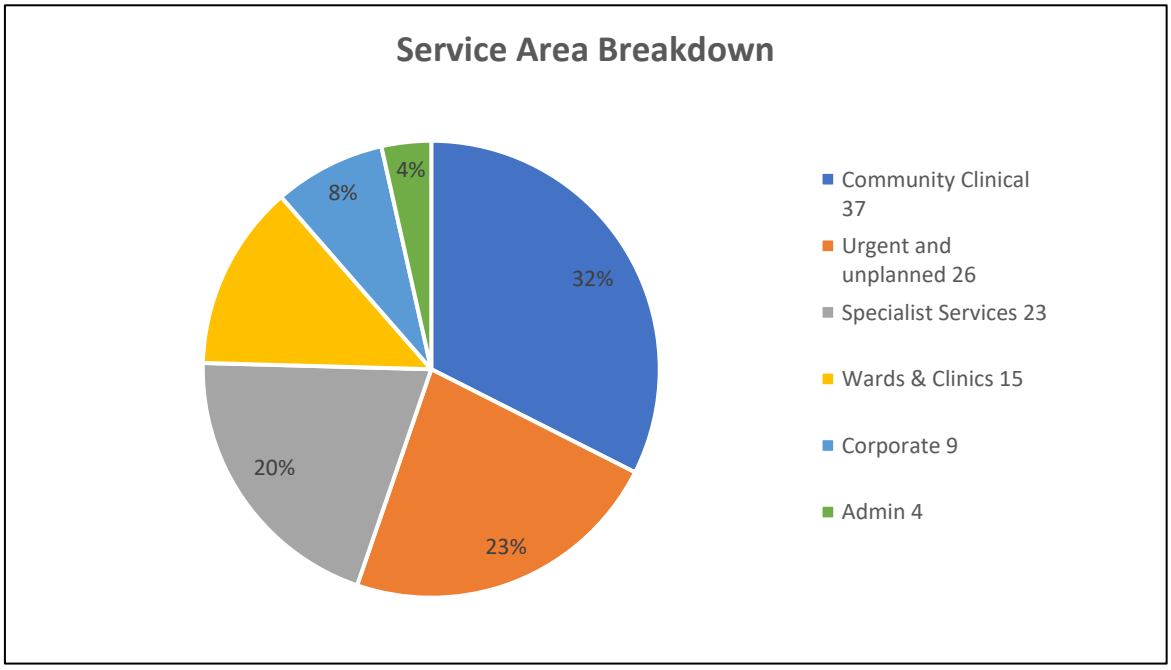
- 'Staff Experience' includes behaviours, communication issues and relationships.
- Systems and Processes - includes service change, questioning decisions, recruitment and selection, leave and interpretation of policies.
- Worker safety' includes health & safety at work and emotional wellbeing issues.
- Bullying and harassment is as identified by the contact.

ULHT

- Behaviours and Relationships
- Flexible Working/rota's
- Bullying and Harassment
- Patient Safety
- Worker Safety
- Systems and Processes
- Staffing
- Car Parking
- Policies and Processes
- Environment
- Job planning
- Recruitment process
- Communication
- Job descriptions/Job Matching
- Fraud
- Training/Development
- Behaviours and Relationships
- Flexible Working/rota's
- Bullying and Harassment
- Breach of Confidentiality
- Health and Safety
- Improvements
- Skill Mix
- Discrimination/Racism
- Staff Wellbeing
- Job banding
- Communication
- Uniform

The main themes are Behaviour and Relationships and the impact being uncivil has on working relationships, performance and wellbeing. Speaking up and not being listened to. Systems, Processes and Policies, Bullying and Harassment, Flexible Working and Recruitment issues and selection.

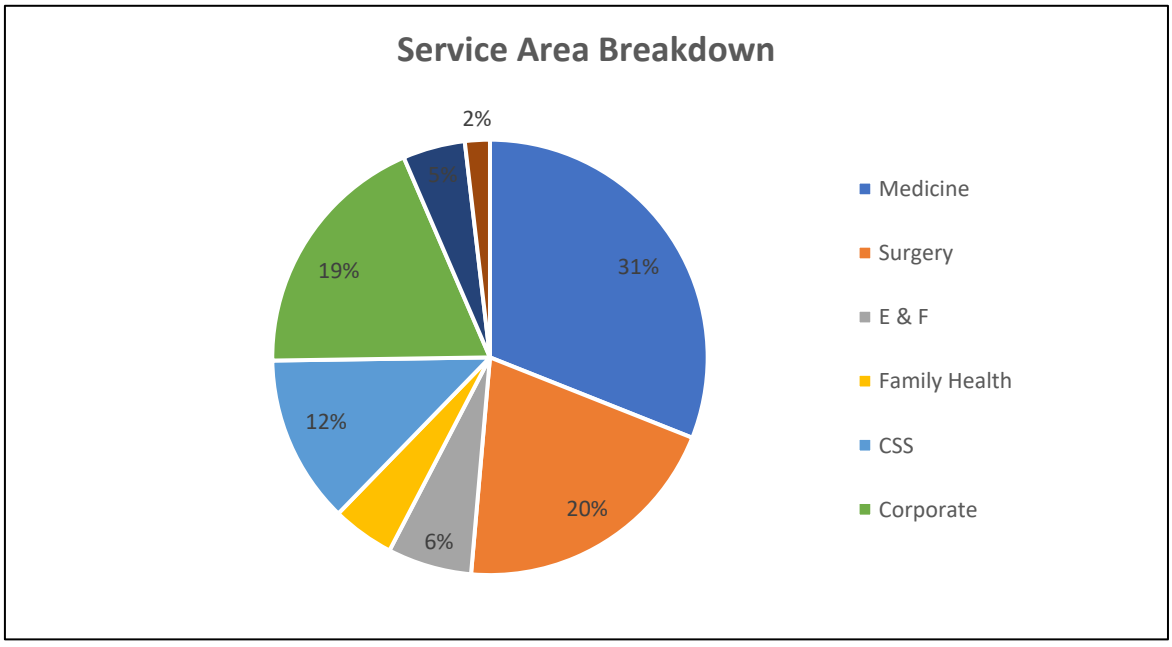
LCHS



Community clinical = Community nurses and HCSW, AHPs.

ULHT

Breakdown of concerns



The 433 referrals received in 2024/25 were across sites, Lincoln 234, Pilgrim 135, Grantham 60, Louth 3, External 1.

Highlight report - Details & Outcomes

Summary of FTSUG Activity LCHS	**Action/Outcome/Narrative**
Working practices.	This has become an increasing theme is recent FTSUG contacts. The FTSUG mainly signposted these to other areas such as unions or encouraged open dialogue with leaders and HR staff. Many of these cases reflect the current situation within the NHS and planned changes to focus services in line with requirements, although a significant amount were relating to mileage payments of community nurses who are disgruntled with the amount of miles they cover in view of staffing levels and the geographical size of Lincolnshire. The themes and narrative of the speak ups have been communicated to leaders of all levels
Staff relationship situations	Staff relationships are fluid and can be very situation specific. Any trends regarding individual behaviours are escalated within the line management structure in the first instance. Certain areas have made immense progress with their staff feeling free to raise all level of concerns and this has been communicated to the senior leadership team. The FTSUG is attempting to replicate this in other divisions. The development of resources to support leaders with team relationship issues have been welcomed and are shared now between the group. 4 cases cited bullying & harassment reason for contact these have not progressed to formal cases.
Summary of FTSUG Activity ULTH	
Behaviour and Relationships	Breakdown in relationships which were either managed via the FTSU route or progressed to mediation and HR processes.
Systems/Processes/Policies	• Policies not being followed. • Favouritism – not adhering to policies. • Breaching policies. • No consultation.

	• Flexible working
Staff Wellbeing	• Referrals to Wellbeing Service and EAP

Additional FTSUG Activities	During the reporting period the FTSUG has been involved in activities to support the workforce and promote the open culture. Activities include, digital promotions, study days, champion support and training sessions, site and group visits, production of a webinar, involvement in national campaigns, input into the sexual safety charter, participation in staff networks, system FTSUG meetings, triangulates themes and data with Trust Board and Senior Leadership Team.

Conclusion/Recommendations:

This report summarises the group contacts to Speak up Guardians for 2024/25. The issues raised and lessons learned have been submitted quarterly to the People Committee and the PSIRF meetings.

Opportunity to explore the themes are incorporated into the reporting process and FTSUG is able to expand on the narrative around specific themes and outcomes.

NHS
Lincolnshire Community and Hospitals NHS Group

Resident Doctors 10 Point Plan (*pertaining to NHSE 10 Point Plan to Improve Resident Doctors' Working Lives*)

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4th November 2025*
Agenda item number	*9.2*
Report title	*Resident Doctors 10 Point Plan (pertaining to NHSE 10 Point Plan to Improve Resident Doctors' Working Lives)*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Discussion* • *Approval* • *Assurance*
Accountable Director	*Professor Colin Farquharson, Group Chief Medical Officer, LCHG*
Author(s)	*Professor Colin Farquharson, Group Chief Medical Officer, LCHG* *Clare Frank, Business Manager to the Group Chief Medical Officer, LCHG*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Reasonable Assurance*
Prior approval process, if applicable	
Financial implications, if applicable	*TBC*
Action / decision required	*The board / committee is asked to:* • *Note the paper for awareness*

Assurance Rating Key:

Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are uncertain or possibly insufficient*
Red: Limited or No Assurance	*Effective controls are not in place or are insufficient to manage the risk identified and / or appropriate assurances are not available. Immediate action is required to address the gaps, weaknesses or non-compliances identified*

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	*X*
2b: Empower our people to continuously improve and innovate	
2c: Nurture compassionate and diverse leadership	*X*
2d: Recognising our people through thanks and celebration	
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	
3b: Move from prescription to prevention, through a population health management & health inequalities approach	
3c: Enhance our digital, research & innovation capability	
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	

Executive Summary

On 28 August 2025, NHSE sent a letter to all acute provider Trusts setting out a “10-Point Plan” to improve the working lives of resident doctors and initial actions to be taken over the next 12 weeks, with further milestones to be achieved into 2026. This letter and the required actions have previously been circulated and discussed at ELT in early September 2025 (and further updated upon in October 2025).

The document was circulated to key stakeholders within the Trust and a baseline compliance / gap analysis assessment undertaken which supported the organisational submission to NHSE on 12 September 2025. This assessment was submitted to NHSE by the Group Chief Medical Officer (GCMO) on behalf of the organisation.

In response to the above, the GCMO established a focused Task and Finish group to ensure that the Group enact the required actions based on the NHS ask and ULTH’s baseline / gap analysis. This group directly reports to the GCMO, and progress on the outstanding actions upwardly reported to ELT / People Committee (and subsequently to Trust Board) on a regular basis to ensure that the Trust meet the deadlines set by NHSE.

An attached Appendix (Appendix C) tabulates the current organisational position relating to the domains of the 10 Point Plan, identifies current area of compliance and gaps, and details actions already undertaken or proposed to deliver the domains of the 10 Point Plan.

Introduction / Background

On 28 August 2025, Sir Jim Mackey and Professor Meghana Pandit on behalf of NHS England (NHSE) wrote to all organisations to launch the national Getting the Basics Right for Resident Doctors programme (as per letter documented in Appendix A).

This initiative has now become colloquially known as the “Resident Doctor 10 Point Plan” and further details related to the components of the plan can be found in the subsequent document circulated from NHSE (called “10 Point Plan to improve resident doctors’ working lives”) and detailed in Appendix B.

As per the asks laid down in these documents from NHSE, this paper will detail the next steps carried out by ULTH (on behalf of the Group).

Key Points / Summary of Current Position

Following on from the above referenced NHSE communications, the Group has already undertaken the following actions:

- Carried out a full baseline assessment / gap analysis as requested by NHSE and submitted this to NHSE on 12 September 2025. Feedback from NHSE regarding the compliance assessment for the organisation is currently awaited.
- Formed a focused 10 Point Plan Task and Finish group meeting weekly that includes Postgraduate Medical Education (PGME), Medical Workforce, Guardian of Safe Working, Estates and Facilities, and Group Chief Medical Officer (GCMO) representatives. This group directly reports to the GCMO.
- Separate to the above, the Director of Medical Education is involved with relevant regional meetings with HEE / NHSE and is keeping the 10 Point Plan Task and Finish group updated with any pertinent information.
- Appointed a “Senior Lead for Resident Doctor Experience” (SLRDE) for the Group, who will be the GCMO.
- Undertaken a competitive process to appoint a Resident Doctor Peer Representative to work closely alongside the SLRDE, and subsequent to this process, Dr Arunpreet Sahota has been appointed on a tenure that will last for his duration with the organisation. In addition, as a result of the strength of the field of prospective candidates, there has also been the appointment of two Associate Peer Representatives to work alongside Dr Sahota.
- The CEO and GCMO have met with the Resident Doctor Peer Representative on 15 October 2025 following on from his appointment, and the GCMO (as SLRDE) and Peer Representative are going to meet on a weekly basis one-to-one, separate to the Task and Finish Group.
- The SLRDE and the Resident Doctor Peer Representative will be attending a face-to-face East Midlands launch event for the “Resident Doctor 10 Point Plan” on 6th November at Queens Medical Centre in Nottingham.

- The CEO, SLRDE and other Executive colleagues are scheduled to attend the LCHG Resident Doctor Forum on 12th November 2025, where the various elements of the 10 Point Plan, the actions already undertaken / completed, and those actions still outstanding can be discussed with the Resident Doctors within that forum. The Department of PGME are already promoting this meeting to ensure as many Resident Doctors as possible are able to attend, and the Care Groups have also been asked to facilitate wherever possible that the Resident Doctors can be released to attend this meeting.

For further detail, the table attached within Appendix C shows the questions asked by NHSE, the organisational response on 12 September 2025, and also the relevant actions on the various elements to date, with the respective RAG ratings on attainment / achievement.

Conclusion / Recommendations

From the baselining assessment, the Trust has already enacted several of the asks, in particular putting in place the most time-critical actions to appoint a senior leader representative (GCMO), recruiting a Resident Doctor Peer Representative, and arranging for the CEO and other key senior leaders to meet with the Resident Doctors to discuss the 10 Point Plan. Other actions are also in place to enable the implementation of the other elements of the 10 Point Plan.

This is demonstrated in the attached table in Appendix C, coupled with the commitment from all relevant stakeholder groups involved to meet weekly within the Task and Finish group, in order to maintain pace of delivery on the outstanding actions.

The Group Board are asked to note the contents of this paper and the attached Appendices for awareness.

It would be anticipated that the Board will continue to receive further information from the SLRDE / Resident Doctor Peer Representative, either via People Committee upward reporting which will update on the progress on actions, or directly to the Board.

To:
- NHS trusts and foundation trusts:
  - chief executive officers
  - medical directors
  - chief people officers
  - directors of communications

cc.
- NHS trusts and foundation trusts chairs
- NHS England regional:
  - directors
  - medical directors
  - directors of workforce, training and education

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

28 August 2025

Dear colleagues

Getting the basics right for resident doctors

Resident doctors are an integral part of the NHS. However, despite previous commitments to act on the concerns they have repeatedly raised about how they are treated as a rotating part of the workforce, many of these problems – payroll errors, poor rota management, lack of access to rest facilities and hot food, and unnecessarily repeating training – persist.

These concerns are within our collective gift to fix, and continued failure to do so risks further erosion of trust between resident doctors and their employers and undermining morale – which inevitably has an impact on patient care and the effective running of the NHS.

Resident doctors and their colleagues make a critical contribution to the NHS, and this will continue as we work together to deliver the 10 Year Health Plan. They should expect that we, as leaders, do everything within our power to make the NHS an excellent place to train and work. That is why we are today launching our 10 Point Plan to improve resident doctors' working lives – with actions set out in the annex below.

The Government is continuing to hold constructive conversations with the BMA RDC over their dispute, but the NHS must not wait for those to make the improvements to working conditions that residents doctors have been promised by their NHS employers and repeatedly let down on. That is why we are asking NHS Trusts to make progress on these actions now.

This plan sets out clear expectations for NHS England and providers, with a **12-week delivery window for initial actions** and further milestones extending into 2026. These

commitments have been made before and are the basics resident doctors should expect. Importantly, we will measure and be transparent about progress.

Next steps
Professor Meghana Pandit, NHS National Medical Director, will lead a national programme over the coming 12 weeks to complete, and make rapid progress on, the actions set out in the plan. Regional medical directors, regional directors of workforce, training and education, and regional deans will support local delivery.

As a first step, we would encourage boards or executive teams to arrange to meet with their resident doctors committee to discuss the issues addressed in the plan and any other local concerns. There will be an opportunity for us to discuss any additional issues raised through these meetings at the national meeting of CEOs on 16 September.

Further, we are undertaking a baseline assessment on several of the key areas for improvement. Please complete this survey by 11:59pm Friday 12 September.

Trust boards should take clear ownership of local improvements, develop action plans informed by feedback and national survey results, and report progress publicly. We understand there will be local circumstances which will impede progress on some of these actions; where this is the case we will work with you to understand and address them.

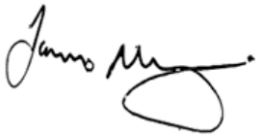
To demonstrate progress, from Autumn 2025 NHS England will begin publishing trust-level data on the following indicators as part of the NHS Oversight Framework:

- access to basic facilities (lockers, rest areas, hot meals, on-call parking spaces)
- work schedule and rota notice compliance
- self/preferential e-rostering
- payroll errors
- board-level reporting and assurance

We will work with all trusts to deliver these actions, support regions in overseeing progress, share updates with resident doctors through educators, medical directors and deans, and – importantly – champion local improvements, working with communications teams. We will host webinars to further discuss the plan and the role of leaders – invitations will be shared separately.

This plan is a recognition that we have not done enough, and a commitment to finally get the basics right. Resident doctors will rightly be sceptical that we will deliver on our commitments after being let down before. It is our job to prove them wrong. We ask for your leadership, urgency and accountability in delivering these changes.

Yours sincerely,





Sir Jim Mackey
Chief Executive Officer
NHS England

Professor Meghana Pandit
National Medical Director
NHS England

Annex: Summary of plan deliverables

Every NHS organisation is expected to act across the following 10 priority areas:

1. **Workplace wellbeing**
    - **Within the next 12 weeks, trusts should:** undertake an audit into the feasibility of improving priority areas like rest areas, parking when on call, mess facilities and 24/7 hot meals, as well as allowing resident doctors autonomy to complete portfolio and self-directed learning from an appropriate location for them.
    - The audit and subsequent plans should be approved by people committees and reported nationally.

    Intended impact for resident doctors: Doctors can expect better access to essential facilities like on-call parking, rest areas and hot meals, enhancing comfort and wellbeing during shifts.

2. **Rota and schedule transparency**
    - **From now, NHS England should:** provide 90% of trainee information to trusts 12 weeks before rotations.
    - **From now, trusts should**: issue work schedules at least 8 weeks in advance and detailed rotas no later than 6 weeks before rotations.
    - Performance data should be submitted and monitored nationally.

    Intended impact for resident doctors: Giving doctors more certainty and control over their work-life balance, reducing last-minute changes and stress.

3. **Annual leave reform**
    - **Within the next 12 weeks, NHS England will**: conduct and publish a review of how annual leave allocation is managed.
    - Recommendations will follow to ensure fair and consistent practices.

    Intended impact for resident doctors: Doctors will benefit from fairer and more consistent annual leave policies, supporting better rest and recovery.

4. **Board-level leadership**
    - **Within the next 6 weeks, trusts should:** appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board.
    - **In September 2025**, **NHS England will**: publish a national role specification for the board lead.
    - Each board should also ensure the executive team engages with resident doctors to understand and address local issues.

    Intended impact for resident doctors: Stronger engagement and accountability will ensure that doctors' working conditions are regularly reviewed and issues can be escalated.

5. **Payroll accuracy**
    - **Within the next 12 weeks, trusts should**: participate in the national payroll improvement programme.

- **By March 2026**: rotation-related payroll errors should be reduced by at least 90%.
- Trusts should establish board-level governance and begin national reporting.

Intended impact for resident doctors: Resident doctors will experience significantly fewer payroll errors as a result of rotations, improving financial stability and trust in the system.

6. **Eliminating mandatory training duplication**
    - **Within the next 12 weeks, trusts should:** comply with the May 2025 Statutory and Mandatory Staff Movement MoU to accept prior mandatory training, where this is not already the case.
    - **By April 2026, NHS England will**: introduce a reformed national framework for statutory and mandatory training.

    Intended impact for resident doctors: Doctors will no longer need to repeat mandatory training unnecessarily, saving time and allowing more focus on clinical duties.

7. **Exception reporting**
    - **NHS England will**: work with the BMA, NHS Employers and DHSC to continue with preparations for the implementation of the new national framework for exception reporting, to enable and encourage resident doctors to engage with this process

    Intended impact for resident doctors: The reforms to the Exception Reporting process will improve safe working practices and ensure doctors are paid fairly when they are asked to work extra hours.

8. **Course-related expenses reimbursement**
    - **Within the next 12 weeks, trusts should**: review their current reimbursement processes to ensure they can reimburse resident doctors upon submission of valid receipts for all approved study leave-related expenses, including travel and subsidence – not evidence of attendance/completion – so that reimbursement can take place within 4 to 6 weeks of claims being submitted.

    Intended impact for resident doctors: Doctors will be reimbursed faster for training costs and feel more able to prioritise their professional development.

9. **Rotation reform**
    - **Within the next 12 weeks**: Department of Health and Social Care and NHS England will develop and launch pilot rotational schemes and continue to look at wider reform.

    Intended impact for resident doctors: Pilot reforms will aim to make rotation management smoother and more predictable.

10. **Lead employer model expansion**
    - **In October 2025**: NHS England will produce a roadmap for extending the Lead Employer model to cover all resident doctors and dentists.

    Intended impact for resident doctors: Doctors will no longer need to change employers with each rotation, reducing paperwork and improving consistency in employment and training.

10 Point Plan to improve resident doctors' working lives

Fixing unacceptable working practices: getting the basics right for resident doctors

The 75,000 resident doctors working across the NHS are the backbone of the service – but too often they are let down on basic issues like payroll errors, poor rota management, lack of access to rest facilities and hot food, and unnecessarily repeating training.

While some progress has been made, it has been too slow, and many still face unfair and inconsistent working conditions.

Supported by our commitment to staff under the recently published 10 Year Health Plan for England, NHS England is setting out 10 ways in which we are improving resident doctors working conditions over the next 12 weeks.

This plan sets out actions for NHS England and individual trusts. To ensure meaningful progress, it will be formally incorporated into the new NHS Oversight Framework. However, trusts should proceed on the basis that it is already in effect and take appropriate action without delay.

Trusts are also expected to develop a Board Assurance Framework to provide oversight of this work. The outcomes should be included in their annual reports to demonstrate accountability and progress.

Every NHS organisation is required to act across all 10 areas within the next 12 weeks. Progress must be reported to their boards and, where actions are not met, a formal explanation and corrective measures should be provided.

Summary of the 10 Point Plan

1. Trusts should take action to improve the working environment and wellbeing of resident doctors
2. Resident doctors must receive work schedules and rota information in line with the Code of Practice
3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing
4. All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards.
5. Resident doctors should never experience payroll errors due to rotations
6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating
7. Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours
8. Resident doctors should receive reimbursement of course related expenses as soon as possible
9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery
10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate

1. Improve workplace wellbeing for our resident doctors

Trusts are expected to take meaningful steps to improve the working environment for resident doctors. Issues will vary by location, so trusts can adapt implementation to reflect local needs and operational realities in these and other areas:

- where possible, [provide designated on-call parking spaces]
- the autonomy to complete portfolio and self-directed learning from an appropriate location for them
- access to mess facilities, rest areas and lockers in all hospitals, including new builds
- a 24/7 out-of-hours menu offering hot meals and cold snacks for staff

Within the next 12 weeks every trust should: Conduct a self-assessment of the feasibility of improving priority areas and develop action plans to address any gaps. This audit and subsequent plans must be approved by the trust's people committee or

equivalent body. Trusts will be expected to provide updates for national reporting on progress.

2. Resident doctors should receive work schedules and rota information as per the requirements of the Rota Code of Practice

From now, and for all rotations going forward NHS England must provide at least 90% of trainee information to trusts 12 weeks prior to rotations commencing.

From now, Trusts must use this information to ensure that resident doctors receive their work schedules at least 8 weeks in advance and detailed rotas no later than 6 weeks before the rotation begins. Where these standards are not met corrective action must be taken. Performance data must be submitted by trusts, and NHS England will monitor and report on national compliance across all stages of the process.

3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing

It is vital that leave is allocated in a way that meets individual needs while maintaining service delivery.

Within 12 weeks, NHS England will: conduct a review of how annual leave is currently agreed and managed for our resident doctors. This review will identify areas for improvement and lead to clear recommendations to ensure a more consistent, transparent and supportive approach across all trusts.

4. All NHS trust boards must appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the board

Within 6 weeks, trusts should: appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board.

In September 2025, NHS England will: publish a national role specification for the board lead.

The senior lead will formally take on this responsibility within an existing role, supported by a national role specification to be published by NHS England in September. The resident doctor lead will act as a peer representative and enable trust boards to hear directly from resident doctors themselves. They should be invited to attend board level discussions on issues which specifically relate to improving doctors' working lives.

Boards should also ensure their executive teams engage directly with resident doctors to understand local working conditions and priorities. This should be supported by national and local data sources (for example, GMC/NET Survey), with improvement plans developed with the same rigour as staff survey responses.

5. Resident doctors should never experience payroll errors due to rotations

Following a successful pilot that has reduced errors by half, we are extending the learning from this work to all NHS trusts.

Within the next 12 weeks, every trust should: Participate in the current roll out of the national payroll improvement programme and ensure that payroll errors as a result of rotations are reduced by a minimum of 90% by March 2026. All organisations are required to establish a board-level governance framework to monitor and report payroll accuracy and begin national reporting as required.

6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating

Within the next 12 weeks if they are not already doing so, every trust should: Comply with agreements set out in the MoU signed by all trusts in May 2025 by ensuring acceptance of prior training.

By April 2026, NHS England will: reform the entire approach to statutory and mandatory training with a revised framework as outlined in the 10 Year Health Plan for England.

7. Resident doctors should be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours

A new national Framework Agreement for Exception Reporting was agreed on 31 March 2025 and will be rolled out for implementation in due course. The changes agreed simplify the reporting process for resident doctors, ensure they are being fairly compensated for the additional hours they are required to work, and will support the safety of their working hours.

We are committed to implementing these reforms as soon as practicable.

8. Resident doctors should receive reimbursement for course-related expenses within 4 to 6 weeks of submitting their claims

We will transition nationally from an approach where expenses for approved study leave are reimbursed only after a resident doctor has attended a course/activity, to one where reimbursement is provided as soon as possible after the expense is incurred.

Within the next 12 weeks every trust should: Review their current processes to ensure they can reimburse resident doctors upon submission of valid receipts for all approved study leave-related expenses, including travel and subsistence.

9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery

A review of how rotations are managed is now underway and is being led by the Department for Health and Social Care (DHSC) in conjunction with the British Medical Association (BMA). NHS England is working closely with the BMA to fully understand trainees' concerns and to find constructive and workable solutions to address their needs as a matter of priority.

Within 12 weeks, NHS England will: develop and launch suggested pilots of reformed rotational changes, while continuing to look at wider reform.

10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate, by expanding the Lead Employer model

NHS England is committed to extending the Lead Employer model to cover all resident doctors and dentists in training. This change will eliminate the need for trainees to change employers with each rotation, reducing duplication and administrative errors while improving continuity, efficiency, and the overall training experience.

By October 2025, NHS England will: develop a comprehensive and financially sustainable roadmap, underpinned by a robust business case. This will include detailed recommendations on costing and funding, service catalogue requirements, and pricing models for national implementation. The roadmap will provide a clear framework for expanding Lead Employer arrangements across the system**.**

Why are we doing this?

- Supporting resident doctors improves the quality of care offered to patients. Many of these steps will also improve the lives of other staff groups across the NHS.
- Our educators work hard to ensure that resident doctors' education and training is world class, but too often they have been let down on basic issues. The 10 Point Plan will help us respond to what resident doctors have been telling us.
- We have long recognised the need to improve the working lives of resident doctors, but we know we need to go further, faster to build on what we have already done.

Why the focus on resident doctors?

- Resident doctors are different from other staff because they provide care while training in different parts of the NHS, which means they move employer regularly for several years.
- All NHS staff are important, and we will continue to support improvements in working conditions, retention, health and wellbeing and facilities through the 10 Year Health Plan and the forthcoming NHS Workforce Plan.

What have we already done?

We have piloted a payroll improvement programme with 31 trusts to tackle the root causes of payroll errors leading to a 48% reduction in errors.	90% of trusts who responded to a recent survey have a named senior resident doctor lead responsible for improving doctors working lives issues and who report directly to trust boards on this issue.
Started a national review of the current system of resident doctor medical rotations to reduce administrative and bureaucratic burdens.	Learned from the best local initiatives such as an enhanced focus on sexual safety, health and wellbeing, improved local facilities such as doctors' mess, on-call facilities and car parking, and enhancements to HR medical staffing teams particularly around reviewing processes to inform these further national plans.

We have agreed a new national framework to improve exception reporting.	Established a new national project to explore extending Lead Employer arrangements, allowing resident doctors to have a single employer throughout their rotations.

What happens next?

We will immediately:

- include this work within the NHS Oversight Framework and work with all trusts to deliver these 10 actions
- ask NHS regions to support and oversee trusts in their delivery
- require trust boards to take clear ownership of local improvements to resident doctors' working lives by developing and implementing action plans informed by staff feedback and national survey results
- share these actions with all resident doctors via their educators, medical directors and deans, including with the new resident doctors who rotated in August, and expect them to hold us to account

From the autumn we will publish new data and information on**:**

- trusts delivering access to the basics – lockers, rest facilities, hot meals, on-call parking spaces
- delivery of 8 week work schedules and 6 week rota notice on rotations
- number of payroll errors
- self/preferential e-rostering
- percentage of trusts delivering board level reporting of issues
- changes to the way in which annual leave can be taken

Resident Doctor 10 Point Plan - Action plan				
Question	**Trust Response to NHSE 12.09.25**	**Actions required**	**Owner**	**RAG**
Facilities and support to Resident Doctors				
Access to lockers	Yes Partially	Maps showing all lockers, communication regarding bringing a padlock to be included in induction pack for all new starters	Lauren Boden Tracy Clarke/Wayne Cross	
Designated on call parking access	Yes Partially	Map showing designated parking spaces. After further clarification with NHSE, this element more reflects the ability of resident doctors to be able to park on hospital sites when on-call (as opposed to off-site street parking a distance away from hospital sites), so likely to be fully compliant with this element once formal confirmation of this guidance received.	Lauren Boden	
Rest Facilities	Yes Partially	Details of all Mess facilities, Progress living and how to book on-call rooms to be communicated out and also included at induction.	Rachel Bell Tracy Clarke/Wayne Cross	
Access to hot and cold food 24/7	Planning to introduce in the next 3 months	Procurement process currently ongoing - Resident Doctors invited to actively participate	Lauren Boden	
Access to cold food 24/7	Yes for all	Monitor		
Access to inductions (Res Drs)	Yes for all	Monitor		
Offer beds/pods free of charge to allow rest post duty for staff who feel to tired to drive home	Yes Partially	Details of all Mess facilities, Progress living and how to book on-call rooms to be communicated out and also included at induction	Rachel Bell Tracy Clarke/Wayne Cross	
Access to free psychological support and treatment	Yes for all	Monitor		
Positive feedback mechanisms to reward and promote staff for excellence	Yes Partially	Values award launched on 01.10.25 and on Resident Doctor Portal - so now compliant.		

Protected breaks	Planning to introduce in the next 3 months	To be discussed with Care Groups regarding factoring in protected breaks for their respective Resident Doctors.	Medical Workforce/Care Groups/GoSW	
Promotion of safe learning environment charter	Yes Partially	Is already included at induction for Resident Doctors, but not fully rolled out across workforce (hence why only partial compliance at present)	Wayne Cross/ELOD	
Sexual safety/harassment training	Yes Partially	Sexual safety charter launched, GCMO directorate already runs workshops for medical staff to attend on both sexual safety and harassment, but plans to roll out more broadly across whole resident doctor workforce (hence why only partial compliance at present)	Clare Frank/ELOD	
Resident Doctors must be able to take annual leave in a fair and equitable manner				
Local policy to encourage good annual leave management which explicitly includes reference to resident doctors	Not yet planning to introduce in the next 6 months	Draft SOP to be approved by GCMO and then to be launched to all Resident Doctors and Care Groups. GCMO has now approved SOP / policy - so now compliant.	Wayne Cross	
Is good annual leave practice covered at resident doctor induction	Yes	Monitor		
Do you allow resident doctors to carry over annual leave between rotations	Yes but for only internal rotations	Monitor		
If you answer Yes - how much leave do you allow	5 days and through mutual agreement	Monitor		

Do your rostering systems for RD allow for self/preferential rostering	No - systems do not allow for self/preferentials rostering	The current electronic platform does not support self rostering; however, RDs are encouraged to communicate with the Trust prior to rotation to enable any requests to be accommodated where appropriate. To be considered when current software tender is up for review and specification is written.	Medical Workforce/Procurement	
Appointing senior leads to take action on Resident Doctor issues				
Has your Trust Boad appointed a senior named accountable resident doctor lead	No	see below	GCMO	
If no - why and when do you intend to appoint one	We are waiting for the circulation of the JD from NHS E but in preparation of this arriving in the near future we have prospective individuals ready to potentially undertake the role pending the information from NHSE becoming available.	After circulation of JD, GCMO is now the appointed Senior Lead for Resident Doctor Experience reporting to Board - so now compliant.	GCMO	
Do you have a peer representative RD who your Board consults with on local issues relating to RD and improving working lives	Not at present, but we will always consult with our LNC or equivalent bodies on these matters	Interviews scheduled for 8 Oct 2025 - 8 candidates have put themselves forward. RAG will move to Green once successful candidate for Peer Representative role appointed. Subsequent to the interview process, Dr Arunpreet Sahota appointed to the Peer Representative position - so now compliant.	Ashok Kumar/Tracy Clarke/Clare Frank	

At what levels of the organisation have you reviewed and discussed the following surveys?				
GMC Trainee Survey	All	Monitor		
NETS survey	All	Monitor		
If you report GMC/NETs survey to any of the groups in Q above does the report contain a quality improvement plan with individuals assigned as responsible for action	Yes	Monitor		
How else do you try to understand and act on issues specific to resident doctors	Meet regularly with a representative body of Resident Doctors e.g. LNC, JCC, RDF, RDC	Continue with current processes		
	Have some other regular similar meetings	Continue with current processes		
	Meet regularly with BMA representatives	Continue with current processes		
	Resident Doctors Forum	Continue with current processes		
	Staff Survey Results specifically for Resident Doctors	Continue with current processes		
Have you implemented local SLAs and board level governance for tracking and reporting payroll errors	No	Need to develop a SOP to ensure all payroll queries go to one central point and then these will ensure tracking and reporting on errors can commence.	Medical Workforce	
Have you seen any changes in payroll errors over the past 12 months?	We do not monitor	See above	Medical Workforce	
Course related expenses must be reimbursed when expenses occur				

In relation to course fee reimbursement do you:	Only after attendance on a course, but planning on changing this approach within the next 3 months.	Reimbursement is done through Accent and PGME and it is now a new process that is documented on the Resident Doctor portal. A course fee can be claimed at time of booking and then expenses once the course has been attended.	PGME	
No resident doctor should unnecessarily repeat mandatory training when rotating				
Do you accept mandatory training completed by resident doctors elsewhere, in line with the Recognition of Statutory and Mandatory Training Memorandum of Training AND do you adhere to the People Policy Framework for Mandatory Learning agreed on 1 May 2025?	Yes to both these questions	No action at this stage - continue with current processes		

NHS
Lincolnshire Community and Hospitals NHS Group

Integration Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*10.1*

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

Accountable Director	*Daren Fradgley, Group Chief Integration Officer / Deputy Group CEO*
Presented by	*Rebecca Brown, Non-Executive Director/Deputy Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the Integration Committee;* • *Receive the Neighbourhood Board Terms of Reference* • *Received the EPR approval letters*

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	
2d: Recognising our people through thanks and celebration	
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*X*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	*X*
3c: Enhance our digital, research & innovation capability	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	*X*

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	4 November 2025
Report from:	Integration Committee
Report from meeting held on:	25 September 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Integration Committee at its meeting held on 25 September 2025 including assurances received and those matters which the committee wish to escalate to the Group Board.

2.0 Matters considered by the committee

2.1 The committee received and considered the following reports on which assurance was received:

Assurances in respect of Objective 3a:

a) Estates and Facilities Update
b) Safer Discharge Report
c) Service Sustainability Review

The Committee noted the progress being made in respect of estates and facilities with space utilisation continuing to progress to support cost reduction and increase utilisation.

Major building works were noted to be continuing with some delays being experienced with the Pilgrim ED build phase 1b, this was due to complete in October. The endoscopy build at Lincoln was progressing well with an anticipated completion of May 2026.

Updates were offered in respect of the strategic projects underway with the Committee noting the need for the operational issues to be addressed with rounded discussions required to support the strategic position of a number of these.

The Committee received the Safer Discharge Report which was commissioned by the Quality Committee and offered an overview of key findings including assessment of patients and readiness for discharge not being where required, with risk appetite higher at peak times of activity resulting in patients being discharged sooner than ready. The report was

considered at this committee due to the oversight of the discharge transformation programme.

Assurance was offered that harm was not being caused through current discharge processes however the issues raised were known and there was a need to rebrand discharge services, and the operating model, as a transfer of care through the work being undertaken with support partner Newton.

The Committee received the new framework in place for evaluating service sustainability, noting that this was based on the NHS England sustainability framework domains and had been adapted from successful deployments in other Trusts. Assurance was received by the Committee on the actions being taken to manage the current risks.

Assurances in respect of Objective 3b:

a) Alliance Sterring Group Upward Report
b) TOM Group Upward Report
c) Neighbourhood Board Terms of Reference **(appended)**

The key projects under the Alliance Steering Group were progressing with health inequalities having been mapped with recognition of ongoing work to produce maps for the care groups. It was noted the work was progressing in respect of rheumatology, with this becoming a blueprint for left shift with the service focusing on community delivery, clinical efficiency and workforce deployment.

Work was due to take place in phase with workshops due to be held with partners to support left shift work and anticipated mobilisation between January to March 2026. The committee agreed that each left shift programme will have a report presented to the committee

The Committee noted that work has paused in respect of the target operating model due to the work of the ICBs to move to cluster arrangements. It was noted that some activity continued with due diligence being undertaken.

The Neighbourhood Board terms of reference were received by the Committee with recognition that these has been agreed by the Chief Executive's within the system with the first meeting scheduled for October 2025.

Assurances in respect of Objective 3c:

a) M365 Business Case Evaluation
b) Lessons learnt – Migration and BadgerNet
c) Shared Care Record
d) Research and Innovation Group Upward Report

The Committee received a suite of reports associated with a number of significant IT projects noting the lessons learned from the projects and the significant work achieved by the teams.

The Electronic Patient Record approval letters **(appended)** had been received at the August Committee and appended to the report for Board oversight.

The revised report in respect of the Shared Care Record offered the figures associated with the novation of the contract to the Group with recognition that upward reporting of this would move to the Digital Oversight Group.

Research and Innovation was noted to be progressing in respect of the development of the 5-10 year strategy, as well as the increase in local research activity, which was on track to achieve the target for recruits to trials.

Further discussions continued to be required in respect of clinical academics with a proposal for a job description to be produced to facilitate discussions.

Assurances in respect of Objective 3d:

a) Productivity and Transformation Oversight Forum Upward Report

The report was received for information with the Committee noting the position presented.

Assurances in respect of other areas:

a) Board Assurance Framework 2025/26
b) Committee Performance Dashboard
c) Avoidance Dashboard
d) Risk Register

The Committee received the new style dashboard noting that this remained in development with narrative updates requiring population. Feedback had been received in respect of the style and functional areas now grouped for easier oversight. Further developments would continue, and the performance reported was noted.

The first iteration of the avoidance dashboard was received which offered the number of beds saved and considered for each of the services that continued to the bed position. The headline bed days saved, and units of activity would be included in the main dashboard moving forward.

The Committee received the risk register noting a decrease in the score of the TB risk, not other changes had been made.

3.0 Matters on which the committee was not assured and has requested additional information and assurance:

3.1 The committee requested additional information and assurance on the following matters:

a) None

4.0 Matters for reporting / escalation to the Group Board

4.1 The committee agreed the following matters for reporting / escalation to the Group Board:

a) None

5.0 Confirm or challenge of the Board Assurance Framework (BAF):

5.1 The committee considered the areas of the BAF for which it has oversight and no changes are proposed.

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the Integration Committee;
- Receive the Neighbourhood Board Terms of Reference
- Received the EPR approval letters

Rebecca Brown, Non-Executive Director/Deputy Chair

25 September 2025

Lincolnshire Neighbourhood Health Board

Version Control

Version- Date	Author changes
1- 12/08/2025	AS initial draft
2- 02/09/2025	SRM post DF recommendations
4- 02/09/25	Further changes
5- 09/09/2025	Final changes post conversations with systems CEOs

Background and Purpose

The **Lincolnshire Neighbourhood Health Board** is a unified vehicle to enable place-based, collaborative care models at scale across a range of partners. Its purpose is to provide strategic alignment, joint planning and resource allocation at system level, enabling partners to deliver the ambitions set out in the 10-year plan. This includes neighbourhood health and integrated neighbourhood working transformation underpinned by a population health approach.

Convened on behalf of the system, the Lincolnshire Neighbourhood Health Board brings together key senior leaders from primary care, community and acute providers, mental health, local authority, and the ICB. This will provide strategic alignment with the national and local direction of travel.

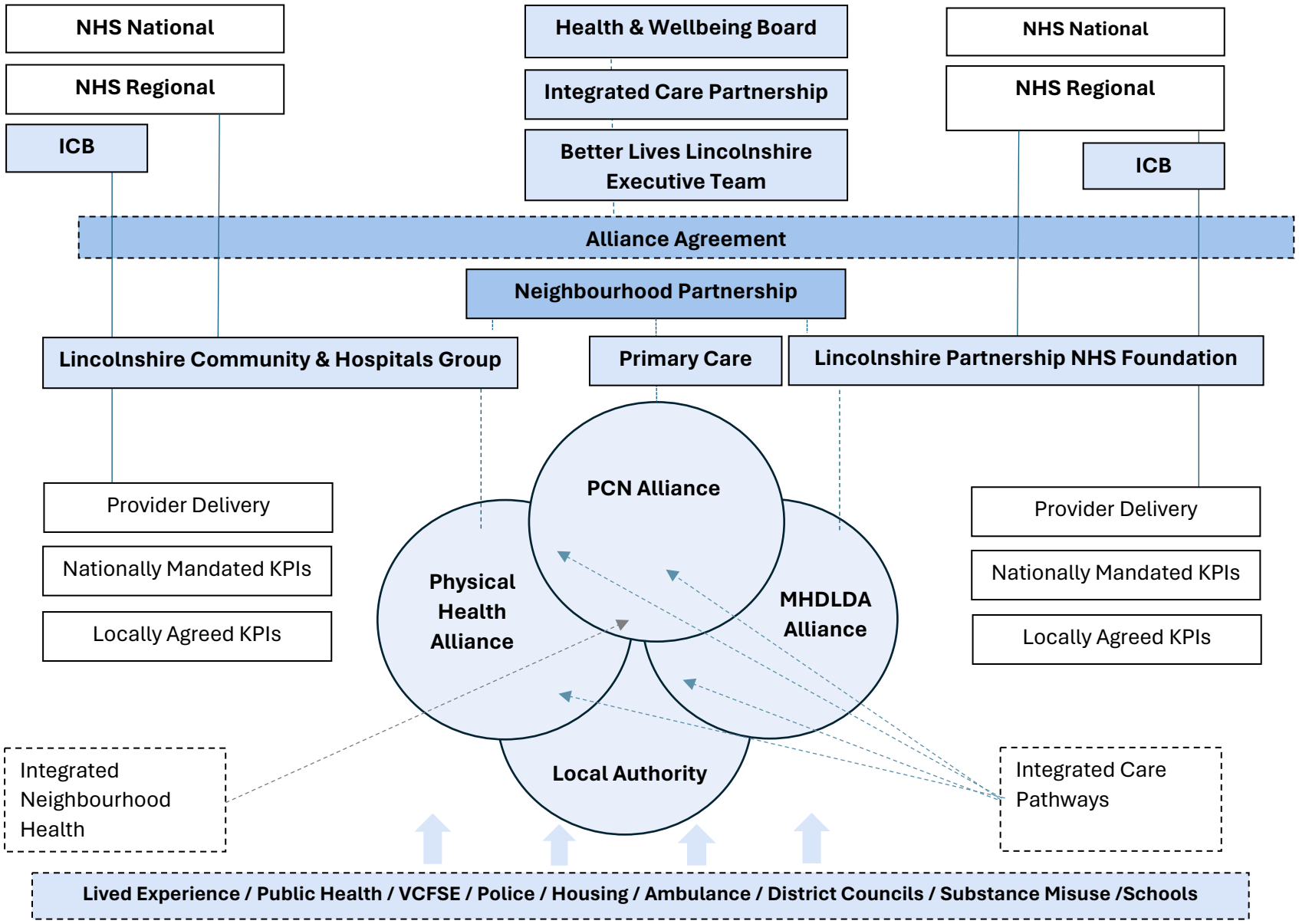
The Board is a robust partnership across NHS partners through which we can respond to future demand and changing levels of need, changing funding levels, new legislation, policy imperatives, and NHS strategic direction.

The **purpose** of the **Lincolnshire Neighbourhood Health Board** is to identify, scope, resource and oversee delivery of the work programme including:

- **Strategic alignment:** Setting the overall direction and priorities to guide the work, ensuring it aligns with strategic goals. Create an Alliance agreement to cement collaboration between independent organisations, defining shared objectives, responsibilities, and governance to achieve mutual benefits for our Lincolnshire population.
- **Decision-making:** Collectively making key decisions related to the Alliance Board's activities and projects.
- **Delivering:** Driving and delivering key pathway redesign, service improvement and large-scale change with clear improvement on KPIs and benefits realisation for our staff, citizens and patients.
- **Monitoring and evaluation:** Monitoring the progress of the Alliance Board's work and evaluating its effectiveness.
- **Engagement and communication:** Ensuring effective engagement and communication with patients, public, staff, stakeholders and interested parties.

The Lincolnshire Neighbourhood Health Board forms a key part of **collaborative governance arrangements** for Lincolnshire. It pulls the substantial work already be completed in the alliance approach of each organisation and aligns it to deliver neighbourhood health. It brings together key programmes of work across the NHS partners, enabling the focus and delivery of the Lincolnshire neighbourhood heath approach as outlined in the 10 year health pla

Lincolnshire Healthcare Alliance Model



The Lincolnshire Neighbourhood Health Board will be underpinned by a set of **agreed collaborative partnership principles**, objectives and behaviours that will support delivery of the key priorities.

- The Board will **operate on a "one system" ethos**, recognising that collaboration is essential to achieving sustainable change.
- **The Board does not have authority over individual organisational boards and will report into appropriate organisational governance mechanisms.** (This board has similar authority as the System Planned Board/Urgent Emergency Care Board)
- Collective responsibility: all members are committed to a common vision of improving population health and reducing inequalities through integrated neighbourhood delivery.
- **Decisions will be guided by what is best for the communities served**, rather than individual organisational interests.
- Shared purpose and mutual trust.
- Equity and inclusion.
- Transparency and accountability.
- Continuous learning and improvement.

Responsibilities

- Strategic planning and population health management including ensuring interdependencies for key 'left shift' specialities are identified and managed across the partnership.
- Service integration, workforce development and managing service fragility across neighbourhood.
- Deploying a standardised approach to Neighbourhood Health and Integrated Neighbourhood Teams.
- Driving deployment of digital integration.
- Ensure health and care system sustainability through more effectively managing system cost whilst maintaining appropriate quality and safety.
- Innovation, improvement, Health Inequalities insights and a standardised QI approach across Lincolnshire.
- Shared accountability and data driven decision-making and programme delivery.
- Hold leads to account on delivery of key priorities.
- Unblock wicked issues/legacy relationships and escalate matters through system and individual governance routes to achieve resolution.
- Learn and share best practice to achieve the best outcomes for our population.

Measures of success

- Trust between partners
- Meeting neighbourhood health needs
- Health outcomes and inequalities
- Service access and integration
- Workforce engagement and stability
- Financial efficiency and delivery
- Community co-production and satisfaction.

Membership

The Lincolnshire Neighbourhood Health Board consists of a small core membership with each organisation nominating 2 members on the Board. The Board will be chaired by Group Deputy

Chief Executive/Group Chief Integration Officer, LCHG (Daren Fradley), who will be the SRO. The Deputy Chairs will be Dr Kaval Patel and Chris Higgins.

- LCHG x 2
- LPFT X2
- Primary Care Network Alliance (PCNA) x2
- Lincolnshire County Council x2
- Lincolnshire ICB x2
- Lincolnshire Care Association (Linca)x1
- Age UKx1
- St. Barnabas x1

Where appropriate, **members should nominate a suitable deputy** who is able to attend, decision make and actively participate on their behalf during periods of absence.

Other clinical and corporate leaders, subject matter experts, patient reps, and other stakeholders will be invited to attend as required by the agenda.

Attendance and Quorum

The Lincolnshire Neighbourhood Health Board will be quorate when, as a minimum, the following are present:

- Chair.
- At least one representative from LCHG and LPFT.
- At least one representative from PCNA and LCC.
- At least one representative from Lincolnshire ICB and the local authority.

Members should attend at least 80% of meetings in each financial year but should aim to attend all. Ad hoc attendance by other staff or changes/additions to membership will be agreed as required or to support the agenda. Observers will be permitted by agreement with the Chair.

Frequency & Review

The Lincolnshire Neighbourhood Health Board will meet **monthly**.

The Terms of Reference for the Lincolnshire Neighbourhood Health Board will be reviewed quarterly by the members and submitted to LLG and the relevant organisational committees/boards for approval to ensure they remain fit for purpose.

Accountability and Reporting Arrangements

The Lincolnshire Neighbourhood Health Board is appointed and established by the system leaders and the outputs and reporting from the meetings, including a monthly upward report from the Chair on the work programmes, assurance against milestones and any escalations, will be shared with:

- Member's committees/boards.
- Lincolnshire Leaders Group.
- The relevant board, committee or group for any matters outside the Lincolnshire Neighbourhood Health Board Terms of Reference as required.

To note: the restructuring of Lincolnshire ICB—marked by clustering with neighbouring ICBs and the transfer of operational functions to neighbourhood providers—will significantly affect the

coordination and oversight mechanisms embedded in key forms like BLLET and LLG, we will update the TOR (reporting lines/accountability structures) via the Neighbourhood Health Board.

Department of Health & Social Care

NHS

Paul Tritton
Deputy Director – Investment Appraisals, Major Projects and Capital Delivery Portfolios, Department of Health and Social Care
Email: Paul.Tritton@dhsc.gov.uk

Ollie Clarke
Director of Capital, NHS England
Email: oliver.clarke5@nhs.net

BY E-MAIL

27/05/25

Karen Dunderdale
Chief Executive Officer
United Lincolnshire Hospitals NHS Trust

Cc:

Daren Fradgley
Chief Information Officer
United Lincolnshire Hospitals NHS Trust

Dear Karen,

United Lincolnshire Hospitals NHS Trust Electronic Patient Record Full Business Case

We are writing to confirm full approval of the Full Business Case (FBC) for the United Lincolnshire Hospitals NHS Trust (ULHT) Electronic Patient Record (EPR).

Approval is subject to the requirements set by EPRIB and Cabinet Office approval. A full list of conditions will be set out in the EPRIB Letter of Endorsement. You must comply with all requirements set out in that letter.

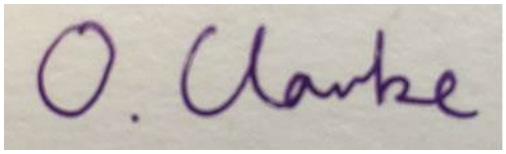
Yours sincerely,



Paul Tritton

Deputy Director - Investment, Major Projects and Capital Delivery Portfolios
Department of Health and Social Care

Victoria Street, London, SW1H 0EU



Ollie Clarke

Director of Capital
NHS England

CC:

dermot.ryan@nhs.net

Lizzie.love@nhs.net

kevin.briggs@nhs.net

Paul.Tritton@dhsc.gov.uk

Emily.Curtis@dhsc.gov.uk

rparr@nhs.net

IA@dhsc.gov.uk

nicola.hollins@nhs.net

To: Karen Dunderdale (CEO, United Lincolnshire Hospitals NHS Trust)

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

27 May 2025

BY E-MAIL

Karen.Dunderdale@ULH.nhs.uk

Dear Karen,

United Lincolnshire Hospitals NHS Trust (ULHT) Electronic Health Record Programme – Full Business Case (FBC)

I am writing to you as the Chair of the Electronic Patient Record Investment Board (EPRIB) to confirm approval, with conditions, of the Full Business Case (FBC) for the Electronic Health Record programme for United Lincolnshire Hospitals NHS Trust (ULHT).

The EPRIB considered v3.0 of the case, this was endorsed conditionally for Joint Investment Committee (JIC) and Cabinet Office approval on Wednesday, 08 January 2025.

Subsequently the Cabinet Office Spend Controls assurance has concluded, and the status is approved. The FBC will therefore be fully approved on receipt of the JIC approval letter, noting any additional conditions of approval that may arise.

Conditions of Approval

The key approval conditions applied by EPRIB and Cabinet Office, are attached in Annex A. The Department of Health and Social Care (DHSC) and NHS England will need to see these fulfilled by the Trust, to ensure achievement of the core capabilities as defined in the Digital Capability Framework, and what is set out in the FBC. Please note this includes the addition of the following condition raised during the EPRIB meeting:

- Regional Support & Collaboration - Given the challenging timeline set out in the case, the constrained financial context, and the developing digital capabilities at ULHT, the trust are required to work closely with, and to share services relating to the provision of the EPR, with the trusts in the East Midlands Acute Provider (EMAP) collaborative.

We can acknowledge the resubmitted, updated conditions log (attached) that confirms that pre-contract approval conditions have been met as stated in Annex A. Therefore, upon receipt of the JIC approval letter, the Trust are authorised to proceed to contract signature subject to any JIC approval conditions that are stipulated.

Please note that any post contract-signature conditions must be completed as stated, including those set by Cabinet Office; all of which are consolidated within the conditions log in Annex A:

- ULHT to provide lessons learned from the initial procurement and the market failure of the subsequent procurement with detail of root causes of such failures and recommendations on how these can be avoided in future EPR procurements under the new LPP framework for same provision. The Lessons Learned report to be provided to NHSE EPR team, LPP and the CO Commercial Controls by *1st August 2025*.

- ULHT to provide a contingency plan for a case of the selected supplier's performance failure, either during implementation or operational phase. ULHT to include with the contingency plan detail of mitigations to be put in place to avoid supplier lock in at the end of the contract period. To be provided by *1st July 2025*.

The central funding allocation from the Frontline Digitisation programme (FD) is £57.4m Capital and £9.5m Revenue as set out in Annex C. The trust has already received £16m Capital and £3.8m Revenue from this total amount.

This approval has been agreed subject to revenue affordability, which will remain under review. Should the financial position deteriorate we reserve the right to rescind the approval.

Should there be any fundamental or material changes to the project that would impact the approved FBC or contract (either prior to or after contract signature), or more than a 5% increase above the approved costs at FBC, then you must inform the Business Case Review Service (BCRS) Team via the BCRS mailbox (nhsdigital.fd-businesscasereview@nhs.net). This should occur in advance of any solution or agreement being implemented.

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Public communications regarding the EPR scheme will need approval by FD, via your FD Partnering Engagement Lead Ian.Nelson@nhs.net.

We wish you every success in your implementation and go-live. If you require any support in the interim, please do not hesitate to reach out to Ian.Nelson@nhs.net.

Yours sincerely,

Derm Ryan
Senior Responsible Owner for Frontline Digitisation

cc. Daren Fradgley (SRO, United Lincolnshire Hospitals NHS Trust)
Will Goodwin (NHS England, Regional Director of Digital Transformation – Midlands)
Laura Mills (NHS England, Regional Finance Lead – Midlands)
Ian Nelson (NHS England, Engagement Lead – Midlands)
Kevin Briggs (NHS England, FD Business Case Review Service Lead)
Richard Parr (NHS England, Head of Capital and Cash)

Please note - We recommend that you download this letter and open in Adobe Acrobat Reader. Any embedded attachments should then show on the attachments side panel (to the right-hand side of the letter).

Annex A – Conditions Log

ULHT EPRIB Conditions.xlsx

Annex B – EPR Query Log

ULHT EPR queries log.xlsx

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Annex C – Capital and Revenue

Incremental SoCI

SoCI

Type	BAU	£ Year 0	£ Year 1	£ Year 2	£ Year 3	£ Year 4	£ Year 5	£ Year 6	£ Year 7	£ Year 8	£ Year 9	£ Year 10	£ Year 11	£ Year 12	£ Year 13	£ Year 14	£ Total
Income																	
Income	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	**£ -**
Savings	£ -	£ -	£ -	£ -	£ -	£ -	£ 4,086,452	£ 9,003,442	£ 13,123,854	£ 14,578,222	£ 15,369,622	£ 15,369,622	£ 15,369,622	£ 15,369,622	£ 15,369,622	£ 15,369,622	**£ 148,379,324**
	£ -	**£ -**	**£ -**	**£ -**	**£ -**	**£ 4,086,452**	**£ 9,003,442**	**£ 13,123,854**	**£ 14,578,222**	**£ 15,369,622**	**£ 15,369,622**	**£ 15,369,622**	**£ 15,369,622**	**£ 15,369,622**	**£ 15,369,622**	**£ 15,369,622**	**£ 148,379,324**
Expenditure																	
Depreciation	£ -	£ -	£ -	£ -	-£ 25,000	-£ 50,000	-£ 174,000	-£ 5,526,000	-£ 5,584,000	-£ 5,784,000	-£ 5,569,000	-£ 4,961,000	-£ 5,017,000	-£ 4,805,160	-£ 4,805,160	-£ 4,805,160	-£ 489,500	**-£ 47,594,980**
Direct Pay Expenditure	£ -	-£ 29,000	-£ 150,000	-£ 624,000	-£ 870,800	-£ 316,900	-£ 425,100	-£ 425,100	-£ 425,100	-£ 425,100	-£ 425,100	-£ 425,100	-£ 425,100	-£ 425,100	-£ 425,100	-£ 425,100	-£ 425,100	**-£ 6,241,700**
Direct Non-pay expenditure	£ -	-£ 1,046,000	-£ 2,619,992	-£ 1,683,700	-£ 4,655,903	-£ 7,244,000	-£ 4,903,600	-£ 5,333,300	-£ 5,333,300	-£ 5,333,300	-£ 5,333,300	-£ 5,333,300	-£ 5,333,300	-£ 5,333,300	-£ 5,333,300	-£ 5,333,300	-£ 5,333,300	**-£ 70,152,895**
	£ -	**-£ 1,075,000**	**-£ 2,769,992**	**-£ 2,332,700**	**-£ 5,576,703**	**-£ 7,734,900**	**-£ 10,854,700**	**-£ 11,342,400**	**-£ 11,542,400**	**-£ 11,327,400**	**-£ 10,719,400**	**-£ 10,775,400**	**-£ 10,563,560**	**-£ 10,563,560**	**-£ 10,563,560**	**-£ 6,247,900**	**-£ 123,989,575**
Operating Surplus / (Deficit)	**£ -**	**-£ 1,075,000**	**-£ 2,769,992**	**-£ 2,332,700**	**-£ 5,576,703**	**-£ 3,648,448**	**-£ 1,851,259**	**£ 1,781,454**	**£ 3,035,822**	**£ 4,042,222**	**£ 4,650,222**	**£ 4,594,222**	**£ 4,806,062**	**£ 4,806,062**	**£ 4,806,062**	**£ 9,121,722**	**£ 24,389,748**
Finance Costs																	
PDC	£ -	£ -	£ -	-£ 26,000	-£ 51,000	-£ 128,000	-£ 1,938,000	-£ 1,769,000	-£ 1,645,000	-£ 1,541,000	-£ 1,428,000	-£ 1,278,000	-£ 1,278,000	-£ 1,278,000	-£ 1,278,000	-£ 1,278,000	-£ 1,278,000	**-£ 14,916,000**
Impact of Trusts I&E (Surplus / (Deficit))	**£ -**	**-£ 1,075,000**	**-£ 2,769,992**	**-£ 2,358,700**	**-£ 5,627,703**	**-£ 3,776,448**	**-£ 3,789,259**	**£ 12,454**	**£ 1,390,822**	**£ 2,501,222**	**£ 3,222,222**	**£ 3,316,222**	**£ 3,528,062**	**£ 3,528,062**	**£ 3,528,062**	**£ 7,843,722**	**£ 9,473,748**

Income and Expenditure

Revenue	22/23 £'000	23/24 £'000	24/25 £'000	25/26 £'000	26/27 £'000	27/28 £'000	28/29 £'000	29/30 £'000	30/31 £'000	31/32 £'000	32/33 £'000	Total £'000
Total revenue costs	-1,075	-2,770	-2,359	-5,628	-7,863	-12,793	-13,111	-13,187	-12,868	-12,147	-12,053	-95,854
Cash releasing benefits					4,086	9,003	13,124	14,578	15,370	15,370	15,370	86,901
PDC funding received	1,075	2,770	2,359	3,279								9,483
Net system revenue position ((deficit)/surplus)	**0**	**0**	**0**	**-2,349**	**-3,777**	**-3,790**	**13**	**1,391**	**2,502**	**3,223**	**3,317**	**530**
Adjustment for depreciation funding not assumed in case												
Anticipated depreciation funding available to drawdown			25	50	174	5,526	5,584	5,784	5,569	4,961	5,017	32,690
Net system revenue position ((deficit)/surplus) (adjusted for anticipated depreciation funding)	**0**	**0**	**25**	**-2,299**	**-3,603**	**1,736**	**5,597**	**7,175**	**8,071**	**8,184**	**8,334**	**33,220**

* Revenue funding assumed by trust in 2024/25, but not confirmed in system allocation.

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Sources and Applications of Funding

	22/23 £'000	23/24 £'000	24/25 £'000	25/26 £'000	26/27 £'000	27/28 £'000	28/29 £'000	29/30 £'000	30/31 £'000	31/32 £'000	32/33 £'000	Total £'000
Capital spend - FBC position	**£5,343**	**£6,104**	**£4,600**	**£41,308**	**£1,287**	**£2,312**	**£2,444**	**£999**	**£2,154**	**£2,702**	**£2,444**	**£71,697**
Funding source												
PDC drawdown	£5,343	£6,104	£4,600	£41,308								£57,355
Lincolnshire ICS					£1,287	£2,312	£2,444	£999	£2,154	£2,702	£2,444	£14,342
Revenue spend - FBC position	**-£1,075**	**-£2,770**	**-£2,359**	**-£5,628**	**-£3,777**	**-£3,790**	**£13**	**£1,391**	**£2,502**	**£3,223**	**£3,317**	**-£8,953**
Funding source												
PDC drawdown	£1,075	£2,770	£2,359	£3,279								£9,483
Lincolnshire ICS contribution / (benefit)				£2,349	£3,777	£3,790	-£13	-£1,391	-£2,502	-£3,223	-£3,317	-£530

*Revenue - £2,348k funding assumed in 2024/25 is deferred to 2025/26

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NHS
Lincolnshire Community and Hospitals NHS Group

Integration Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*10.1*

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

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Rebecca Brown, Non-Executive Director/Deputy Chair*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the Integration Committee;*

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	
2d: Recognising our people through thanks and celebration	
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*X*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	*X*
3c: Enhance our digital, research & innovation capability	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	*X*

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	4 November 2025
Report from:	Integration Committee
Report from meeting held on:	24 October 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Integration Committee at its meeting held on 24 October 2025 including assurances received and those matters which the committee wish to escalate to the Group Board.

2.0 Matters considered by the committee

2.1 The committee received and considered the following reports on which assurance was received:

Assurances in respect of Objective 3a:

a) Estates and Facilities Update
b) Continuous Planning Update (Transformation) **(appended)**
c) Update on Lymphoedema Service Transformation
d) MSK AQP Physiotherapy
e) Transformation of Clinical Pathways via Left Shift – Focussed discussion
f) Mapping of Integrated Neighbourhood Teams
g) Patient Service Hub update
h) UCR/HV/Falls/LIVES update
i) Stroke/CLEAR Project update

Progress of the Carbon Energy Project with the chosen supplier now noted with the project now mobilising and the contract being finalised. Neighbourhood health hubs were being explored with recognition that external investment may be required to support delivery.

The Committee was pleased to note the identification of space for the booking centre and noted the changes made to open space bookings, resulting in potential cost savings, through the requirement of proactive bookings.

Concern was noted in respect of underoccupancy with Progress Living which had resulted in a financial impact with work being undertaken to determine how occupancy levels could be increased.

The Continuous Planning update was received by the Committee, with recognition that this would be led by the Finance and Performance Committee, however this would support alignment of transformational change. The planning cycle would move to a 5-year plan, with 2-year continuous planning, focused on bottom-up planning.

The improvements in the Lymphoedema service were noted to be significant following the reviewed of the service to address the 52-week wait backlog. The Committee noted that there was further work to do to ensure that those patients being seen by the service were appropriate however the reduction in the waiting list had been achieved in a little over 4-months.

There was recognition of the work being undertaken to redesign the MSK service with the report offering an ambitious and modern way forward with a need to push for improvement in patient care whilst being financially effective. The Group would need to support and influence the direction of travel, driven by the leadership of the Group.

Left-shift work had focused on 2 women's health projects, unscheduled bleeding and CNS clinics with system involvement and partnership working. The active education with primary care had shown improvement in the patient experience and it was hoped that this would result in a reduction in in 2-week wait referrals that were not appropriate.

The Integrated Neighbourhood Teams report offered oversight of the proposed 8 teams that would link into the Primary Care Networks and GPs with a need to map teams against the operating model, creating core teams with specialists overlayed. Further input would now be sought on the proposal and this would be taken through approval process.

Progress was noted in respect of the patient services hub project with the Committee noting that this was not a new approach nationally and the changes would impact on both clinical teams and patients. The project was being supported by the Executive Team and further updates would be offered to the Committee at future meetings.

Integration of the Urgent Community Response, home visiting, falls and LIVES was noted to have had a significant impact on both patient and staff experience with an improvement in timely responses to patients and the engagement and partnership working for staff. It was noted that there were some challenges with digital barriers and data sharing however action was being taken to resolve this.

The Stroke/CLEAR project continued to progress with the outputs expected to be available to the Group by the end of October which would offer a pathway for the service. Improvements were noted in processes as well as community bed provisions enabling patients to return home following a shorter length of stay in acute services.

Assurances in respect of Objective 3b:

a) Alliance Group Upward Report
b) TOM Group Upward Report
c) Overarching Health Inequalities Plan Update

The Committee was pleased to note the programme being made in the Alliance Group and the workstreams beneath thing noting that updates in relation to these workstreams were being seen through the reports being offered to the Committee.

The position in relation to the Target Operating Model (TOM) was noted with a pause in the programmes of work due to the changes taking place within the ICB. The Group would pause work in this area whilst changes took place.

Health inequalities activity was noted to be progressing in line with the plan in place with the development of a dashboard to support the understanding of available data. There has been an increase in Health Inequalities champions supporting the work and following an internal audit, further actions were being identified.

Assurances in respect of Objective 3c:

a) Digital Oversight Group Upward Report
b) Digital Planning and Delivery Update

Progress was noted in respect of both the Electronic Patient Record (EPR) and Electronic Documentation Management System (EDMS) however continued resource challenges were noted, with actions in place to address these. It was noted that digital clinical oversight would move into the patient safety remit and would therefore begin to report through to the Quality Committee.

Assurances in respect of Objective 3d:

a) Productivity and Transformation Oversight Group Forum Upward Report

The Committee received the report noting the position presented and recognised that updates were being received by the Committee through reports to the Committee.

Assurances in respect of other areas:

a) Board Assurance Framework 2025/26
b) Staff Story
c) Committee Performance Dashboard
d) Risk Register
e) Policy position

The Committee received the performance dashboard noting the progress being made in respect of the new format and the detail now included within this which was being aligned to the National Oversight Framework (NOF).

The risk register was received with the Committee noting the movement in risks presented and the need for confirmation of appropriate ownership of the risks presented, to enable mitigations and actions to be delivered.

The policy position was received and noted in respect of research policy documents.

3.0 Matters on which the committee was not assured and has requested additional information and assurance:

3.1 The committee requested additional information and assurance on the following matters:

a) None

4.0 Matters for reporting / escalation to the Group Board

4.1 The committee agreed the following matters for reporting / escalation to the Group Board:

a) None

5.0 Confirm or challenge of the Board Assurance Framework (BAF):

5.1 The committee considered the areas of the BAF for which it has oversight and no changes are proposed.

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the Integration Committee;

Rebecca Brown, Non-Executive Director/Deputy Chair

24 October 2025

NHS
Lincolnshire Community and Hospitals NHS Group

Continuous Planning Update: NHSE Planning Framework Update including LCHG Planning overview

Caring and building a healthier future for all

Meeting	*Integration Committee*
Date of meeting	*24/10/25*
Agenda item number	*9.2*
Report title	*Continuous Planning Update- NHSE Planning Framework Update including LCHG Planning overview*
Report Purpose: • Discussion	*Update IC (following ELT approval and GLT discussions) on the proposed planning framework process, timeline and approach*
Accountable Director	*Daren Fradley, Deputy CEO, CIO*
Author(s)	*Sameedha Rich-Mahadkar, Group Director of Strategy, Improvement and Redesign* *Becky Maxwell, Strategy Manager* *Gareth Hart, Strategic Business Partner – Strategy and Planning* *Angela Sharp, Deputy Director of Strategy & Partnership* *Dave Plumb, Deputy Director Strategy & Partnership*
Financial implications, if applicable	*N/A*
Action / decision required	*IC is asked to note the proposed planning framework process, timeline and approach*

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	✓
2d: Recognising our people through thanks and celebration	✓
Population: Better Health – Improve population health:	✓
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	✓
3b: Move from prescription to prevention, through a population health management & health inequalities approach	✓
3c: Enhance our digital, research & innovation capability	✓
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	✓

Executive Summary

The 10-Year Health Plan (10YHP) sets out the need for a significant change to the way we organise, deliver and fund services. A new model of planning is required to meet the challenges and changing needs of England's population and, crucially, build the foundation for the transformation of our services. Change needs to be delivered at scale, and planning is a key supporting function to deliver this in a coordinated way.

To achieve at scale change, planning will **shift to 5-year plan** (Year 1 in greater detail, 4 years high level). Planning must be continuous, iterative and support transformational change.

A **draft Planning Framework has been released by NHSE setting out the approach to planning through to 2031** outlining roles and responsibilities for providers, the ICB and the expected planning activities.

All organisations will be asked to prepare credible, integrated five-year plans and demonstrate how financial sustainability will be secured over the medium term.

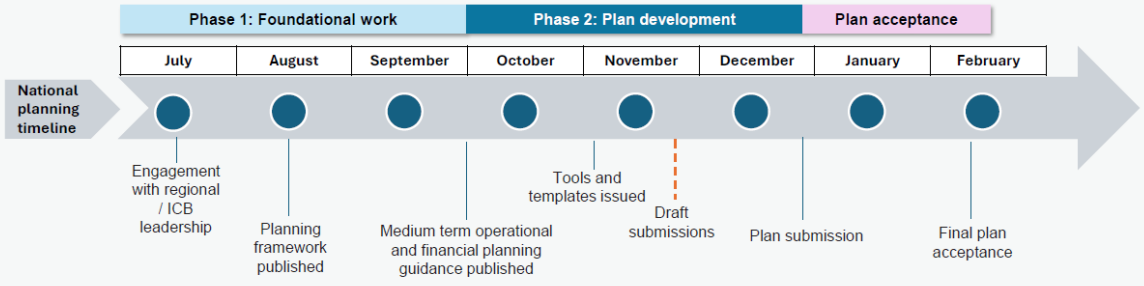
This means developing plans that:

- Build and align across time horizons
- Join up strategic and operational planning
- Are co-ordinated and coherent across organisations and different spatial levels
- Demonstrate robust triangulation between finance, quality, activity and workforce.

The delivery of planning is proposed to be carried out in **2 distinct phases:**

- **Phase One**: Foundation setting (governance, evidence base, strategy refresh)
- **Phase Two**: Plan development (triangulation, assurance, board sign-off).

Potential timetable for 2026/27 – across two phases



Regional activities	Develop medium-term strategic framework Engage with ICBs and providers to identify support needs		Risk-based planning support to ICBs and providers		Review of draft plans	Plan assurance and acceptance
ICB activities	Set up process, governance and build a robust evidence base	Create outline commissioning intentions and discuss with providers	Integrated planning		Finalise plans & board sign-off	Respond to outcome of plan assurance / Prepare to implement plans
Provider activities	Set up process, governance and build a robust evidence	Complete foundational work	Integrated planning		Finalise plans & board sign-off	
Outputs		Underlying financial position Block contract reviews		Draft Planning returns	Five year plans National returns	

Note - potential of a pre-Christmas submission deadline (tbc)

The attached slide pack includes detail on the proposed key actions and milestones in Phase 1 and 2. Based on feedback from the 2024/25 planning round, the Planning Team has developed a **continuous planning approach** to embed with planning activities across the year and not in one peak time period (usually winter).

Planning is underway for **Q3 including the following workshops for Care Group triumvirates/quadrumvirates, Business Partners, Efficiency Managers and key enablers.** However the **key Autumn planning tasks** to December 2025 include:

September:

- Finalise PHM packs, Re-establish Planning Steering Group (PSG), Review last years plans with Care Groups.
- Overarching approach to annual plan (26/27) and 5 year integrated plan socialised with care groups
- Data packs created by the planning team
- Demand and capacity modelling

October:

- Care Groups to review Insights- Population health/Productivity and Efficiency packs to inform 5 year integrated plans
- Demand and capacity modelling complete
- Planning assumptions for activity/workforce/finance to commence planning round
- CIP workshops

November:

- CIP workshops contd.
- Draft 5 year care group integrated plans

December:

Triangulation and agree overarching priorities and plans for 25/26 sign off

Recommendations:

- IC is asked to note the proposed planning framework process, timeline and approach.

NHS
Lincolnshire Community and Hospitals NHS Group

Continuous Planning Update: NHSE Planning Framework Update including LCHG Planning overview

12 October 2025- v3

Caring and building a healthier future for all

Purpose

This paper provides a summary of the recent NHS England (NHSE) planning framework (see https://www.england.nhs.uk/long-read/planning-framework-for-the-nhs-in-england/), highlighting key updates and implications. In parallel, it outlines progress on our internal planning process, including associated timelines and identified risks.

Key developments to date include:

1. **Reinvigoration of the Planning Steering Group**: The group has been re-established with active involvement from key subject matter experts (SMEs) and deputy leads to collaboratively shape planning assumptions and drive the planning round.

2. **Collaborative Engagement with Care Groups**: A structured approach has been initiated to work with care groups in developing a comprehensive 5-year Integrated Delivery Plan.

3. As part of our **continuous planning approach**, the Strategy, Improvement and Redesign Team is actively working with care groups throughout the year to identify and develop additional Cost Improvement Programme (CIP) schemes (highlights in **Appendix 1**). This ongoing engagement enables:

    - Proactive Identification: Supporting care groups in spotting emerging opportunities for efficiency and transformation outside of the annual planning cycle.

    - Responsive Planning: Allowing plans to evolve in real-time, reflecting operational pressures and strategic priorities.

    - Enhanced Delivery: Strengthening the pipeline of CIP schemes to improve delivery confidence and financial sustainability

4. **Commencement of the Planning Round**: The planning cycle is now underway, supported by targeted engagement and data-driven insights. **Appendix 2**: Provides an illustrative example of the information, data, and analytical outputs being used to support care groups in the planning process.

NHSE Draft Planning Framework – Overview

Executive Summary

- The 10-Year Health Plan (10YHP) sets out the need for a significant change to the way we organise, deliver and fund services.
- A new model of planning is required to meet the challenges and changing needs of England's population and, crucially, build the foundation for the transformation of our services.
- Change needs to be delivered at scale, and planning is a key supporting function to deliver this in a coordinated way.
- To achieve at scale change planning will **shift to 5-year plan** (Year 1 in greater detail).
- Planning must be continuous, iterative and support transformational change.
- A **draft Planning Framework has been released setting out the approach to planning taking trust to 2031** outlining roles and responsibilities for providers, the ICB and the expected planning activities.

The Planning Aim

All organisations will be asked to prepare credible, integrated five-year plans and demonstrate how financial sustainability will be secured over the medium term.

This means developing plans that:

- Build and align across time horizons
- Join up strategic and operational planning
- Are co-ordinated and coherent across organisations and different spatial levels
- Demonstrate robust triangulation between finance, quality, activity and workforce.

The delivery of planning is proposed to be carried out in **2 distinct phases**.

Phase One: Foundation setting (governance, evidence base, strategy refresh)
Phase Two: Plan development (triangulation, assurance, board sign-off)

Principles of Planning

Outcome Focused:
Planning should be anchored in delivering tangible and measurable improvements in outcomes for patients and the public, and improved value for taxpayers. Involving patients, carers, and communities is critical for ensuring that plans deliver better outcomes and services that are responsive to local needs.

Accountable and Transparent:
Effective planning requires clarity on roles, responsibilities, and accountabilities. Governance structures must support transparent decision-making, provide regular oversight and constructive challenge, and ensure alignment with strategic objectives at organisation, place and system level.

Evidence Based:
The decisions made as part of planning should be underpinned by robust analytical foundations, including population health analysis, demand and capacity modelling, workforce analytics, and financial forecasts. This should be informed by best practice.

Multidisciplinary:
Planning must bring together staff from across different functional areas (finance, workforce, clinical etc) to ensure that work is co-ordinated and that those responsible for delivery have shaped its content.

Credible and Deliverable:
Plans must set ambitious yet achievable goals. They should clearly articulate the resources required, realistically reflect workforce and financial constraints, and include mitigation strategies for key risks. Robust triangulation between finance, performance, workforce and quality is critical.

LCHG Planning Principles

Why Planning Matters:

- We care for thousands of people and spend £1 billion of public money each year.
- Strong planning ensures we deliver high-quality, efficient, and safe care.
- The NHS environment is complex and constantly changing – we must stay ahead.

What Is Our Planning Intent:

- A clear plan for how we'll work together to deliver care in 2025/26 and beyond to 2030/31.
- Shift from annual peaks to **continuous, year-round planning**.
- Align efforts across care groups, enablers, and system partners.

What have we Learned:

- Planning teams merged successfully across Group – we're now one team.
- Strong governance exists; we need to ensure timely decision making.
- We must:
  - Start earlier
  - Communicate better
  - Ensure we don't stand down planning/CIP workshops

Our New Approach – Continuous Planning, A year-round cycle of:

1. Planning Preparation – Learn from the past year.
2. Care Group Engagement – Workshops, check-ins.
3. Embed Strategic Business Partners with Care Groups
4. Data-Led Delivery – Use insight to inform actions.
5. Review & Refine – Adapt continuously based on results.

Monthly Planning Check-ins, each month, we will:

- Review delivery of current year's plan.
- Co-design next year's priorities.
- Provide targeted support from Strategic Business Partners.
- Build a shared view across the Group.

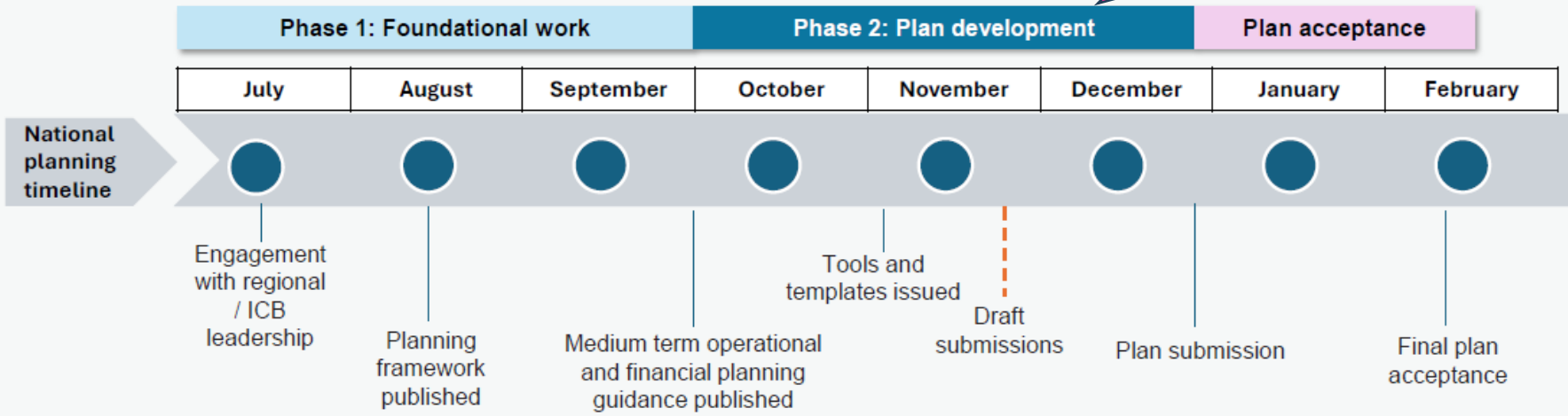
What We Need from Senior Leaders:

- Champion the approach – show planning matters.
- Attend monthly check-ins and key workshops.
- Make timely decisions and communicate clearly.
- Be honest, tell us when its working and when its not
- Encourage Care Group ownership and collaboration.

NHSE Planning Framework Draft Timeline

NOTE Potential pre- Christmas planning submission (21 Nov first draft and final plans w/c 15th Dec)

Potential timetable for 2026/27 – across two phases



Regional activities	Develop medium-term strategic framework Engage with ICBs and providers to identify support needs		Risk-based planning support to ICBs and providers		Review of draft plans	Plan assurance and acceptance	
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Key Autumn Planning Tasks

October:

- Care Groups to review Insights- Population health/Productivity and Efficiency packs to inform 5-year integrated plans
- Demand and capacity modelling complete
- Planning assumptions for activity/workforce/finance to commence planning round
- Care group workshops

November:

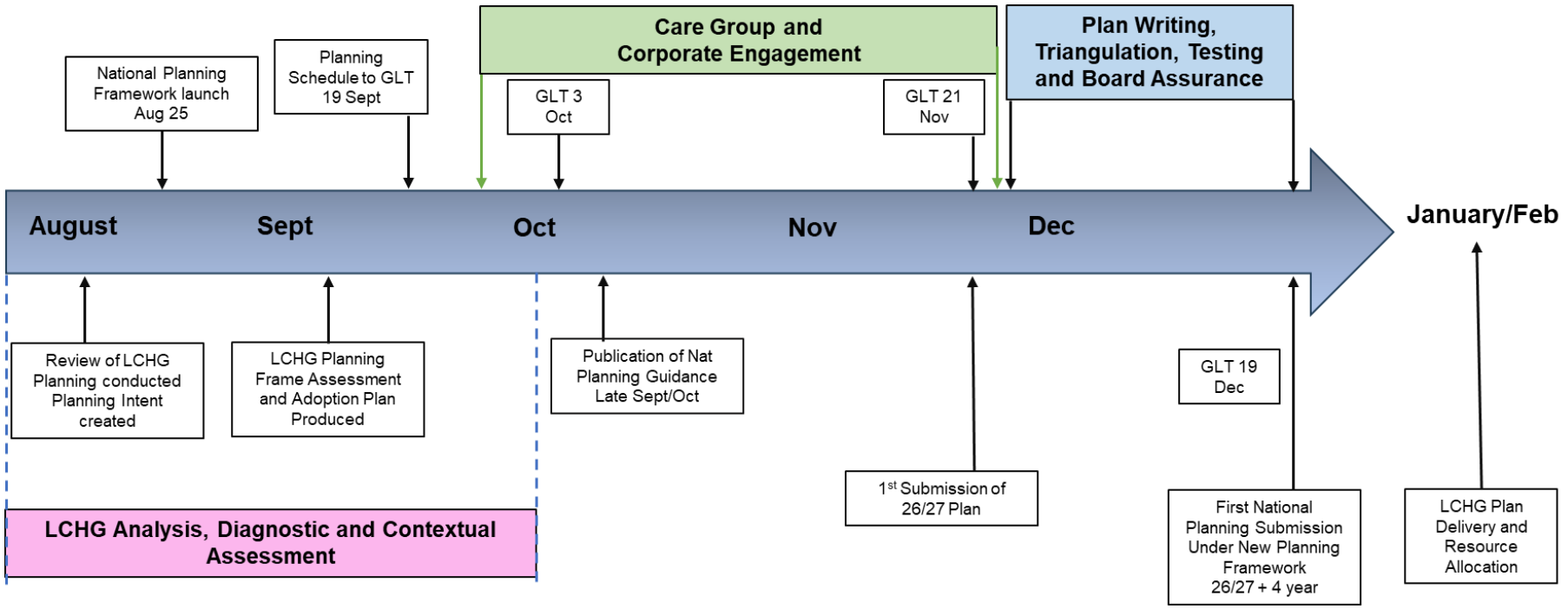
- Care group workshops contd.
- Draft 5-year care group integrated plans

December: triangulation and agree overarching priorities and plans for 25/26 sign off

Indicative NHSE Planning Timescales

Month (2025)	Date	Key Milestones
August		Publication of National Planning Guidance
September	19th	Planning Framework update - GLT
	30th	Diagnostic exercise to inform planning
	Late Sept/Oct	Publication of national planning priorities and templates
October	2nd	ELT update following publication of guidance
	3rd	GLT update
	8th – 22nd	Care Group workshops
		Triangulation / Plan writing / Draft submission
November	21st (approx.)	First Submission
	End Nov – Dec	Finalise Plan / Triangulation
December	w/c 8th	LCHG Board Assurance
	w/c 15th (approx.)	ICB Full Submission to NHSE

LCHG Planning Touch Points



Key Risks

- The timescales set by NHS England are extremely tight, requiring an agile and flexible approach.
- There is a risk that care groups, business partners, and supporting corporate functions may not have sufficient capacity to deliver the required work within the timeframe.
- Limited capacity could impact the depth and quality of the plans being developed.
- The compressed timeline may affect the robustness of the outputs

Key components of the NHS Planning Framework

NOTE the key Phase 1 and 2 actions and milestones on slides 5 and 6

- **Integrated Planning Process**:
  - **Phase One**: Foundation setting (governance, evidence base, strategy refresh)
  - **Phase Two**: Plan development (triangulation, assurance, board sign-off)

- **Triangulation**:
  - Align finance, workforce, activity, and quality plans using shared data and assumptions.

- **Plan Assurance**:
  - Ensure plans are credible, deliverable, and affordable through scenario planning and sensitivity analysis.

- **Roles & Responsibilities**:
  - **National**: Strategy, tools, guidance
  - **Regions**: Support and assurance
  - **ICBs**: Strategic commissioning, system coordination
  - **Providers**: Operational delivery, collaboration
  - **Place Partners**: Local input and integration

Note the key outputs from the planning round

- **Core Planning Outputs**:
  - Five-year strategic commissioning plans (ICBs)
  - Five-year integrated delivery plans (Trusts)
  - Neighbourhood health plans
  - National plan returns

- **Specialised Services Transition**:
  - ICBs to take full commissioning responsibility for screening, vaccinations, and health & justice services by April 2027

Care Groups – What Does Planning 2026/27 Look Like?

Monthly triumvirate/ quadrumvirate meetings with LCHG Planning Team:

- Commencing August 2025, with Planning and key enabler colleagues to look at progress on 2025/26 plan delivery and to think about and define 2026/27 plan content.
- These monthly meetings will support the embedding of a continuous planning approach, with planning activities undertaken across the year and not in one peak time period.
- Dedicated support to Care Group MDs via introduction of Strategic Business Partner roles (on-going).
- Importantly these meeting will enable review of progress towards set plans but through a supportive conversation.

Examples of Supportive Products:

- Strategy and planning led, co created insights through co-ordination with SMEs to provide planning oversight.
- Transformation of planning to become more Care Group focused to support Care Groups and their teams to plan effectively.
- Leading productivity and efficiency with SME support.
- Dedicated CIP/transformation/productivity and capacity and demand modelling packs based on model hospital data to inform business planning for the care groups.
- Introduction of seasonal planning approach across LCHG with clear roles and responsibilities for Care Group leaders and a coordination role for the LCHG Planning Team.

What support can Care Groups expect this year?

October/November- 5 year integrated delivery plan/ CIP and productivity workshops

Format:

- Attendees will be, as a minimum, divisional triumvirates/quadrumvirates, Care Group Business Partners, HR/Finance BPs/Efficiency Managers and key enablers

- Dedicated workshop in October/Nov 2025/26 which will:
  - Build a shared understanding of population health needs
  - Identify areas of transformation/fragile services and opportunities for redesign
  - Draft a 5-year strategic plan and Y1 operational plan
  - Review CIP and productivity delivery against plan for 2025/26
  - Identify CIP and productivity schemes to carry over from 2025/26 to 2026/27

- Supported by a pre-shared data pack which will include:
  - Best practice and PLICS data suggesting opportunities for consideration
  - Model hospital/GIRFT opportunities

Output:

- 5 year integrated delivery plan per care group
- Ideas generation based on data insights and CIP/productivity/service transformation
- Clear actions with timescales and owners
- Agreed year 1 operational plan
- Agreed transformation/QI/CIP and productivity plan for 2026/27

December 2025 – Annual Plan workshop

- Key enablers, with co-ordination by LCHG Planning, will triangulate delivery of plans across finance, activity and workforce at the end of H1 which will inform 2nd quarterly meeting.

- Utilising this information, they will identify areas of non-delivery with a suggested reasoning for this to inform Care Group Action Plans to recover position.

- Data and Insight will be utilised to drive planning with a more iterative approach to plan development being used.

- Thematic planning is likely to be driven around key patient pathways i.e. Unplanned Care across Group.

- The aim is to be less bureaucratic and more holistic and supportive of functional planning.

In discussion with key corporate subject matter experts, given tight timescales, we may utilise GLT workshop style for some of the CIP and productivity opportunity discussions (TBC).

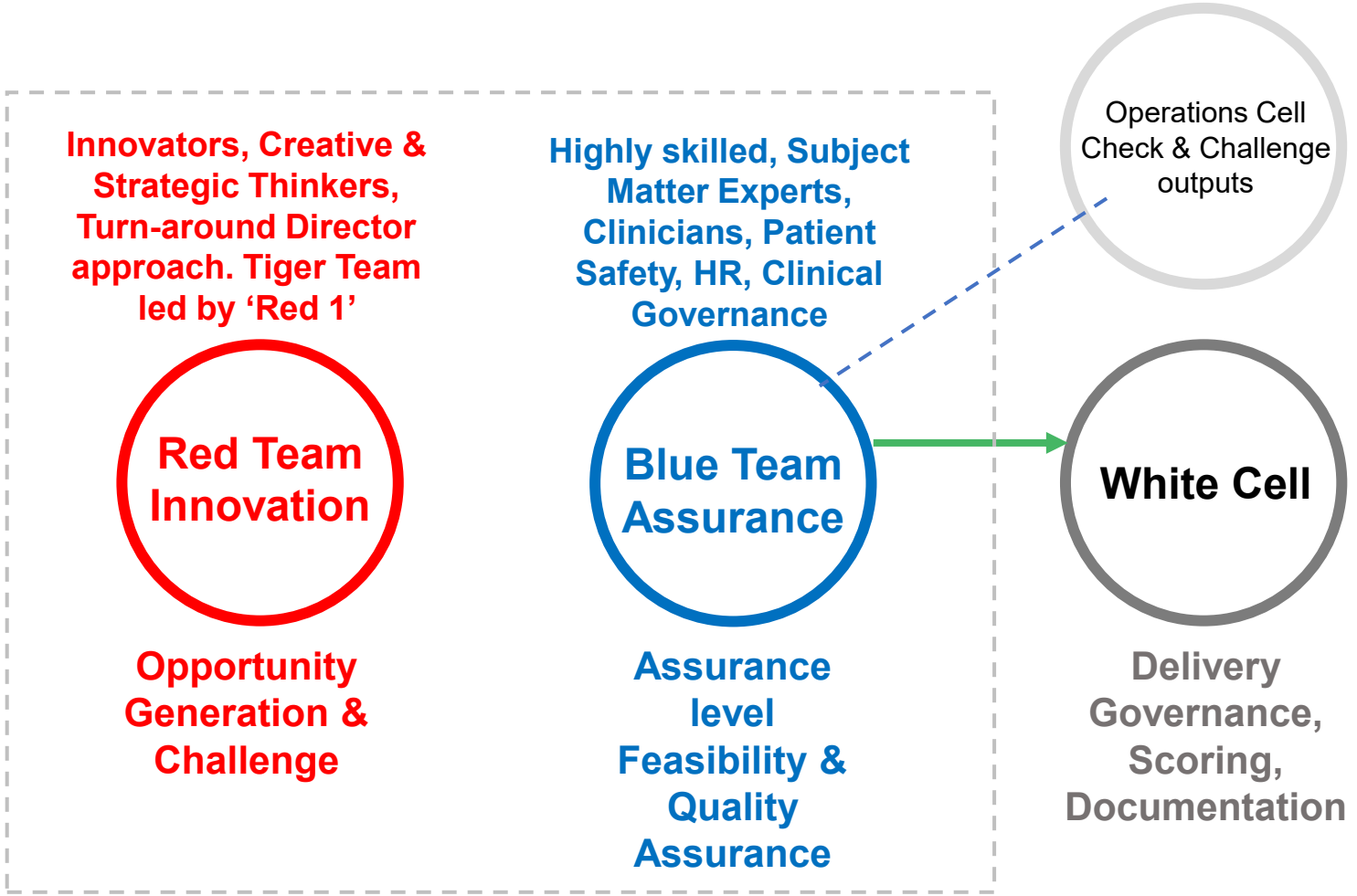
Appendix 1

- As part of our continuous planning approach, the Strategy, Improvement and Redesign Team is actively working with care groups throughout the year to identify and develop additional Cost Improvement Programme (CIP) schemes. This ongoing engagement enables:
    - **Proactive Identification**: Supporting care groups in spotting emerging opportunities for efficiency and transformation outside of the annual planning cycle.
    - **Responsive Planning**: Allowing plans to evolve in real-time, reflecting operational pressures and strategic priorities.
    - **Enhanced Delivery**: Strengthening the pipeline of CIP schemes to improve delivery confidence and financial sustainability

Tiger Team Approach – Key principles

- Be clear what you are trying to achieve e.g. 5% annual saving in 26/27
- Any internal/externa constraints
- Apply clear, consistent criteria (see scoring and selection) and filter into ‘buckets’:
  - Develop the idea (Red, Blue, White team roles including Red 1)
  - Pipeline for next year
  - Park
- Get the right people on the pitch in the right roles and trust the team
- Face-to-face ideally
- Expect conflict, be uncomfortable
- Question assumptions
- Use data to identify opportunities but don’t get bogged down in the detail
- Record of decisions

Tiger Team Approach – Building the team



Tiger Team Approach – Methodology

ACTIVITY	LEAD	OUTPUT
SLT and Red 1– Launch & Briefing: Red/ Blue/White teams including enablers (finance, estates, HR, IT, data). Define target, scoring criteria & gates, templates. Brief those not in the room (role in sourcing key information etc)	SLT/ Red 1	Team roles identified and shared aim Timeline Set of tools including scoring approach
Tiger team – Idea Generation & Filtering – (e.g. aim for 10 x £300K rather than 30 x £100K)	Red 1	Longlist, everything on the table
White Cell – Cost Base Analysis – identify top cost drivers & hotspots.	White Cell	Prioritised cost areas
Red Team - Shortlisting & Draft Scoring – Apply 0–9 scoring (impact, run-rate, complexity). Include cost pressure services, benchmarking outliers etc.	Red 1	Shortlist of 6–8
Blue Team - Feasibility & Risk Testing – risks and mitigations, assess operational, patient safety, and experience impacts. Adjust estimates.	Blue 1	Validated shortlist QIAs
White Cell – Financial Confirmation & Draft Pack – Finance signs off figures; PMO builds narrative & risk log.	White Cell	Costed and QIA schemes for confirm and challenge
SLT and Red 1 – Final Review & prep for submission e.g. to ELT.	Red 1	Products for submission (ELT, GLT, PRM pack etc)

Tiger Team Approach – Scoring and Selection

1. **In year impact** – delivered by M12
2. **Impact** – sustainable from M6

GATEWAY 1: If either 1 or 2 does not confidently score about 7 each, move to pipeline for next year or park

1. **Simplicity** – lower complexity = higher score
2. **Risk to patient safety** – lower risk = higher score
3. Impact on patient **experience – lower negative impact** = higher score

GATEWAY 2: If either 4 or 5 score under 4, remove. If either score below 7, complete QIA.

1. **Reputational / regulatory risk** – lower negative impact = higher score

NB. Fully explore politically sensitive schemes considering all alternatives

Score scale: **0 (least attractive) → 9 most attractive)**
Maximum possible: 54

Tiger Team Approach – In practice

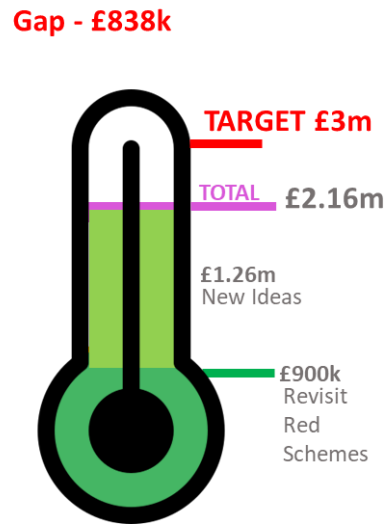
Across one week in August, the Planned and Unplanned Care Groups applied a Tiger Team approach to identifying schemes to meet the £3M CIP gap in the community.

Using the approach set out above the team identified the following aim:

Deliver a focused, achievable **£3M in-year CIP within 5 days**,
(ensuring proposals are operationally viable, proportionate,
& capable of measurable savings in year or starting at Month 6) and

without compromising **quality, patient safety** or **patient experience,**
(while reviewing performance impact and ensuring NOF ratings are not altered negatively
& NOF outlier recovery is included) and

ensuring schemes cause **minimal effect on our people metrics**
(particularly strides taken to reduce temporary spend & staff survey results).



Outcome = £2.2M of CIP opportunities identified in year and a pipeline of schemes to be developed for 2026/27. Work continued after the initial sprint to meet the remaining gap.

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Appendix 2: Provides an illustrative example of the information, data, and analytical outputs being used to support care groups in the planning process.

Medicine Care Group
Creating a 5-Year Integrated Plan
Workshop 1

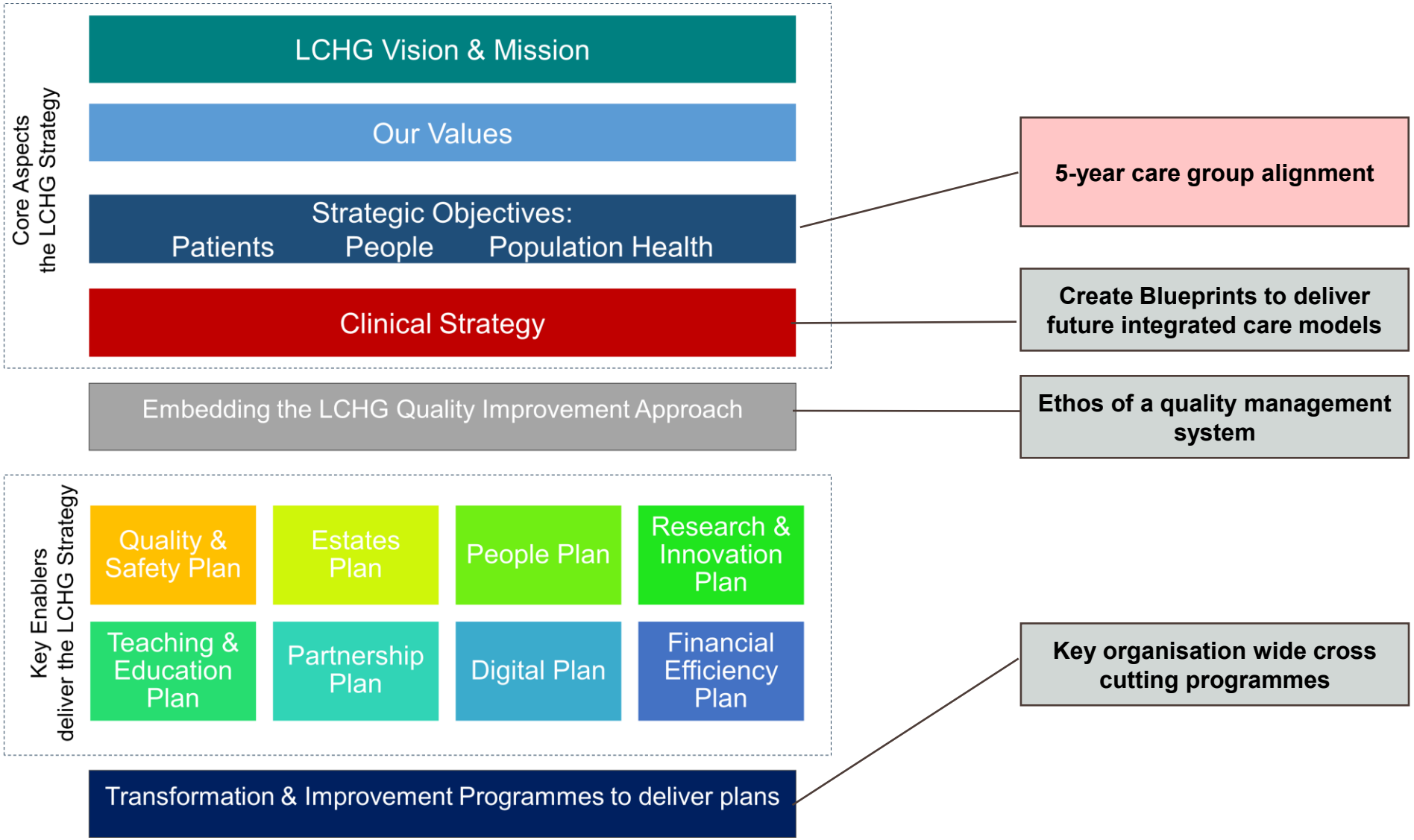
Overview of leadership and services in the Care Group



URGENT AND EMERGENCY CARE	CARDIOVASCULAR	SPECIALTY MEDICINE
• A&E and UEC • Acute Medicine • Major Trauma	• Cardiology • Stroke • Diabetes and Endocrine • Renal	• Respiratory • Gastroenterology • Health Care of Older People • Neurology • Dermatology • Rheumatology

Context

LCHG Strategy 2025-2030



NHSE Planning Framework – Overview

Executive Summary

Why Change?
Services must evolve to meet population needs and system pressures.

New Planning Model:
Shift to **5-Year Plans** (Year 1 in detail) to enable **scale transformation**.

Planning Principles:
•Continuous and iterative
•Supports strategic redesign
•Aligns with national ambitions

Framework Released:
Draft Planning Framework outlines roles for **Providers**, **ICBs**, and **System Partners** through to **2031**.

The Planning Aim

All organisations must develop **credible, integrated plans** that secure **medium-term financial sustainability** by:

- Aligning across time horizons
- Joining strategic & operational planning
- Ensuring coherence across organisations & geographies
- Triangulating finance, quality, activity & workforce

Delivery Phases:

- **Foundation Setting** – Governance, evidence base, strategy refresh
- **Plan Development** – Triangulation, assurance, board sign-off

Principles of Planning

Outcome Focused

Accountable and Transparent

Evidence Based

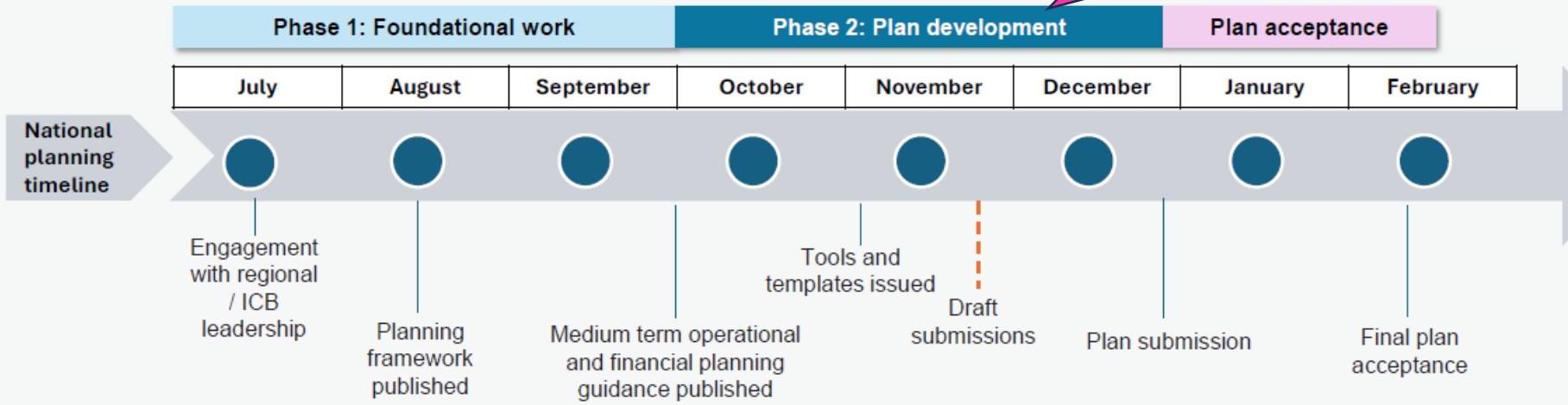
Multidisciplinary

Credible and Deliverable

NHSE Planning Framework Draft Timeline

NOTE Potential pre- Christmas planning submission (21 Nov first draft and final plans w/c 15th Dec)

Potential timetable for 2026/27 – across two phases



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Key Autumn Planning Tasks

October:

- Care Groups to review Insights- Population health/Productivity and Efficiency packs to inform 5-year integrated plans
- Demand and capacity modelling complete
- Planning assumptions for activity/workforce/finance to commence planning round
- Care group workshops

November:

- Care group workshops contd.
- Draft 5-year care group integrated plans

December: triangulation and agree overarching priorities and plans for 25/26 sign off

Purpose

What are we looking to create with each Care Group?

To develop a 5-Year Integrated Delivery Plan (2026/27–2030/31) specific to your Care Group based on:

- Ambition of the 10-Year Health Plan
- NHS Planning Framework
- National and local strategic priorities
- Population Health & Service Needs
- Demand, Capacity & Workforce Planning
- Financial Sustainability & Quality Improvement
- Digital, Estates & Enabling Functions.



Proposed approach to develop Care Group 5-year Integrated Plan

Session 1 Service Planning Based on Health Needs

Session 1 focuses on developing service plans informed by population health needs and redesign priorities.

Session 2 Workforce and Capacity Planning

Session 2 creates workforce and capacity plans aligned to service transformation and projected demand.

Session 3 Financial and Quality Improvement Plans

Session 3 delivers financial, quality improvement, estates, and digital plans to enable sustainable delivery.

Integrated and Sustainable Delivery

Combined session outputs create a coherent, evidence-based plan supporting sustainability and transformation.



Given tight timescales dictated by NHSE- session 2 & 3 maybe combined/GLT sessions with task and finish groups to support

Purpose

This first workshop is designed to kick-start the development of each Care Group's 5-Year Integrated Delivery Plan by focusing on understanding the population served and identifying service priorities.

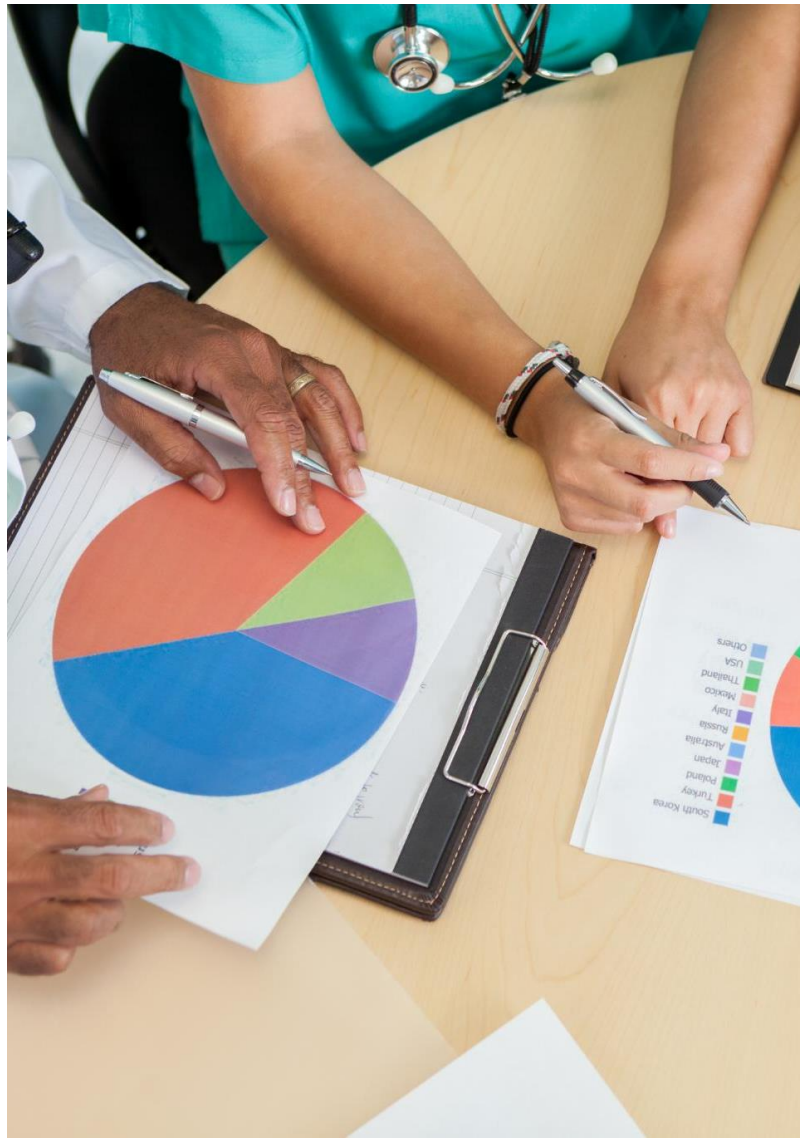
Key Objectives:

- Build a shared understanding of population health needs
- Identify areas of transformation/fragile services and opportunities for redesign
- Align care group priorities with system-wide ambitions, including the 10-Year Plan and 'left shift' strategy

Why It Matters:

This session lays the foundation for the care group's integrated plan by defining what services are needed, where, and for whom.

It ensures that future workforce, financial, and operational planning is grounded in real population needs and strategic direction.



Inputs for Population Health & Service Needs

This companion pack provides useful data on the current position for the Care Group including

Population Health Data Review:
Comprehensive analysis of population health data including JSNA insights, health inequalities, and underserved groups.

Service Configuration and Redesign:
Analysis of current service setup, fragile services and left shift opportunities to identify priorities for redesign and improvement.

However, it would be useful for you to have to hand in the session:

Service Performance Metrics:
Evaluation of service activity focusing on access, quality, productivity, and benchmarking with Model Hospital and GIRFT data.

Patient and Community Feedback:
Incorporating feedback from patients and communities to align services with local health needs and priorities.



Outputs from Population Health & Service Needs

A **template for your 5-year strategic plan and Y1 operational plan** is provided as part of your resource pack however outputs will include:

Identify Priority Populations:

Clear identification of priority population groups and their specific health needs is essential for targeted care.

Fragile Services & Redesign:

Care groups identify fragile services and explore potential redesign opportunities to improve healthcare delivery.

Service Transformation Themes:

Draft themes for service transformation form the foundation for strategic future healthcare planning including ‘left shift’.

Alignment with System Priorities:

Outputs support alignment with system-wide priorities, enhancing integration with broader strategic goals.



Companion Pack

Key Insights – Workshop 1

Population Health/Health Inequalities

10-year Plan/national/local policy

LCHG Strategy/Left shift specialities

Model Hospital/GIRFT/ Productivity Benchmarking

Key Quality Improvement/Transformation/ Digital

System Strategic Priorities

ICB 25/26 Priorities – What this mean for Medicine Care Group?

- **Elective Care & Diagnostics/Productivity & Recovery Initiatives**:
  - Reduction in waiting lists and outpatient redesign.
  - High Volume Low Complexity (HVLC) and Day Case optimisation.

- **Urgent & Emergency Care (UEC)/ System-wide UEC Programme**:
  - Intermediate care development for complex medical patients.
  - Support for care homes and end-of-life pathways.

- **Access & Interface Improvements**:
  - Enhanced access to same-day and planned appointments.
  - Integration with community services and digital inclusion.

- **Neighbourhood Health Services**- focus on long term conditions: CVD, diabetes, respiratory, frailty and end of life

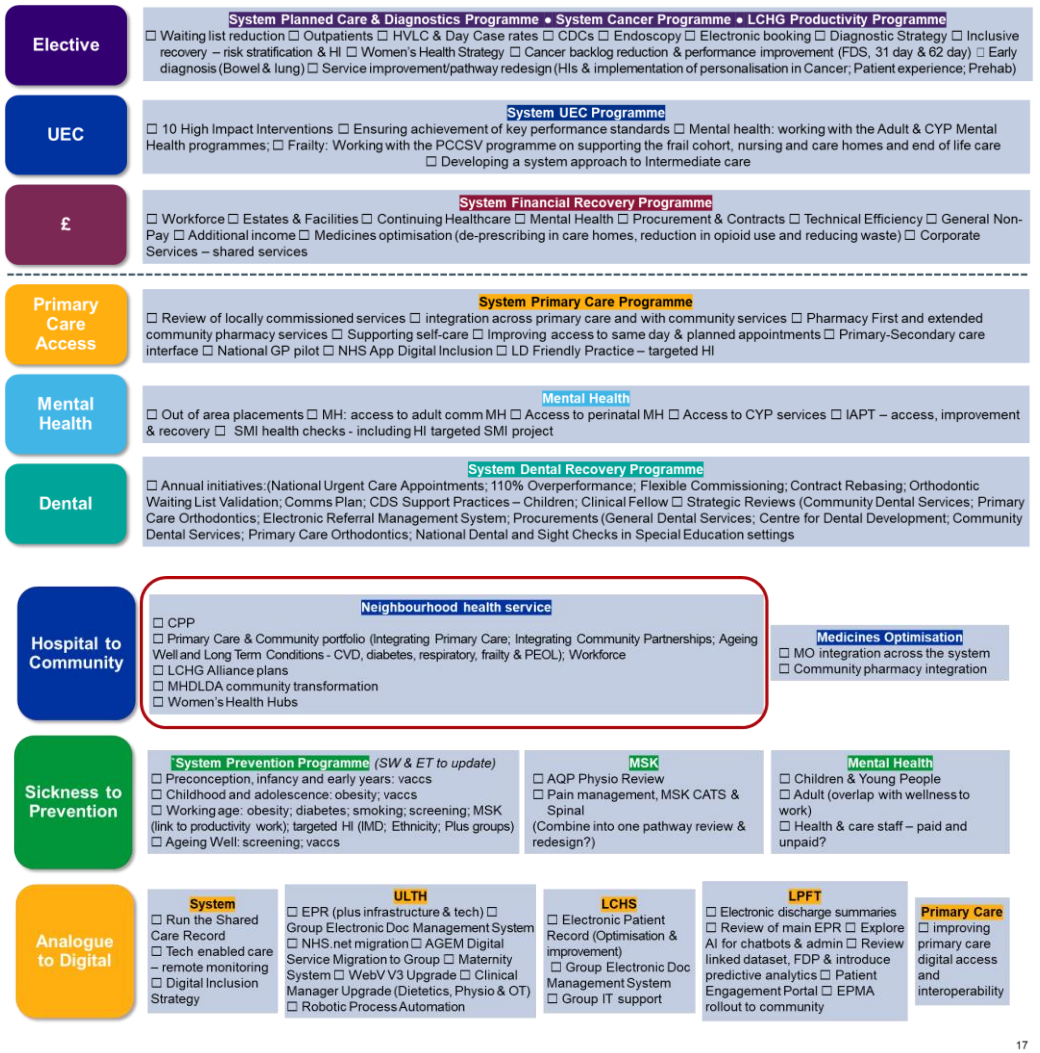
- **Life-stage interventions**: vaccinations, obesity, diabetes, smoking cessation, MSK health.

- MSK Pathway Redesign

- Enhancing digital access and interoperability in primary care.

- EPR/document management

- Infrastructure upgrades, automation and predictive analytics



Population Health Insights – Lincolnshire

‘Quick Facts’ about the Lincolnshire Population:

Aligning insights to the 810,655 population in Lincolnshire

Generally Healthy

393,915 people (49%)

1 in 3 people

Of the people considered healthy (110k people) are obese.

24%

Increase in resource use if on a waitlist over 52 weeks

Acute Episodic

12,034 people (2%)

c.6,700

People have had 5 or more A&E attendances in the last 12 months

21%

Of people are on a waitlist and attending A&E more than once

Long Term Conditions

348,833 people (43%)

58%

Of people who use A&E are in the LTC segment and account for 45% of all A&E activity.

+50%

Increase in total resource for those diagnosed with a Mental Health condition

High Need

47,978 people (6%)

30%

Moderate or severely frail people are on a waitlist

78 vs 83

Life expectancy in the most deprived areas vs in the most affluent areas

Palliative & End of Life

7,905 people (.001%)

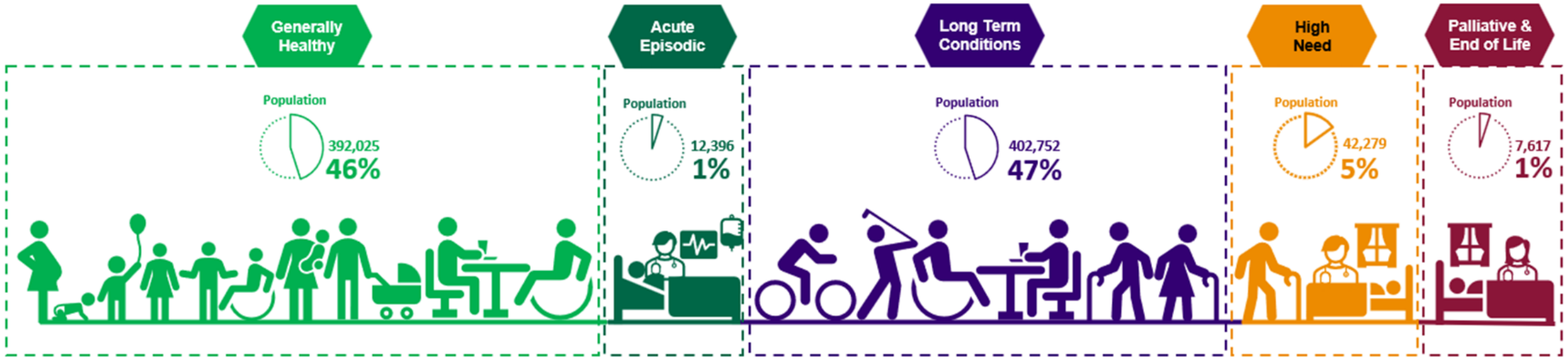
4,664 or 59%

Of people who are at end of life had an emergency admission

6%

Of all health and care resources are used on this .001% of the population

How we Allocate Our Financial Resource



Total Annual Spend £1.3 Billion

- £163m (14%) At Risk , *Children & Maternity age 0-16, Low Risk* — 14%
- £55m (4%) Major, *HIU – 6 or more attendances in year* — 4%
- £712m (53%) Moderate Frailty, *Big Six Disability, Mental health, MSK, Living with Illness* — 53%
- £310m (23%)Severe Frailty, *High Complexity, Dementia* — 23%
- £96m (7%), Cancer, *Non-Cancer* — 7%

Average spend/resident: £1,559 per resident

Core20Plus5 Priorities



People with Eastern European Backgrounds



People experiencing homelessness



Rural communities



Sensory Impairment



Coastal Communities



Carers



- Temporary Residents
- Gypsy, Roma &Travellers



Farming Communities



People from Ethnic Minority Backgrounds



Military Personnel, Families & Veterans

REDUCING HEALTHCARE INEQUALITIES

NHS

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Target population

20%

CORE20 PLUS 5

Key clinical areas of health inequalities

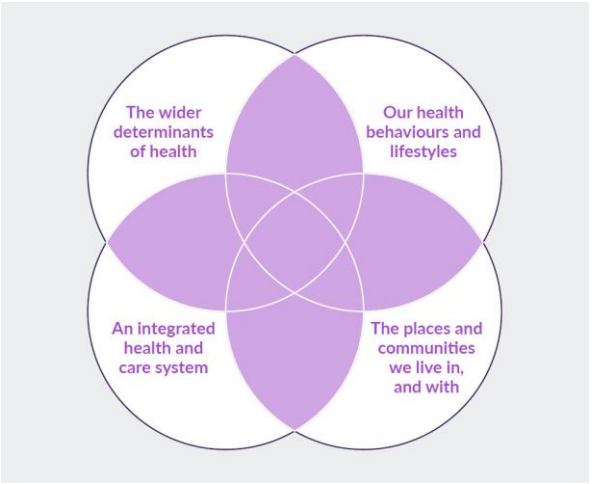
1. **MATERNITY** ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups
2. **SEVERE MENTAL ILLNESS (SMI)** ensure annual Physical Health Checks for people with SMI to at least, nationally set targets
3. **CHRONIC RESPIRATORY DISEASE** a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations
4. **EARLY CANCER DIAGNOSIS** **75%** of cases diagnosed at stage 1 or 2 by 2028
5. **HYPERTENSION CASE-FINDING** and optimal management and lipid optimal management

SMOKING CESSATION positively impacts all 5 key clinical areas

Population Health Insights – Medicine specific

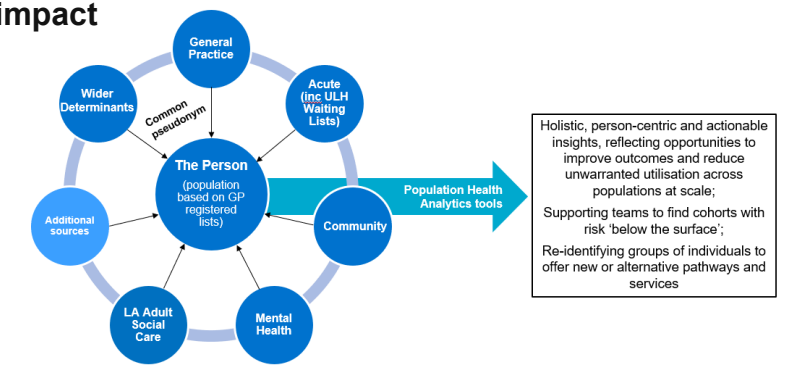
Population Health Management

"An approach aimed **at improving the health of an entire population.**
It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while **reducing health inequalities**.
It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. **It requires working with communities and partner agencies**."
Buck et al 2018, p 18



Lincolnshire Linked Data Set

The tool to allow us to **understand our population, model pathway changes and track impact**



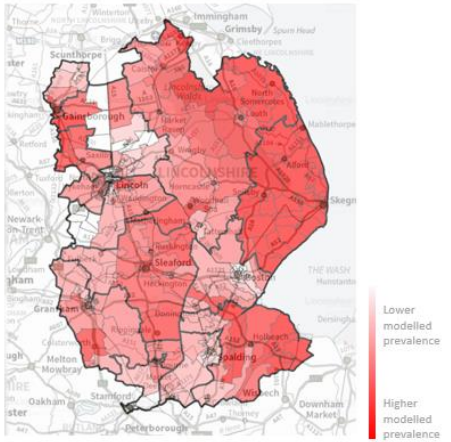
Respiratory as an example

(from PHM Linked Dataset)

- 114k People Diagnosed with a Respiratory Illness
- c.285k Outpatient Appointments in 12 months
- 34% Had an A&E appointment in the last 12 months
- 4.5k People with 4 or more A&E attendances



Integrated Neighbourhood Teams will be different in each locality – driven by PHM Data



The following map shows the prevalence of COPD in Lincolnshire at lower super output area (LSOA) across Lincolnshire for 2022/23 modelled by the dominant registered GP practice prevalence for each LSOA.

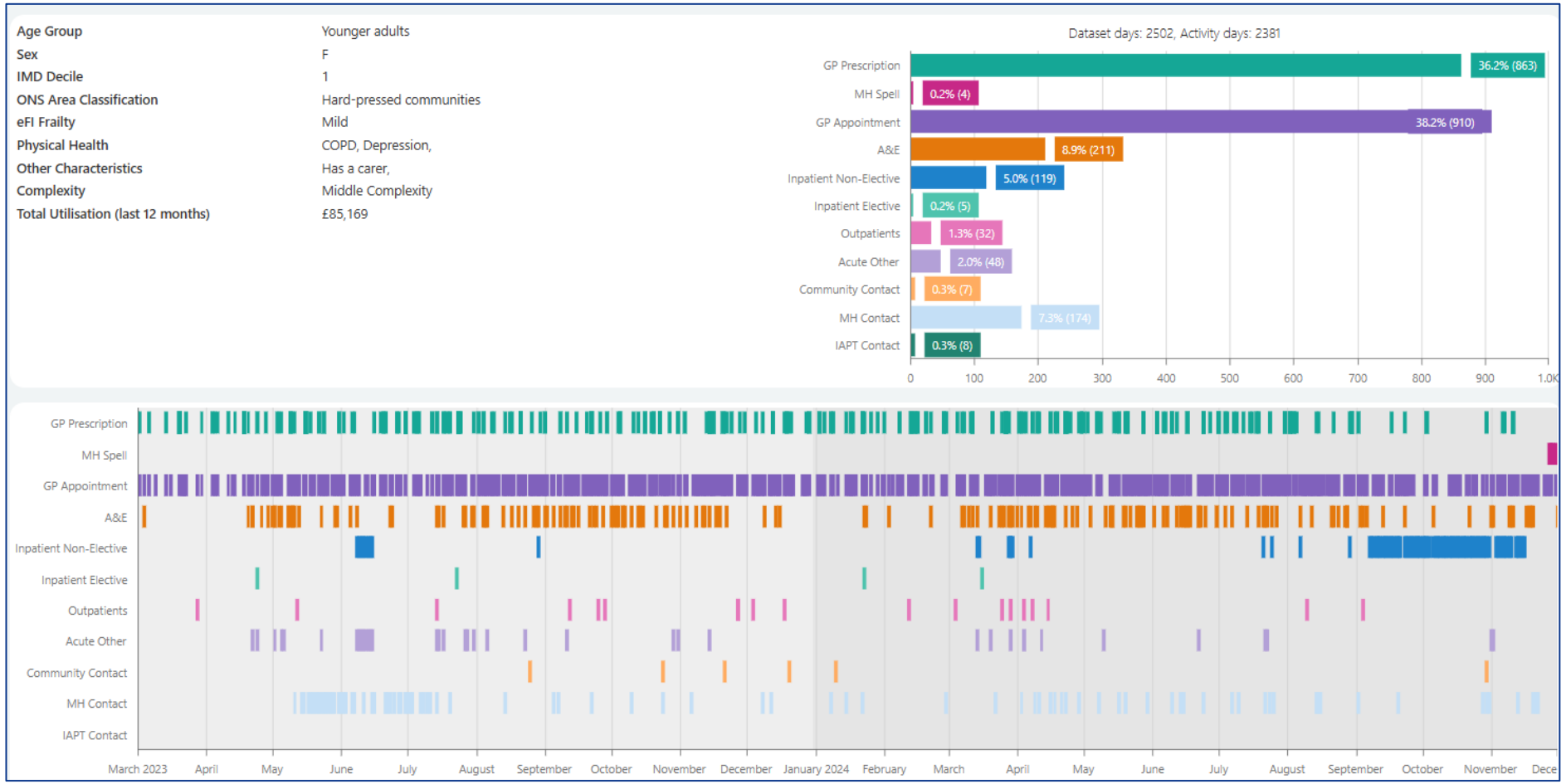
Lincolnshire Population – A patient example

A patient theographic from the PHM linked dataset can show us the interactions an individual is having with health and care settings.

The patient shown is a young female adult, living in the most deprived areas of Lincolnshire. She has COPD and Depression as well as having a carer.

Total system spend in the last 12 months is £85k

She has high level of Primary Care Prescriptions, GP Encounters, MH Contacts and has accessed **A&E 211 times**



Optum

NHS Lincolnshire Integrated Care Board

Lincolnshire Demographic Summary

- Lincolnshire has an ageing population.
- Significant inward migration of older people moving to the county and a significant undocumented people living in Lincolnshire but registered to GP practices in other counties.
- By 2040 the population will be older with more complex health needs.
- Lincolnshire has significant wealth inequality leading to difference in health outcome and mortality age.
- Lincolnshire's deprivation can be seen on the East Coast but also in pockets within most large market towns and the City of Lincoln.
- Rurality and low population density poses a change for patients and health care providers.

Stand out population health concerns:

- Higher levels of smoking in younger people than national averages.
- Children and Young People have significant unhealthy weight seen at both age 5 and 11 yrs.
- Low levels of physical activity across the population.
- More cancer diagnosis at stage 1 and 2.
- A significant difference in life expectancy when comparing wealthier and poor areas of Lincolnshire.

Top Lincolnshire Disease Burden

- MSK – Back pain, neck pain, shoulder pain
- Diabetes – Obesity
- Cancer
- Digestive issues
- Poor mental health
- Urinary issues

Medicine Care Group – Considerations for our Older Population

Ageing Population and Falls Risk

- **Lincolnshire's 65+ population is projected to grow significantly**, with a sharp increase in those aged 85+.
- This demographic shift is expected to drive a **36% rise in fall-related incidents over the next 20 years**, with 70% of these occurring in the over-85 age group.
- Falls are a major contributor to urgent care demand.
- **Recovery Challenges**: Age-related frailty and limited social support in rural areas can slow recovery and increase readmission rates.

Long-Term Conditions and Carer Strain

- By 2035, a growing number of residents will live with **two or more long-term conditions**, increasing complexity in urgent care needs.
- Older carers supporting adult children with disabilities face mounting challenges. As both carers and dependents age
- **urgent care services may see more crisis interventions** due to unsustainable home arrangements.

Health Inequalities and Deprivation

- Lincolnshire's health profiles reveal **regional disparities in disease burden, hospital admissions, and mortality**, especially in deprived areas.
- These inequalities correlate with **higher rates of urgent care usage**, as residents in poorer areas often experience delayed access to preventative services

Digital Exclusion and Access Barriers

- Many older residents struggle with digital tools, limiting their ability to access online urgent care triage or booking systems.
- This digital divide can lead to **increased reliance on emergency departments**, even for non-critical issues

Support for Growing 65+ Population- Plan for increased demand and complexity in urgent & emergency care.

Address Frailty in Rural Communities- Enhance recovery pathways and reduce readmissions.

Manage Multi-Morbidity- Develop integrated care models for patients with multiple conditions.

Prevent Crisis Interventions- Strengthen home support and community-based care.

Tackle Health Inequalities- Improve access to preventative services in deprived areas.

Promote digital inclusion to reduce inappropriate ED usage.

Health Inequalities Legal Duties Data – Elective Recovery

- 18-30yrs old experienced significantly poorer performance in cardiology compared to other age groups within the same speciality.
- By the end of Q1 25/26 18–39-year-old females experienced a lower proportion of 18 week waits in cardiology and dermatology compared to other age groups in these specialties.
- Data suggests that those under the age of 60 wait longer than those in older cohorts.
- Where referrals are made to ULTH, the gap between males and females who have been on a waiting less than 18 weeks is getting wider.

Elective Recovery – Waiting Lists (under 18 weeks) by Sex and Specialty

Specialty	Female Q4 23/24	Male Q4 23/24	Female Q4 24/25	Male Q4 24/25	Female Q1 25/26	Male Q1 25/26
Urology	**43.1%**	49.1%	**42.9%**	49.3%	54.0%	55.6%
T&O	58.7%	57.6%	50.9%	51.0%	49.0%	50.0%
ENT	35.6%	35.4%	36.0%	34.8%	33.8%	33.3%
Ophthalmology	56.2%	56.1%	52.2%	54.5%	54.5%	56.6%
Gastroenterology	36.9%	37.0%	50.6%	53.0%	**47.0%**	50.8%
Cardiology	49.9%	49.1%	56.6%	59.2%	58.9%	61.5%
Dermatology	**52.8%**	56.5%	61.0%	63.1%	63.4%	65.4%
Respiratory	31.8%	29.5%	58.5%	62.9%	55.5%	55.0%
Neurology	**41.5%**	44.1%	37.0%	39.3%	35.9%	38.2%
Gynaecology	42.4%	Suppressed due to low counts	44.3%	Suppressed due to low counts	44.9%	Suppressed due to low counts
All specialties	**45.2%**	46.6%	**48.6%**	50.4%	**48.8%**	51.1%

Gastroenterology, Cardiology and Dermatology specialities showing persistent and significant differences between access times for males and females.

Gastroenterology, cardiology, dermatology, neurology, and gynaecology where there appear to be lower (if not always significant) proportions who were/are on a waiting list for less than 18 weeks

ICB Elective Recovery Legal Duties Pack

1. Cardiovascular Conditions

These are among the **highest burden of disease** in Lincolnshire and a major cause of premature mortality.

Key Conditions:

- **Hypertension** – High prevalence and many undiagnosed cases (estimated 84,100 people). lhih.org.uk
- **Atrial Fibrillation** – Estimated 6,700 undiagnosed cases; above national average prevalence.
- **Coronary Heart Disease (CHD)** – Higher than national average, especially in East Lindsey, West Lindsey, and South Holland.
- **Stroke** – High mortality and disability burden.
- **Vascular Dementia** – Linked to CVD risk factors.
- **High Cholesterol –** A major modifiable risk factor.

Gaps Identified:

- Lack of Tier 3 and Tier 4 obesity services.
- Low uptake of NHS Health Checks in deprived areas.
- No cohesive county-wide CVD prevention programme.

2. Neurological Conditions

These account for **20% of acute hospital admissions** and have a significant impact on disability and quality of life. lhih.org.uk

Key Conditions:

- **Epilepsy** – Slightly higher prevalence in eastern Lincolnshire.
- **Parkinson's Disease**
- **Motor Neurone Disease (MND)**
- **Multiple Sclerosis**
- **Migraines and Chronic Headaches**
- **Traumatic Brain Injury**
- **Cerebral Palsy in Adults**
- **Post-Polio Syndrome**
- **Spinal Muscular Atrophy**
- **Myasthenia Gravis**

Gaps Identified:

- Limited specialist neurology support within Lincolnshire.
- High reliance on out-of-county services.
- Lack of neuropsychology and rehabilitation services.
- Poor care coordination and long waiting times.
- Low satisfaction among patients with neurological conditions (only 37% felt their needs were met).

3. Dementia

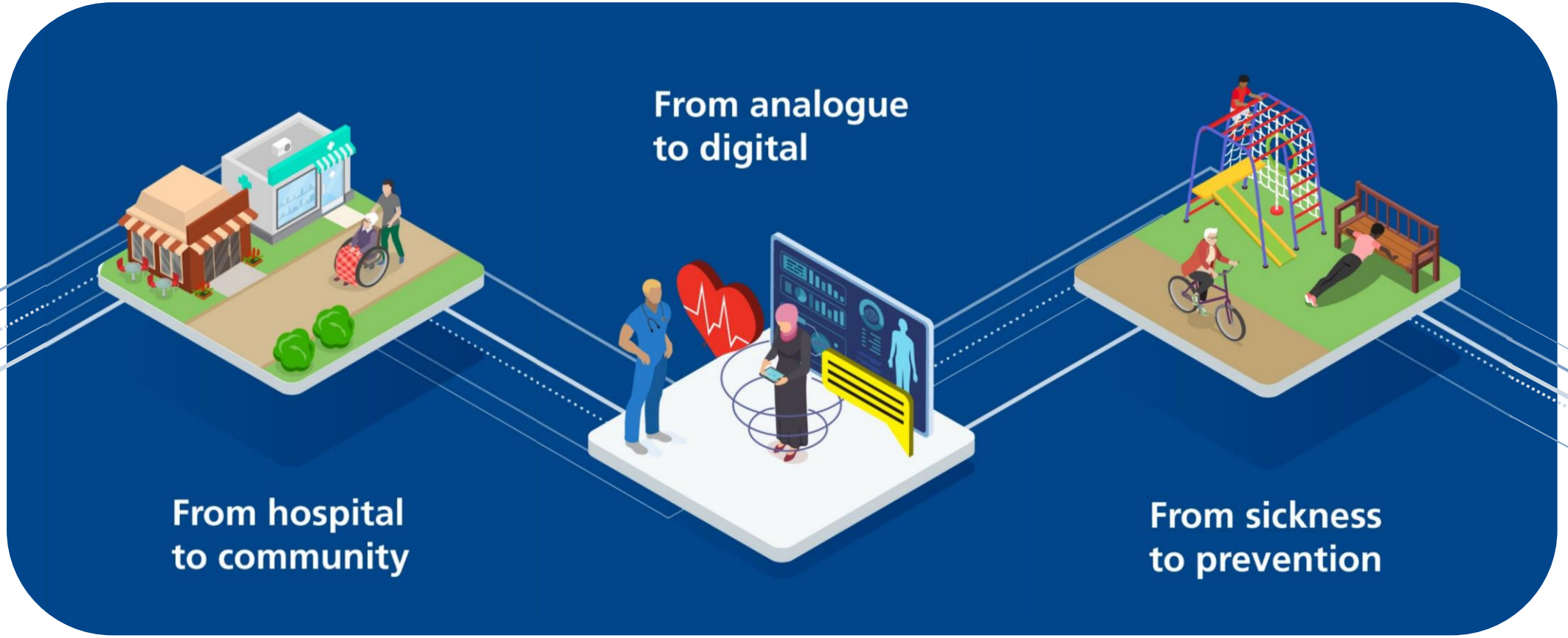
Although covered separately in the JSNA, dementia is closely linked to both neurological and cardiovascular conditions and is a growing concern in the ageing population.

Recommendations for the Medicine Care Group

- **Early Detection & Management** Focus on hypertension, atrial fibrillation, and high cholesterol.
- **Strengthen Neurological Rehabilitation** Enhance support for rare and complex neurological conditions.
- **Improve Data Sharing & Coordination** Enable seamless care across services and settings.
- **Reduce Health Inequalities**
- Target rural and deprived areas for improved access and outcomes.
- **Support Carers & Complex Patients** Develop multidisciplinary hubs and tailored care pathways.

10-year Health Plan insights

We will reinvent the NHS through 3 radical shifts:



10 year plan what this means for Medicine Care Group

1. Shift from Hospital to Community

- **Develop Neighbourhood Health Services**:
  - Integrate acute medicine with community-based care.
  - Support same-day emergency care and virtual wards.
  - Collaborate with primary care and social care to reduce unnecessary admissions.

- **Expand Ambulatory and Frailty Pathways**:
  - Prioritise early discharge and home-based care models.
  - Use predictive analytics to identify high-risk patients.

2. Digital Transformation

- **Adopt the Single Patient Record (SPR)**:
  - Ensure seamless access to patient data across settings.
  - Enable clinicians to use AI tools for diagnostics and documentation.

- **Utilise NHS App Features**:
  - Support patient-initiated follow-up (PIFU).
  - Encourage use of My Care, My Consult, and My Medicines tools for chronic disease management.

3. Prevention and Population Health

- **Implement Genomics and Risk Stratification**:
  - Use polygenic risk scores and genomic testing for early identification of cardiovascular, renal, and metabolic conditions.
- **Support Secondary Prevention Accelerators**:
  - Improve hypertension and diabetes control.
  - Increase uptake of screening and vaccinations (e.g., HPV, lung cancer).

4. Workforce and Clinical Leadership

- **Upskill Staff for Community and Digital Care**:
  - Train in AI, genomics, and remote monitoring.
  - Develop advanced practice roles for nurses and allied health professionals.

5. Embed PROMs and PREMs:

- Use patient-reported outcomes to guide service improvement.
- Integrate feedback into clinical governance.

6. Innovation and Research

- **Participate in Clinical Trials and Innovation Zones**:
  - Engage in genomic and wearable tech studies.
  - Use AI for triage, diagnostics, and operational efficiency.

Medicine – Strategic Alignment to 10-Year Health Plan

Left Shift
Respiratory
Dermatology
Rheumatology
Diabetes

Hospital to Community

Shift Spending Patterns
with proportionally greater investment in out-of-hospital care

18 Weeks
Restore the NHS constitutional standard of 92% of patients beginning elective treatment within 18 weeks

All Hospitals Fully AI
enabled within the lifetime of this plan

Analogue to Digital

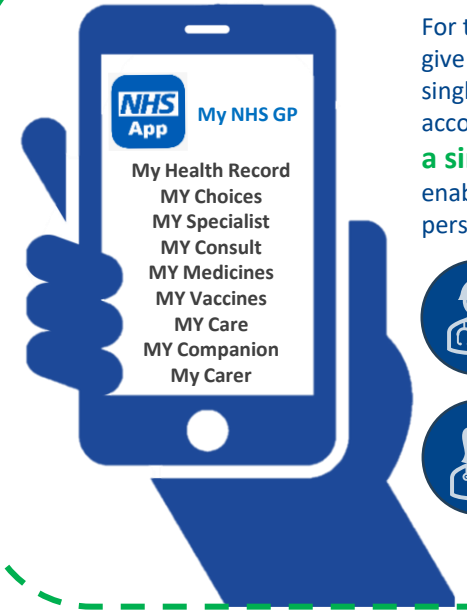
Introduce single sign on for staff
scale the use of technology like **AI scribes** to liberate staff from their current burden of bureaucracy and administration, freeing up time to care and to focus on the patient

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

Sickness to Prevention

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 dependency
Treatment as key part of preventing illness and improving health



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

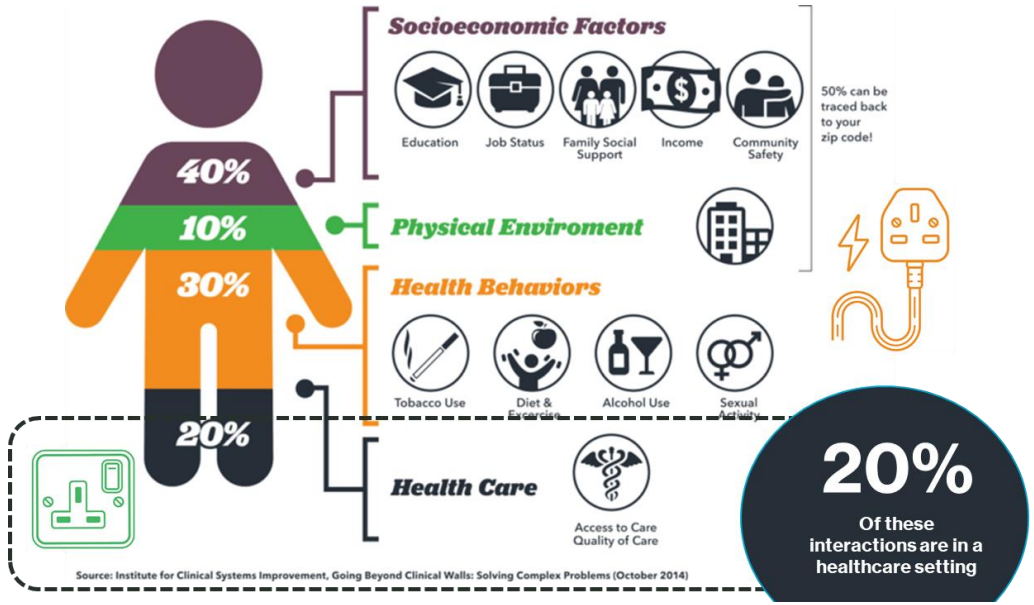
MY Consult
Hold consultations through the app with **My Consult**

MY Specialist
Book directly into tests where clinically appropriate through **My Specialist**.

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

Left Shift

What is Left Shift and why is it important?



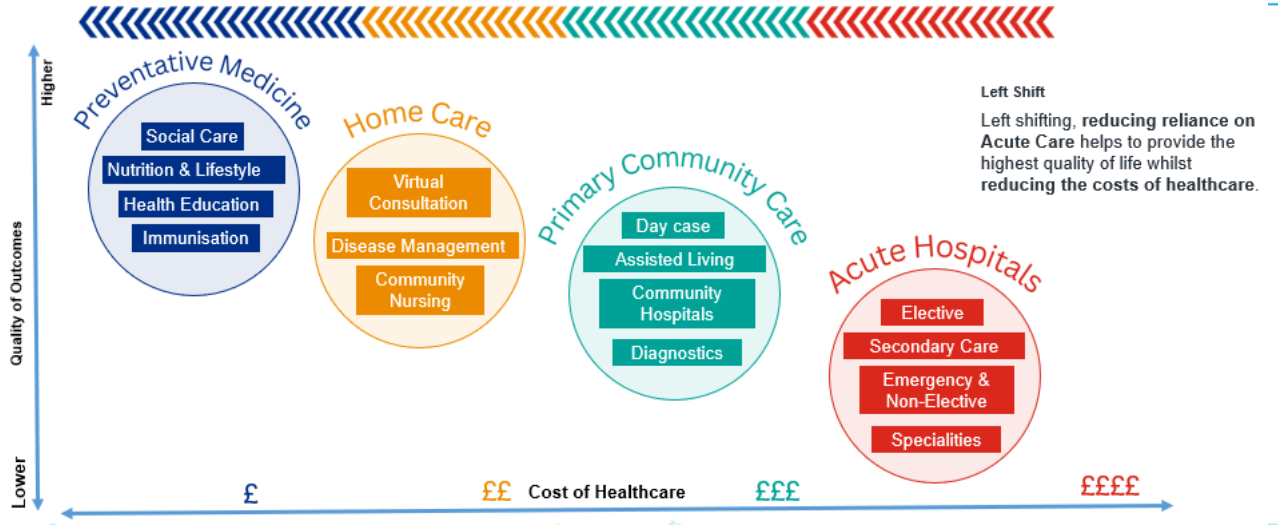
Left shift is a term used to describe moving healthcare services and resources from hospitals to the community, and from reactive care to more preventative solutions.

This should be done in partnership with residents and communities to prevent ill-health, reverse the impact of disease/disability and avoid necessary hospital admissions.

Location Shift – Moving existing services to an appropriate alternative setting in the community, so the Lincolnshire population can access care closer to their home and reduce the need to come to a busy acute hospital site unnecessarily.

Delivery Shift – this type of shift involves working with a wide range of partners including GPs/PCNs/health and social care and voluntary sector, to deliver services in a different way.

Service Redesign – the biggest transformation is a redesign of services so that care is provided in a more innovative way using technology and different clinical models of care. All of which has the biggest impact on health outcomes.



Left Shift

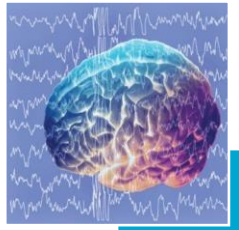
Left shifting, **reducing reliance on Acute Care** helps to provide the highest quality of life whilst **reducing the costs of healthcare**.

Medicine care group ‘Left Shift’ priorities for transformation



Dermatology

- Primary scope agreed- further development of existing community dermatology clinics, simple surgery, development of primary care education programme, AI opportunity and possible development of GP rotation placement
- Specialty re-engaged – meeting 9th September 2025 to discuss scope
- All PHM and best practice data collected to support identification of left shift opportunities
- **Move Service to Alliance Care Group and commence delivery**



Neurology/Neuro -rehabilitation

- Initial workshop 25th September 2025
- Working in tandem with Neurology sustainable services process
- Interdependencies with Therapies
- Innovation and pathway change opportunities associated with national rehabilitation centre opening



Diabetes

- Agreeing scope of pathway transformation opportunities that could include:
- Different workforce models
- Long term management and prevention with primary care
- Links to CVRM
- Community nursing

Medicine care group ‘Left Shift’ priorities for transformation



Rheumatology

- Co-create and agree Early Inflammatory Arthritis (EIA), Fibromyalgia, EDS, Chronic Pain clinical pathways with primary care
- SOP for Denusumab Injection Model
- Community Based Rheumatology Model – in-reach/MDU/biologics
- Deploy GP led care model/left shift to community services with virtual MDTs/GPeWR
- Exploring radiology MDT’s, virtual clinics, one stop shop, reducing DNA’s
- Coding Accuracy: Improve depth of coding to maximize income
- Clinic Templates: Require standardisation and optimisation
- Estates utilisation review



Respiratory

- ICB project resource ending September 2025
- Handover scope being agreed ideas identified in the winter plan a paediatric respiratory physician in UTC’s and the development of community based respiratory infection hubs, potentially based in CDC’s or Neighbourhood Health Centres.
- Interdependencies with full transition of OPAT service
- Further public health opportunities including HEPA filters in schools



Other left shift opportunities?

- **What other opportunities are there in the Medicine Care Group to explore new ways of working to:**
  - **Deliver in different locations?**
  - **Transform the way services are delivered?**
  - **Intervene further upstream to support prevention?**

Key Operational Targets

Reforming Elective Care for Patients – January 2025

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

Empowering Patients

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

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

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

Reforming Delivery

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

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

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

Delivering Care in the Right Place

Ensure both primary care and secondary care are funded to deliver Advice and Guidance, by splitting the existing elective tariff to deliver better Reforming elective care for patients – **January 2025 11 outcomes for patients.**

Ensure PIFU is offered as standard in all appropriate pathways **March 2026**

Set out clear expectations for significant elective care reform to be delivered in at least 5 specialties ENT, gastroenterology, respiratory, urology and cardiology

Work with patients, carers and clinicians to establish a consistent model of 'collective care' approaches, including group appointments and one-stop clinics, **September 2025**

Align funding, performance oversight & delivery standards

Update the Payment Scheme to reflect elective priorities, including with a stronger focus on activity that directly ends a patient's wait for their care, and by developing, testing and introducing relevant tariffs throughout the duration of this plan

Run a capital incentive scheme for providers that improve the most in meeting RTT standards

Put robust arrangements in place to performance manage and deliver elective care targets and standards, including making best use of NHS IMPACT improvement support, national metrics, dashboards and toolkits

Work with system partners to ensure adoption of best practice

Targets

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

Non-Elective Care

4hr — Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026.

12hr — A higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25

30 Minutes — Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26

15 Minutes — Reduce avoidable ambulance conveyances and handover delays by delivering hospital handovers within 15 minutes and improving access to urgent care services at home or within the community

Elective Care

65% — 65% RTT by March 2026

92% — 92% RTT by March 2029

72% — Improve percentage of people waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% improvement

Less than 1% — Reduce proportion of people waiting over 52 weeks for treatment to less than 1% of total waiting list by March 2026

Cancer

75% — Improve performance against 62-day cancer standards to 75% by March 2026

80% — Improve performance against 28-day FDS to 80% by March 2026

Maternity

Improve Safety — Improve safety in maternity and neonatal services, delivering the key actions of the “Three Year Delivery Plan”

Prompt – Gap analysis against the constitutional standards?
12-hour ED wait
4 hour

Targets

Health Inequalities

CORE 20 PLUS5 — Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people

Increase % — Increase the % of patients with hypertension treated according to NICE guidelines

Quality

Fragile Services — Maintain focus on overall quality and safety of services, with a focus on challenged and fragile services

Digital and Data

CYBER Security — All providers achieve and maintain compliance with the NHS Multi-Factor Authentication Policy and act to strengthen their cyber security

Digital Inclusion — All systems mitigate against digital exclusion, including by implementing the framework for NHS action on digital inclusion

85% FDP — Adoption of elective reform Federated Data Platform by 85% of secondary care trusts by March 2026

NHS App — Proactively offer NHS App-first communications to patients, by default through NHS Notify service

EPR — All systems complete planned electronic patient record (EPR) system procurements and upgrades

Finance

£0 — Deliver a balanced net system financial position for 2025/26

-30% — Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems

Pre COVID Levels — Close the activity/ WTE gap against pre-Covid levels

Efficiency and Productivity

STOP & Improve — Drive improvements in operational and clinical productivity, including stopping lower value activity

National Oversight Framework (NOF)

Average score	Trust in financial deficit?	Segment	Trust rank
2.88	No	4 - Low performing	122 out of 134

Focussed performance areas

Access to services	4 - Low performing
Finance and productivity	3 - Below average
Effectiveness and experience of care	3 - Below average
Patient safety	4 - Low performing
People and workforce	4 - Low performing

Segment	Finance and productivity domain segment
4 - Low performing	3 - Below average

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank
Finance and productivity	Finance	Combined finance	Q1 2025/26		score	1.00	
Finance and productivity	Finance	Planned surplus/deficit	2025/26	0.00	percent	1.00	12 out of 134
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 3 2025	0.00	percent	1.00	54 out of 134
Finance and productivity	Productivity	Implied productivity level	To M12 2024/25 vs 2023/24	-1.02	percent	3.59	116 out of 134

Segment	Access to services domain segment
4 - Low performing	4 - Low performing

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank
Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q1 2025/26	65.96	percent	3.13	81 out of 118
Access to services	Cancer care	Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	Q1 2025/26	75.38	percent	3.12	79 out of 118
Access to services	Elective care	Difference between planned and actual 18 week performance	Jun-25	-0.40	percentage points	2.30	92 out of 131
Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Jun-25	54.60	percent	3.68	117 out of 131
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Jun-25	3.14	percent	2.90	50 out of 80
Access to services	Elective care	Percentage of patients waiting over 52 weeks for elective treatment	Jun-25	2.57	percent	2.85	73 out of 131
Access to services	Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q1 2025	76.00	percent	2.53	62 out of 123
Access to services	Urgent and	Percentage of emergency department attendances	Q1 2025/26	18.09	percent	3.85	117 out of 123

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National Oversight Framework (NOF)

Segment	Effectiveness and experience domain segment
4 - Low performing	3 - Below average

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Jun-25	1.00	days	3.16	91 out of 126
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2023		score	2.00	
Effectiveness and experience	Patient experience	Summary Hospital Level Mortality Indicator	Apr 24 - Mar 25		score	2.00	

Segment	Patient safety domain segment
4 - Low performing	4 - Low performing

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.06	out of 10	3.71	121 out of 134
Patient safety	Patient safety	Number of MRSA infections	Jul 24 - Jun 25	3.00	count	2.63	55 out of 134
Patient safety	Patient safety	Rate of C-Difficile infections	Jul 24 - Jun 25	1.13	rate	2.50	48 out of 134
Patient safety	Patient safety	Rate of E-Coli infections	Jul 24 - Jun 25	1.38	rate	3.69	117 out of 134

Segment	People and workforce domain segment
4 - Low performing	4 - Low performing

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	6.59	out of 10	3.57	115 out of 134

Key areas to consider

1) 18 week wait RTT
2) % emergency department attendances
3) Implied productivity level
4) Effective flow and discharge
5) Rate of e-colii
6) NHS staff survey engagement & raising concerns
7) Sickness absence rates

Productivity Opportunities and Intelligence

Summary

Trust-Level Signals

- ULTH's trust-level productivity signals indicate ongoing challenges in operational efficiency and workforce utilisation.
- Year-to-date productivity growth compared to 2019/20 remains significantly negative, averaging around –15.5%, while peer and provider medians show less severe declines (around –10%). This suggests ULTH has not yet recovered to pre-pandemic productivity levels.
- Workforce productivity growth also remains negative, with ULTH trailing behind both peer and provider benchmarks.
- Outpatient attendances per consultant WTE are consistently lower than peers (e.g., ULTH averages ~85 vs. peer median ~100), and elective admissions per clinical WTE are slightly below peer levels. These indicators point to underutilisation of clinical capacity and highlight the need for strategic workforce planning and operational redesign.

Biggest Specialty Cost Gaps (2023/24 Reference Cost)

- ULTH exhibits significant cost variation across specialties when compared to peer averages. The largest gaps include:
- Stroke: Cost per WAU at £5501 vs. peer average £4193 – a 31% gap.
- General & Acute Medicine: £4856 vs. £3728 – a 30% gap.
- Spinal Surgery: £4945 vs. £3432 – a 44% gap.
- Rheumatology: £4788 vs. £3381 – a 41% gap.
- Breast Surgery: £4894 vs. £3796 – a 29% gap.
- These gaps suggest high resource consumption relative to peers, potentially driven by longer lengths of stay, lower day case rates, or inefficiencies in clinical pathways. Addressing these areas could yield substantial financial savings and improve value for money.

Where Pathway and Theatre Changes Could Move the Dial

Several specialties show theatre inefficiencies that could be addressed to improve productivity:

- ENT: Average late start of 27 minutes, early finish of 51 minutes, and theatre utilisation below 77%.
- General Surgery: Late starts averaging 22 minutes, early finishes of 50 minutes, and utilisation around 81%.
- Oral & Maxillofacial Surgery: Late starts of 34 minutes, early finishes of 51 minutes, and utilisation below 70%.
- Orthopaedics: Early finishes of 73 minutes and utilisation below 75%.
- These metrics suggest opportunities to improve theatre scheduling discipline, reduce delays, and extend session productivity. Interventions such as standardised start times, improved pre-operative readiness, and better list planning could yield measurable gains.

6–12 Week "Quick Wins" (Pragmatic, Cross-Cutting)

- Several cross-cutting opportunities exist for short-term improvement:
- High DNA Rates: Specialties such as Neurology, Endocrinology, Paediatrics, and ENT show DNA rates exceeding 10%, impacting clinic efficiency and patient flow. Implementing multi-channel reminders, flexible scheduling, and targeted engagement could reduce missed appointments.
- Day Case Conversion: Increasing day case rates in Breast Surgery, ENT, and General Surgery could reduce inpatient bed occupancy and improve throughput.
- Procedure on Admission: Low rates in General Medicine and Spinal Surgery suggest scope for pathway redesign to ensure procedures are delivered promptly, reducing unnecessary bed days.
- These quick wins are achievable within 6–12 weeks through focused operational changes, better use of data, and collaborative clinical engagement.

Summary

Specialty-Level Signals

This table summarises actionable opportunities across ULTH's clinical specialties, based on performance metrics from the Model System and Headline Productivity datasets. It highlights areas where operational inefficiencies—such as high DNA rates, extended lengths of stay, low day case utilisation, and theatre delays—can be addressed through targeted interventions. The suggested actions are pragmatic and cross-cutting, offering a blend of pathway redesign, scheduling improvements, and enhanced patient engagement that could deliver measurable impact within 6–12 weeks.

Specialty	Issue Identified	Opportunity Area	Suggested Action
Cardiology	High outpatient DNA rates	Outpatient efficiency	Implement appointment reminders and flexible scheduling
Diabetes & Endocrinology	Longer LOS for DKA and high readmission after amputation	Acute care and post-op management	Improve acute protocols and post-discharge support
ENT	Low day case rate and high outpatient follow-up ratio	Surgical throughput and outpatient utilisation	Optimise surgical pathways and reduce unnecessary follow-ups
Endocrine Surgery	Long LOS for parathyroidectomy	Perioperative efficiency	Streamline discharge planning and adopt best practices
Gastroenterology	Extended LOS and high DNA rates	Inpatient flow and outpatient engagement	Review appointment systems and enhance communication
General & Acute	Low procedure-on-admission rate and long LOS	Elective care efficiency	Redesign pathways and improve pre-admission coordination
General Surgery	Low day case rates and high readmissions	Surgical pathway optimisation	Increase day case rates and enhance discharge planning
Geriatric Medicine	High super stranded rate and follow-up ratio	Discharge coordination and outpatient utilisation	Improve care home coordination and reduce unnecessary follow-ups
Gynaecology	Low day case rate and high readmissions	Surgical efficiency and post-op care	Redesign pathways and standardise discharge protocols
Neurology	High DNA rates across appointment types	Outpatient engagement	Use reminders and virtual consultations
Obstetrics	High DNA rates	Outpatient attendance	Enhance scheduling and patient education
Ophthalmology	High DNA rates	Outpatient attendance	Improve reminders and offer virtual options
Oral & Maxillofacial	High cancellation and late theatre starts	Theatre efficiency	Strengthen pre-op checks and theatre governance
Orthopaedics	Low day case rate and long LOS	Surgical throughput	Redesign pathways and improve post-op care
Paediatrics	Long LOS for trauma and high DNA rates	Inpatient flow and outpatient engagement	Optimise trauma pathways and reduce DNAs
Respiratory	Long LOS and low procedure-on-admission rate	Inpatient efficiency	Improve scheduling and discharge planning
Rheumatology	High DNA rates and non-procedural day cases	Outpatient utilisation	Tighten triage and improve patient communication
Spinal Services	Low procedure-on-admission rate	Admission efficiency	Align pathways with procedural intent

Analysis by specialty | Cost per WAU by specialty

Cost per WAU by specialty	Data period	Provider value	Peer average	National value	Peer average	National value	Expenditure £m	Theoretical Opportunity Vs Peer average	Theoretical Opportunity Vs National value
Breast Surgery - Cost per WAU (MFF adjusted)	2023/24	£ 4,894	£ 3,796	£ 3,477	29%	41%	11.47	2.57	3.32
Cardiology - Cost per WAU (MFF adjusted)	2023/24	£ 4,292	£ 3,515	£ 3,581	22%	20%	24.58	4.45	4.07
Dentistry - Cost per WAU (MFF adjusted)	2023/24	£ 4,770	£ 3,995	£ 3,529	19%	35%	2.27	0.37	0.59
Dermatology - Cost per WAU (MFF adjusted)	2023/24	£ 2,949	£ 3,443	£ 3,490	-14%	-16%	5.46		
Diabetes and Endocrinology - Cost per WAU (MFF adjusted)	2023/24	£ 4,046	£ 3,774	£ 3,633	7%	11%	12.74	0.86	1.30
Ear, Nose and Throat - Cost per WAU (MFF adjusted)	2023/24	£ 4,090	£ 3,685	£ 3,537	11%	16%	10.62	1.05	1.44
Emergency Medicine - Cost per WAU (MFF adjusted)	2023/24	£ 4,184	£ 3,871	£ 3,522	8%	19%	70.75	5.29	11.19
Gastroenterology - Cost per WAU (MFF adjusted)	2023/24	£ 4,281	£ 3,647	£ 3,636	17%	18%	16.24	2.41	2.45
General & Acute Medicine - Cost per WAU (MFF adjusted)	2023/24	£ 4,856	£ 3,728	£ 3,611	30%	34%	101.04	23.47	25.91
General Surgery - Cost per WAU (MFF adjusted)	2023/24	£ 3,987	£ 3,315	£ 3,583	20%	11%	49.89	8.41	5.06
Geriatric Medicine - Cost per WAU (MFF adjusted)	2023/24	£ 4,758	£ 4,203	£ 3,741	13%	27%	18.57	2.17	3.97
Gynaecology - Cost per WAU (MFF adjusted)	2023/24	£ 4,168	£ 3,725	£ 3,459	12%	20%	17.76	1.89	3.02
Oncology - Cost per WAU (MFF adjusted)	2023/24	£ 2,928	£ 3,412	£ 3,439	-14%	-15%	23.66		
Neurology - Cost per WAU (MFF adjusted)	2023/24	£ 3,281	£ 3,373	£ 3,412	-3%	-4%	3.66		
Obstetrics - Cost per WAU (MFF adjusted)	2023/24	£ 3,490	£ 4,415	£ 3,543	-21%	-1%	33.42		
Ophthalmology - Cost per WAU (MFF adjusted)	2023/24	£ 3,813	£ 3,691	£ 3,507	3%	9%	16.11	0.52	1.29
Oral and Maxillofacial - Cost per WAU (MFF adjusted)	2023/24	£ 3,547	£ 3,799	£ 3,458	-7%	3%	4.96		0.12
Orthopaedic Surgery - Cost per WAU (MFF adjusted)	2023/24	£ 4,110	£ 3,557	£ 3,525	16%	17%	63.56	8.55	9.05
Paediatrics - Cost per WAU (MFF adjusted)	2023/24	£ 3,853	£ 3,568	£ 3,405	8%	13%	22.57	1.67	2.62
Plastic Surgery and Burns - Cost per WAU (MFF adjusted)	2017/18	£ 2,887	£ 3,328	£ 3,444	-13%	-16%			
Respiratory Medicine - Cost per WAU (MFF adjusted)	2023/24	£ 3,691	£ 3,729	£ 3,562	-1%	4%	16.34		0.57
Rheumatology - Cost per WAU (MFF adjusted)	2023/24	£ 4,788	£ 3,381	£ 3,412	42%	40%	3.17	0.93	0.91
Spinal Surgery - Cost per WAU (MFF adjusted)	2023/24	£ 4,945	£ 3,432	£ 3,436	44%	44%	4.52	1.38	1.38
Stroke- Cost per WAU (MFF adjusted)	2023/24	£ 5,501	£ 4,193	£ 3,688	31%	49%	14.15	3.36	4.66
Urology - Cost per WAU (MFF adjusted)	2023/24	£ 4,201	£ 3,562	£ 3,513	18%	20%	20.97	3.19	3.43
Vascular Surgery - Cost per WAU (MFF adjusted)	2023/24	£ 4,239	£ 3,721	£ 3,455	32%	42%	9.66	1.18	1.79
							Total £'m	73.72	88.15

High-Cost Specialties

- Stroke and General Medicine have the highest costs per WAU, surpassing peer and national averages significantly.

Cost Efficiency in Oncology

- Oncology shows cost efficiency with lower WAU values, demonstrating effective resource utilisation.

Strategic Planning Impact

- Comparing specialty costs aids ULTH in identifying areas for redesign and prioritising value-enhancing interventions.

Analysis by specialty | Cardiology

	Latest Data	ULTH	Peer Average	National Value
Inpatients				
Average length of stay for elective admissions (days) - rolling 6 months	Jun-25	5.5	2.7	3.3
% of elective admissions with the length of stay > 20 days	Feb-25	16.7%	0.0%	0.0%
Outpatients				
Missed outpatient appointments (DNAs) rate in cardiology	Jul-25	9.0%	6.0%	6.1%
Missed outpatient appointments (DNAs) rate for face to face outpatient appointments in cardiology	Jul-25	14.0%	5.6%	6.8%
Missed outpatient appointments (DNAs) rate for follow up outpatient appointments in cardiology	Jul-25	11.7%	6.0%	5.9%

Importance of DNA Rates

- High missed appointment rates cause inefficiencies, care delays, and administrative burdens in cardiology clinics.

ULTH DNA Rate Overview

- ULTH's DNA rate is higher than peer and national averages, highlighting a critical challenge in outpatient cardiology care.

Strategies to Reduce DNAs

- Targeted interventions like appointment reminders and flexible scheduling can help lower DNA rates at ULTH.

Analysis by specialty | Diabetes & Endocrinology

	Latest Data	ULTH	Peer Average	National Value
Inpatients				
% of elective admissions with the length of stay > 6 days	May-25	20.0%	7.7%	8.1%
% of bed days that are due to elective patients staying beyond > 6 days	May-25	71.7%	47.3%	42.0%
GIRFT				
Mean length of stay for emergency admissions with DKA as the primary diagnosis on admission (Patients aged 26 to 50 Years) (12mths to qtr end)	Q4 2024/25	5.3	3.4	2.7
Mean length of stay for emergency admissions with Hypoglycaemia as the primary diagnosis on admission (Patients aged 17 to 50 Years) (12mths to qtr end)	Q4 2024/25	3.8	2	1.4
Diabetes: Mean length of stay for non-elective Major amputation admissions (36mths to qtr end)	Q4 2024/25	38.4	28.9	25.2
Diabetes: Emergency readmissions (with >zero day stay) within 30 days following a Major amputation admission (36mths to qtr end)	Q4 2024/25	21.6%	7.1%	7.5%
Diabetes: Mean length of stay for all elective Minor amputation admissions (36mths to qtr end)	Q4 2024/25	4.7	2.1	0.7
Diabetes: Mean length of stay for all elective Lower Limb Angioplasty admissions (36mths to qtr end)	Q4 2024/25	2.1	1.1	0.2
Diabetes: Mean length of stay for non-elective Lower Limb Angioplasty admissions (36mths to qtr end)	Q4 2024/25	24.6	14.1	12.4
Outpatients				
Missed outpatient appointments (DNAs) rate in endocrinology	Jul-25	13.3%	7.7%	8.6%

Length of Stay for DKA

- ULTH's mean length of stay for diabetic ketoacidosis is longer than peer and national averages, indicating room for acute care improvement.

Emergency Readmission Rates

- Emergency readmission after major amputation at ULTH is significantly higher than peer and national benchmarks, highlighting post-operative care needs.

Outpatient DNA Rates

- Higher outpatient Did Not Attend rates in endocrinology at ULTH suggest the need for better patient engagement strategies.

Analysis by specialty | Endocrine Surgery

	Latest Data	ULTH	Peer Average	National Value
Mean elective length of stay for Parathyroidectomy without Chronic Renal Failure	Q4 2024/25	3	0.4	0.4

Importance of Metric

- Mean elective length of stay for parathyroidectomy without chronic renal failure is a key indicator of surgical efficiency and post-operative recovery. Lower lengths of stay typically reflect streamlined perioperative pathways and effective discharge planning.

ULTH Performance Overview

- ULTH's mean elective length of stay for parathyroidectomy is **3.0 days**, significantly higher than both the peer average (**0.4 days**) and the national average (**0.4 days**). This suggests potential inefficiencies in patient flow or post-operative care protocols.

Strategies for Improvement

- ULTH could reduce length of stay by reviewing perioperative pathways, enhancing discharge planning, and adopting best practices from high-performing peers. Standardising clinical criteria for discharge and improving coordination with post-discharge services may help align performance with benchmarks.

Analysis by specialty | General & Acute

	Latest Data	ULTH	Peer Average	National Value
Inpatients				
Average length of stay for elective admissions (days) - rolling 6 months	Jun-25	5.5	4.7	4.5
% of elective admissions with the length of stay > 20 days	Feb-25	33.0%	0.0%	0.0%
Procedure on Day of Admission rate for elective admissions – rolling 6 months	Jun-25	25.0%	76.9%	87.8%
GIRFT				
Average length of stay for patients with Pulmonary Embolism admitted into Acute or General Medicine with an overnight stay (12mths to qtr end)	Q4 2024/25	8.2	6.3	4.6
Emergency readmissions with an overnight stay within 30 days of discharge for admissions with Atrial Fibrillation into Acute or General Medicine (12mths to qtr end)	Q4 2024/25	14.6%	10.0%	7.6%
Average length of stay for patients with Chest Pain admitted into Acute or General Medicine with an overnight stay (12mths to qtr end)	Q4 2024/25	4.2	2.6	1.6
Emergency readmissions without an overnight stay within 30 days of discharge for admissions with Chest Pain into the Emergency Department or selected medical specialties, excluding Acute or General Medicine (12mths to qtr end)	Q4 2024/25	7.0%	4.8%	5.1%
Average length of stay for patients with Headache admitted into Acute or General Medicine with an overnight stay (12mths to qtr end)	Q4 2024/25	5.3	2.8	1.8

Length of Stay Analysis

- ULTH's average elective admission length of stay is **5.5 days**, longer than the peer average of **4.7 days** and the national average of **4.5 days**. Additionally, **33%** of elective admissions exceed 20 days, compared to **0%** for both peer and national benchmarks, indicating significant variation in patient flow.

Procedure on Day of Admission

- Only **25%** of elective admissions at ULTH receive a procedure on the day of admission, well below the peer average of **77%** and national average of **88%**. This suggests potential inefficiencies in scheduling and pre-operative readiness.

Improvement Opportunities

- ULTH could improve throughput and reduce length of stay by increasing the rate of procedures on the day of admission. This may involve pathway redesign, enhanced pre-admission assessment, and better coordination between surgical and anaesthetic teams.

Analysis by specialty | Geriatric Medicine

	Latest Data	ULTH	Peer Average	National Value
Inpatients				
Procedure on Day of Admission rate for elective admissions – rolling 6 months	Jun-25	82.8%	100.0%	87.8%
GIRFT				
Rate of super stranded patients in EM pathways that were discharged to but not admitted from a care home (12mths to qtr end)	Q4 2024/25	8.2	6.3	4.6
Outpatients				
Outpatient follow up to new ratio in Geriatric Medicine (12mths to qtr end)	Q4 2024/25	2.6	1.2	0.5
Rate that did not attend their outpatient appointment in Geriatric Medicine (12mths to qtr end)	Q4 2024/25	8.3%	6.2%	3.2%

Length of Stay Analysis

- ULTH's rate of super stranded patients discharged to but not admitted from a care home is **8.2%**, higher than the peer average of **6.3%** and the national average of **4.6%**. This suggests potential delays in discharge planning and coordination with community care services.

Follow-up and DNA Metrics

- The outpatient follow-up to new ratio in Geriatric Medicine at ULTH is **2.6**, significantly above the peer average of **1.2** and national average of **0.5**, indicating potential overuse of follow-up appointments. The outpatient DNA rate is **8.3%**, also higher than peer (**6.2%**) and national (**3.2%**) benchmarks.

Improvement Opportunities

ULTH could improve geriatric care efficiency by reducing unnecessary follow-ups and enhancing discharge coordination with care homes.
Efforts to reduce DNAs through patient engagement and reminder systems may also improve clinic utilisation and continuity of care.

Analysis by specialty | Neurology

	Latest Data	ULTH	Peer Average	National Value
Outpatients				
Missed outpatient appointments (DNAs) rate in neurology	Jul-25	12.8%	7.3%	8.5%
Missed outpatient appointments (DNAs) rate for face to face outpatient appointments in neurology	Jul-25	16.4%	6.7%	9.5%
Missed outpatient appointments (DNAs) rate for first appointments in neurology	Jul-25	14.4%	6.9%	10.4%
Missed outpatient appointments (DNAs) rate for follow up outpatient appointments in neurology	Jul-25	12.1%	7.4%	7.8%

Outpatient DNA Rates

- ULTH's overall outpatient DNA rate in neurology is **12.8%**, which is higher than the peer average of **7.3%** and the national average of **8.5%**.
  First appointment DNA rate is **14.4%**, also above peer (**6.9%**) and national (**10.4%**) benchmarks.
  Follow-up appointment DNA rate stands at **12.1%**, compared to peer (**7.4%**) and national (**7.8%**) averages.

Face-to-Face Appointment DNAs

- Face-to-face DNA rate at ULTH is **16.4%**, significantly above the peer average of **6.7%** and national average of **9.5%**, indicating challenges in patient attendance for in-person neurology consultations.

Improvement Opportunities

- ULTH could reduce neurology outpatient DNAs by implementing multi-channel appointment reminders, offering virtual consultations where clinically appropriate, and improving scheduling flexibility to better accommodate patient needs.

Analysis by specialty | Respiratory

	Latest Data	ULTH	Peer Average	National Value
Inpatients				
Average length of stay for elective admissions (days) - rolling 6 months	Jun-25	8	4.5	3.7
% of elective admissions with the length of stay > 20 days	Feb-25	20.0%	0.0%	0.0%
% of emergency admissions with the length of stay > 20 days	Jun-25	16.7%	8.0%	10.4%
Procedure on Day of Admission rate for elective admissions – rolling 6 months	Jun-25	57.1%	94.1%	91.3%

Performance Overview

- ULTH shows extended inpatient stays in respiratory medicine, with elective length of stay nearly double that of peers and national benchmarks. A high proportion of both elective and emergency admissions exceed 20 days, indicating systemic delays in discharge or recovery.

Key Challenges

- Low rates of procedures on the day of admission suggest inefficiencies in scheduling and pre-operative readiness. Combined with prolonged stays, this points to opportunities for streamlining care pathways and improving coordination.

Improvement Opportunities

- ULTH could reduce length of stay and improve throughput by increasing procedure-on-admission rates and enhancing discharge planning. Adopting best practices from peers may help align performance with national standards.

Analysis by specialty | Rheumatology

	Latest Data	ULTH	Peer Average	National Value
GIRFT				
Percentage of day case admissions with no procedures in rheumatology (12mths to qtr end)	Q4 2024/25	4.9%	0.9%	0.4%
Day Case/Outpatients				
Missed outpatient appointments (DNAs) rate for face to face outpatient appointments in rheumatology	Jul-25	10.8%	6.2%	7.0%
Missed outpatient appointments (DNAs) rate for follow up outpatient appointments in rheumatology	Jul-25	7.8%	6.1%	5.8%

Performance Overview

- ULTH's rheumatology service shows elevated DNA rates for face-to-face and follow-up appointments, indicating challenges in patient engagement and scheduling reliability. Additionally, a notable share of day case admissions occur without procedures, suggesting inefficiencies in pathway design or pre-assessment.

Key Challenges

- High non-attendance and non-procedural day cases point to wasted capacity and suboptimal resource use. These issues may stem from unclear referral criteria, poor triage, or inadequate communication with patients.

Improvement Opportunities

- ULTH could improve rheumatology efficiency by tightening referral and triage protocols, aligning day case admissions with procedural intent, and deploying robust reminder systems to reduce DNAs and improve clinic utilisation.

Medicine Care Group Fragile Services

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2024 assessments		
Stroke	Unsustainable	**Workforce –** medical, nursing and AHP (with national shortages of medical workforce) covered by locums and additional duties, **Capacity** – IP beds and some OP capacity, **Demand** – higher than national prevalence, **Performance** - psychology services waiting lists, failure to meet best practice standards, **Quality** – poor SNAPP score – Level D
Health Care of the Older Person	Partially Fragile	**Workforce** - establishment does not meet service need, **Demand** - ASR incorporates a frailty service on Grantham 3rd ward which is not established. Requirement for HCOP to provide in reach into Surgical Care Group which is not established and provided ad hoc, **Performance** - service does not meet requirement of 70 hours/week of 'front door' cover, **Finance** - service (£846) against budget Jan 2024
Respiratory	Partially Fragile	**Workforce** - establishment does not meet service need, - Demand does not meet capacity. Current recurrent demand is 6,188 (New) and 10,400 (FU) per year. Capacity is 3,787 (New) and 7,988 (FU) per year. Pleural Service based only at Lincoln and should be Trust Wide, **Performance** - Ranked 125th out of 126 Trusts for RTT. Did not meet no 65 weeks by end March 2024, **Quality** - RSU and 7B rated Amber on Quality Dashboard, **Finance** - £409 over budget Jan 2024. High Locum spend additional to establishment
Gastroenterology	Partially Fragile	**Workforce** - Consultant vacancies (1 PHB, 3 LCH, 1 GDH). UGI Bleed rota safely established as 1 person at LCH, 1 at PHB, regularly running as 1 Consultant providing Trust Wide cover. Outpatient activity and registrar training opportunities regularly cancelled to provide Ward Cover. **Demand** - Demand does not meet capacity. Current recurrent demand is 9,412 (New) and 13,520 (FU) per year. Capacity is 8,961 (New) and 12974 (FU) per year. **Performance** - Gastro has continued to struggle with 78-week performance and did not meet 65-week directive by end Mar 2024. **Quality** - Dixon Ward rated Amber on Quality Dashboard. 8A has high acuity on the Ward. **Finance** - service underspent but has significant overspend on external providers, £521k over budget at year end.
2025 new SSR assessment		
Neurology		**Workforce** – consultant recruitment successful – back to x 4 consultants in service sickness rate 6.83%, **Demand** – GP referrals grown from 1930 in 2019 to 3449 in 2024. There are currently 8700 patients on the Neurology PBWL, 5494 of which are overdue (Sept 2025 – largest PBWL in ULTH), **Performance** - June 25 RTT performance – 40.2%, July 25 RTT performance – 37.3%. **Finance** - ULTH total staff cost for Neurology is £1.73m, Model hospital £1.59m peer average, £2.30m national value. Cost per WAU data according to Model Hospital: Overall productivity = £3,281 compared to peer average of £3,373, Cost per WAU by setting £618 compared to peer average of £1,572. **Quality** - FFT average from the 3 sites: 87.14% positive ratings

- Updated position for 2024 services?
- Priority for SSR review?
- Which are:
  - In our gift to solve?
  - Need local system support?
  - Need regional support?
  - Any difficult decisions to be made?

Medicine Care Group GIRFT Areas of Focus

Speciality	Plan updated	Latest Summary	Priority areas	RAG
Acute and General Medicine	2022	Action plan shows follow up meeting with GIRFT not booked, likely that actions are superceded by other specialty plas e.g. UEC.	1. Developing access to AMU at weekends 2. Review and improve ambulatory care to decrease length of stay 3. Reduce readmissions	Grey
Cardiology	2024	First follow-up meeting to be booked. Actions from 2023 have been reviewed and discussed with the team; progress is being made, and actions were prioritised.	1. Efficient use of cath labs 2. Review of echocardiography to ensure it is fit for purpose 3. Address long waits in outpatients	Amber
Dermatology	2019	First specialty follow-up meeting held. National recommendations added following publications of the national report. Meeting to be arranged to discuss progress of local actions and prioritise national recommendations.	1. Improve cancer nurse specialist provision 2. Provision of psychology services 3. Implement system for taking photographs of cancer patients	Grey
Diabetes	2024	Follow up meeting to be arranged. Actions from 2023 have been reviewed and discussed with the team. Of seven proposed recommendations, all but one were agreed and progress has been made against all six agreed actions.	1. Seven day working to support inpatient length of stay 2. Review access to vascular services 3. Improve perioperative pathways for diabetes patients	Green
Diabetes in Children and Young Adults	2024	Internal follow up meeting to discuss progress was held on 31/10/2024. As of September 2025, attempts are being made for another progress review meeting.	1. Resolve issues with primary care around duplicate blood tests 2. Redesign some adult clinics to CYP clinics 3. Improve response rate for PREM	Amber
Endocrinology	2019	National recommendations added following publication of the national report. Where these mirror local actions from the deep dive, this has been noted. Unsure when actions last reviewed. No significant progress recorded against 2019 actions which are now out of date. Recommend new GIRFT review.	1. Resolve issues around day case coding 2. Expand specialised thyroid clinics 3. Increase outpatient pre-testing	Grey
Gastroenterology	2024	Actions reviewed 13/11/2024, and the clinical lead is keen to keep some of the older actions live to progress the specialty towards change. Some actions are more relevant to the Endoscopy team so it was agreed the Best Practice Manager will reach out for further information and update the plan accordingly.	1. Reduce incidents of day case procedures being cancelled on the day 2. Ensure endoscopy is coded as day case 3. Address issue of insufficient clinic space to reduce wait times	Amber

Medicine Care Group GIRFT Areas of Focus



Speciality	Plan updated	Latest Summary	Priority areas	
Acute and General Medicine	2022	Action plan shows follow up meeting with GIRFT not booked, likely that actions are superseded by other specialty plans e.g. UEC.	1. Developing access to AMU at weekends 2. Review and improve ambulatory care to decrease length of stay 3. Reduce readmissions	Grey
Geriatric Medicine	TBC	National recommendations added following publication of the national report. Deep dive was never arranged.	TBC	Grey
Neurology	2024	19.07.21 - CBU UPDATE - Outpatient work is currently the priority, to review in 12 months. Actions have been reviewed in 2024 and are to be picked up as part of the Specialty Support Programme.	1. Develop inpatient neurology services 2. Consider employing trainees from Nottingham	Red
Renal	TBC	National recommendations added following publication of the national report. Renal is no longer part of the GIRFT national team activity therefore they are unable to facilitate a deep dive.	TBC	Grey
Respiratory	2024	We understand the financial issues facing the trust and therefore recommend that the initial two stage approach as highlighted in the respiratory department level section is actioned, as this has the ability to transform the service provision and reduce the length of stay at minimal cost. We would strongly recommend that the trust has a GIRFT respiratory re-visit in a year or so.	1. Expand consultant, registrar and nursing workforce 2. Develop non-invasive ventilation services including sufficient and protected beds 3. Improve access to pleural services across sites	Green
Rheumatology	2023	First follow-up meeting to be booked. Actions reviewed and progress discussed with the team. Progress made against 15 of 22 agreed actions and 3 delivered.	1. Reduce routine waiting time for appointments to 8 weeks 2. Improve access to National Early Inflammatory Arthritis Audit 3. Digital system for DMARD monitoring	Green
Urgent and Emergency Care	2024	Following the review in 2023, several actions were agreed for progression as part of the Urgent & Emergency Care programme within the Improvement & Integration Directorate. Actions have now been deemed out of scope for this programme however it is unclear where actions are progressing and need to check with Deputy COO for confirmation.	1. Expand SDEC to increase capacity and throughput 2. Improve ambulance conveyances 3. Improved frailty services	Red

Medicine Care Group PLICS (Patient level information and costing system) Areas of Focus

2024-25 PLICS Quarter 1 to 4 - Specialty Summary
Medicine Care Group

Specialty	Actual Cost	National Average Cost	Activities	External Cost Variance	Average Actual Unit Cost	National Average Unit Cost
General & Acute Medicine	£111,403,576	£78,305,560	53,676	£33,098,015	£2,075.48	£1,458.86
Accident & Emergency	£83,733,840	£66,291,736	172,358	£17,442,104	£485.81	£384.62
Cardiology	£27,862,713	£23,255,523	22,092	£4,607,190	£1,261.21	£1,052.67
Geriatric Medicine	£27,598,461	£24,183,804	8,308	£3,414,657	£3,321.91	£2,910.91
Respiratory Medicine	£18,495,485	£16,960,080	18,648	£1,535,405	£991.82	£909.49
Gastroenterology	£15,609,389	£12,479,928	30,109	£3,129,461	£518.43	£414.49
Stroke Medicine	£11,121,563	£5,539,970	887	£5,581,594	£12,538.40	£6,245.74
Dermatology	£6,081,930	£7,246,017	38,968	-£1,164,087	£156.07	£185.95
Nephrology	£6,056,385	£5,367,953	6,861	£688,432	£882.73	£782.39
Rheumatology	£4,319,625	£3,329,124	12,971	£990,501	£333.02	£256.66
Neurology	£3,779,862	£4,198,016	14,411	-£418,155	£262.29	£291.31
Endocrinology	£3,495,303	£1,902,655	786	£1,592,648	£4,446.95	£2,420.68
Diabetic Medicine	£2,673,251	£4,464,901	21,099	-£1,791,650	£126.70	£211.62
Clinical Physiology	£1,770,907	£1,511,337	14,968	£259,570	£118.31	£100.97
Audiological Medicine	£1,475,664	£1,511,516	7,217	-£35,852	£204.47	£209.44
Transient Ischaemic Attack	£294,636	£615,261	2,668	-£320,625	£110.43	£230.61
Paediatric Cardiology	£145,801	£171,840	638	-£26,039	£228.53	£269.34
Clinical Immunology and Allergy	£1,229	£2,497	5	-£1,268	£245.76	£499.45
Grand Total	**£325,919,620**	**£257,337,718**	**426,670**	**£68,581,902**	**£763.87**	**£603.13**

2025-26 PLICS Quarter 1 - Specialty Summary
Medicine Care Group

Specialty	Actual Cost	National Average Cost	Activities	External Cost Variance	Average Actual Unit Cost	National Average Unit Cost
General & Acute Medicine	£30,202,611	£26,692,861	14,077	£3,509,749	£2,145.53	£1,896.20
Accident & Emergency	£21,887,980	£17,342,124	43,867	£4,545,855	£498.96	£395.33
Geriatric Medicine	£8,503,715	£7,784,802	2,661	£718,913	£3,195.68	£2,925.52
Cardiology	£7,175,491	£5,788,879	5,172	£1,386,612	£1,387.37	£1,119.27
Respiratory Medicine	£4,697,847	£4,000,277	3,537	£697,570	£1,328.20	£1,130.98
Gastroenterology	£3,733,195	£3,244,651	7,595	£488,544	£491.53	£427.21
Endocrinology	£2,088,947	£1,334,639	327	£754,308	£6,388.22	£4,081.46
Nephrology	£1,525,275	£1,686,352	1,619	-£161,077	£942.11	£1,041.60
Dermatology	£1,382,337	£2,008,875	9,975	-£626,538	£138.58	£201.39
Rheumatology	£1,302,349	£1,029,660	3,347	£272,689	£389.11	£307.64
Clinical Physiology	£1,118,648	£626,046	5,754	£492,602	£194.41	£108.80
Neurology	£889,577	£1,023,769	3,406	-£134,193	£261.18	£300.58
Diabetic Medicine	£721,437	£1,270,615	5,723	-£549,178	£126.06	£222.02
Audiological Medicine	£366,317	£442,268	2,022	-£75,951	£181.17	£218.73
Transient Ischaemic Attack	£85,869	£138,110	508	-£52,241	£169.03	£271.87
Paediatric Cardiology	£53,897	£59,279	205	-£5,381	£262.91	£289.17
Grand Total	**£85,735,491**	**£74,473,207**	**109,795**	**£11,262,284**	**£780.87**	**£678.29**

Key Outliers: General medicine, A&E, Cardiology, Geriatric Medicine, Respiratory Medicine, Gastro, Endocrinology, Stroke, Nephrology, Rheumatology

Productivity and Efficiency - Medicine

	Assumed costbase £m	Opportunity £m	% Opp	Size of Opp vs.135 Acutes	Cash releasing £m	Equivalent	Opportunity notes
Non-Elective overnight stays	279.3	52	*0.0%*	*113*	26.0	**1.49** LoS days Opp **63.5k** beddays p.a.	***Key area:*** *target long lengths of stay and improving flow through the system.*
A&E and SDEC	132.5	12	*9.0%*	*113*	6.0	**22.8k** SDEC	***Data:*** ***c.210*** *fewer A&E attendances per Emer Medical Consultant WTE at ULHT than England median* ***Key area:*** *standardise SDEC offer & optimise staffing.*
Elective opportunity	164.5	10.2	*6.2%*	*96*	5.1	**8.3k** Episodes	***Key area:*** *improve theatre utilisation, day case rate, outpatient procedures, maximise core capacity and reduce premium costs (incl. WLI, agency, insourcing/ outsourcing).*
Outpatient opportunity	76.2	1.5	*2.0%*	*53*	0.8	**3.7k** attends	***Data:*** ***c.17*** *OP attendances less per Consultant WTE at ULHT than the England median* ***Key area:*** *utilise GIRFT outpatient (Further Faster) tools to embrace best practice, improving productivity of core capacity.*
Other acute	95.6	1.9	*2.0%*		1.0		
Clinical & Ops productivity	**817**	**77.6**	***9.5%***		**38.9**		
Temp staff	548	16.8	*3.1%*	*13*	16.8		***Key areas:*** *Reduce temp staff focus non-clinical;* *- Reduce sickness & absence to pre-covid levels and review establishment mix;* *- **Agency:** reduce last minute booking via better rosters/plans; No off framework; switch to bank if cheaper;* *- **Bank:** Estab review of high growth areas; reduce bank rates (either collab or locally).*
Corporate Services	62	19.3	*31.3%*	*16*	19.3		***Key areas:*** *reduce variation vs. peers in spend per £100m income; reverse growth vs 2020.*
Medicines	76	1.4	*1.8%*	*68*	1.4		***Key areas:*** *embrace all new biosimilars - New pats within 3 months, 80% existing pats within 8 months; Increase adoption of secondary care framework;* ***Core opps:*** *Ustekinumab **£0.5m** is a 24/25 opp carried fwd;* *Aflibercept **£0.26m**; Pomalidomide **£0.23m**;*
Commercial	223	2.1	*0.9%*	*91*	2.1		***Key areas:*** *Use NHS supply chain where possible; reduce prices to cheaper alternatives; reduce spend in areas of high growth and supplier fragmentation.* ***Core opps:*** *Estates **£1.46m**; Digital **£0.26m**; Commercial price switching **£0.22m***
Efficiency opportunity	**817**	**39.6**	***4.8%***		**39.6**		
Total	**817**	**117.2**	***14.3%***	*5*	**78.5**		



- **Non-Elective Overnight Stays**: Focus: Reduce long lengths of stay, improve patient flow.
- **A&E and Same Day Emergency Care (SDEC)**: Focus: Shift activity from ED to SDEC, optimise staffing and space.
- **Outpatients**: Focus: Increase consultant-led activity, streamline booking and attendance
- **Other Acute Clinical & Ops**: Focus: Improve operational efficiency and reduce delays

Model Hospital – Overnight Stay

Stroke	Provider Value	Peer average	National value	Comment
% emergency admissions with Length of stay > 6 days	41.7%	42.9%	37.5%	For emergency admissions, Stroke activity is 4.2% higher than the national average but 1.2% lower than the peer group average. In contrast, elective Stroke admissions are 8.3% above the national average and broadly aligned with the peer group average.
% of bed days that are due to emergency patients staying beyond >6 days	87.2%	90.5%	87.4%	
% of elective admissions with the length of stay >6 days	100.0%	100.0%	91.7%	
% of bed days that are due to elective patients staying beyond > 6 days	100.0%	100.0%	100.0%	

Cardiology	Provider Value	Peer average	National value	Comment
% emergency admissions with Length of stay > 6 days	34.3%	26.0%	26.5%	For emergency admissions, Cardiology activity is 7.8% above the national average and 8.3% above the peer group average. Elective Cardiology admissions show a more pronounced variance, at 33.7% above the national average and 42.3% higher than the peer group average.
% of bed days that are due to emergency patients staying beyond >6 days	65.6%	66.8%	72.2%	
% of elective admissions with the length of stay >6 days	50.0%	7.7%	16.3%	
% of bed days that are due to elective patients staying beyond > 6 days	72.4%	47.4%	68.5%	

Gastroenterology	Provider Value	Peer average	National value	Comment
% emergency admissions with Length of stay > 6 days	66.7%	42.9%	41.2%	For emergency admissions, Gastroenterology activity is 25.5% higher than the national average and 23.8% above the peer group average. In contrast, elective Gastroenterology admissions compare very favourably, performing in line with or better than both the national and peer group averages.
% of bed days that are due to emergency patients staying beyond >6 days	82.9%	78.6%	83.9%	
% of elective admissions with the length of stay >6 days	16.7%	33.3%	16.7%	
% of bed days that are due to elective patients staying beyond > 6 days	63.6%	87.5%	68.8%	

- **Stroke**
  - **Overall Stroke Admissions**: 42.9% (↑ 9.6% above national average)
  - **Age 75+ Admissions**: 67.2% (↑ 10.7% above peer average)
  - **Age 75+ Stay >2 Days**: 100% (no national/peer comparison available)

- **Cardiology activity is 78% above national average**
  - **Heart Failure Admissions**: 34.7%
    - Above national average (29.8%)
    - In line with peer average (26.6%)

- **Gastroenterology activity is 25.5% higher than national average**
  - **GI Bleed Admissions**: 65.7%
    - Significantly above national average (41.2%)
    - Above peer average (47.9%)

Productivity Opportunities



Cardiology	Diabetes and Endocrinology	Gastroenterology	HCOP	Rheumatology
• Develop and embed career progression pathway. • Develop business case for remote device monitoring. • Introduction of specialist clinics. • Develop business case for 3rd cath lab and enable dedicated labs. • Ward reconfiguration. • Improvement in ECHO waiting and processing times	• Work with primary care partners to left shift activity and create alternative future models of care. • Develop Specialist Nurse/ ACP role. • Increase speciality in-reach. • Work with multi-disciplinary team to extend workforce. • Tier 3 and 4 Obesity Service • Reduction of beds through development of integrated diabetes clinical pathways	• Enable Research and Innovation Culture. • Implement Lincolnshire Liver Pathway. • Develop and enhance role of ACPs. • Address population health issues due to addiction and substance misuse	• Enable all patients to receive comprehensive geriatric assessment. • Direct access from ED/EMAS/Care Homes • Develop capacity and demand model • Work with partners to extend and develop multi-disciplinary workforce • Outpatient transformation • ULHT Care Home • ACD's/EOL Improvements	• Creation of a Workforce Plan. • Work with primary care partners to left shift activity, e.g. OPAT support infusions and Fibromyalgia • Develop demand and capacity model for next 10 years. • Outpatient transformation. • Dedicated clinical outpatient facilities that are fit for purpose

Are there opportunities to work in a more integrated way with community, dental and primary care partners?

Digital Plans

Key Priorities in the LCHG One Digital Strategy 2025-2028

Electronic Patient Records (EPRs):

- A unified, secure digital record for each patient.
- Designed to improve continuity of care and reduce duplication.
- Requires robust data governance, including clear roles for data controllers/processors and transparency with patients.

Revamped NHS App:

- Evolving into a personal health assistant.
- Will integrate genomic data, wearables, and electronic health records.
- Enables self-referral, appointment booking, and care management directly from smartphones.

Virtual Wards & Remote Monitoring:

- Expansion of **hospital-at-home** models.
- Patients receive acute care remotely, supported by digital tools and monitoring devices.

Ambient AI & Automation:

- AI tools to assist with diagnostics, triage, and even clinical documentation (e.g., automated scribing).
- Aimed at reducing clinician workload and administrative burden.

Five Transformative Technologies:

1. **Data**
2. **Artificial Intelligence (AI)**
3. **Genomics**
4. **Wearables**
5. **Robotics**

These are seen as essential to modernising care delivery, improving outcomes, and driving efficiency.

LCHG Digital Enablers – What does this mean to your teams?

Improved Day-to-Day Operations

- **Reliable infrastructure**: Fewer system crashes, faster devices, and better connectivity mean less time troubleshooting and more time with patients.
- **Responsive support**: IT issues resolved quickly—urgent problems within an hour, routine ones the same day.

Clinician-Centered Design

- **User-led system design**: Clinical teams will be involved in shaping digital tools, ensuring they're intuitive and aligned with real-world workflows.
- **Reduced admin burden**: Fewer systems to log into, less duplication of data entry, and automation of routine tasks (e.g., vitals from monitoring devices auto-uploaded to records).

Less Time on Screens, More Time with Patients

- **50% reduction in systems used**: Streamlined digital environment means clinicians spend less time navigating tech and more time delivering care.
- **Paperless ambition**: Transition away from hybrid paper-digital workflows to fully digital records, reducing risk and improving access.

Smarter, Safer Care

- **AI and automation**: Tools like AI-supported diagnostics and robotic process automation (RPA) will assist in clinical decision-making and reduce backlog.
- **Voice tech pilots**: Ambient voice solutions in anaesthetics and other areas could reduce documentation time and improve accuracy.

Equity and Access

- **Digital inclusion**: Services will be designed to accommodate patients with varying levels of digital literacy, ensuring no one is left behind.
- **Patient portals**: Easier access to records and communication for patients, improving engagement and transparency.

Collaboration and Innovation

- **Clinical services as co-creators**: Teams will be encouraged to bring forward problems and work with digital teams to co-design solutions.
- **AI Academy**: Opportunities for clinicians to upskill in emerging technologies and participate in innovation projects.

Clear Roadmap and Accountability

- **Group-wide governance**: Decisions will be made transparently with clinical input, ensuring alignment across services.
- **Performance tracking**: Success will be measured by usability, time saved, and improvements in care quality.

Key Digital Themes From The NHS 10 Year Plan- to consider

Digital Priorities 10YP
Electronic Prescription Service (EPS)
- Full deployment across all care settings.
- Integration with the **NHS App** for patient prescription tracking and repeat ordering.

Medicines Interoperability
- Seamless sharing of medication data (prescriptions, allergies, intolerances) across NHS systems.

Closed-Loop Medicines Systems
- End-to-end tracking of medicines from supply to administration.
- Enhances safety, reduces waste, and supports cost analysis.

Hospital Medicines Data Analytics
- Weekly data collection on prescribing and administration.
- Used for research, safety audits, and optimisation.

Digital Workforce Development
- Upskilling staff in digital tools and data literacy.
- Embedding digital competencies into clinical roles.

AI-Enabled Decision Support
- AI tools for prescribing, risk stratification, and antimicrobial stewardship.
- Ambient AI for documentation and workflow automation.

Integration with Virtual Wards and Remote Monitoring
- Medicines support for patients receiving care at home.
- Digital prescribing and monitoring via wearables and apps.

Sustainability and Green Medicines Strategy
- Focus on reducing emissions from medicines (e.g., inhalers, anaesthetic gases).
- Align with NHS Green Plan targets.

Medicines Optimisation Framework
- Use of national prescribing data to identify efficiency opportunities.
- Adoption of biosimilars and generics to reduce costs.

Single Patient Records (SPR)
- Unified digital records including medicines history.
- Supports continuity of care and reduces duplication.

Key Digital Themes From The NHS 10 Year Plan- to consider



What are we already doing?

Digital Priorities 10YP
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and repeat ordering.

ULTH EPS Optimisation
- **EPS system Optimisation:** What is the next steps for the EPS system?

Medicines Interoperability
- Seamless sharing of medication data (prescriptions, allergies, intolerances) across NHS systems.

Closed-Loop Medicines Systems
- End-to-end tracking of medicines from supply to administration.
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Hospital Medicines Data Analytics
- Weekly data collection on prescribing and administration.
- Used for research, safety audits, and optimisation.

LCHG Digital Workforce Development
- **Digital inclusion**: Services will be designed to accommodate patients with varying levels of digital literacy, ensuring no one is left behind.
- **AI Academy**: Opportunities for clinicians to upskill in emerging technologies and participate in innovation projects.

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AI tools: What are the areas of large risk or opportunity for efficiency and reduced duplication?
Potential area for exploration with Digital & Transformation.

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Virtual Wards and Remote Monitoring: What are the areas of large risk or opportunity for efficiency and reduced duplication?
Potential area for exploration with Digital & Transformation.

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LCHG Green Plan:
- Connected into the LCHG Green Plan with clear plan and deliverables.
- **Is there more we can do?**

Medicines Optimisation Framework
- Use of national prescribing data to identify efficiency opportunities.
- Adoption of biosimilars and generics to reduce costs.

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LCHG Electronic Patient Records (EPRs):
- A unified, secure digital record for each patient.
- Rollout across group starts in 2026

Innovation Opportunities Developed by Health Innovation East Midlands

Health Innovation East Midlands Clinical and Cross Cutting Priorities

These are based on ongoing engagement with ICSs around their needs and challenges

Clinical priorities 2023-2024

- Cardiovascular
- Respiratory
- Mental health
- Medicines pathways and safety
- Maternity and Neonatal Care
- Cancer
- Wound care

Cross-cutting priority themes 2023-2024

- Enabling safer systems of care
- Digital technology and AI
- Tackling health inequality (with a focus on NHS Core20PLUS5)
- Sustainability (to achieve NHS Net Zero)
- Workforce (embedding a culture of innovation across the East Midlands health and care workforce)

Health Innovation East Midlands work is continually evolving and as an agile and flexible organisation they are keen to hear about any promising health innovations that could:

- Address any East Midlands health and care challenge in addition to those listed above, and;
- Support any of their three overarching aims: transforming patient outcomes; generating efficiencies; and enabling inward investment and growth into the East Midlands.

Innovation Opportunities – Examples from other areas

Cardiac High Intensity Observation Care Unit (CHOCU)

A virtual care model for patients who are medically fit but whose treatment needs to be optimised to prevent future exacerbations and hospital admissions.

EMAHSN exploring opportunities to test this model with system partners, potential funders and the CVD Clinical Network.

Islacare Visual Record https://vimeo.com/790460649

A web-based platform utilising existing device hardware to capture high quality images, videos, video and text data and submit to health practitioners. Data is structured to immediately highlight changes in conditions – enabling wide scale remote management, early escalation and rapid review of health conditions.

Indicative data supports efficiencies across many clinical specialties, for example:
Teledermatology: 50% in medical photographer time per patient, 15% reduction in minor operations.
Neurology: 6 monthly Epilepsy treatment cycle condensed to 2-3 weeks.

Being utilised in 45 specialties across 25 NHS Trusts including NUH and Notts Healthcare.

Outpatient Digital Follow Up Programme

Clinicians enable suitable patients to opt in to a digital pathway, using bespoke questionnaires to establish whether follow up appointments are needed.

For one pathway this reduced follow up appointments for patients on the digital pathway by 97%.

As at May ’23, spread to 60 pathways within NUH and rolling out in two other Trusts.

O2 Matic https://www.nice.org.uk/advice/mib308

Optimises oxygen treatment by automatically titrating the oxygen supply based on a continuous measurement of the blood oxygen content.

Expected impact to improve and optimise patient care, free up nursing time and reduce bed days for patients requiring oxygen.

An example of how Health Innovation East Midlands are supporting industry and NHS collaboration to undertake real world evidence project to develop the evidence base in support of adoption and scale up of innovation.

Innovation Opportunities – Examples from other areas

MBI Technologies – Intelligent Automation software 'Luna' and 'Rova'

UDHB have used Luna and Rova IA software for last 9 years with highly positive outcomes. The Trust has embedded Luna within their waiting list validation team to check that the right patients are on each outpatient waiting list.

Rova can read all documentation attached to a patient EPR record and is given 'classifiers' to check for certain scenarios – i.e. a patient is given a discharge letter but remains on a waiting list to find patients who should be removed.

The innovation can monitor clinical outcomes against pathway events, determining where RTT status does not match the EPR entry for the patient or where a patient has been given a diagnosis within a letter that is not logged on the system, ensuring Trusts have the most accurate information possible for their patients.

Atrial Fibrillation (AF) Virtual Ward

Virtual AF ward to provide multi-disciplinary care with remote hospital-level monitoring. Patients satisfying the virtual ward on-boarding criteria are provided with a Bluetooth integrated blood pressure machine, pulse oximeter and Kardia single lead portable ECG. This information is then uploaded through a smart phone or electronic tablet to a digital platform where they are visible to specialised clinicians for review.

Provides virtual monitoring for up to 10 days allowing comprehensive management of patient symptoms, incorporating lifestyle advice and patient education which, in turn significantly improves the overall quality of life.

Final evaluation report due July 2023.

Innovation Opportunities – Examples from other areas



PMD Solutions/ RespiraSense https://www.pmd-solutions.com/product

Motion tolerant, continuous respiratory rate monitor. Transmitting information via Bluetooth enables healthcare professionals to examine respiratory rate remotely with minimal contact with the patient.

Community pilot in Ireland in a very rural area focused on individuals with 3-5 admissions in last 12 months with COPD/lung disease – 100% avoidance of admission to hospital during 6 months of monitoring.

Used by NUH.

Proxximos https://proxximos.com/

Where a particular infection is identified in a patient, IPC aim to identify contacts and treat / respond appropriately to reduce the possibility of spread/outbreak. Proxximos, through the provision of a wearable device, can pinpoint individuals' position and movement in a building to a 15cm accuracy. When an infection is identified contacts can be identified and where people have been to enable deep cleaning.

Impact is reduction in a length of stay.

Currently being tested at Manchester NHS Trust.

Innovation opportunism – What are we already doing? What opportunities are there to adopt some of these innovations?

LCHG Strategy

Year 1 Delivery
what are we going to achieve in 2024/25?

LCHG 2025-2030 Strategy

Everything in our Care Group strategic and operational plans should contribute to delivering our strategy and the 3Ps

PATIENTS
Better Care

AIMS

Provide timely, high quality, affordable care in the right place

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

PEOPLE
Better Opportunities

AIMS

Develop, empower and retain great people

OBJECTIVES

- 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

POPULATION
Better Health

AIMS

Improve population health

OBJECTIVES

- 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 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

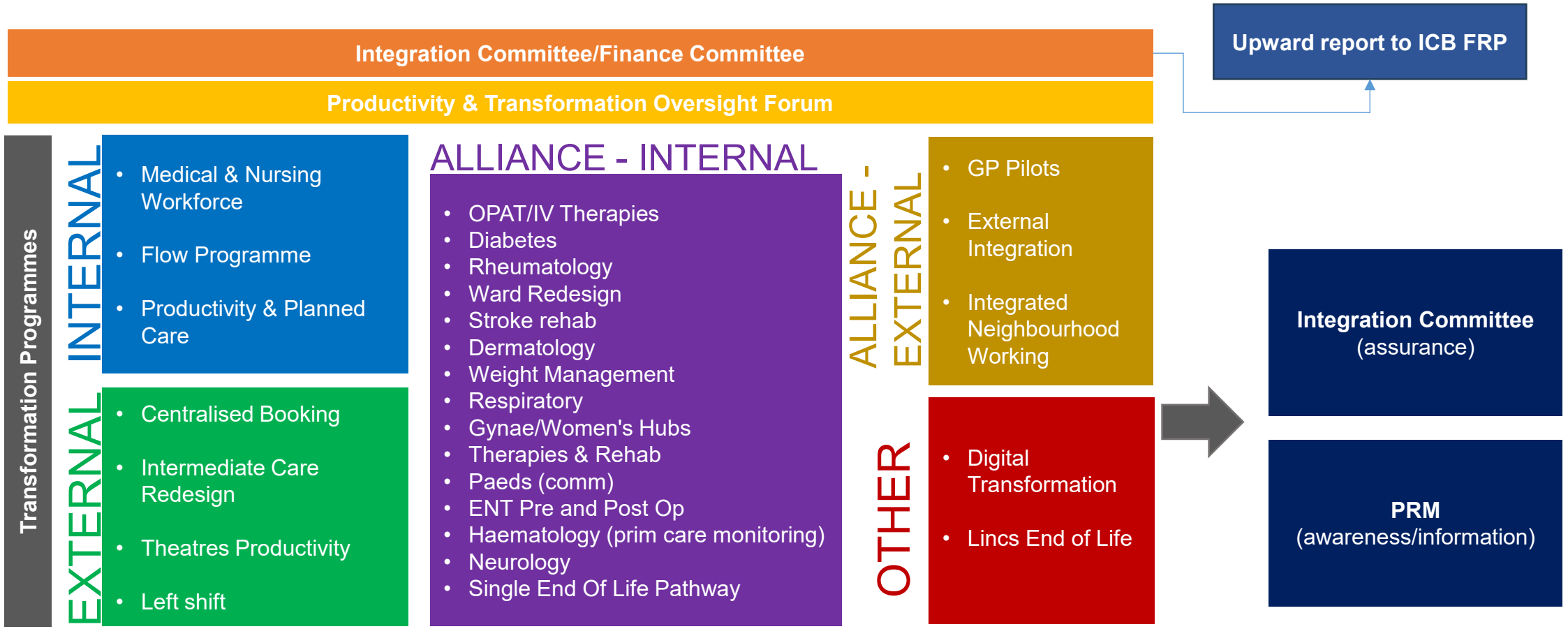
Summary: Key Deliverables for 2024/25

1. Patients: Quality of Care and Patient Experience	
Focus Area	**Key Actions / Goals**
Patient Safety & Experience	• Reduce harm • Enhance Infection Prevention & Control (IPC) • Address patient feedback
Diagnostics	• Better utilise Community Diagnostics Centres
Access & Flow	• Reduce waiting times in acute and community settings • Improve planned care, A&E, ambulance response, and diagnostics • Deliver QI programmes on Urgent & Emergency Care (UEC), flow, and intermediate care • Reduce community waits and improve UTC targets
Productivity & Sustainability	• Increase productivity and financial sustainability • Deliver QI programmes on theatre and outpatient transformation, medical workforce productivity & booking centre efficiency • CIP delivery
Infrastructure & Environment	• Addressing backlog maintenance and capital investment. • Conduct space utilisation reviews • Integrate services across acute and community settings

2. People: Workforce Development and Culture	
Focus Area	**Key Actions / Goals**
Staff Development	• Provide training, appraisals, leadership development, and research and expand apprenticeship opportunities
Workforce Planning	• Sign off job plans • Strengthen consultant and middle-tier workforce planning • Stabilisation and succession planning
Culture & Leadership	• Promote inclusive leadership • Embed Civility and Respect • Listen to staff feedback • Monitor organisational culture using a 'Hot Spot' Dashboard • Embed QI ethos & Research & Innovation culture
Recognition	• Celebrate staff contributions through awards and recognition programmes

3. Populations: Transformation, Innovation and Sustainability	
Focus Area	**Key Actions / Goals**
Care Pathway Transformation	• Strengthening collaboration with our partners through our partnership strategy • Shift services to community settings (OPAT/IV Therapies, Stroke, Dermatology, Weight Management, Respiratory, Rheumatology, Therapies Rehab, Paediatrics, Cataract Surgery, ENT Surgery, Neurology)
Estates Strategy	• Rationalise estate use • Develop business cases for maternity and theatres
Population Health	• deploy integrated neighborhood health • Tackle inequalities • Embed prevention models • Integrating CDC pathways into primary care and deploying neighbourhood health models
Digital Capabilities	• Upgrade infrastructure • Implement EPR and e-prescribing • Hosting system-wide digital and BI services.
Sustainability	• Drive Green Plan • Track carbon • Conduct Adaptation risk assessments
Research & Innovation	• Deploy new LCHG Research Strategy • Support research opportunities and academic growth

LCHG Productivity & Transformation Programmes



On going work on alignment of key programmes and reporting

What areas should the Care Group focus on?



1. Patients: Quality of Care and Patient Experience

Focus Areas for Care Groups:

- **Safety & Experience**: Reduce harm, improve IPC, and act on patient feedback (communication, appointments, clinical care).
- **Access & Flow**: Prioritise programmes that:
  - Eliminate 52-week waits and meet 18-week RTT.
  - Reduce A&E and ambulance response times.
  - Increase diagnostics within 6 weeks via CDCs.
  - Reduce community waits and improve UTC targets
- **Productivity & Finance**: Deliver CIP targets and embed Quality Improvement initiatives (e.g. Theatre and outpatient transformation, Medical workforce productivity, Booking centre).
- **Infrastructure & Integration**: Prioritise capital projects, space utilisation reviews, and service integration across acute and community settings.

2. People: Workforce Development and Culture

Focus Areas for Care Groups:

- **Staff Development**: Ensure all staff have appraisals, objectives, and access to training (including leadership and research).
- **Workforce Planning:** Sign off job plans; Strengthen consultant and middle-tier workforce planning, succession planning
- **Leadership & Culture**: Promote Civility and Respect, embed Just Culture, and use the Hot Spot Dashboard to monitor team wellbeing.
- **Recognition**: Actively participate in staff awards and long-service celebrations to boost morale and retention.

3. Populations: Transformation, Innovation and Sustainability

Focus Areas for Care Groups:

- **Pathway Transformation**: Prioritise “left shift” services to community settings in key specialties (e.g. OPAT, Stroke, Dermatology).
- **Estates Planning**: Contribute to rationalisation strategy and business cases for maternity and theatres.
- **Population Health**: Embed prevention and health inequality actions, including neighbourhood health models and CDC integration.
- **Digital & Research**: Support EPR and e-prescribing rollout, digital upskilling, and research strategy implementation.
- **Sustainability**: Deliver Green Plan actions, monitor carbon footprint, and complete risk assessments.

How Can Care Groups Prioritise?

- Align initiatives with **measurable impact** on patient outcomes, staff wellbeing, and system efficiency.
- Focus on **high-leverage programmes** that support multiple objectives (e.g. diagnostics improving both access and productivity).
- Use **existing dashboards and metrics** to track progress and identify areas needing urgent attention.
- Ensure **cross-functional collaboration** to avoid duplication and maximise resource use.
- Score each initiative across **Impact**, **Effort**, **Urgency**, and **Strategic Alignment** (scale 1–5).

How Can Care Groups Prioritise?

Score each initiative/opportunity across **Impact**, **Effort**, **Urgency**, and **Strategic Alignment** (scale 1–5) to create a realistic, deliverable plan that focuses on the top priorities. For example:

Strategic Pillar	Initiative	Impact (1-5)	Effort (1-5)	Urgency (1-5)	Total Score
Patients	Improve patient safety and experience by reducing harm, enhancing IPC, and addressing key feedback areas	5	3	5	7
Patients	Reduce waiting times in planned care, A&E, and ambulance response, community waits and UTC	5	4	5	6
Patients	Maximise diagnostics access via Community Diagnostic Centres	4	3	4	5
Patients	Increase productivity and financial sustainability through CIP and QI programmes	5	4	4	5
Patients	Modernise care environments and optimise space across acute and community settings	4	4	3	3
People	Ensure appraisals, training, leadership development, and expand apprenticeship and research opportunities	5	3	5	7
People	Embed culture of QI and R&I	5	3	5	7
People	Signed off job plans, and strengthen consultant and middle-tier workforce planning	4	4	4	4
People	Promote inclusive leadership and monitor culture via Hot Spot Dashboard	4	3	4	5
People	Celebrate staff through awards and long-service programmes	3	2	3	4
Populations	Shift services to community settings across key specialties	5	4	5	6
Populations	Rationalise estate use and develop business cases for maternity and theatres	4	4	4	4
Populations	Deploy integrated neighbourhood health models	4	3	4	5
Populations	Embed prevention and inequality reduction strategies	5	3	5	7
Populations	Upgrade infrastructure, implement EPR and e-prescribing	5	4	5	6
Populations	Deliver Green Plan, track carbon footprint, and complete risk assessments	4	3	4	5
Populations	Implement LCHG Research Strategy and expand academic partnerships	4	3	4	5

To consider….

Specialty	Strategic Goals	Key Actions (2025–2027)	Key Actions (2028–2030)
Cardiovascular	Improve hypertension control, enable genomic risk scoring, expand remote monitoring	- Launch Prevention Accelerators for hypertension - Integrate genomic risk scores - Deploy wearables for cardiac monitoring	- Link genomic data to SPR - Expand AI diagnostics - Scale virtual cardiology clinics
Respiratory	Enhance access to diagnostics, reduce outpatient waits, support virtual care	- Implement tele-respiratory services - Use AI for triage - Expand community diagnostics	- Integrate respiratory pathways into SPR - Trial predictive analytics for exacerbation prevention
Rheumatology	Improve access, support self-management, reduce delays in diagnosis	- Launch virtual clinics via NHS App - Enable PIFU - Use wearables for symptom tracking	- Integrate rheumatology into SPR - Trial AI-supported triage and diagnostics
Diabetes	Expand digital weight management, improve inpatient pathways, personalise care	- Roll out flash glucose monitoring - Expand NHS Digital Weight Management Programme - Trial GLP-1 access models	- Integrate pharmacogenomics into prescribing - Link diabetes data to SPR - Scale virtual diabetes clinics
Dermatology	Reduce hospital referrals, expand teledermatology, adopt AI triage	- Standardise photo clinics - Pilot AI-supported lesion triage - Use NHS App for image uploads	- Make AI dermatology standard by 2029 - Integrate dermatology into community hubs
Neurology	Improve access, support long-term condition management, expand virtual care	- Launch virtual neurology consults - Use wearables for seizure and Parkinson’s tracking - Trial AI diagnostics	- Integrate neurology into SPR - Expand remote monitoring and rehabilitation pathways



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NHS
Lincolnshire Community and Hospitals NHS Group

Integrated Performance Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4th November 2025*
Agenda item number	*11*
Report title	*Integrated Performance Report September (ULTH)*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• Discussion • Assurance • Information
Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Author(s)	*Sharon Parker, Performance Manager*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• Reasonable assurance
Prior approval process, if applicable	*Accountable Director sign off*
Financial implications, if applicable	
Action / 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.*

Assurance Rating Key:

Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are uncertain or possibly insufficient*
Red: Limited or No Assurance	*Effective controls are not in place or are insufficient to manage the risk identified and / or appropriate assurances are not available. Immediate action is required to address the gaps, weaknesses or non-compliances identified*

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	

Key to Note

Quality

- Medication incidents reported as causing harm has decreased in September to 16.4% against a trajectory of 10.7% compared to 17.9% in August.

- Duty of Candour for verbal compliance in August has deteriorated to 86%, compared to 91% in July. Written compliance in August has deteriorated to 76%, compared to 87% in July.

Performance

- The March 2026 target for the 4-hour wait time has been set at 78% with a rolling trajectory by month to achieve by year end.
  The full UEC combined Type 1, Type 3 (both co-located and separate sites) achieved 74.9% in September representing a 0.23% decline compared to August 2025.

- Long Waiters - at the end of August, the Trust reported 0 patients waiting longer than 104 weeks, 23 patients waiting over 65 weeks, 2012 patients waiting over 52 weeks.

- Performance for DM01 in September showed a decrease to 68.84% from 70.92% in August. Whilst this was a slight deterioration from August, there has been significant improvement in several modalities.

- 28-day Faster Diagnosis Standard (FDS) in August achieved 74.32%

- 62-day (Combined) performance for August increased to 61.8%.

- 104+ day waiters decreased to 111 as of 8th October, the highest risk specialities are colorectal, head & neck and lung and upper GI.

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 £14.3m deficit, which is £0.1m favourable to the planned £14.5m deficit.

CIP position - The Group YTD has delivered CIP savings of £24.9m, which is £0.2m lower than planned CIP savings of £25.1m.

Capital position - The Group YTD has delivered capital expenditure of £15.9m, which is £15.5m lower than planned capital expenditure of £31.4m.

Agency position – The Group YTD has expenditure of £8.6m on agency staffing, which is £0.8m higher than planned agency expenditure of £7.7m.

Cash position - The Group's cash balance is £26.9m, which is £8.0m lower than the planned cash balance of £34.9m.

Workforce

- Mandatory training for September is 92.86% against a plan of 90%
- September sickness rate is 5.37% against Q2 target of 4.31%
- Staff AfC appraisals at 80.25% for September against Q2 target 85.00%
- Staff turnover at 8.84% for September against Q2 target of 9.00%
- Vacancies at 6.02% for September against Q2 target of 6.81%

Executive Summary

Quality

VTE

In September, compliance remained below the 95% target, reaching 91.40%. 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, from 1st September, a three-month trial of stickers was launched across three wards with the lowest ePMA compliance. These stickers are inserted into clerking proforma to act as a prompt for clinicians, reminding them to complete VTE risk assessments directly in ePMA rather than in the proforma.

Medications

Medication incidents reported as causing harm has decreased to 16.4% 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. A pilot in Lincoln ED where a pharmacist and pharmacy technician were deployed to support has shown that where pharmacy support is available this has significantly improved access to medicines in a timely manner. There are plans to try and get funding for pharmacy support in EDs on a permanent basis.

Patient safety Alerts

There were no Patient Safety Alert with a deadline for completion in September, however, deviances still continue to be seen in compliance. 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 continues to decrease and is 107.5 for September and remains within expected limits. Any diagnosis group alerting is subject to a case note review. HSMR is at 97.25 (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 91.42% for sending eDDs within 24 hours of a patient's discharge. A dashboard has been developed for Care Groups to monitor their compliance.

Sepsis compliance – based on August data

Sepsis Screening Inpatient Children – Screening for sepsis for inpatient children increased to 89% (target 90%), 24 of the 27 children had sepsis screening within 60 minutes. Harm reviews were completed for all children with delayed treatment, and no harm was found. A deep dive into the notes will also still be carried out to assist with identifying any issues staff have with bundle / treatment.

IVAB Inpatient Children – The administration for IVAB for inpatient children increased to 75% (target 90%). 3 children out of 4 received their antibiotics within 60 minutes. Compliance may change once a full review of notes has been completed. No harm has been reported for patients included in audit.

IVAB ED Children – The administration of IVAB for children in ED has increased to 69% (target 90%). 11 children out of 16 were treated with IV antibiotics within the 60-minute timeframe. Harm reviews completed for all patients with delayed treatment – No harm found.

Stil Birth per 1000 Births

For September, the rate of still birth was 4.31 (target 3.8). The stillbirth rate is consistently monitored and reviewed, displayed on the maternity dashboards and outcomes of reviews are actioned. All stillbirths are reviewed using the national perinatal mortality review tool (PMRT), this facilitates identification of issues in care. Quarterly reports are used to collate themes and trends for all those reviews published in that quarter. A task & finish group with the LMNS as external representation has been set up to complete thematic review.

Duty of Candour (DoC) – August Data

DoC compliance decreased in August; verbal was 86% and written was 76%. Dedicated members of the Incident Team have been aligned to Care Groups to improve compliance.

Operational Performance

Cancer

Provider Level			Variance	Apr25-Mar26 Total	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
E.M.35	Percentage	62 Day Performance	PLAN	70.6%	65.6%	65.6%	68.2%	69.7%	70.8%	71.6%	70.4%	71.2%	73.0%	71.7%	73.9%	75.2%
			ACTUAL		67.3%	65.9%	64.7%	64.5%								
			Variance		1.70%	0.30%	3.5%	5.2%								
E.M.27	Percentage	28 Day FDS	PLAN	78.7%	77.8%	77.5%	78.0%	78.4%	79.0%	78.8%	78.5%	78.8%	79.5%	79.0%	79.3%	80.0%
			ACTUAL		72.5%	75.8%	77.7%	76.0%								
			Variance		5.3%	1.7%	0.3%	2.4%								
E.M.38	Percentage	31 Day Performance	PLAN	94.6%	94.4%	93.9%	94.2%	94.4%	94.4%	94.3%	94.8%	95.0%	94.9%	94.6%	94.8%	95.1%
			ACTUAL		87.4%	84.6%	86.6%	90.8%								
			Variance		7.0%	9.3%	7.6%	3.6%								

At the end of August all 3 Cancer standards were below plan

28 day at the end of August delivered 74.3% which was a deterioration from July and is below plan. This has predominantly been driven by Gynaecology and Breast. Breast is one of two specialties that really drives the organisations overall 28 day performance and deterioration has been evident since April, largely due to a reduction in activity due to financial pressures. This is now resolved and significant activity has been built into October and will continue throughout the remainder of the year. Improvements are already starting to be seen and should be reflected in October performance.

31 day at the end of August delivered 89.5% and was a slight deterioration from July and is below plan. This is largely driven by the surgical specialties and access to theatres with the competing pressure of dating 65 weeks. Work is ongoing to implement a new theatre schedule which will allocate theatre space more appropriately and match each specialties capacity and demand. Improvement is expected to be seen in November performance.

62 day at the end of August delivered 64.8% which was a slight improvement on July but still below plan. A number of specialties have impacted 62 day performance due to increased backlogs, particular pressure has been seen in UGI, Gynae and Breast but the main contributor to performance is Colorectal. Additional Cancer recovery funding has been obtained for Gynae, Breast and Colorectal and delivery plans are currently being implemented. Gynae and Breast and UGI should start to see an Impact in October but Colorectal is expected to take longer. Colorectal are engaged in a national pathway review to streamline processes, reduce diagnostics and improve performance.

Elective

Whilst there are a number of Elective metrics included in the 25/26 plan, Total waiting list, 52 weeks and 18 week RTT % are seeing the most scrutiny from NHSE. 65 weeks is still a clear priority with a mandate to clear by the end of November. A return to plan for these metrics is reliant on achieving our productivity ambitions that Ernst & Young are supporting the trust with.

Revised Table: Submitted		Incomplete RTT Waiting List	Variance	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
E.B.3a	Count	Total	PLAN	71,305	71,096	70,986	70,952	70,993	70,884	70,684	70,475	69,866	69,657	69,447	69,003
			ACTUAL	70,044	70,185	70,366	69,763	69,630							
			Variance	1.77%	1.28%	0.87%	1.68%	1.92%							
E.B.18	Count	52+ weeks	PLAN	1,750	1,650	1,553	1,458	1,364	1,268	1,170	1,073	971	875	780	684
			ACTUAL	1,775	1,951	1,805	1,882	2,012							
			Variance	1.43%	18.24%	16.23%	29.08%	47.51%							
	%	Less than 18 weeks	PLAN	53.9%	54.4%	55.0%	55.6%	56.1%	56.7%	57.2%	57.8%	58.3%	58.9%	59.5%	60.0%
			ACTUAL	53.8%	54.2%	54.6%	54.5%	53.6%							
			Variance	0.10%	0.22%	0.40%	1.06%	2.48%							

Total Waiting List remains on plan in terms of submission but is not inclusive of the ASI position. At the time of this report, ASIs sat at 3912 which is an improving picture but would put total waiting list over plan. A trajectory is being developed factoring in productivity improvements and a return to plan is expected by December.

52 Weeks Remains the most pressured Elective standard with August delivering 2,012 patients against a plan of 1,364. Significant improvement had been made until Mar 25 with financial pressures reducing activity and worsening performance. Numbers have now stabilised, and plans are being worked up to see a return to plan by December.
18 week RTT for August delivered 53.6% verses a plan of 56.1%. It is important to note that if ASIs were included in the total waiting list RTT would be ~0.2% behind plan as all of these patients are <18 weeks and therefore increase the denominator. Recovery plans are the same as the above two metrics with a return to plan expected in December.

65 weeks has seen significant improvement over the last 12 months but Aug and September have been challenging with reduced capacity over the summer holidays. August recorded 23 patients >65 weeks and whilst the majority were due to complexity or patient choice, some capacity breaches were recorded. There has been a clear directive from NHSE to achieve zero, which the trust has committed to deliver. Recent updates through tiering has clarified the ask is to clear December's 65 week cohort by the end of November. Whilst the original ask was achievable, the December cohort increases the number to be cleared from 1056 to 2256. Plans to clear are as above but the escalated November clearance date is currently being worked through because the new ask is very challenging.

Diagnostics

While no formal trajectories were submitted for diagnostics, DM01 and long waiting diagnostic patients have been closely monitored.

UNITED LINCOLNSHIRE HOSPITALS — **August 2025 Position**

Modality	Total Activity	Total Waits	<6wk Waits	>6wk Waits	6wk Compliance	6wk Compliance Change SPLM	<13wk Waits	>13wk Waits	13wk Compliance	13wk Compliance Change SPLM
Audiology Assessments	282	3,515	375	3,140	10.7% ↓	-1.9%	1,089	2,426	31.0% ↓	-1.4%
Colonoscopy	577	401	396	5	98.8% ↓	-0.6%	401	0	100.0% ✓	0.0%
CT	8,975	953	929	24	97.5% ↑	5.1%	951	2	99.8% ↑	2.3%
Cystoscopy	179	542	241	301	44.5% ↑	3.8%	332	210	61.3% ↓	-4.0%
DEXA	514	390	387	3	99.2% ↑	2.4%	390	0	100.0% ✓	0.0%
Echocardiography	1,687	1,194	1,009	185	84.5% ↑	6.3%	1,094	100	91.6% ↑	0.5%
Flexi Sigmoidoscopy	289	232	227	5	97.8% ↓	-1.0%	232	0	100.0% ✓	0.0%
Gastroscopy	555	288	287	1	99.7% ↑	0.9%	288	0	100.0% ✓	0.0%
MRI	5,314	3,997	3,335	662	83.4% ↓	-9.7%	3,983	14	99.6% ↓	-0.0%
Non-obstetric Ultrasound	6,631	6,788	5,870	918	86.5% ↓	-2.6%	6,776	12	99.8% ↓	-0.1%
Peripheral Neurophysiology	529	967	635	332	65.7% ↓	-9.6%	965	2	99.8% ↓	-0.2%
Urodynamics	1	41	2	39	4.9% ↓	-16.7%	19	22	46.3% ↑	0.4%
Total	**25,533**	**19,308**	**13,693**	**5,615**	**70.9% ↓**	**-3.9%**	**16,520**	**2,788**	**85.6% ↓**	**-0.9%**

August delivered 70.9% for DM01 and whilst this was a slight deterioration from July, there has been significant improvement in several modalities. NOUS and Dexa have been pressured diagnostics for the past year with both demonstrating increased and sustained performance recently. Overall DM01 performance is now driven by Audiology and reflects the services inability to keep up with the demand from ENT recovering their 65w position. The reliance on the service to date 65w patients in a matter of days has not given them the ability to focus on and recover DM01 performance. Increased capacity plans are being developed for Audiology, but this will be used to address increased ENT activity to deliver the Elective standards required by the end of December. DM01 is not expected to recover currently.

Workforce

Mandatory Training – Our September 2025 Core Learning Rate is 92.86% against a Target of 90.00%. This is a decrease in compliance when compared to last month, although we are exceeding our overall target. Compliance will continue to be monitored as we move into 2025/26 to ensure that we remain in line with our overall trajectory.

Our biggest challenge is to offer time to our colleagues to be able to complete all mandatory training as required for the role they do. Work continues to ensure that all areas and individuals are given the time to complete core learning modules, with focussed support being offered to those with low compliance (50% and less).

Sickness Absence – Our September 2025 Sickness Rate is 5.37% against a Q2 Target of 4.78%. This is outside of the Q2 Target which is a stabilised position despite a slight increase in month. We are putting some additional resource in place to support the active and robust management of absence over the next twelve months. This will include identifying trends, supporting Care Groups with the local management and monitoring of absence and is inclusive of co-ordination and occupational health roles - 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 September 2025 appraisal rate is measured against a Q2 Target of 85.00%, and in month we have achieved a Trust wide position of 80.87%. This is a slight decrease when compared to the previous month. It is the Agenda for Change appraisals which require the focus. The move in 2025/26 to an appraisal window in Q1 is expected to support attaining the target and sustaining in year.

Work continues to educate leaders on the process required to update ESR, including the use of ‘how to’ guides/sessions and utilising reporting to identify areas of low completion. Our Education, Learning & OD Team are developing an approach which will support specific teams where compliance rates are less than 50% in the same way we did with Core Learning.

Staff Turnover – Our September 2025 Turnover Rate is 8.84% against a Target of 9.00%, this is exceeding target.

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.

Continue to work closely with Divisional colleagues to reduce the impact of staffing and associated operational pressures.

Vacancies – Our September 2025 Vacancy Rate is 6.02% against a Target of 6.81%.

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.

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 £14.3m deficit, which is £0.1m favourable to the planned £14.5m deficit.

CIP position - The Group YTD has delivered CIP savings of £24.9m, which is £0.2m lower than planned CIP savings of £25.1m.

Capital position - The Group YTD has delivered capital expenditure of £15.9m, which is £15.5m lower than planned capital expenditure of £31.4m.

Agency position – The Group YTD has expenditure of £8.6m on agency staffing, which is £0.8m higher than planned agency expenditure of £7.7m.

Cash position - The Group's cash balance is £26.9m, which is £8.0m lower than the planned cash balance of £34.9m.

Month 6 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)	(14.5)	(14.3)	0.1	(2.5)	(2.3)	0.1	(12.0)	(12.0)	0.0
CIP Delivery	25.1	24.9	(0.2)	2.3	2.6	0.4	22.8	22.3	(0.5)
Capital Spend	31.4	15.9	(15.5)	2.5	1.9	(0.6)	28.9	14.1	(14.8)
Agency Spend	(7.7)	(8.6)	(0.8)	(0.8)	(0.4)	0.4	(6.9)	(8.2)	(1.2)
Cash Balance	34.9	26.9	(8.0)	24.7	18.9	(5.8)	10.2	8.0	(2.2)

Daren Fradgley
Group Chief Integration Officer
October 2025

Key to Variation and Assurance Icons and SPC Dots

Within this report we have used XmR Statistical Process Control (SPC) charts. An SPC chart is a plot of data over time. It allows you to distinguish between common and special cause variation. It includes a mean and two process limits which are both used in the statistical interpretation of data. They also indicate whether the process is able to meet any stated target/trajectory.

To help interpret the data a number of rules can be applied. These are:

1. Any single point outside the process limits.
2. A run of 7 points above or below the mean (a shift).
3. A run of 7 points all consecutively ascending or descending (a trend).
4. 2 out of 3 points that lie beyond the two-sigma line but not beyond the three-sigma line (i.e. process limit) on a consistent side of the mean.

To highlight whether there is improvement or deterioration we use 'Variation' and 'Assurance' icons to represent this.

Variation					Assurance		
							
Special Cause Variation – Improvement (indicator where high is good)	Special Cause Variation – Improvement (indicator where low is good)	Special Cause Variation – Cause for Concern (indicator where high is a concern)	Special Cause Variation – Cause for Concern (indicator where low is a concern)	Common Cause Variation – No Significant Change	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target	Variation indicates inconsistently passing and falling short of the target

Variation icons and SPC dots: **Orange** indicates concerning **special cause variation** requiring action. **Blue** indicates where improvement appears to lie, and **Grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **Grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation.

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

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

Caring and building a healthier future for all

Performance Overview - Quality

NHS
Lincolnshire Community and Hospitals NHS Group

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-25	Aug-25	Sep-25	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	7	9	5	48	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.18	0.05	0.17	0.12		
	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	0.39	0.32	0.31	0.34		
	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	0.10	0.13	0.02	0.11	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	4	2	3	15	P	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	1	0	0	2	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	91.84%	91.25%	91.40%	92.16%	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	5.45	5.64	5.25	5.05	P	

Caring and building a healthier future for all

Performance Overview - Quality

NHS
Lincolnshire Community and Hospitals NHS Group

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-25	Aug-25	Sep-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%	13.80%	17.90%	16.40%	14.47%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	100.00%	50.00%	None due	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	100.75	99.57	97.25	N/A		
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 5 month time lag)	Effective	Patients	Medical Director	100	108.47	107.84	107.50	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%	90.20%	91.42%	90.80%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	87.88%	96.15%	Data Not Available	91.90%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	69.00%	89.00%	Data Not Available	88.20%	?	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	97.38%	98.41%	Data Not Available	96.84%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	38.00%	75.00%	Data Not Available	80.20%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	92.93%	98.41%	Data Not Available	94.51%	P	

Caring and building a healthier future for all

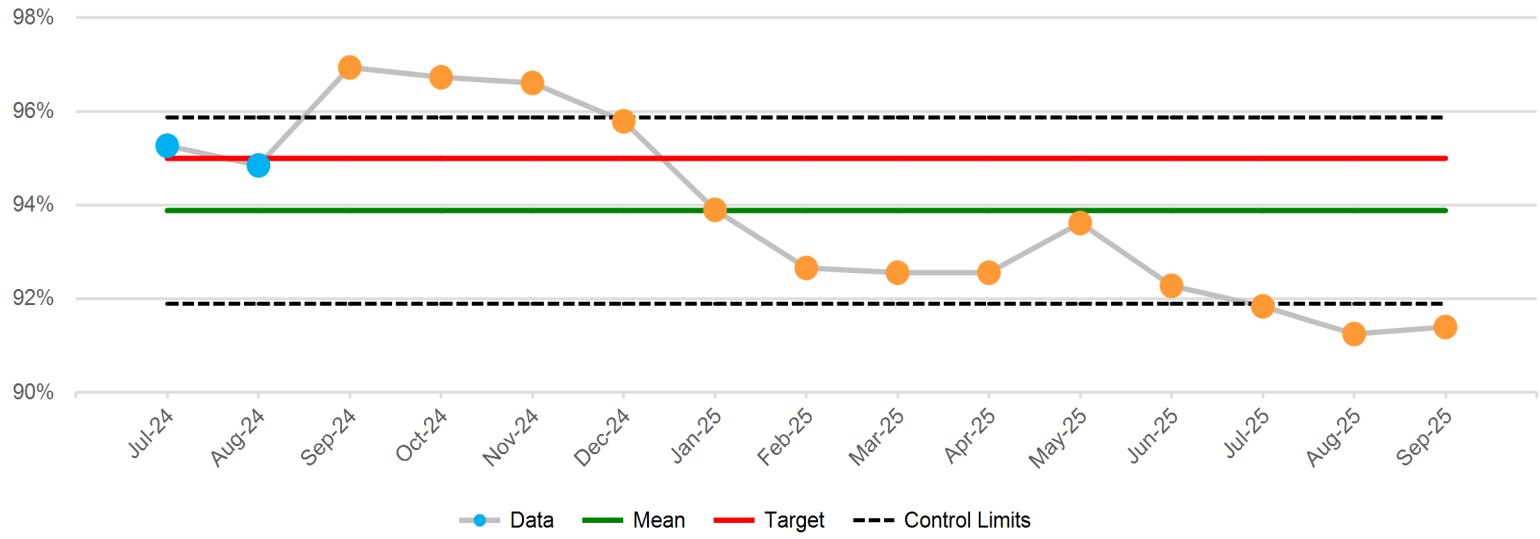
Performance Overview - Quality

NHS
Lincolnshire Community and Hospitals NHS Group

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-25	Aug-25	Sep-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%	90.00%	94.00%	Data Not Available	91.80%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	94.88%	94.78%	Data Not Available	95.02%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	53.00%	69.00%	Data Not Available	58.00%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	3.20	3.64	4.31	3.31	P	H
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%	91.00%	86.00%	Data Not Available	88.00%	F	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	87.00%	76.00%	Data Not Available	83.60%	F	

Performance Overview - Quality

Venous Thromboembolism (VTE) Risk Assessment



Sep-25
91.40%
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

Background:
Completion of VTE risk assessment within 14 hours of admission remains a national patient safety requirement.

What the chart tells us:
In September, compliance was recorded at 92.25%, showing a slight improvement compared to previous months, but still below the national target of 95%. These figures reflect assessments completed within the required timeframe, based on data collected from both CareFlow and ePMA systems.

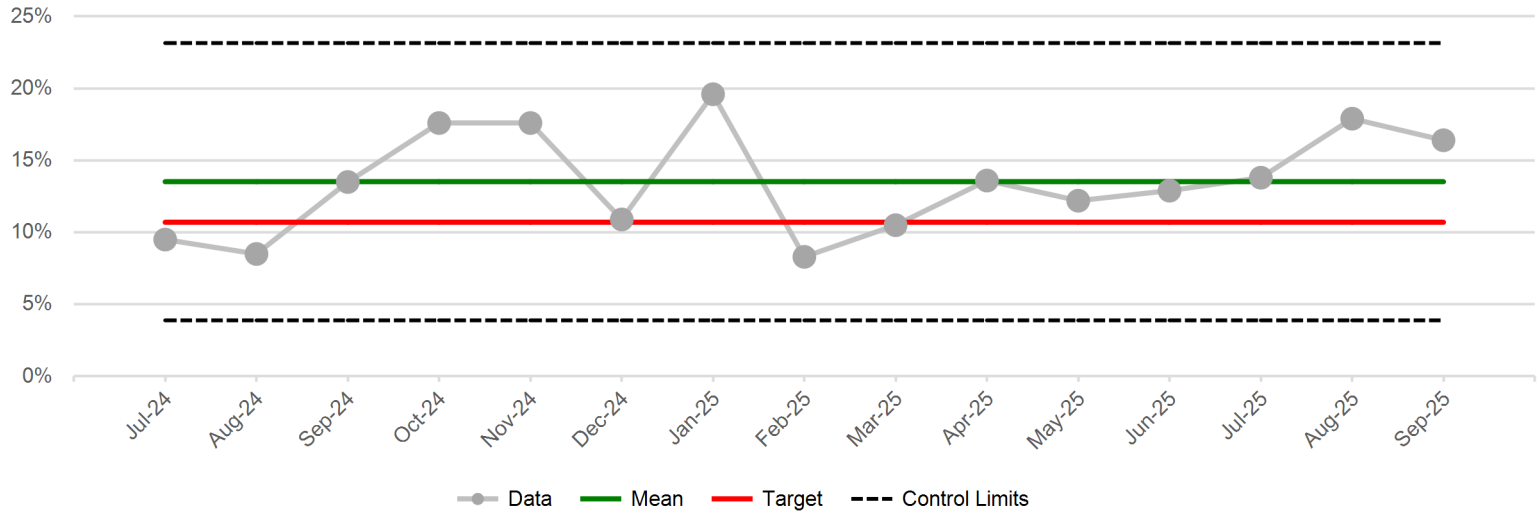
Issues:
The main challenges remain consistent with previous months. The inconsistent use of ePMA continues to affect compliance accuracy, as ePMA is currently the only system that accurately captures the actual time of assessment completion. Many clinicians still complete assessments within the clerking proforma, which are later transcribed into CareFlow by ward clerks. Since CareFlow records the time of data entry rather than completion, this leads to underreporting of compliance and potential duplication between systems.

Actions:
The 3 – month sticker trial, launched on 1st September, continues across Shuttleworth, 3A and 3B wards, which had the lowest ePMA compliance rates. The stickers serve as visual prompts within clerking documentation reminding clinicians to complete VTE risk assessments directly in ePMA rather than in the proforma. Early results show a slight improvement in ePMA use for VTE risk assessments on these wards, reflected in improved local compliance figures.
Additionally, targeted communication was delivered to medical staff in these areas, reinforcing the importance of completing VTE risk assessments within ePMA to ensure accurate recording and compliance monitoring.

Mitigations:
There is ongoing close collaboration with ward managers and matrons in the trial areas to support compliance improvement and sustain progress.
VTE Nurse Specialist continues to work closely with the matron leading on VTE to monitor outcomes from the sticker trial and provide ongoing education and support to clinical teams.
Overall, early indicators suggest that the sticker trial is having a positive effect on ePMA utilisation and compliance in participating wards. Continued focus on staff engagement, accurate documentation and system standardisation will support further improvement toward achieving the 95% target.
As in previous month, compliance figures may change slightly after end – of – month submission due to retrospective entries in CareFlow. These late entries can alter final reported figures and should be considered when reviewing the data.

Performance Overview - Quality

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



Sep-25
16.40%
Variance Type
Common cause variation
Target
10.70%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of September the number of medication incidents reported was 188. This equates to 5.25 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 16.4 % which is above the national average of 11%.

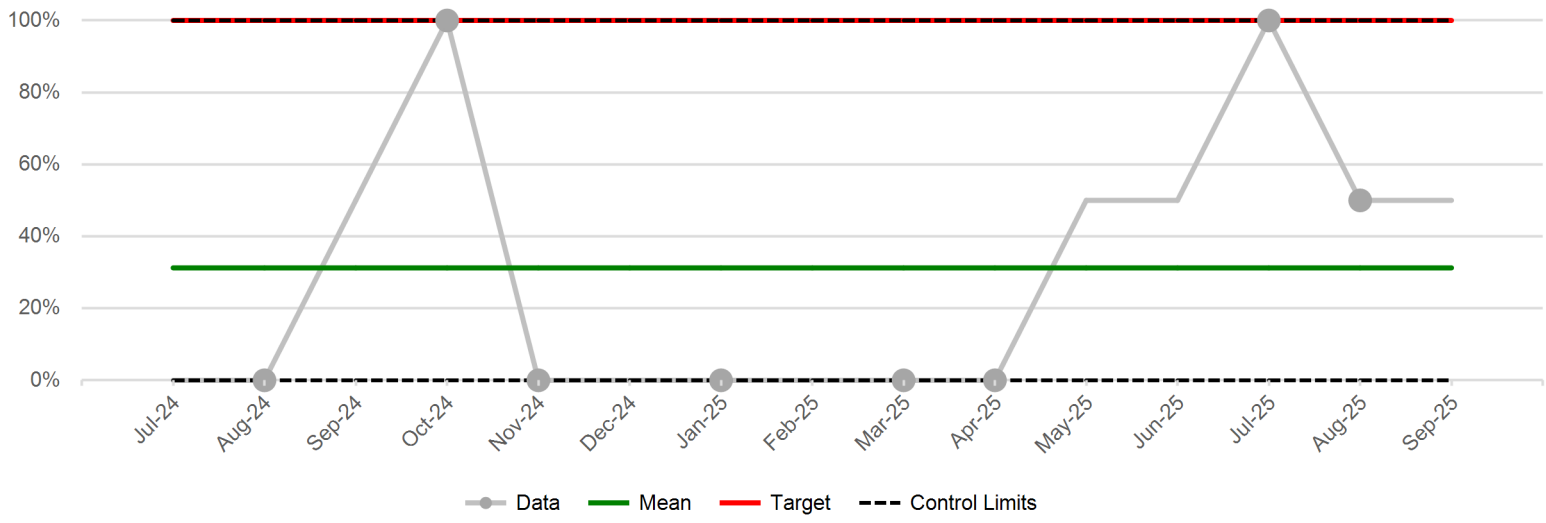
Issues:
The majority of incidents are at the point of prescribing and administration of medication and the main errors are omitting medicines.

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.
A pilot in Lincoln ED where a pharmacist and pharmacy technician were deployed to support has shown that where pharmacy support is available this has significantly improved access to medicines in a timely manner. There are plans to try and get funding for pharmacy support in EDs on a permanent basis.

Mitigations:

Performance Overview - Quality

Patient Safety Alerts responded to by agreed deadline



Sep-25
None Due
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Patient safety alerts responded to by agreed deadline.

What the chart tells us:
There were no Patient Safety Alerts due for closure in September 2025.

However, deviances still continue to be seen in compliance.

Issues:
The Trust was previously not demonstrating compliance with the target set for Patient Safety Alerts. The performance continues to fluctuate.

Actions:
Monthly Patient Safety Alerts exception report is now discussed at Patient Safety Group, and a full Quarterly review report submitted and escalation where appropriate to Divisions for overdue actions.

Compliance is monitored on DatixIQ dashboards by Risk & Datix Team and Leads with overall responsibility for the alerts and escalated where appropriate.

CAS/FSN Alerts Oversight Group meetings held monthly – outstanding actions monitored and escalation when appropriate to Divisions and Patient Safety Group for upward reporting to Quality Committee.

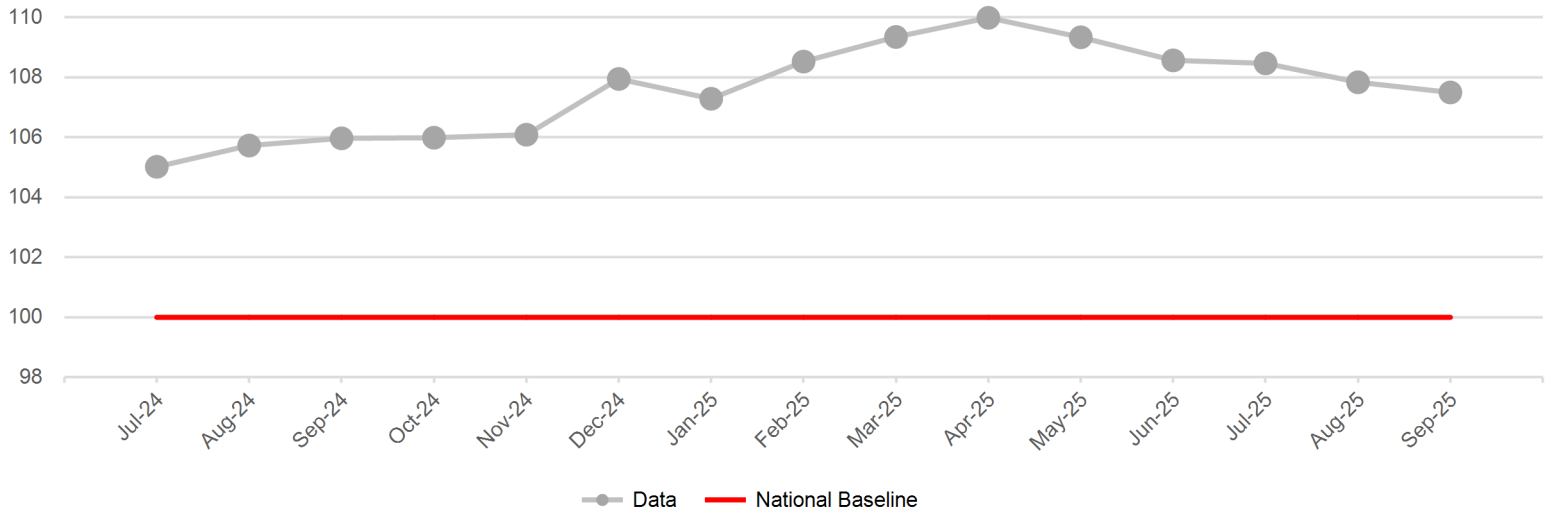
Mitigations:
Compliance is discussed monthly at Patient Safety Group, and a monthly escalation report highlights Alerts with upcoming deadlines for Leads to action and outstanding actions for overdue Alerts.

A CAS/FSN Alerts Oversight Group convenes monthly to discuss issues which may arise and prevent the Trust meeting the deadlines and to put plans in place to mitigate.

Use of Dashboards for monitoring compliance on Alerts Module on DatixIQ.

Performance Overview - Quality

Summary Hospital Mortality Indicator (SHMI) (rolling year data 5 month time lag)



Sep-25
107.50
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'. SHMI has been decreasing month on month.

Issues:
The data includes deaths within 30 days.

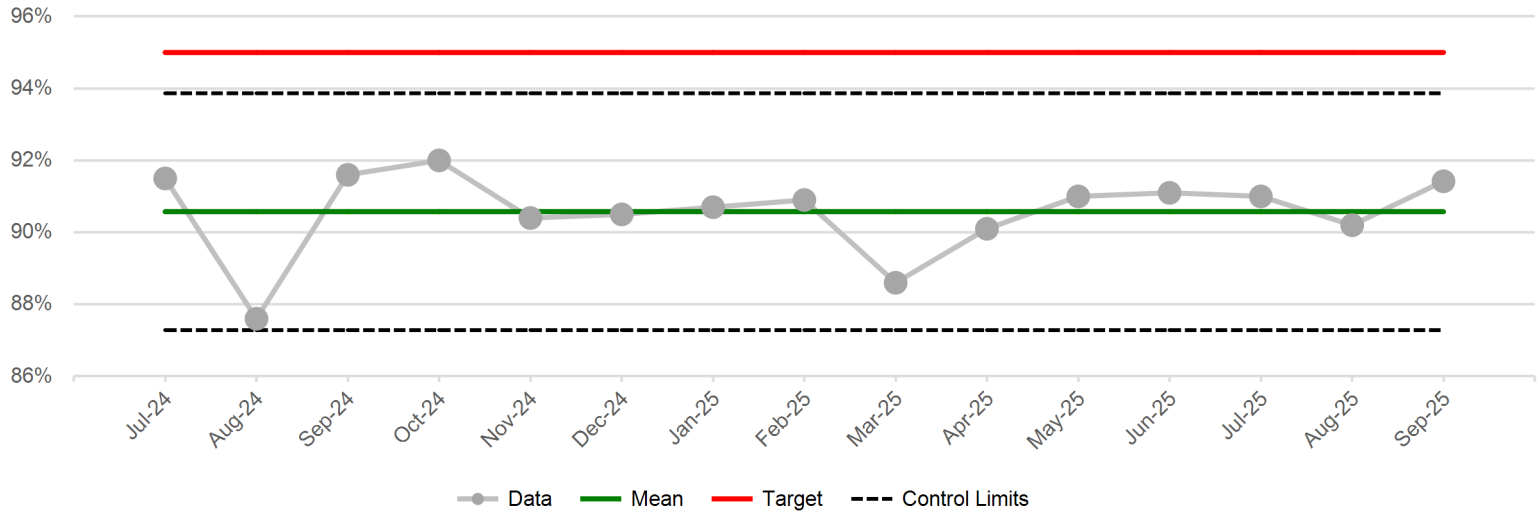
The SHMI methodology has changed, the data is being reviewed as the Trusts SHMI has increased.

Actions:
Clinical Governance & Clinical Coding met with Telstra Health UK for a greater understanding into the recent increases in the Trust's HSMR/SHMI. Reviewing specific areas such as the 'Global Frailty Index' and 'Elixhauser-Bottle Comorbidity Index'. We are also reviewing the diagnosis groups with trend increases.

Mitigations:
The MEs have commenced reviewing all deaths in the community which will enable oversight of deaths in 30 days post discharge of which learning can be identified.

Performance Overview - Quality

eDD issued within 24 hours



Sep-25
91.42%
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 91.42%.

Issues:
Ownership of completion of the EDD remains an issue, including the timely completion.

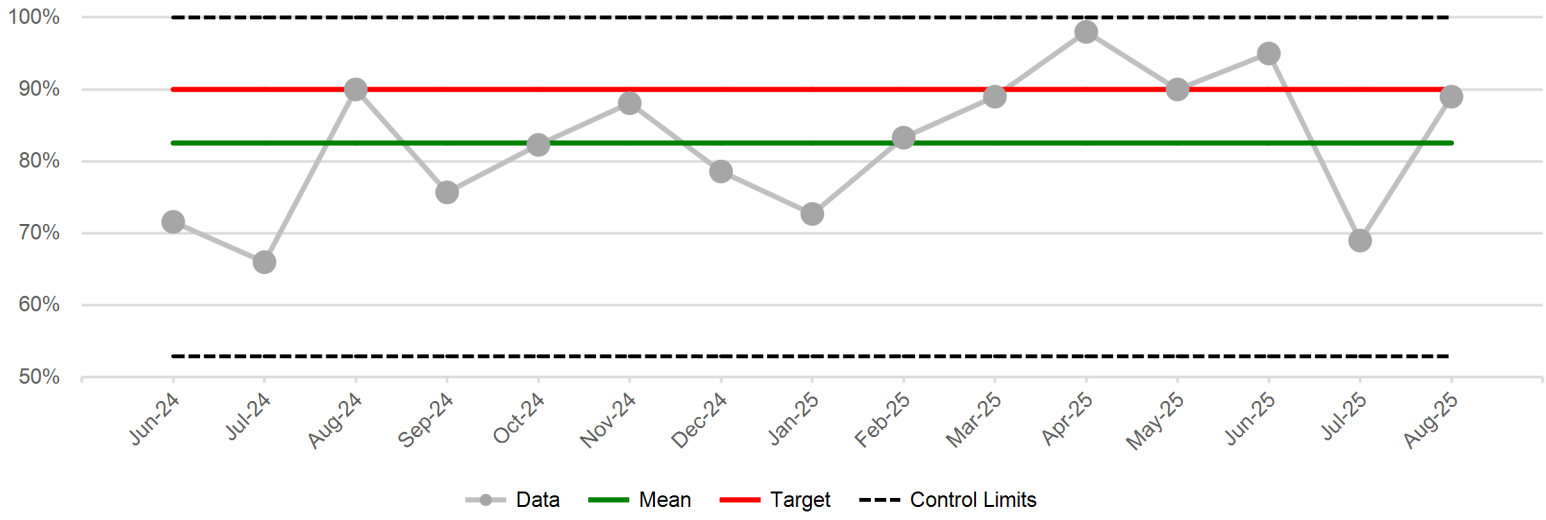
No Narrative owner

Actions:
A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric.

Mitigations:
eDD should be considered by Divisions to include in PRM discussions.

Performance Overview - Quality

Sepsis screening (bundle) compliance for inpatients (child)



Aug-25
89.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of Nursing

Background:
Sepsis screening (bundle) compliance for inpatients (child)

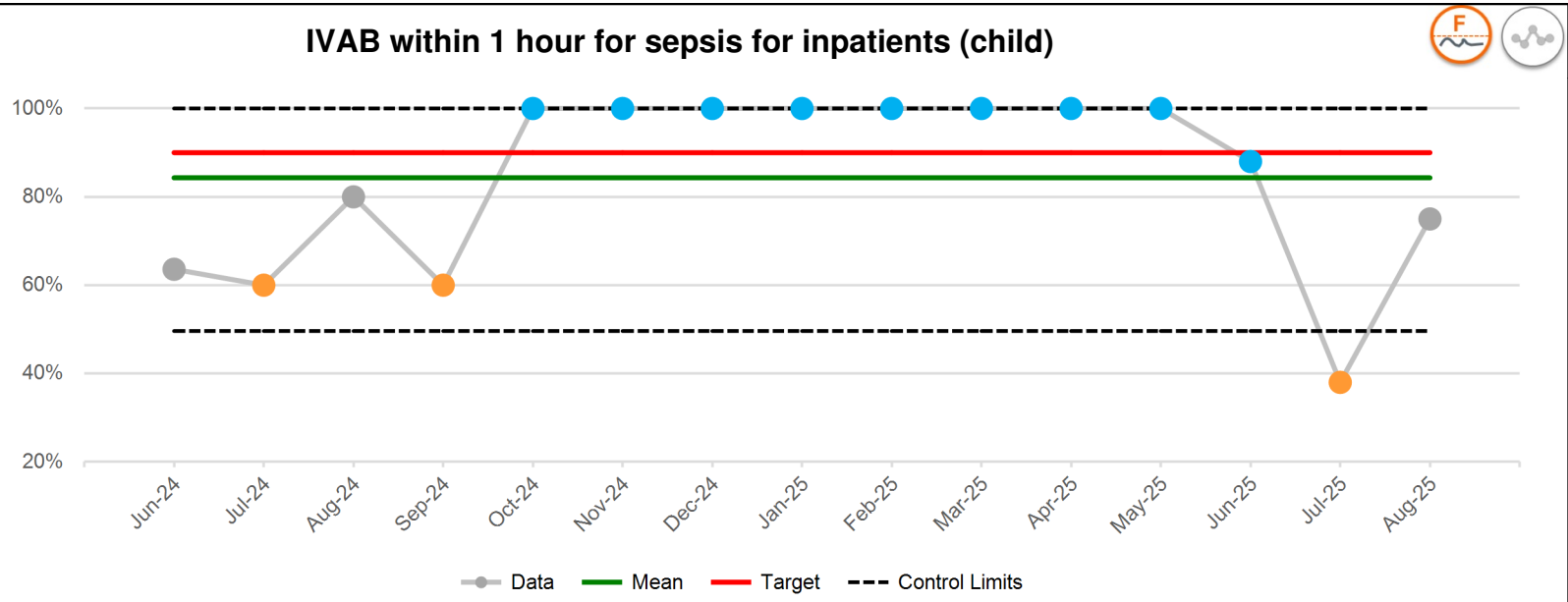
What the chart tells us:
The screening compliance this month was 89% which is just below the 90% trust target. 24 out of 27patients had Sepsis screening within the required 60 minutes.

Issues:
There were 3 patients this month with delayed sepsis screening in inpatient areas.
1 child was the one discussed in delayed treatment. Screened and treated as per Birmingham plan.
2 children had viral / non-bacterial illness but did not have a screen on webv or a medical review at time of score. Both these children had score of 5 – no red flags.

Actions:
Although still not at target the wards have made improvements this month. On going action plans continue as previous reports.

Mitigations:
No harm has been reported related to any patients involved in the audit. Improvements have been made compared to previous month.

Performance Overview - Quality



Aug-25
75.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

Background:
IVAB within 1 hour for sepsis for inpatients (child)

What the chart tells us:
The compliance for IVAB administration for inpatients this month was 75%, which is well below the 90% target. 3 children out of 4 received their antibiotics within a timely manner.

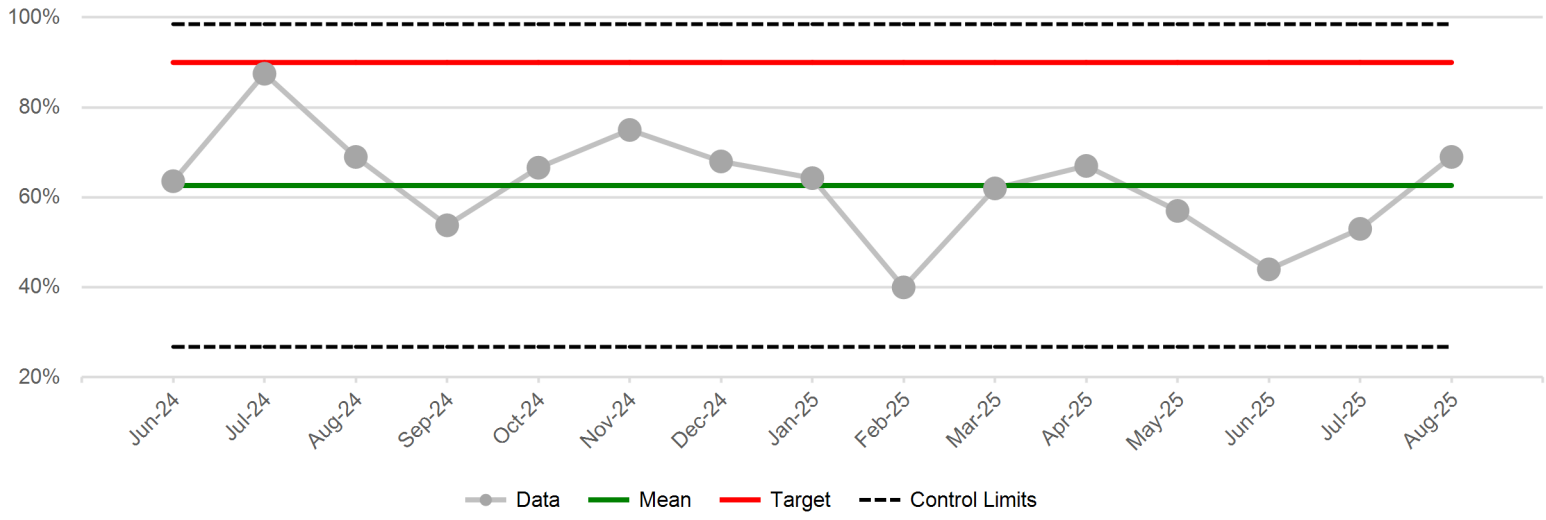
Issues:
There was 1 patient this month with delayed IVAB treatment. Patient had previously had a liver transplant and was on immunosuppressants but had numerous courses of IV antibiotics previously. Drs wanted to speak with Birmingham children's hospital before starting treatment but this led to a lengthy delay.

Actions:
Child treated as per Birmingham plan. Drs aware that they could have started broad-spectrum antibiotics and then changed them following Birmingham advice if needed.

Mitigations:
No harm found – although child initially presented with sepsis red flags a viral cause was found for illness.

Performance Overview - Quality

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



Aug-25
69.00%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance for administration of IVAB within one hour was 69%, which is well below the 90% standard.11 out of 16 patients received their antibiotics within a timely manner.

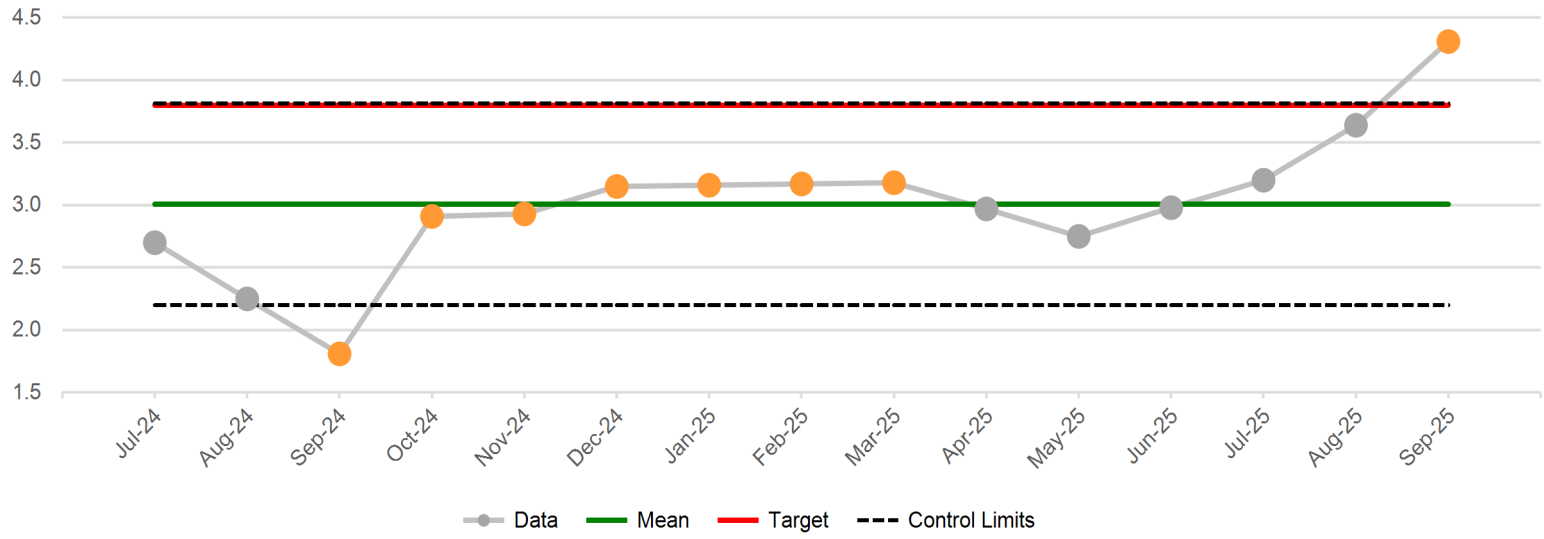
Issues:
There were 5 patients this month with delayed Sepsis treatment. There was 1 patient on Lincoln site and 4 on Pilgrim site due to:
- Difficult cannulation.
- IV antibiotics not being given until child has been transferred to ward / often significant delay with transfer x 3.
- 1 long delay between diagnosis and treatment – reason not documented.
Site are often requesting children be moved out of department as breaching but this is delaying treatment with transfer time.

Actions:
A new Sepsis link group has been set up on the Lincoln site in order to identify problems and find ways to help / work towards resolving them. Work is ongoing to replicate this working group at Pilgrim but this has been delayed due to staff sickness. Medical engagement is lacking at Sepsis focus group meeting - escalated.

Mitigations:
Harm reviews completed for all patients with delayed treatment – No harm found.

Performance Overview - Quality

Rate of stillbirth per 1000 births



Sep-25
4.31
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
3.80
Achievement
Variation indicates consistently passing the target
Executive Lead
Director of Nursing

Background:
Rate of stillbirth per 1000 births.

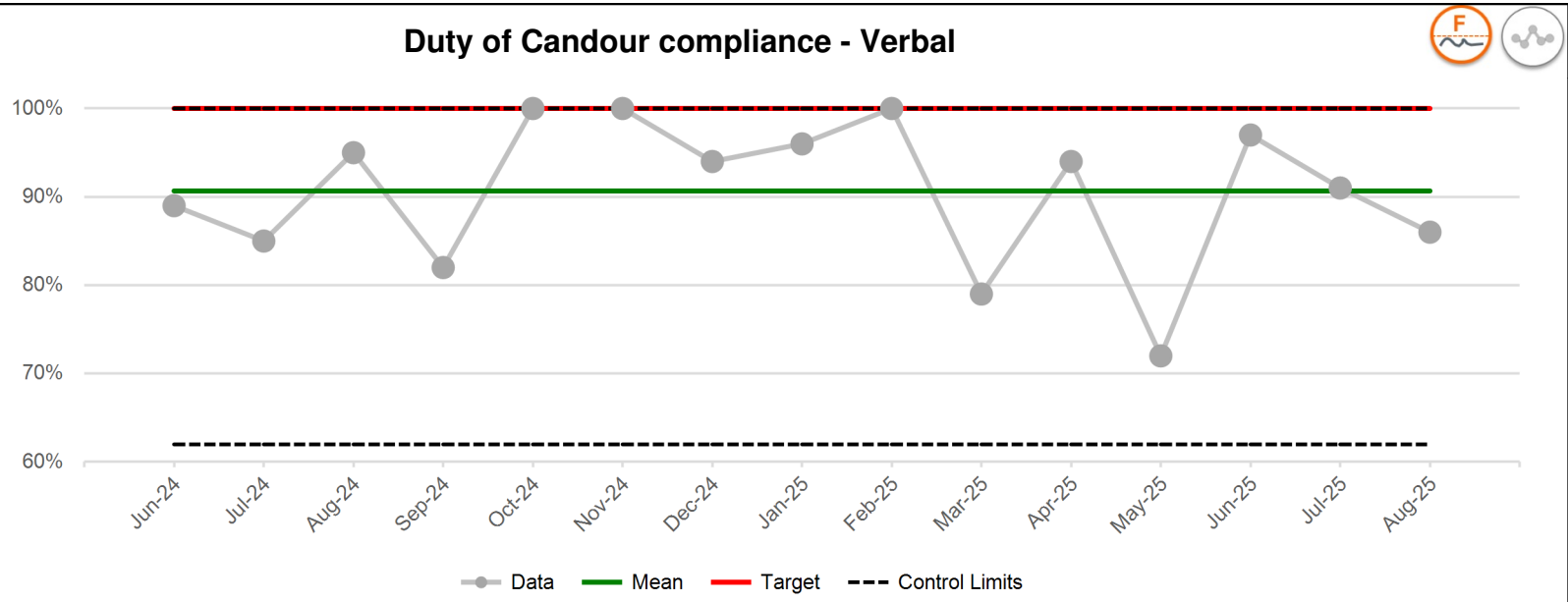
What the chart tells us:
We are currently at 4.31 against a threshold of 3.8.

Issues:
We are consistently below the national threshold however are aware that this is now displaying a special cause of concerning nature.

Actions:
All stillbirths are reviewed using the national perinatal mortality review tool (PMRT), this facilitates identification of issues in care. Quarterly reports are used to collate themes and trends for all those reviews published in that quarter.
A task & finish group with the LMNS as external representationhas been set up to complete thematic review. TOR drafted for inclusion criteria, demographic assessment and thematic review of PMRT actions and issues, due to be completed end Oct 25 includes late fetal losses, NND >22wks and stillbirths. Data triangulated with MIS, PMRT & bereavement team.

Mitigations:
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. Although this reports on the Trust data, we acknowledge the higher rate at Pilgrim due to a cluster of stillbirths in Oct 24.

Performance Overview - Quality



Aug-25
86.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Verbal Duty of Candour, which applies to all patient safety incidents where harm is moderate or above, is a statutory requirement.

What the chart tells us:
Compliance remains high.

Issues:
The non-compliance figures for this period has been escalated.

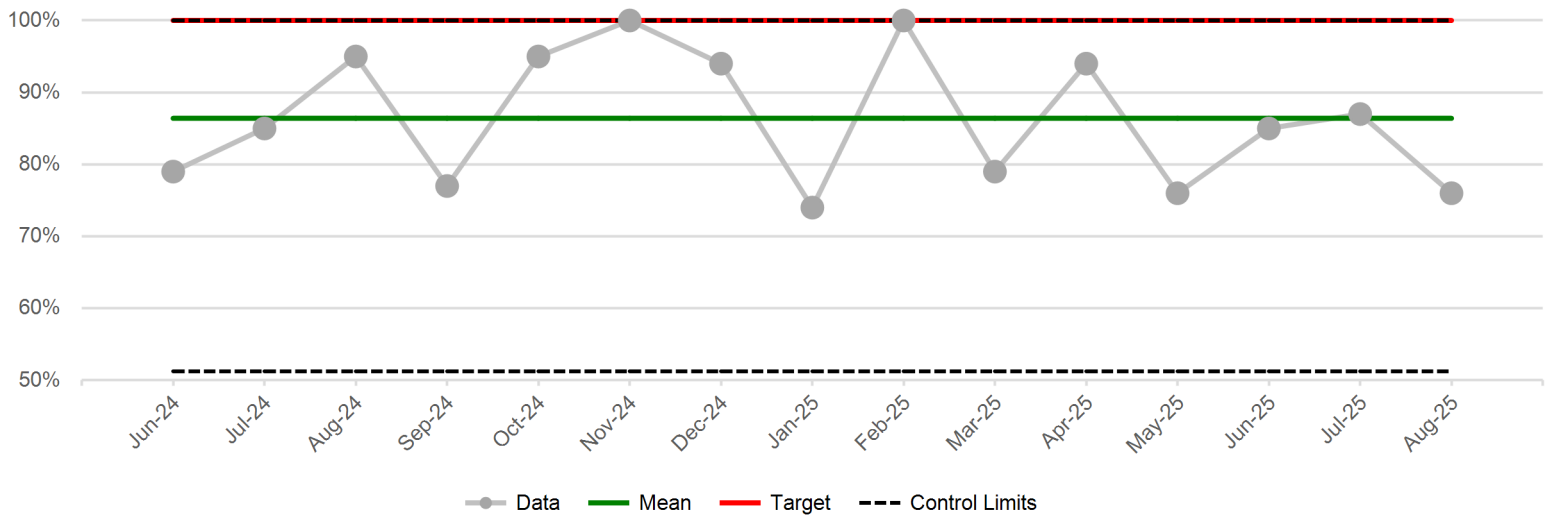
Actions:
Care group position for each service now provided and business partners working with divisions to complete and monitor ongoing compliance.

Weekly tracking in progress by the incident team

Mitigations:
Dedicated members of the incident team have been aligned to care groups which has improved compliance.

Performance Overview - Quality

Duty of Candour compliance - Written



Aug-25
76.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Written follow up to Duty of Candour, which applies to all patient safety incidents where harm is moderate or above, is a statutory requirement.

What the chart tells us:
Compliance remains high.

Issues:
The non-compliance figures for this period has been escalated.

Actions:
Divisional position for each service now provided and business partners working with divisions to complete and monitor ongoing compliance.

Weekly tracking in progress by the incident team.

Mitigations:
Dedicated members of the incident team have been aligned to divisions which has improved compliance.

Caring and building a healthier future for all

Performance Overview - Operational Performance

NHS Lincolnshire Community and Hospitals NHS Group

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-25	Aug-25	Sep-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.43%	0.60%	0.24%	0.34%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	76.50%	73.78%	75.13%	74.90%	75.33%	75.33%	?	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	1,027	1,061	946	6,022	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	76.32%	76.95%	73.12%	75.81%	88.50%	F	
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	1,882	2,012		N/A	N/A	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	9	23		N/A	N/A	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	54.54%	53.62%		54.15%	84.10%	F	H
	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	69,763	69,630		N/A	N/A	F	L
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	76.00%	74.32%		75.26%	75.00%	P	
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	60.90%	61.80%		63.06%	85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	64.50%	56.90%		68.46%	93.00%	F	L

Caring and building a healthier future for all

Performance Overview - Operational Performance

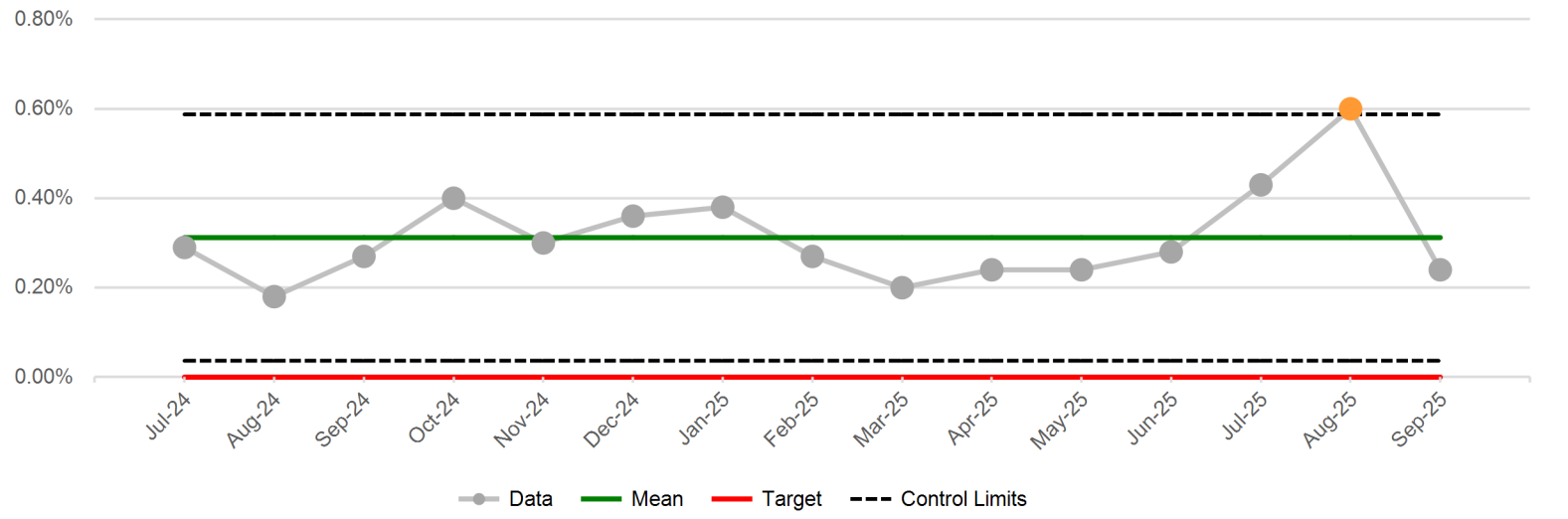
NHS Lincolnshire Community and Hospitals NHS Group

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-25	Aug-25	Sep-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	27.10%	3.30%		38.08%	93.00%	F	L
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	92.50%	87.30%		89.88%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	94.30%	97.20%		96.58%	98.00%	F	H
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	69.60%	80.60%		63.82%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	88.60%	90.80%		83.30%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	57.70%	40.70%		61.52%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	72.20%	77.50%		72.02%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	74.79%	70.92%	68.84%	71.83%	99.00%	F	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.76%	1.54%	1.68%	1.57%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	40	51	28	199	0	F	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	67.95%	32.93%	29.41%	43.99%	90.00%	F	

Performance Overview - Operational Performance

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-25	Aug-25	Sep-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	38.46%	14.63%	11.76%	23.57%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,818	4,757	4,620	4,711	4,657	?	
	% EMAS Conveyances Delayed <45 mins	Responsive	Services	Chief Operating Officer	95.00%	84.94%	85.11%	86.64%	85.89%	95.00%	F	H
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	103	120	111	N/A	N/A	F	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.89	3.53	3.52	3.09	2.80	F	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.34	4.30	4.40	4.45	4.50	P	
	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	41,605	42,275	43,727	40,745	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	38.69%	36.21%	37.03%	37.66%	45.00%	F	

Performance Overview - Operational Performance



Sep-25
0.24%
Variance Type
Common cause variation
Target
0.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded

What the chart tells us:
September reported a non-validated position of 0.24% versus the target of 0%. To note, 73.08% 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 102 minutes.

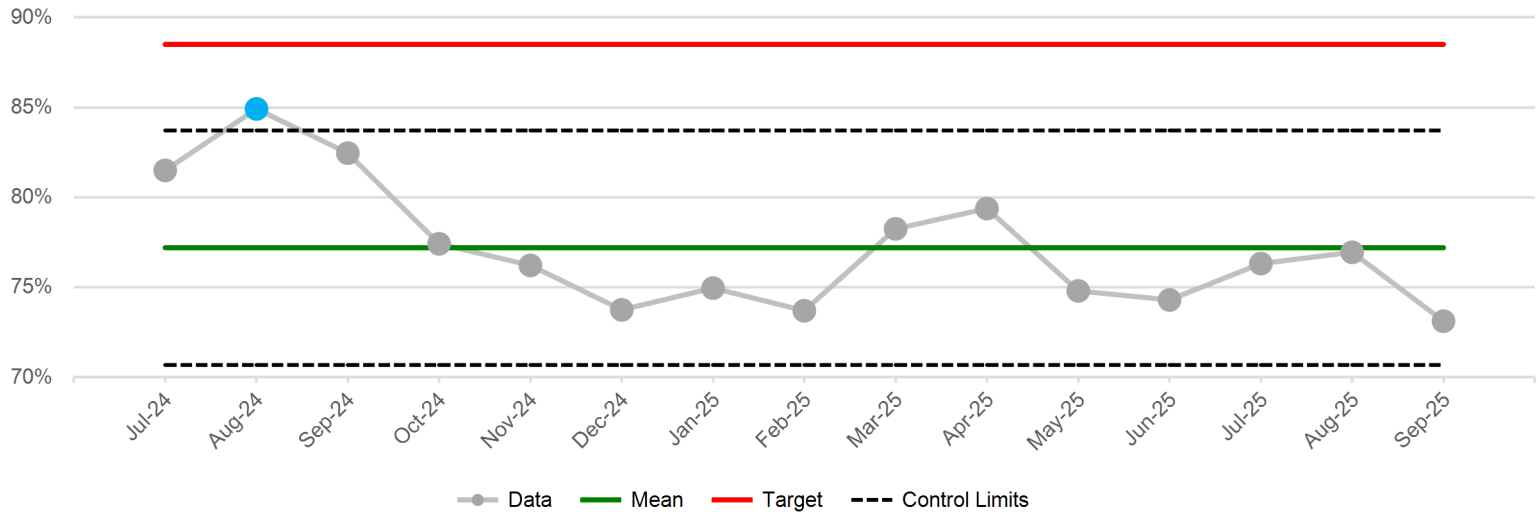
Issues:
- Identification of patients who left or refused treatment prior to triage, as well as patients who were transferred to another site for specialised care.
- It is important that the Manchester Triage trained staff operate two triage streams consistently, particularly during out-of-hours shifts. However, staffing gaps, sickness, and skill mix issues have been causing some problems that need to be addressed.

Actions:
- Increased access to MTS training and time to input data is in place through a rolling teaching programme.
- Increased registrant workforce to support 2 triage streams in place.
- The move to a workforce model with Triage dedicated registrants and remove the dual role component has been more successful but remains problematic.

Mitigations:
- 3 daily capacity and performance meetings to identify recording delays early, along with confirmation through tailored daily updates from the (UEC) team.
- Twice-daily staffing reviews to ensure the appropriate allocation of the Emergency Department (ED) workforce to meet performance indicators.
- The Urgent and Emergency Care Clinical Business Unit is continuing to perform daily interventions to ensure compliance with recording and operational requirements

Performance Overview - Operational Performance

%Triage Achieved under 15 mins



Sep-25
73.12%
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

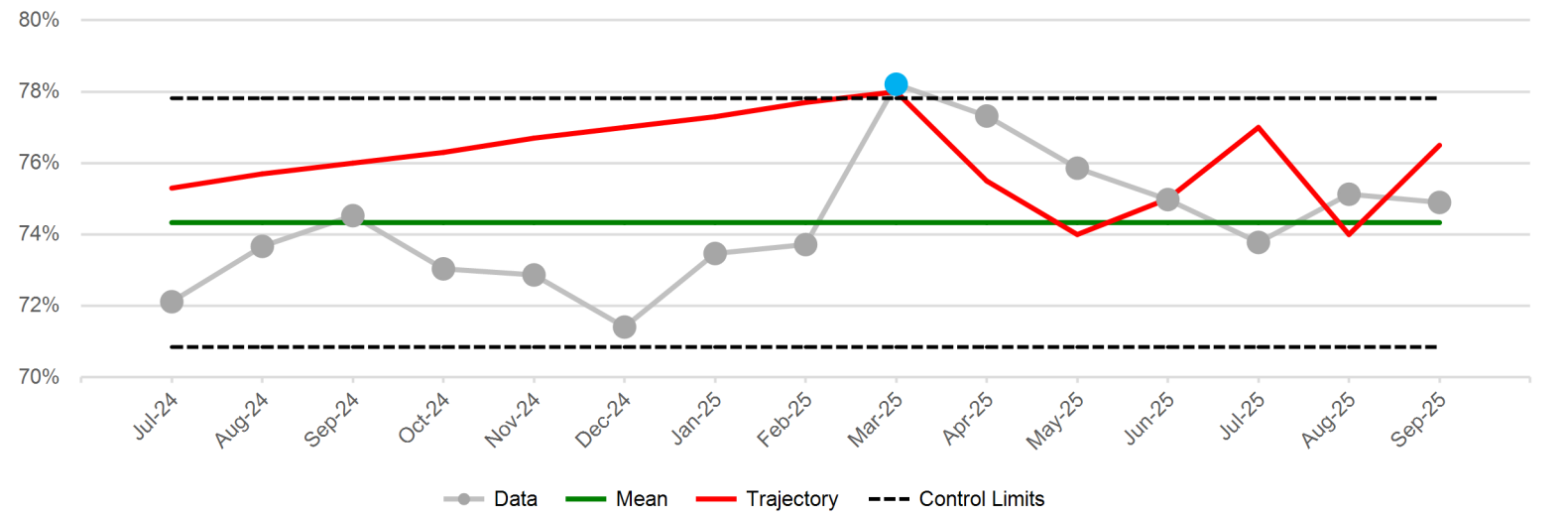
What the chart tells us:
September outturn was 73.12%, compared to 76.95% in August 2025. This represents a negative variance of 15.38% from the target of 88.50%. September's performance shows a 9.34% decline compared to the same month in 2024.

Issues:
- Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 has deteriorated.
- There is a recording issue for UTC transfers of care to ED that skews that data on occasion.
- Dual department roles. For example, the second triage nurse is also the allocated paediatric trained nurse, whilst reduced is still on occasion, problematic.
- Inability to maintain agreed staffing template, particularly registrants, due high to sickness and agency cancellations at short notice.
- Increased demand in the Emergency Depts. and overcrowding.

Actions:
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
The metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings
New escalation process in place
UEC Sprint commenced also in August 2024.

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

Performance Overview - Operational Performance



Sep-25
74.90%
Variance Type
Common cause variation
Trajectory
76.50%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Chief Operating Officer

Background:
The March 2026 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 74.9%, representing a decline over August's performance of 76.95%. It is important to note that the chart does not account for the increased volume and acuity of presentations to the department.

Issues:
In September 2025, Type 1 witnessed an average daily patient volume of 553, reflecting an 3.68% increase from the 533 patients attended to in August 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.

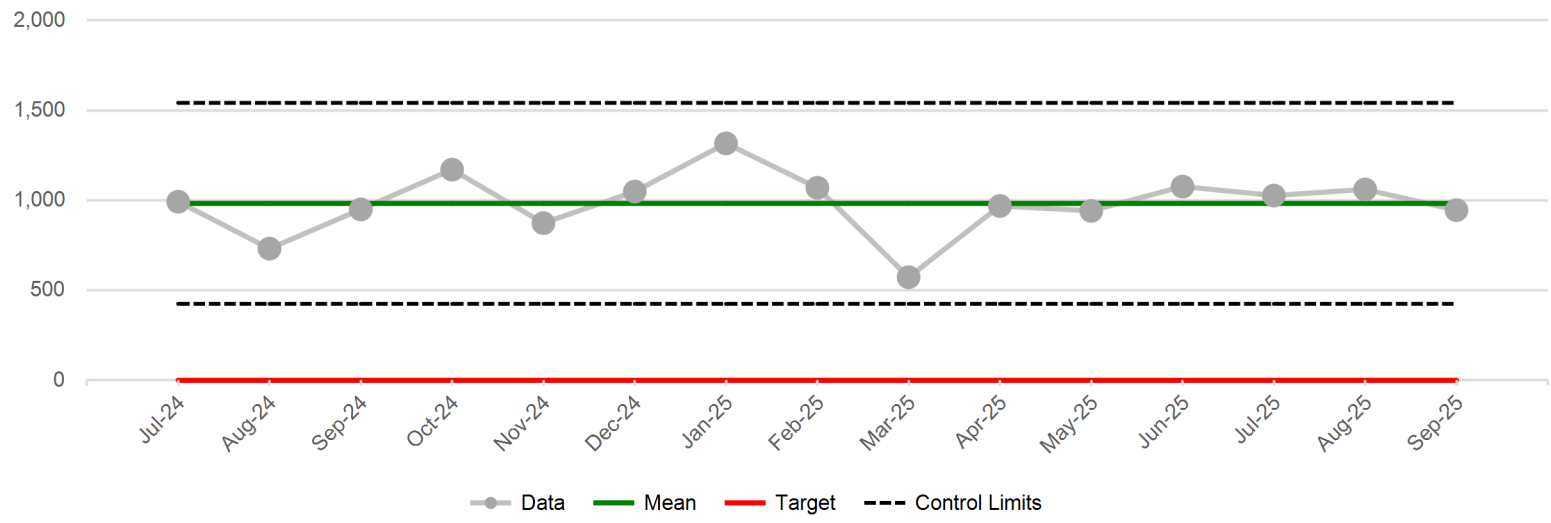
Type 3 (All locations) observed an average of 424 daily patients, representing a 2% decrease to the preceding month.

Actions:
UEC dedicated programmes of work looking at admission avoidance, ED process, acute medicine and direct pathways to reduce overcrowding in EDs and the length of time patients are waiting to be seen. Divisional/organisational action plans monitored weekly by senior leaders from across ULTH and LCHS.
A new Group UEC & Discharge Board has also been set up to focus on the discharge agenda and flow throughout the hospital. The group is chaired by the Chief Nurse and COO and has senior attendees from across the group.

Mitigations:
EMAS continue to enact a targeted admission avoidance process, including no Cat 4 conveyances should arrive at the Emergency Department.
The Discharge Lounge at LCH and PHB continues operating, where possible, a 24/7 service provision to release the burden placed on the Emergency Departments in terms of patients awaiting AIR/CIR and transport home.
Increased CAS and 111 support especially out of hours.
EPIC to Specialty Consultant reviews to ensure DTA applied appropriately.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.

Performance Overview - Operational Performance

12+ Trolley waits



Sep-25
946
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

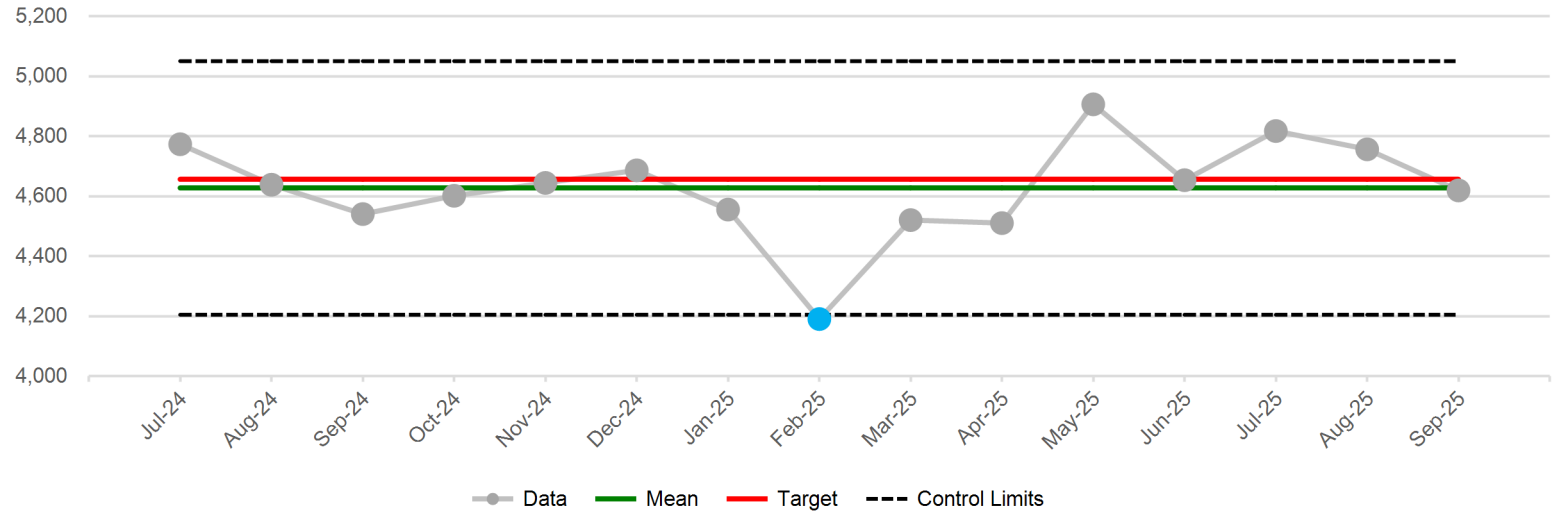
What the chart tells us:
September experienced 946 breaches, an improvement from 1,061 in August, marking a variance of 10.8% (115 less patients). The 946 breaches accounted for 5.71% of all type 1 attendances. Additionally, the chart did not capture the adhoc internal decisions made to prioritise total time in the Emergency Department, aimed at minimising exposure risk and mortality rate.

Issues:
Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings.

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

Mitigations:
A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support.
A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.
An additional consultant shift was funded by winter monies to review all DTAs every day to ensure that they still require admission
Rapid Assessment and Treatment consultant shifts are in place at both ED front doors to assist with length of stay in department and appropriateness of referrals/navigation.

Performance Overview - Operational Performance



Sep-25
4,620
Variance Type
Common cause variation
Target
4,657
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Chief Operating Officer

Background:
EMAS Conveyances to ULHT

What the chart tells us:
In September 2025, the overall number of patients transported to ULHT increased by 1.7% compared to the same period in 2024, which means there were at least 79 more conveyances seen. What the chart doesn't show is that 37.93% of the daily emergency department attendances were from EMAS transports, and 54.85% of these patients were admitted to an inpatient bed.

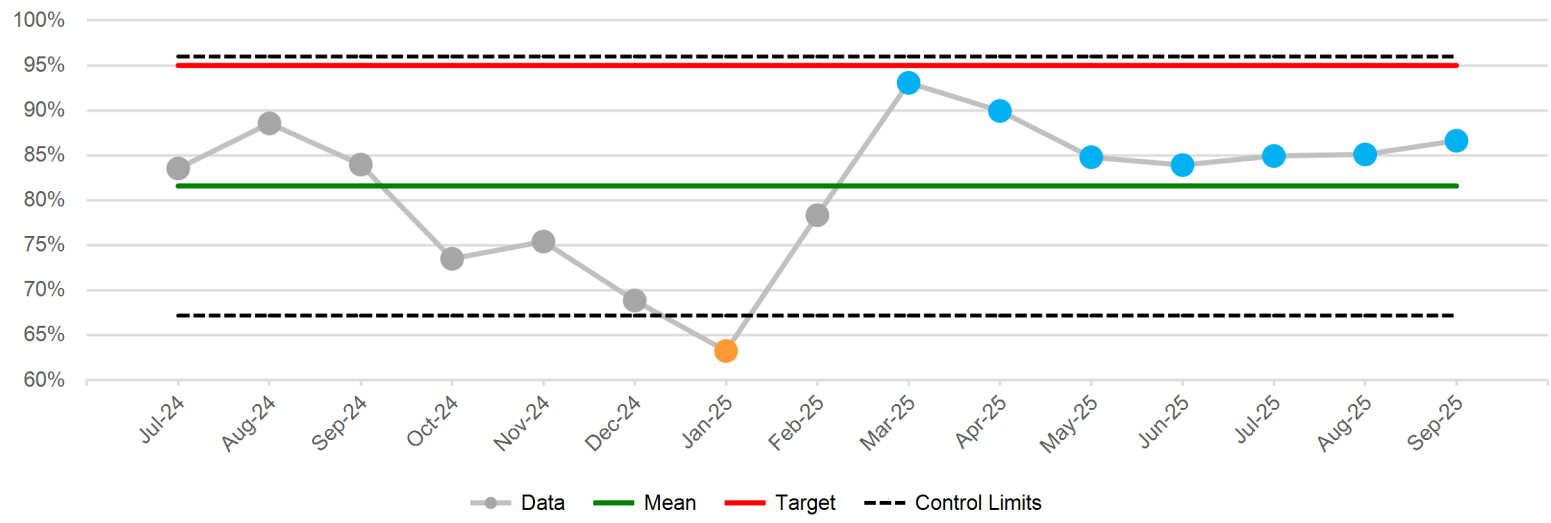
Issues:
The timing of patient arrivals results in a higher influx during late afternoon and evening hours, which corresponds with an increase in walk-in visits. Despite ongoing efforts, the utilisation of alternative pathways to divert patients from being admitted to the Trust remains incomplete, although progress is evident. The pressure experienced by neighbouring Trusts has led to an escalated demand for assistance, most of which has been turned down.

Actions:
• Recovery plans are in place by the Trust for urgent and emergency care (UEC) which include patients being appropriately clinically managed through alternative streams to avoid large numbers of patients in the emergency department leading to possible delays in Ambulance handover. The benefits of these alternative streams have still yet to be fully realised.
• Increased resourcing of CAS by LCHS which includes an extended criterion continues to develop.
• Increased use of and streaming to the UTCs is in place and some benefits are being seen although the pathways and extended criterion needs to be more robust.

Mitigations:

Performance Overview - Operational Performance

% EMAS Conveyances Delayed <45 mins



Sep-25
86.64%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
95.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Delays in offloading patients following a conveyance has a known impact on the ability of EMAS to respond to outstanding calls

What the chart tells us:
Ambulance handovers exhibited a improvement in September with 86.64% arrivals recorded within the maximum threshold. This is a 2.66% improvement to the corresponding month in 2024.What the chart doesn't tell us is also the 1.74% increase in conveyances between the two stats.

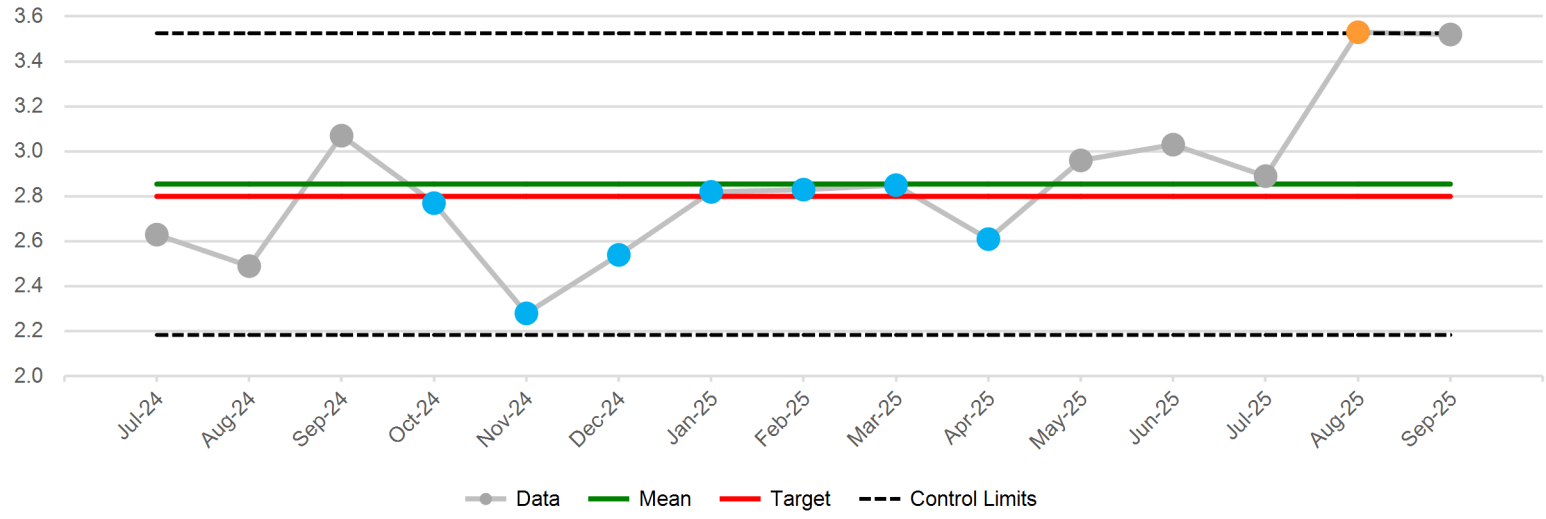
Issues:
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number 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.

Performance Overview - Operational Performance

Average LoS - Elective (not including Daycase)



Sep-25
3.52
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 increased to 3.52 days This represents a negative variance of 0.72 days against the agreed target.

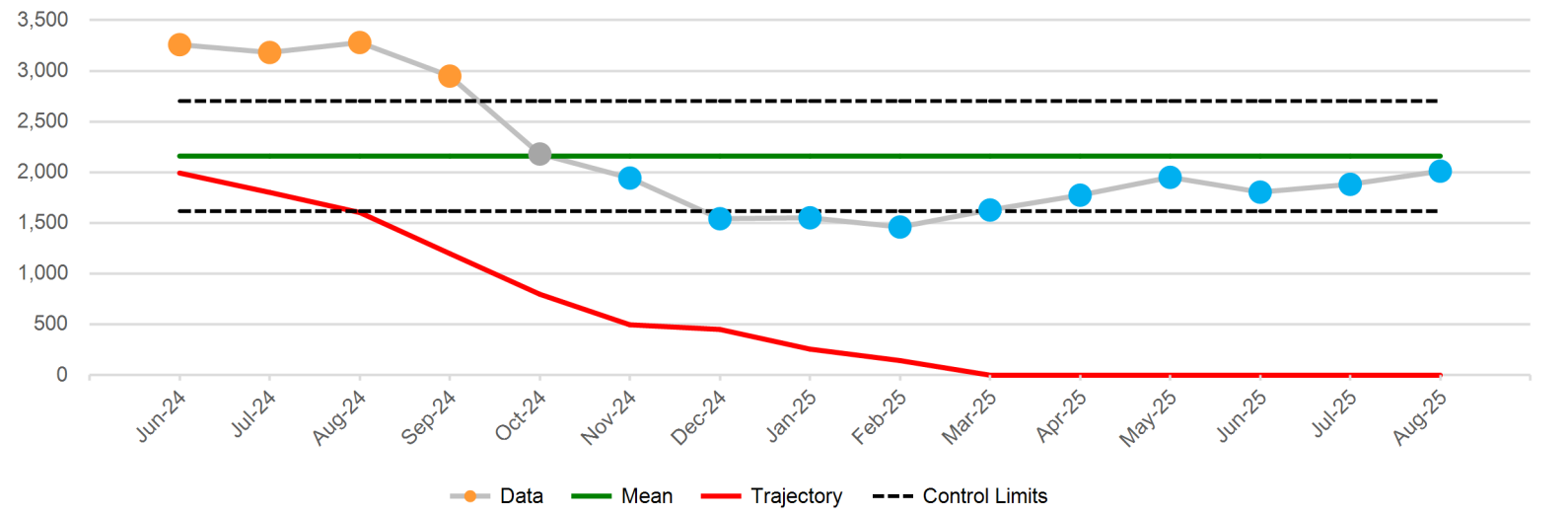
Issues:
The complexity of patients currently being admitted is rising, which will have implications for post-operative recovery and length of stay (LOS). There has also been an increase in the inaccurate coding of day case patients which has led to distorted representation of data, misaligning reported figures with established elective care criteria.

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 investigating specific services/sites who have seen an increase to assess on the accuracy of coded information.

Mitigations:
The weekly 6-4-2 theatre scheduling meetings will identify patients who may require an extended length of stay (LOS) and will consider strategies for increased optimization to reduce the predicted LOS.

All elective areas are now required to pre-operatively escalate any post-operative needs that could lead to an extended LOS beyond what is typically expected.

Performance Overview - Operational Performance



Aug-25
2,012
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Number of patients waiting more than 52 weeks for treatment

What the chart tells us:
The Trust reported 2,012 incomplete 52-week breaches for August 2025, an increase of 130 from July's 1,882.

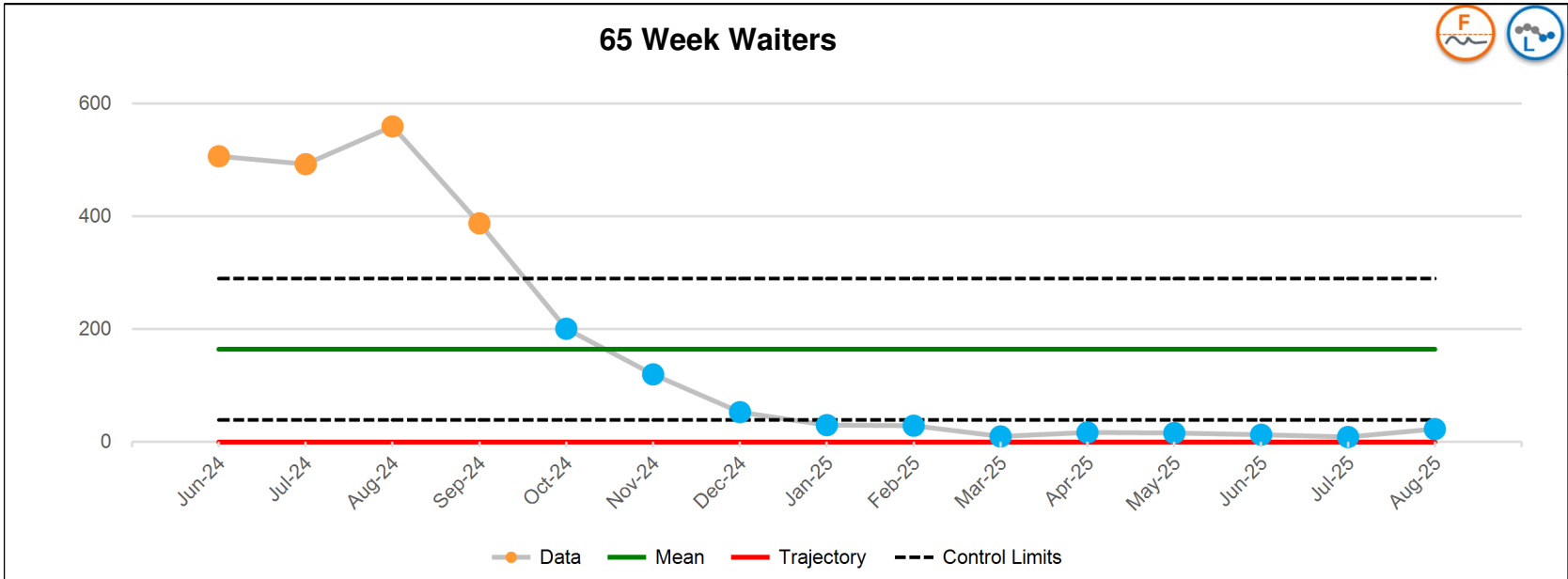
Issues:
As shown above, 52 week waiters are showing a mixed performance against trajectory, with a slight increase since last month. Both admitted and non-admitted patients sit within this wait band, however, the most significant pressure is in the non-admitted pathways. ENT continues to be the specialty under greatest pressure, which together with audiology, accounts for 29% of patients in this wait band. A decrease of 6% from last month.

Actions:
Insourcing for additional ENT clinics and additional DMC clinics for Gastroenterology continues until the end of December. Specialties are currently reviewing clinic templates with Ernst & Young (EY). Changes to ENT clinic templates are taking effect from 1st October and Rheumatology & Diabetic Medicine are changing from the 1st November. Audiology is exploring insourcing of assessments.

Mitigations:
The weekly PTL meetings monitor and track patients down to 52w for the majority of specialties.

52-week performance is being managed through the Trust's Performance Review Meetings with each division.

Performance Overview - Operational Performance



Aug-25
23
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Number of patients waiting more than 65 weeks for treatment

What the chart tells us:
The Trust reported 23 incomplete 65-week breaches for August 2025, an increase of 14 from July's 9.

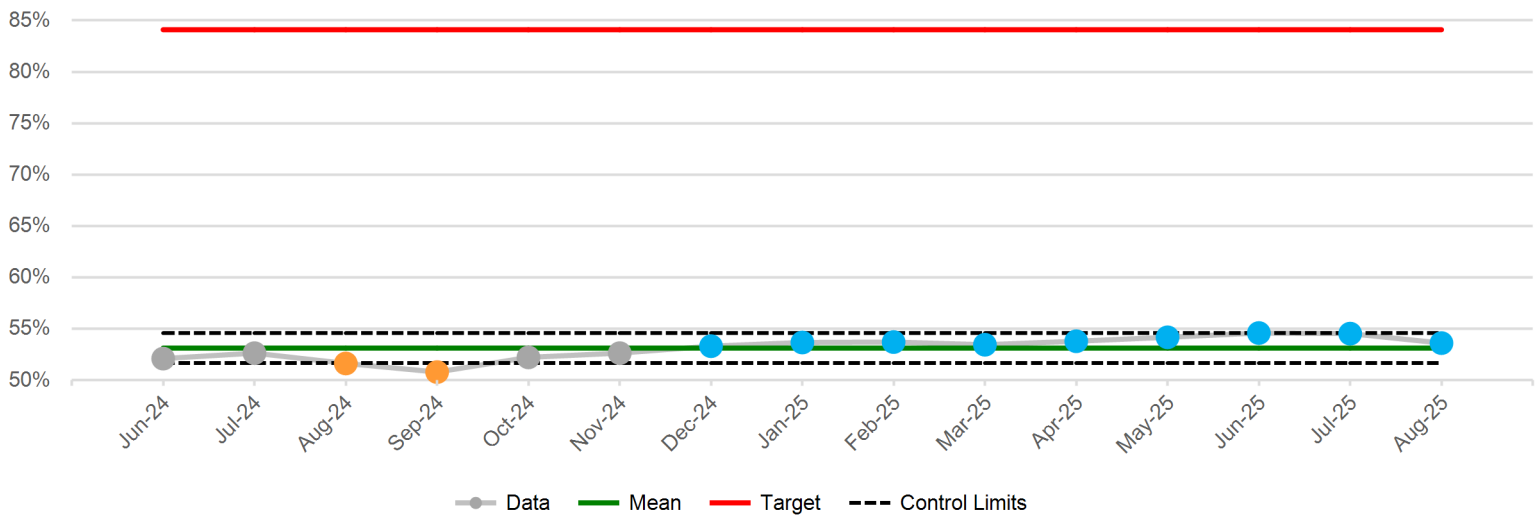
Issues:
ULHT's 104 week wait position was zero for August.

As shown above, 65 week waiters have increased slightly this month.

Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through PTL meetings.
This meeting includes particular focus on patients in the 65w cohort for the current month. Due to the high volume of patients, this is being held twice a week.

Mitigations:
The work being undertaken by EY will support in week productivity and reduce long waiters.

Performance Overview - Operational Performance



Aug-25
53.62%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
84.10%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There is significant backlog of patients on incomplete pathways. August 2025 saw RTT performance of 53.62% against an 84.1% target, which is 0.92% down from July.

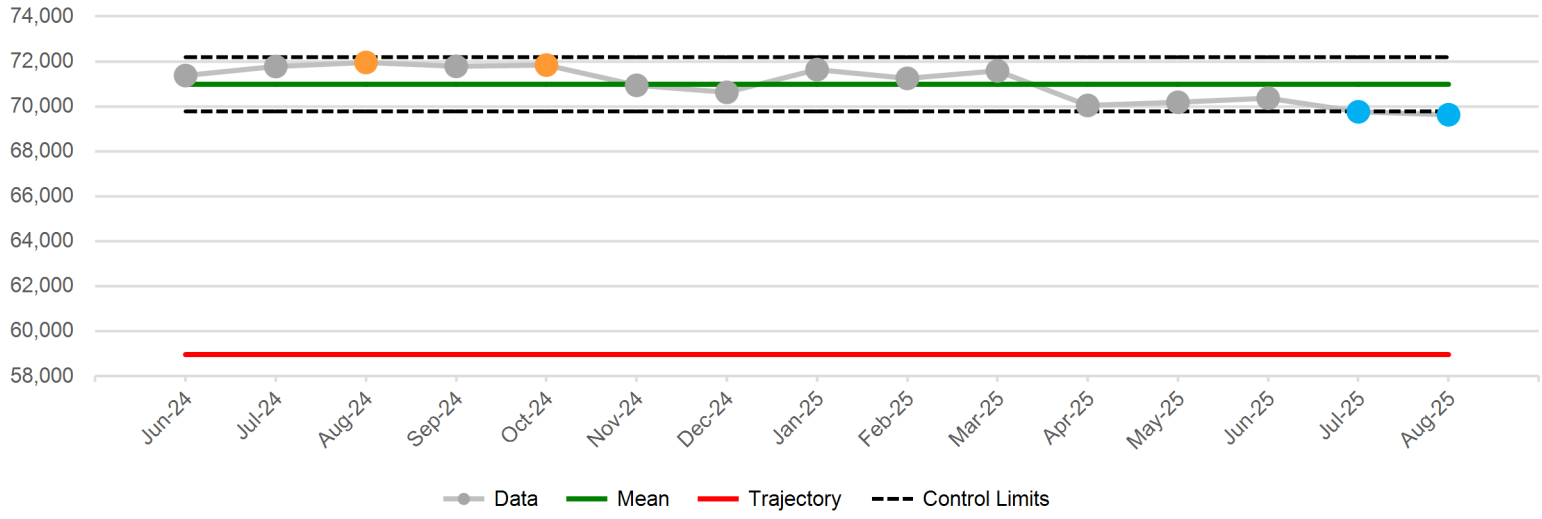
Issues:
Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:
ENT– 4,417 (decreased by 183)
Gynaecology – 3,346
(increased by 111)
T&O–2,962 (increased by 151)
Gastroenterology – 2,435 (decreased by 24)
Neurology – 2,222 (increased by 183)

Actions:
Priority remains focused on clinically urgent and Cancer patients. National focus is now on patients that are waiting 52 weeks and over. with resource targeted at patients who have the potential to be >52 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. An Outpatient Improvement Taskforce group has been set up to focus on recovery.

Performance Overview - Operational Performance

Waiting List Size



Aug-25
69,630
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
58,965
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
The number of patients currently on a waiting list

What the chart tells us:
Overall waiting list size has decreased from July, with August showing a decrease of 133 to 69,630
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 – 7,330
Trauma & Orthopaedics 6,657
Gynaecology – 6,445
Ophthalmology – 5,468
Gastroenterology – 5,406

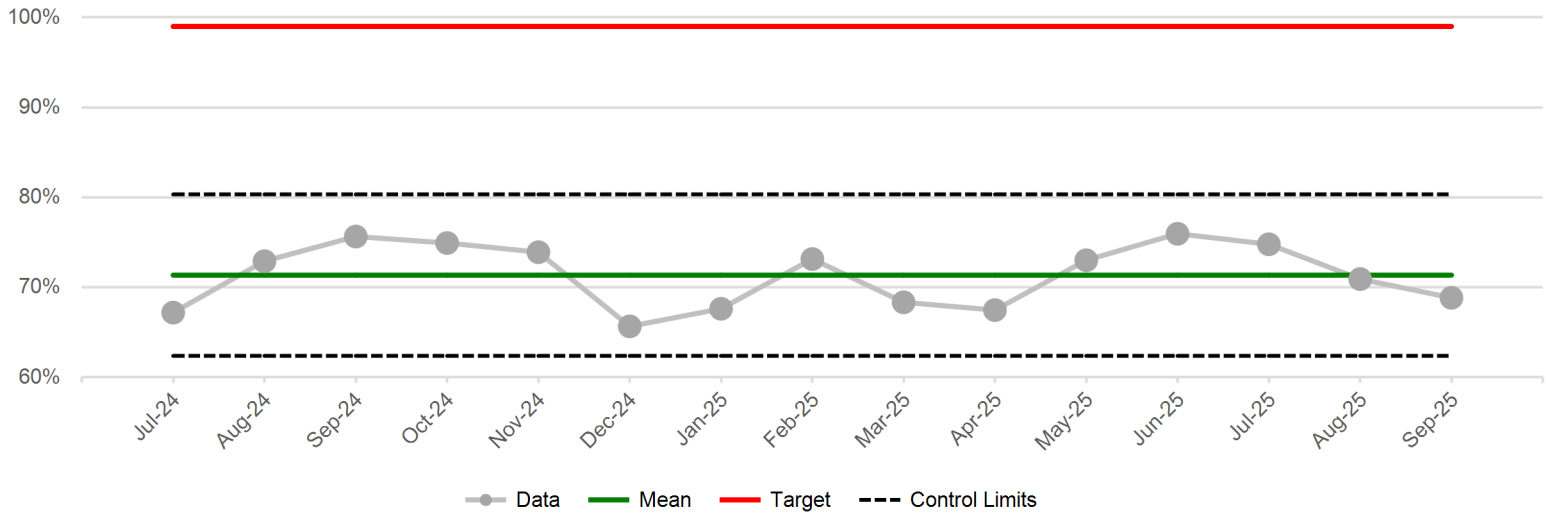
Actions:
EY commissioned to help trust focus on improvement of productivity. Specifically focusing on
- RTT
- Clinic Utilisation
- Outpatient 6-4-2
- Theatre 6-4-2

The internal validation team in conjunction with the EACH have completed National validation sprint 2. A total of 3,648 clock stops were found through the sprint.

Mitigations:
The ongoing review of specialty templates and slot utilisation, aimed at rationalising capacity to ensure efficiency, has identified internal productivity opportunities to improve performance which are being worked through.

Performance Overview - Operational Performance

Diagnostics achieved



Sep-25
68.84%
Variance Type
Common cause variation
Target
99.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Diagnostics achieved in under 6 weeks

What the chart tells us:
DM01 for Sept was 68.84% against the 99.00% target.

Issues:
Reduction in performance form 70.92% in August

• The majority of diagnostic breaches sit in ultrasound, and Audiology.

• Ultrasound has seen increase in demand due to the AQP contract come to an end.

• Audiology will be growing their backlog as no capacity to deal with the increase ENT clinics.

Actions:
Radiology are working to their recovery plans.

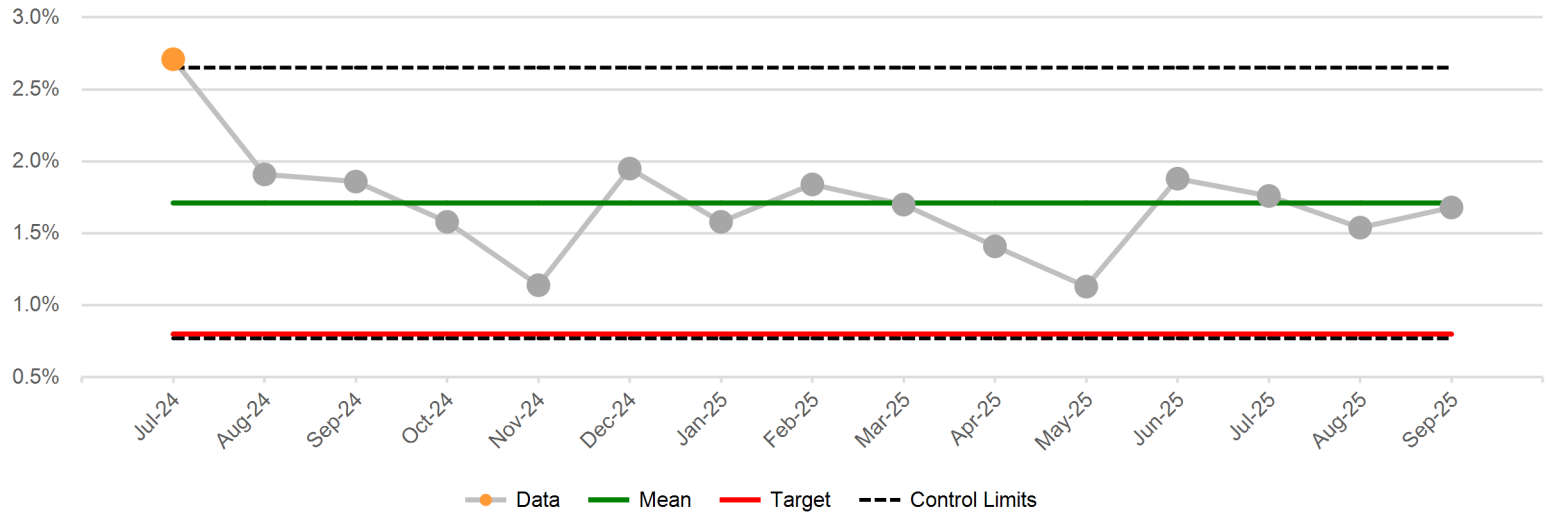
The long waiters demand is stopping any audiology recovery.

Ultrasound are using agency where possible and additional shifts, reduced capacity over the summer holidays.

Mitigations:
Patients are being seen in clinical priority.

Performance Overview - Operational Performance

Cancelled Operations on the day (non clinical)



Sep-25
1.68%
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 an increase in the number of non-clinical cancellations in September, though this remains over the 0.80% target.

Issues:
Top 3 cancellations for September were:

Staff unavailable (surgeon/anaesthetist/theatres) – 33

Lack of time – 12

Did not attend - 10

Actions:
Improvements to theatre staffing review made to reduce on the day cancellations – this has already seen improvements in understanding staffing gaps.

Waiting list team to investigate DNAs to understand reasons.

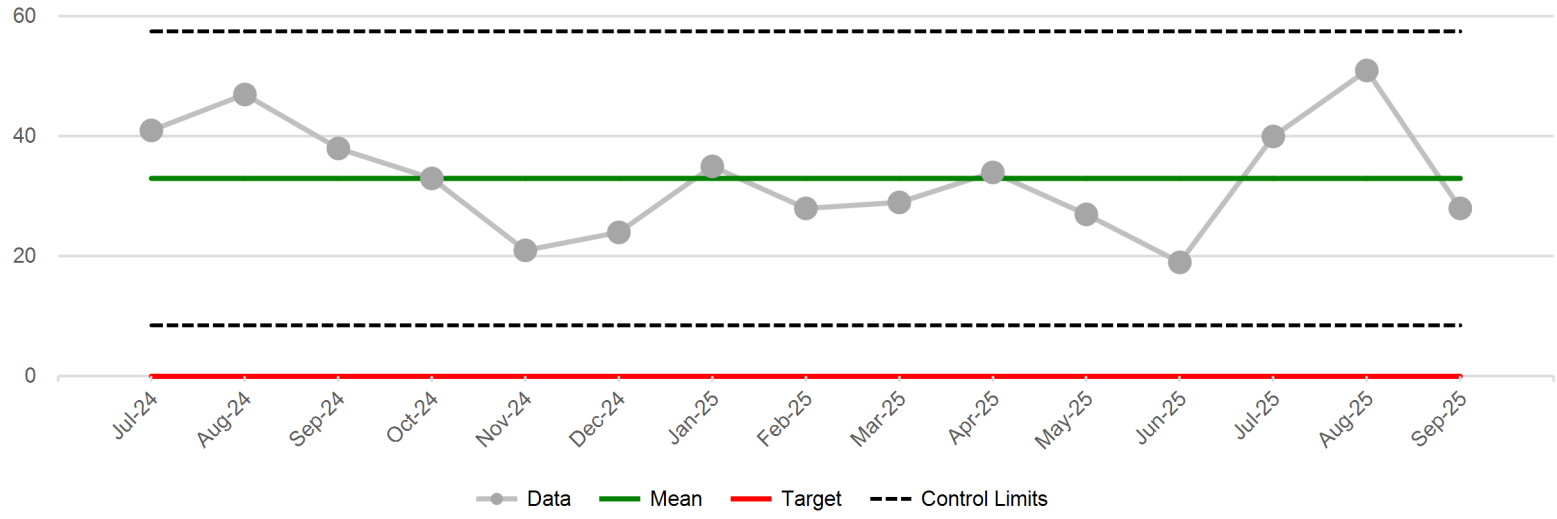
Number of patients receiving a call 72hr before admission, to ensure fitness, rolled out Trustwide.

Mitigations:
Challenge remains in place by senior lead against all non-clinical cancellations.

EY are supporting theatre improvements across all areas.

Performance Overview - Operational Performance

Not treated within 28 days. (Breach)



Sep-25
28
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 significant decrease from 51 in August to 28 in September.

Issues:
Increased activity moving forward due to requirement to resolve long waiter backlogs by the end of December. Some specialties will fill their lists with these patients which may result in difficulty redating non-clinical cancellations. CBUs will manage this as normal.

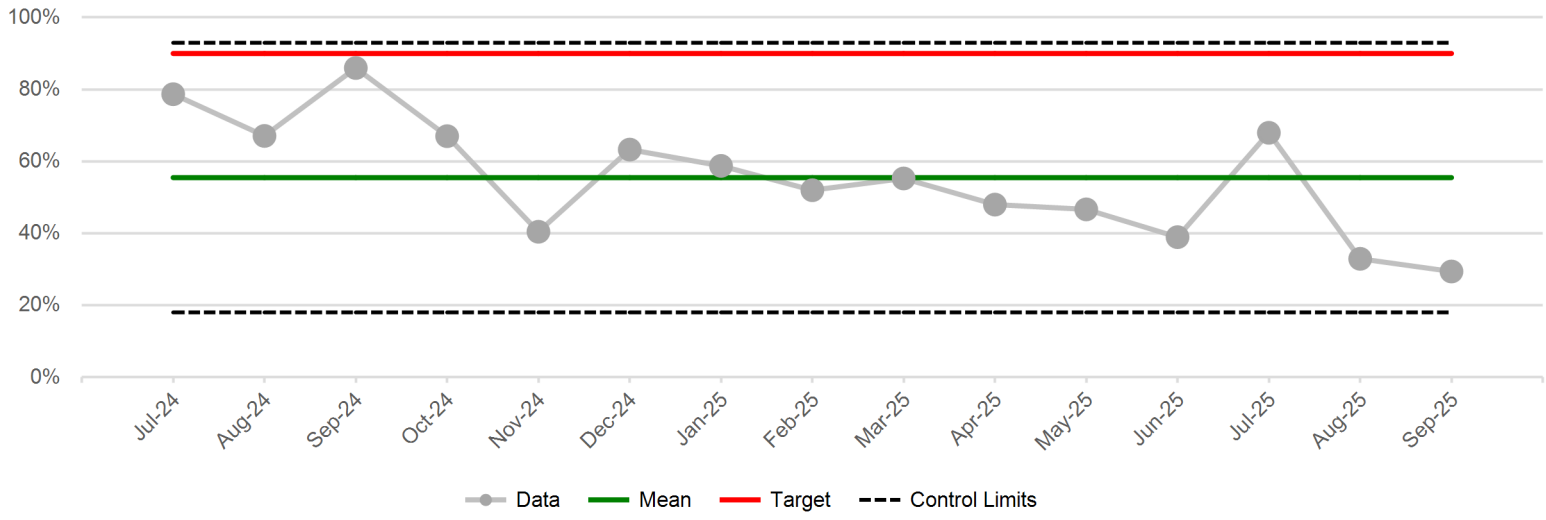
Actions:
Focus to remain on improved utilisation on our lists using 642 with continued focus on effective pre meets.

Mitigations:
There has been an increase in clinical backfill of lists in the last 4 weeks. This impacts our availability treat these patients within 28 days.

List brokering commenced w/c 13.10.25 so we expect to see an improvement in list backfill.

Performance Overview - Operational Performance

#NOF 48 hrs



Sep-25
29.41%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of femur fractures patients time to theatre within 48 hours

What the chart tells us:
The average percentage across both sites for September was 29>41%

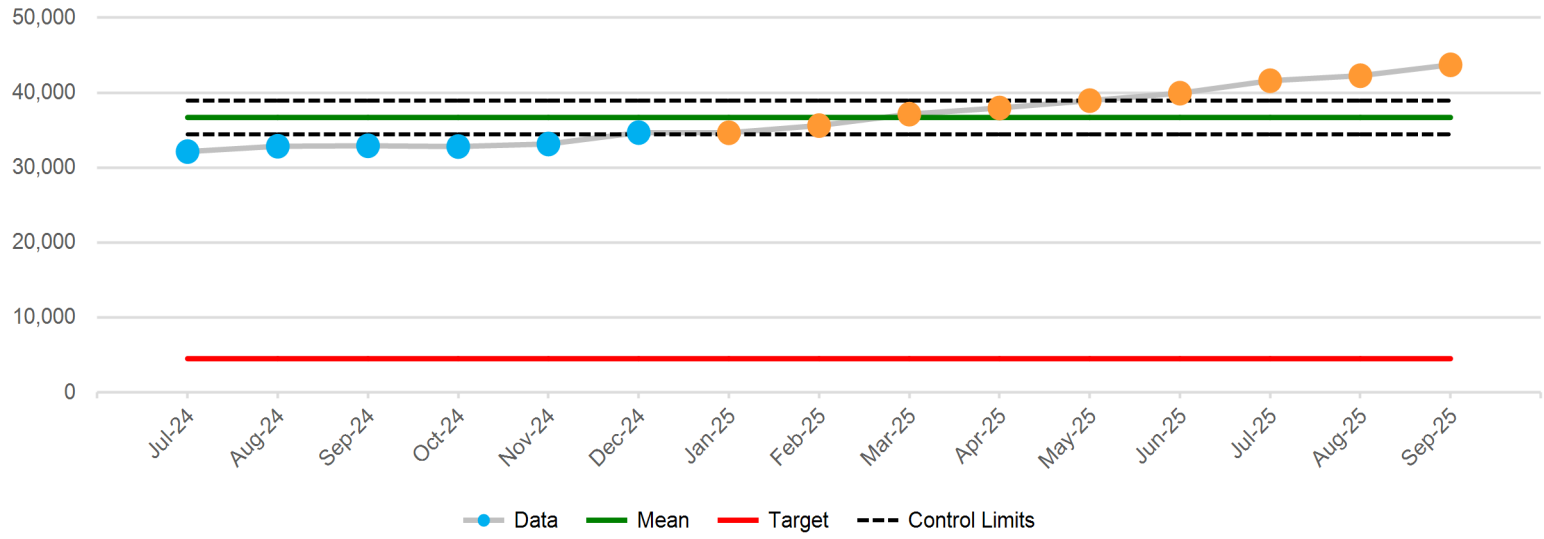
Issues:
- Lack of theatre space to accommodate Femur fractures.
- ULHT continue to have a high demand of trauma patients admitted with one trauma list planned daily on both sites.
- Lack of theatre staff to provide additional trauma capacity.
- ULHT breaching the NHFD best practice tariff for femur fractures.
- Patients not being medically fit for surgery.
- Awaiting specialist surgeon.
- Delays for imaging prior to surgery.
- Patients not being medically fit for theatre.

Actions:
- 'Golden patient' initiative to be fully implemented.
- Additional Trauma lists to be planned on both sites.
- Review of additional trauma lists through job planning process to see if additional trauma lists can be available for Femur fractures to avoid breaches.
- Trauma coordinator team to ensure that femur fractures are listed on the trauma list to avoid breaches.
- Daily Trauma huddles via MS teams with the trauma coordinators and the CBU to discuss extra theatre capacity on all sites.
- Aqua to be accessed daily by the trauma.coordinators to see what capacity is available
- Trauma coordinators to identify suitable. patients that could be operated on at Grantham and Louth.

Mitigations:
- Ensure trauma lists are fully optimised.
- Reduce 'on the day' change in order of the trauma list where clinically appropriate.
- Daily Trauma huddles via MS teams with the trauma coordinators and the CBU to discuss extra theatre capacity on all sites.
- CBU to review elective cases for clinical priority.

Performance Overview - Operational Performance

Partial Booking Waiting List



Sep-25
43,727
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
4,524
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

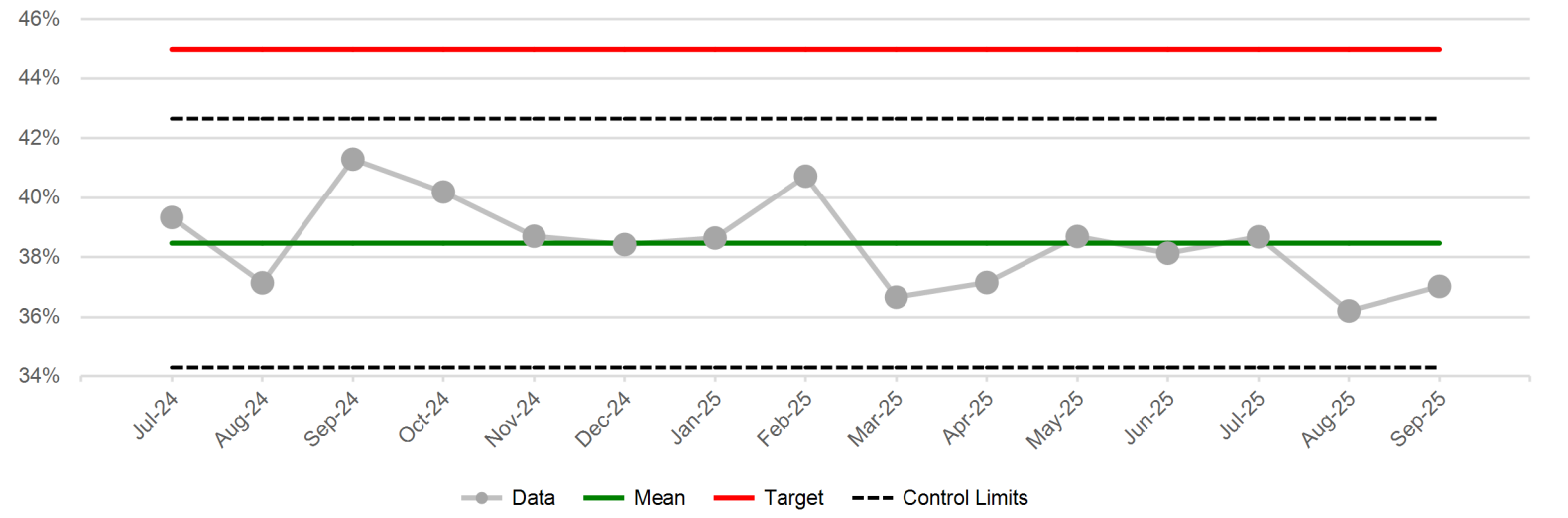
What the chart tells us:
Currently at 43,727 against a target of 4,524. During Covid the number of patients overdue significantly increased and the trend has seen a steady increase, an exception being Aug 23 – Nov 23 and Oct 24, since when the number of overdue follow up patients has continued to increase.

Issues:
The organisation has several competing priorities. The current focus is on the long waiting patients (> 65 and >52 weeks) and urgent suspected 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 further revised to decrease clinic cancellations, improve capacity and vacant slots. Clinic Scheduler x2 in post. Digital room booking system support clinic scheduling and maximise capacity back to procurement phase as initial system not fit for ULTH purpose.

Mitigations:
Booking team priorities are to support rebooking due to short notice patient cancellations and hospital cancellations, the Personalised Outpatient Plan and the booking of the 65-week, 52-week and urgent suspected cancer patient cohort.

Performance Overview - Operational Performance



Sep-25
37.03%
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 an improvement in comparison to August. Septembers out turn of 37.03%, is a 0.82% increase to the preceding month. However, a 4.3% decrease to 2024.

Issues:
The delivery team initially provided support to the wards to enhance compliance with WebV. However, following the discontinuation of this support and the transition of responsibilities to Business As Usual (BAU), there had been a marked decline in performance. Furthermore, the cessation of involvement from SAFER Practitioners raises concerns that compliance may regress if BAU defaults to previous standards.

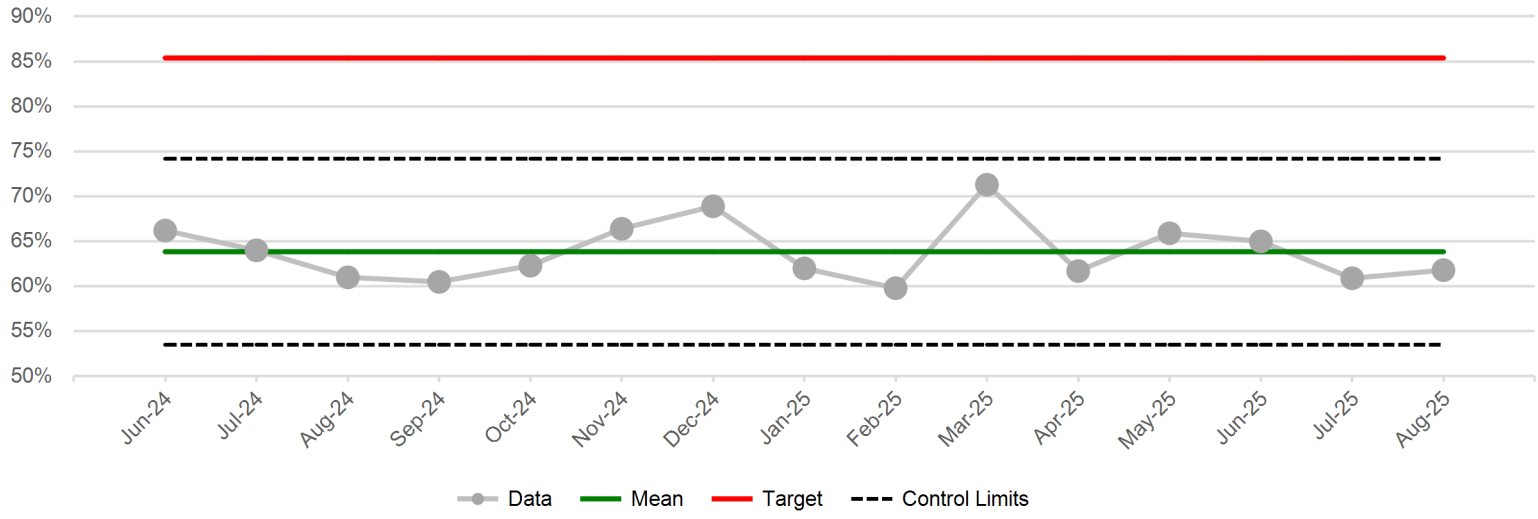
Issues related to staff compliance, competence, and resource allocation persist, particularly during weekends when there is an increased reliance on bank and agency personnel in the wards. Consequently, several WebV fields are not updated with the same accuracy or frequency on weekends as they are during weekdays.

Actions:
Ongoing weekly monitoring is being executed, and any identified areas of concern are communicated to the ward sisters and matrons to facilitate performance improvement.

New processes have been established in conjunction with the weekly non-criteria to reside situational reports to ensure that the data recorded regarding the wards accurately reflects the patients' true conditions. Additionally, themes and trends are identified in real-time to enable timely interventions.

Mitigations:
To enable a successful return to BAU, the clinical education team has been asked to include Web V compliance at the band 6 forums and the IEN ward ready programme.
Weekly monitoring and highlighting of key areas of improvement will continue.

Performance Overview - Operational Performance



Aug-25
61.80%
Variance Type
Common cause variation
Target
85.39%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients to start a first treatment within 62 days combined

What the chart tells us:
We are currently at 61.8% 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 70.80% for August.

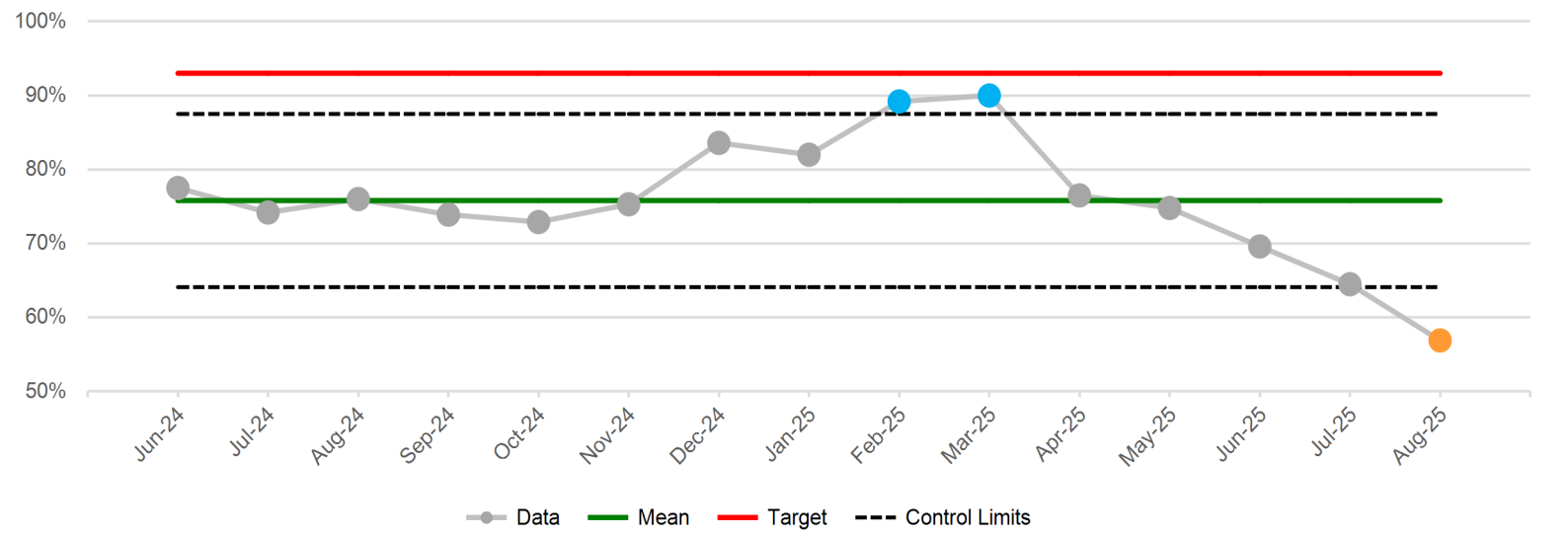
Please also see Issues on accompanying pages.

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. Deep Dives are being undertaken by each CBU to understand how diagnostic turnaround times for positive cancers can be improved as this will be key to achieving the NHSE target of 75% by March '26.

Mitigations:
A process is now in place to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance



Aug-25
56.90%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 56.9% 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 30.36% of the Trust's 14 day breaches.
Additionally, Gynaecology speciality were responsible for 8.29% of the Trust's 14 day breaches in August.
Skin tumour site accounted for 51.53% of the Trust's 14-day breaches in August. There continues to be a seasonal increase for referrals which will likely continue through to autumn.

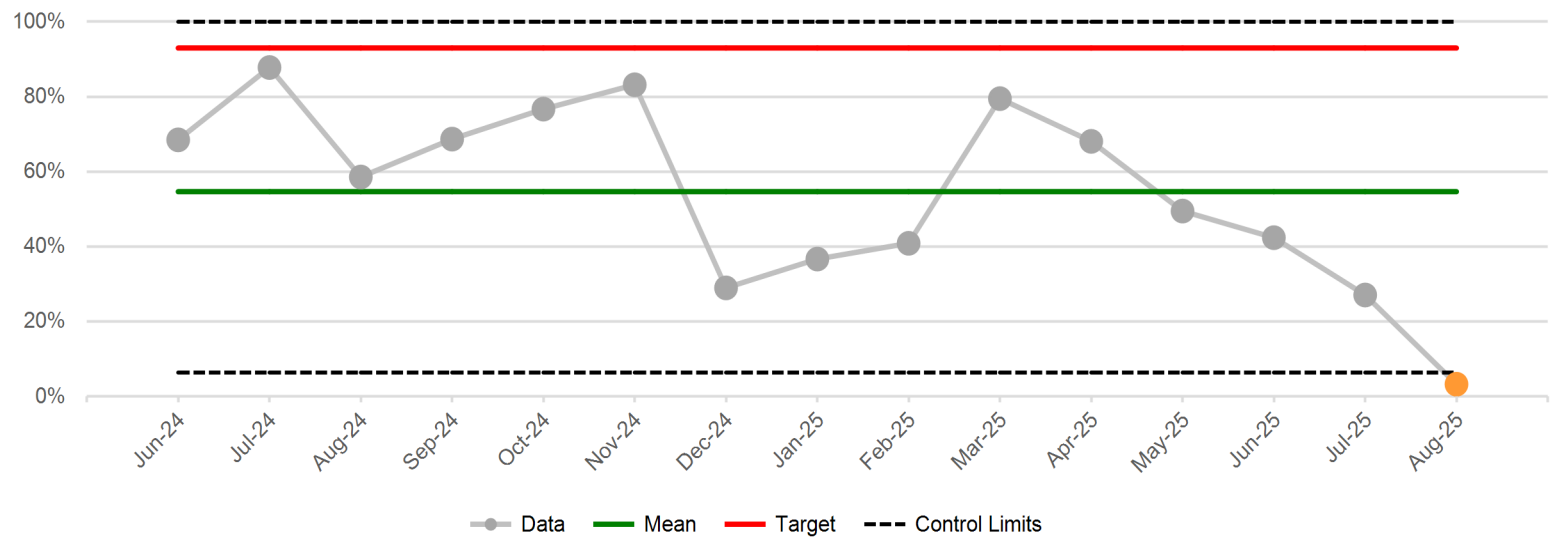
Actions:
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues.
Respiratory Consultant capacity is ongoing as well as the BC for an increase in consultant workforce to 10-15 consultants. 2 x Lung Cancer 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 March 2026. Referral process have now returned to C&A, the division continue to monitor to ensure a streamlined transition.

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.

Performance Overview - Operational Performance

2 week wait breast symptomatic



Aug-25
3.30%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
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 3.3% against a 93% target

Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.

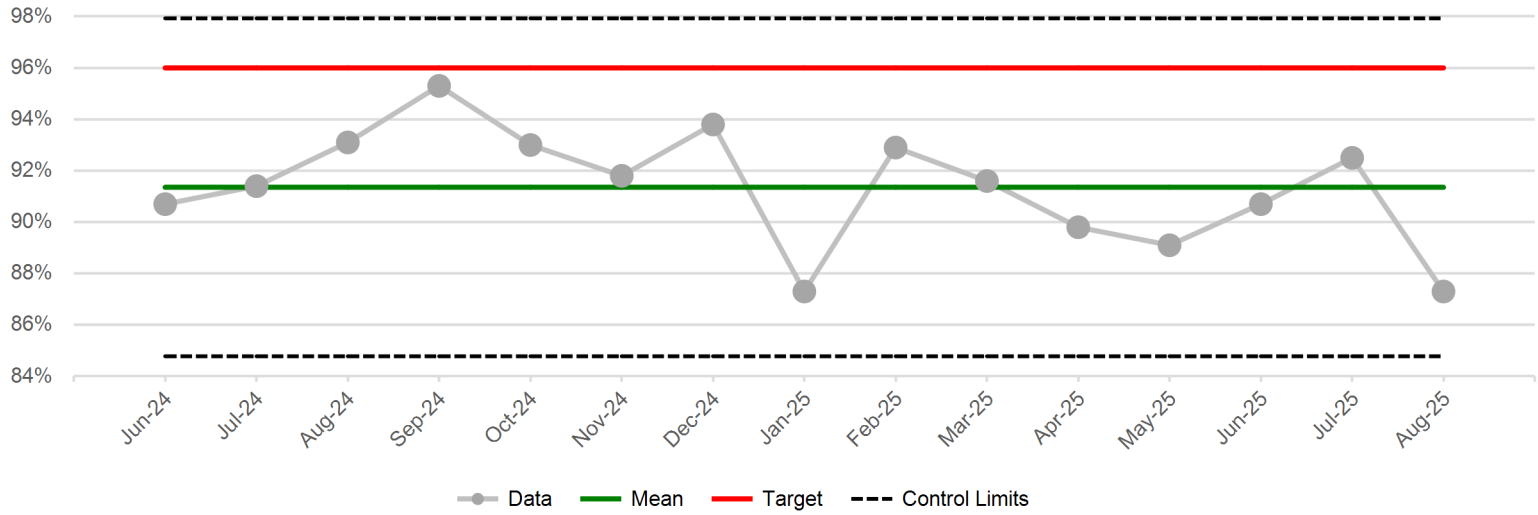
Actions:
A comprehensive review of Breast Services and consultant workload is ongoing.

The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues.

Mitigations:
A mastalgia pathway is now up and running with primary care and system partners which has the potential to reduce inbound referrals by circa 15-20%. Further and more regular comms to improve utilization of this pathway within Primary Care are being supported by the ICB.

Performance Overview - Operational Performance

31 day first treatment



Aug-25
87.30%
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 87.3% against a 96% target

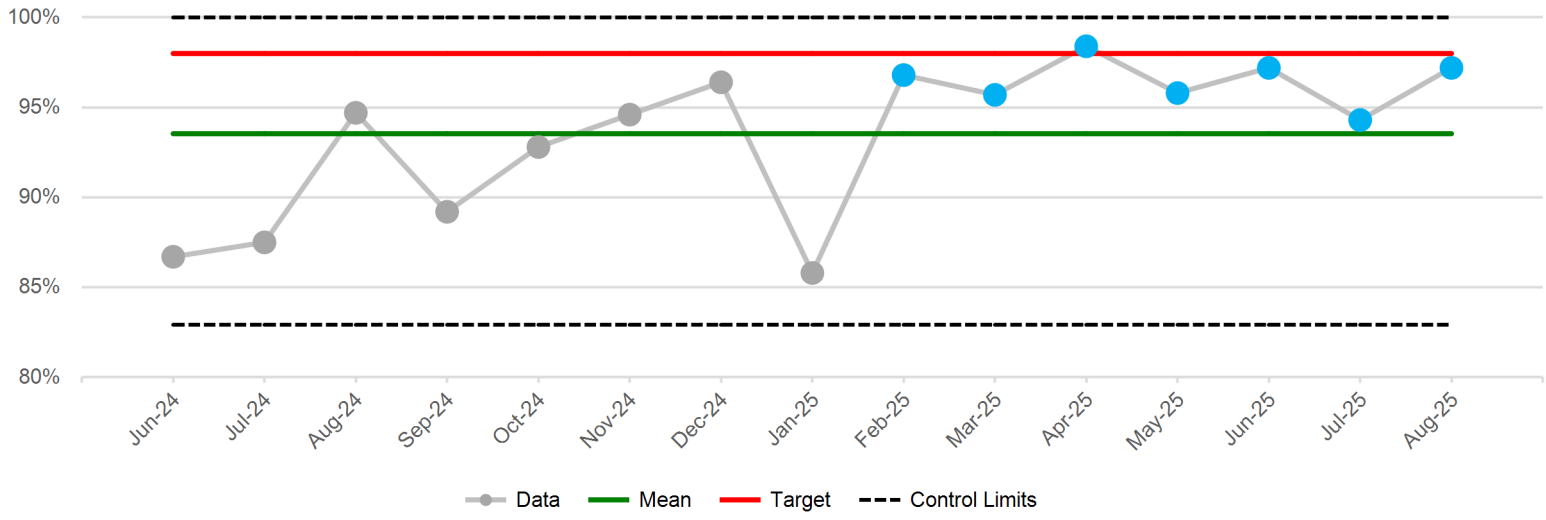
Issues:
The failure of the 31 Day standards was primarily attributed to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment 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.

Performance Overview - Operational Performance

31 day subsequent drug treatments



Aug-25
97.20%
Variance Type
Special cause variation - improvement (Indicator where high is good)
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.

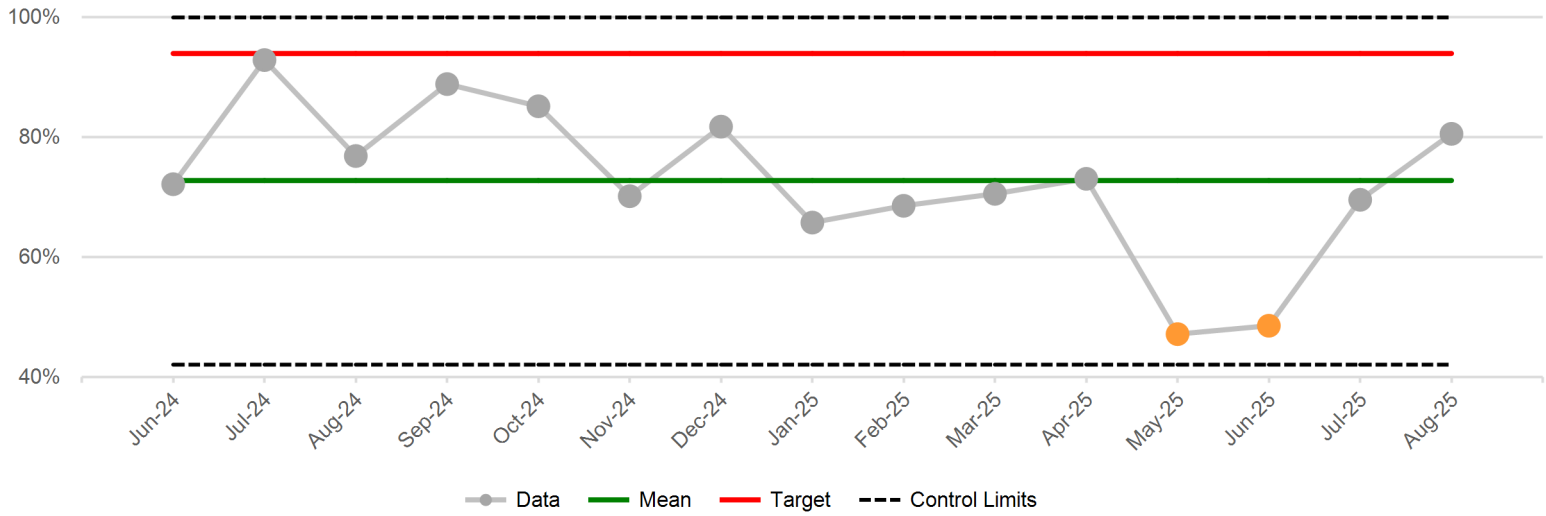
Issues:
In Chemotherapy, staffing shortages, treatment capacity and recent pharmacy staffing shortages have resulted in delayed treatment start dates.

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.

Performance Overview - Operational Performance

31 day subsequent surgery treatments



Aug-25
80.60%
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 surgery

What the chart tells us:
We are currently at 80.6% against a 94% target

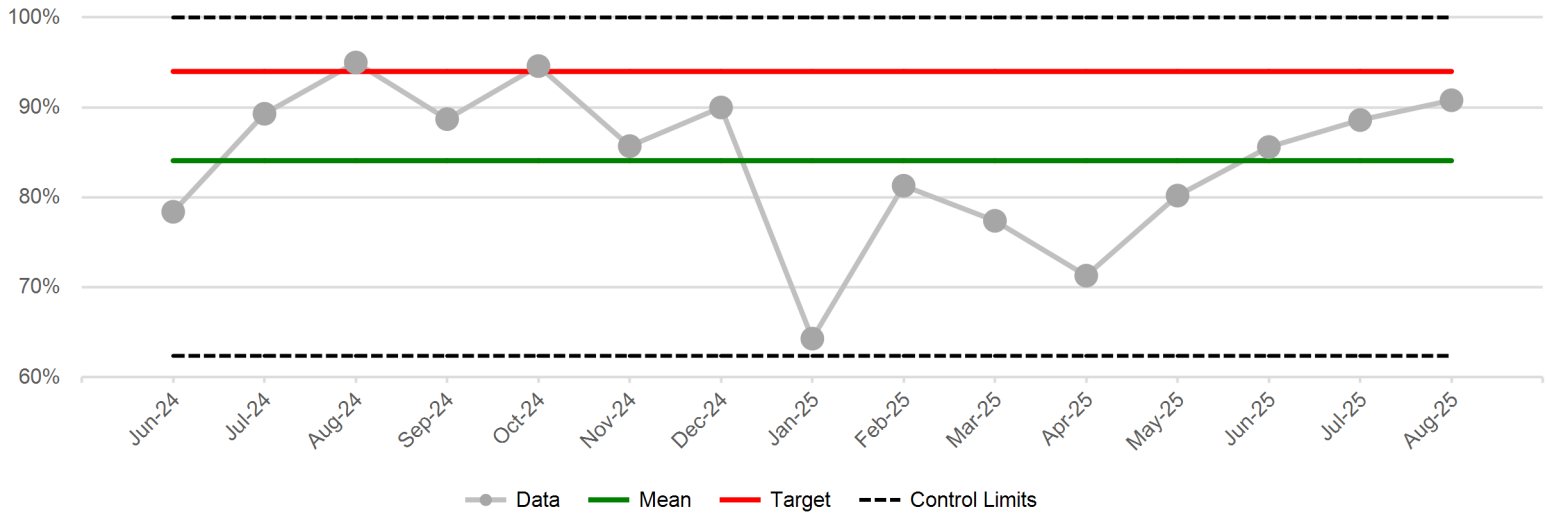
Issues:
The failure of the 31 Day surgery standard was due to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
Colorectal – Current activity complexity is causing delays in allocating surgery dates, e.g. the increase in anterior 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.

Performance Overview - Operational Performance

31 day subsequent radiotherapy treatments



Aug-25
90.80%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 90.8% against a 94% target

Issues:
Radiotherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

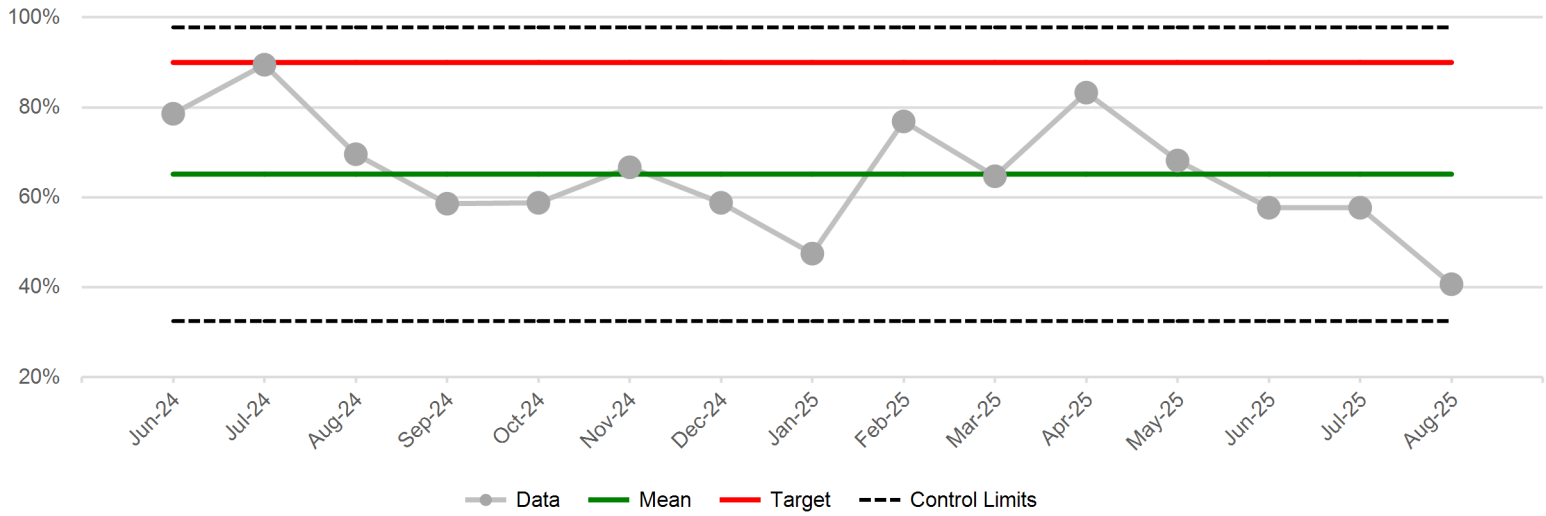
Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce is ongoing, consultant started in June 2025.
Continuous work is being undertaken to ensure shared access to information to ensure breach reasons and treatment adjustments are recorded accurately.

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.

Performance Overview - Operational Performance

62 day screening



Aug-25
40.70%
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 40.7% 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.

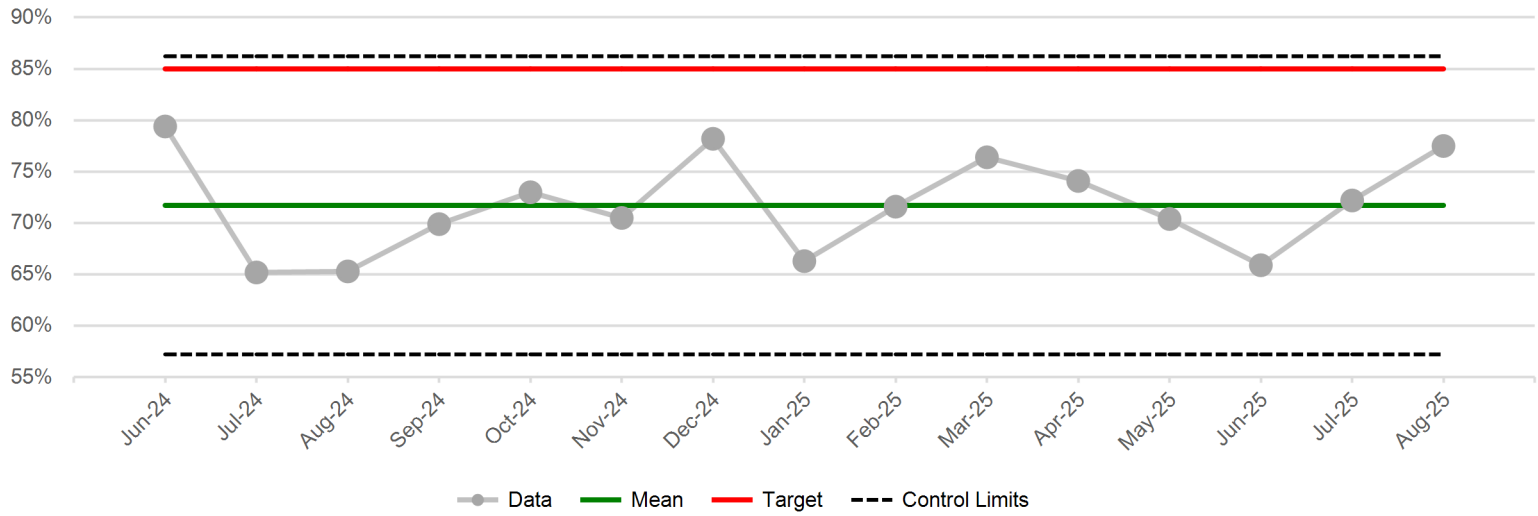
Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing, consultant to start June 2026.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations. Additional slots for cancer specialties to increase from 2 to 3 slots per day starting from July 24.

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

62 day consultant upgrade



Aug-25
77.50%
Variance Type
Common cause variation
Target
85.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 77.5% 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.

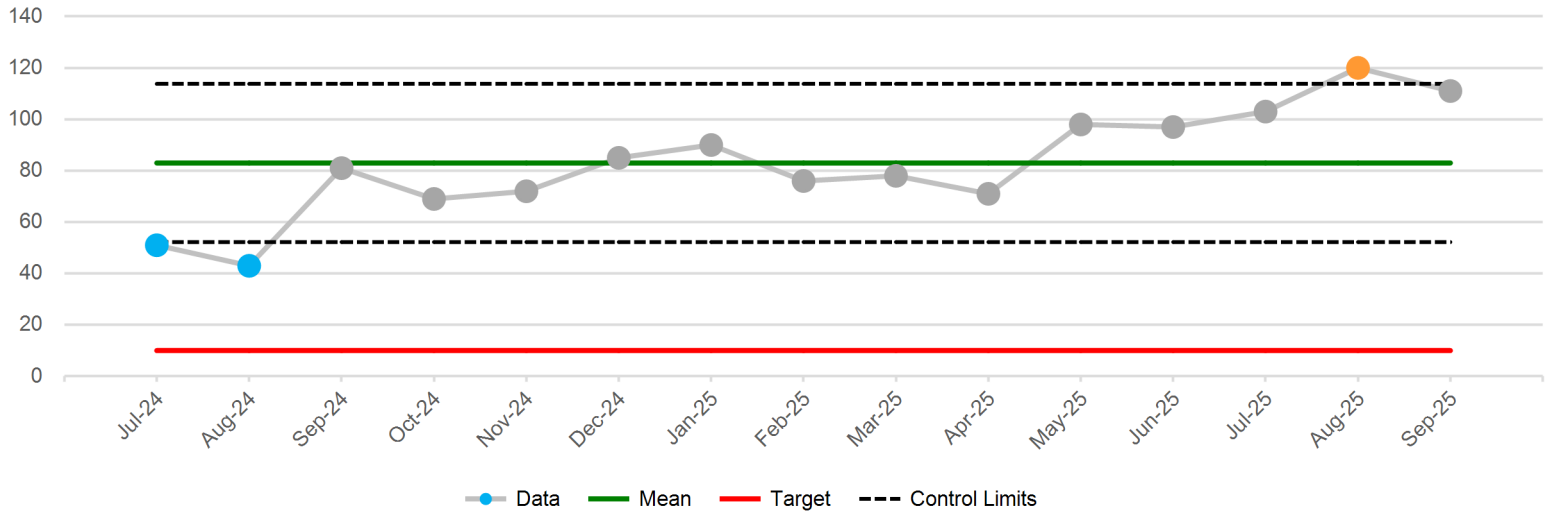
Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing, consultant to started June 2025.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, 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.

Performance Overview - Operational Performance

104+ Day Waiters



Sep-25
111
Variance Type
Common cause variation
Target
10
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Number of cancer patients waiting over 104 days

What the chart tells us:
As of 8th October the 104 Day backlog is at 111 patients.
There are 3 main tumour sites of concern:-

Colorectal 43
Upper GI 19
Head and Neck 16
Lung 11

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 16.2% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

Actions:
Intensive Support Meetings in place to support Colorectal, Urology, Head & Neck, Lung, Upper GI, Skin, Gynae and Breast recovery.

Please also see Actions on accompanying pages.

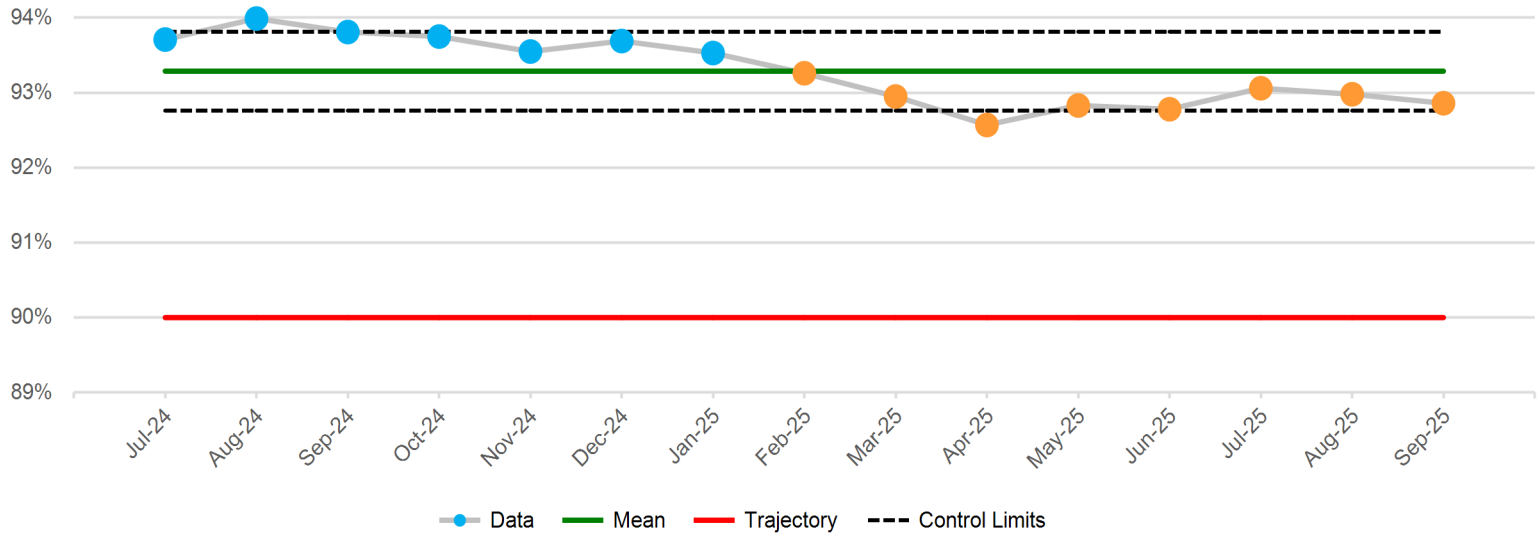
Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Workforce

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-25	Aug-25	Sep-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	90.00%	93.06%	92.98%	92.86%	92.85%	90.00%	P	L
	Number of Vacancies	Well-Led	People	Director of HR & OD	6.81%	6.47%	6.24%	6.02%	6.10%	6.91%	P	L
	Sickness Absence	Well-Led	People	Director of HR & OD	4.31%	5.26%	5.32%	5.37%	5.30%	4.46%	F	
	Staff Turnover	Well-Led	People	Director of HR & OD	9.00%	8.93%	8.90%	8.84%	9.00%	9.00%	P	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	85.00%	81.17%	80.04%	80.25%	78.64%	82.50%	F	

Performance Overview - Workforce

Overall percentage of completed mandatory training



Sep-25
92.86%
Variance Type
Special cause variation - cause for concern (Indicator where low is a concern)
Trajectory
90.00%
Achievement
Variation indicates consistently passing the target
Executive Lead
Director of HR & OD

Background:
Our September 2025 Mandatory Training Rate is 92.86% against a Q2 target of 90.00%.

What the chart tells us:
That we are consistently achieving the target although have seen a decrease in the last 3 months.

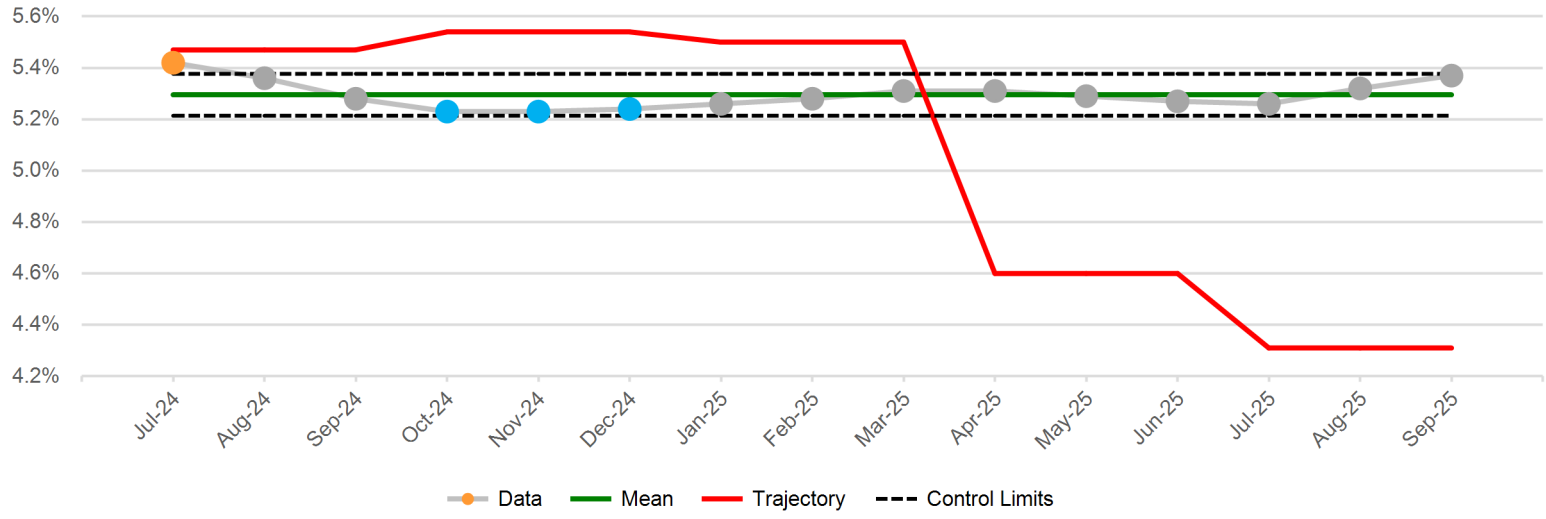
Issues:
• Offer of time to our colleagues to be able to complete all mandatory training as required for the role they do.

Actions:
• 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).

Mitigations:
• Core Learning cycles encouraged where possible in line with appraisal window approach to support early in year compliance, avoiding the winter period when activity and demand on staff and services is higher.

Performance Overview - Workforce

Sickness Absence



Sep-25
5.37%
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 September 2025 Sickness Rate is 5.37% 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.

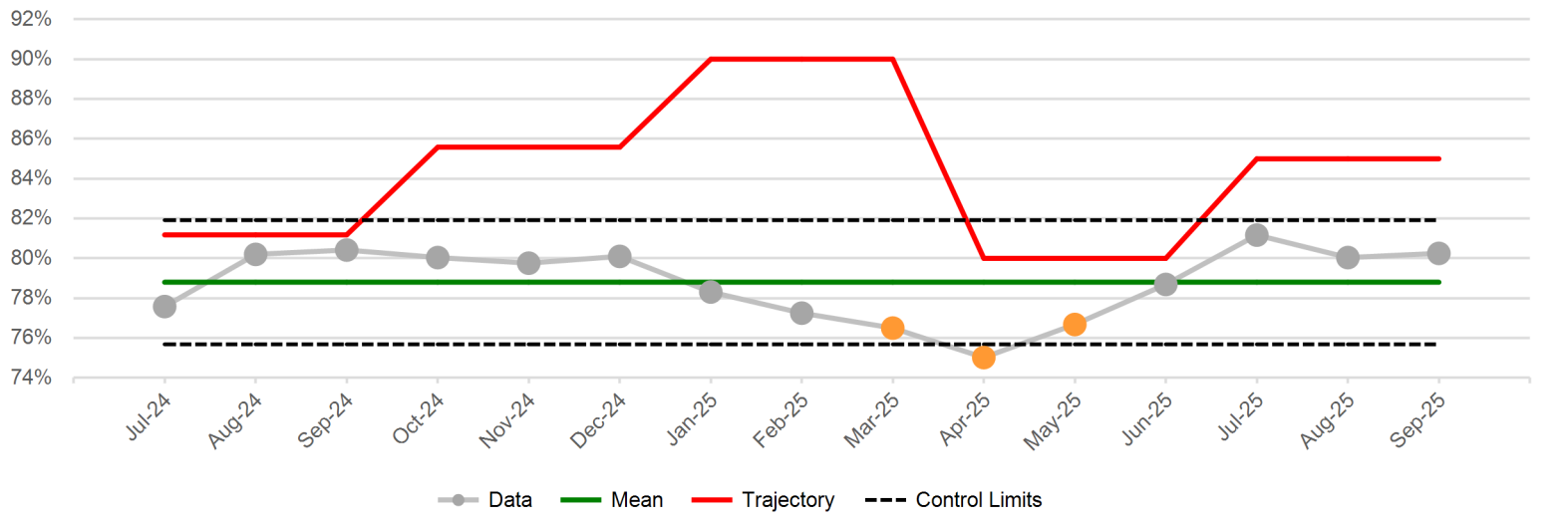
Issues:
Reducing long term absence to mitigate impact on services.

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.

• Additional resource allocated to absence to support the co-ordination and support to staff.

Mitigations:
See actions.

Performance Overview - Workforce



Sep-25
80.25%
Variance Type
Common cause variation
Trajectory
85.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
Our September 2025 completion is currently 80.25% 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.

NHS
Lincolnshire Community and Hospitals NHS Group

Integrated Performance Report
October 2025 (September Data)

Caring and building a healthier future for all

Meeting	*Integrated Performance Report*
Date of meeting	*November 2025*
Agenda item number	
Report title	*Finance & Performance Report*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Information*
Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Author(s)	*Ben Storer*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial assurance*
Prior approval process, if applicable	
Financial implications, if applicable	
Action / decision required	*The board / committee is asked to:*

Assurance Rating Key:

Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are uncertain or possibly insufficient*
Red: Limited or No Assurance	*Effective controls are not in place or are insufficient to manage the risk identified and / or appropriate assurances are not available. Immediate action is required to address the gaps, weaknesses or non-compliances identified*

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	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	

Executive Summary

Performance up until the end of September is set out in the report.

The number of metrics in each cell in the SPC grid is as follows:

Target Capability	SPC Variation: Special Cause Improvement	SPC Variation: No Variation	SPC Variation: Special Cause Deterioration
Consistently Capable	2	9	3
Inconsistently Capable	2	12	0
Not Capable	1	1	1
No Target	5	16	3

3 indicator is not statistically capable of achieving performance targets without redesign:

1. 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.

2. Home Visiting Compliancy.

As expected, home visiting activity has increased in line with the pilot process. These 1236 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.

3. Patient Incidents

Narrative

- The graph shows LCHS patient safety incidents per 1000 WTE from 1st July 2024 to 30th September 2025.
- 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.

7 indicators are showing special cause deterioration currently:

1) Mandatory Training Compliancy

Overall mandatory compliance as of 30th September 2025:

The overall mandatory training compliance rate which includes all core and role specific modules has increased to 91.83% 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 95.38% which exceeds the national/local target of 90%.

All Divisions have increased this month or remain stable and all, except IUEC who sit just below, have overall compliance above the national/local target of 90%.

Children's, Young People's, and Specialist Services	93.93%	↑
Collaborative Community Care	91.03%	↔
Corporate Services	96.66%	↔
Integrated Urgent and Emergency Care	88.01%	↑
Operational Business Services	94.53%	↑
Operational Leadership	94.71%	↑
System	96.78%	↑

2) UTC Discharge Summaries

September has seen a slight decrease in discharge letters being sent to GPs in a timely manner, the hotspots are Louth UTC and Skegness UTC. We are currently doing a deep dive in to this, and this will be present on the narrative next month, The remaining UTCs remain at acceptable percentages of letter's being sent

3) 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.

Actions

On target – the Trust has a low overall vacancy rate compared to the 8% target.

4) Total Falls

Average falls and activity continue with falls working group. We are consistently under control limit.

5) Urgent Community Response - Accepted Referrals

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 September this was 1565. The compliance is achieved by measuring the

time between the referral being made and the initial assessment (completed in CAS). A compliance of 91.18% 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.

6) Transitional Care Activity

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: the procurement process was concluded mid-August. 35 block contract beds are currently in use. 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.

7) Ethnicity recording in A&E data sets.

Ethnicity in A&E dataset has shown special cause concern since April 2025. This metric is not capable of achieving the 95% target without further redesign.

10 indicators are showing special cause improvement this month which is a strong indication of our continuous improvement culture:

(i) Discharge to Assessment: Distinct Patient Contacts
(ii) Staff Turnover.
(iii) Discharge To Assessment: Accepted Referrals
(iv) Home Visiting Compliancy
(v) Ops Centre – Calls Offered
(vi) Agency Expenditure
(vii) GU Patients Seen Within 2 Working Days
(viii) Virtual wards
(ix) Combined Home Visiting & UCR Cases
(x) UTC 15 Minute Assessment

Main body of the report: should not exceed 5 sides of A4, should be prepared using Arial, font 12 and should include the following elements:

Contents

Introduction / Background

Section Headings

Key Points (findings, key risks & issues and any actions already taken)

Conclusion / Recommendations

Board / Committee Action Required

Appendices, if applicable

Lincolnshire Community Health Services NHS Trust

INTEGRATED PERFORMANCE REPORT

September 2025 Performance Data

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SPC Scorecard

Target Capability	SPC Variation: Special Cause Improvement	SPC Variation: No Variation	SPC Variation: Special Cause Deterioration
Consistently Capable	Staff Turnover GU patients seen within 2 working days	Environmental Cleanliness Community Hospital Bed Occupancy Community Hospital Falls per 1000 OBDs MRSA Screening Completion Of NHS Numbers for A&E Data Sets Chlamydia Screening Positivity Rate Compliance Ops centre -Emails answered within 24 hours Ops centre - Standard calls answered within 10 minutes Combined Home Visiting & UCR 2-Hour Compliance	Mandatory Training Compliancy UTC Discharge Summaries Vacancy Rate
Inconsistently Capable	UTC 15 minute Assessment Agency Expenditure	Sickness Absence Complaints - Rate per 1000 WTE Friends & Family Test Community Hospital Discharge Summaries Average Length of Stay Long Term Sickness 15 Minute Ambulance Handover Better Payment Practice Code UTC 4 Hour Ops Centre Calls: Answered in Timescale Ops Centre Calls Abandoned Ops centre - Prioity calls answered 2 minutes	
Not Capable	Home Visiting Compliancy	Patient Incidents Per 1000 WTE	Ethnicity in A&E Data Sets
No Target	Ops centre- calls offered Combined Home Visiting & UCR Cases Discharge to Assess Accepted Referrals Discharge to Assessment: Distinct Patient Contacts Virtual Wards:Frailty Referrals	Total Medication Incidents Complaints CHPPD Overdue Datix Compliments Children in Care Community Pressure Ulcer - Rate per 1000 contacts (C2, C3 & C4 Community Hospital Injurious Falls per 1000 OBDs Community Hospital Pressure Ulcers - Rate per 1000 OBDs (C2, C3 & C4 Home Visiting Activity Ops Centre Calls Answered Out of Hours and CAS Cases Closed CAS Activity Virtual Wards: Cardiology Referrals UTC Activity Ops centre- Emails offered	Total Falls Urgent Community Response - Accepted Referrals Transitional Care Activity

Executive Summary

Safe

✓ Total LCHS Patient Medication Incidents has decreased in September to 31 from 46 in August.

X Total Community Hospital Falls performance rates per 1000 OBD has increased from 3.61 for August to 3.91 for September

✓ Injurious Community Hospital Falls performance rates per 1000 OBD is 0 for this reporting month.

✓ MRSA compliance achieving target.

✓ Patient Incidents Community Rate per 1000 WTE decreased from 229.80 in August to 221.41 in September.

Caring

X FFT scores not achieving 95% target.

X Complaints have increased from previous month.

X Compliments decreased slightly from the previous month.

Responsive

✓Performance against the UTC targets-4-hour waits is achieving the 95% target

X Home Visiting performance is not achieving 95% target and is not capable of doing so without redesign

X 15-minute Ambulance Handover is not achieving 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

✓ Community Hospitals Pressure Ulcers rate per 1000 OBDs – decrease from previous month

✓ Environmental Cleanliness achieving target.

✓ Bed Occupancy rate is achieving 89% while the target is at 85%.

X Average Length of Stay is not achieving the 16 Day target

✓ Chlamydia positivity rate of 15-24 years old achieving target.

✓ LiSH GU patients seen within 2 working days continues to meet target.

Well-Led

✓ Valid NHS Numbers for A&E Data Sets achieving the 95% target.

X Ethnicity in A&E Data Sets not achieving 95% target

✓Staff Turnover is within the 15% target.

✓ Year to date agency expenditure is within plan.

X Month 06 position is -£3k unfavourable to plan.

✓ Overall efficiency (CIP) ahead of plan.

X Cash balances are slightly lower than forecast.

X Better Payment Practice Code (by volume) is not achieving the 95% target

X Capital expenditure is in behind plan.

X Vacancy rate is not 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.

✓ Long-Term Sickness Absence has improved 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.

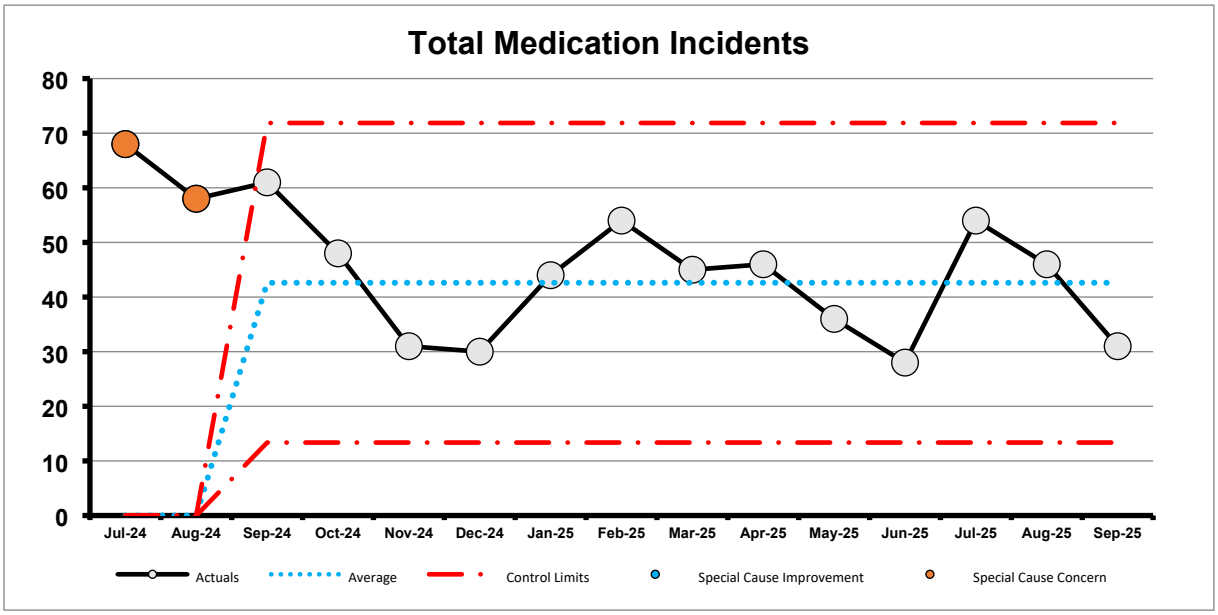
A medicine-related incident can pose a threat to the patient as well as the organisation. The member of staff who made the error can also be affected. Broadly speaking, medicine-related incidents encompass prescribing, preparation, dispensing, administration, and monitoring.

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.

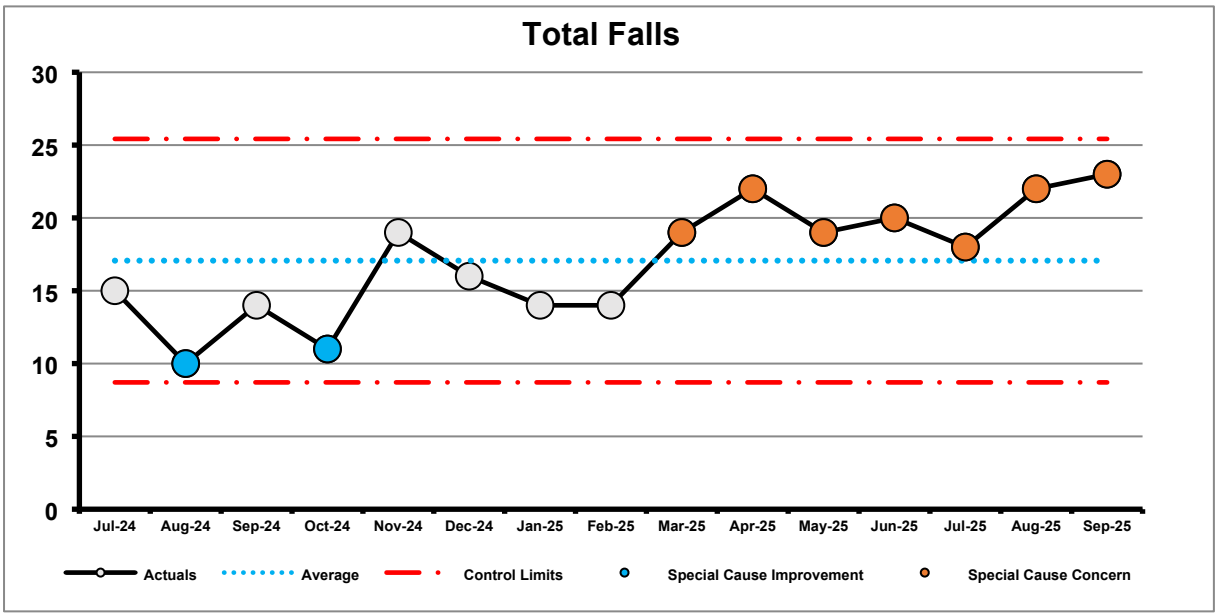
SPC

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

There has been a steady upwards trend for falls across LCHS since July 2024. Total trust falls currently reports falls for patients , staff and visitors to services across LCHS care environments. Falls with harm are low. However, changes to care pathways for patients in community hospitals (which remains the biggest areas for falls across LCHS) are being monitored to identify if this is affecting overall numbers of falls. Increases in D2A capacity will also mean an increase in falls are seen within this service as more and more patients are receiving this type of therapeutic care in their own home.

SPC

SPC shows that the Trust's total falls have shown special cause concern since March 2025.

Falls in Community Hospitals

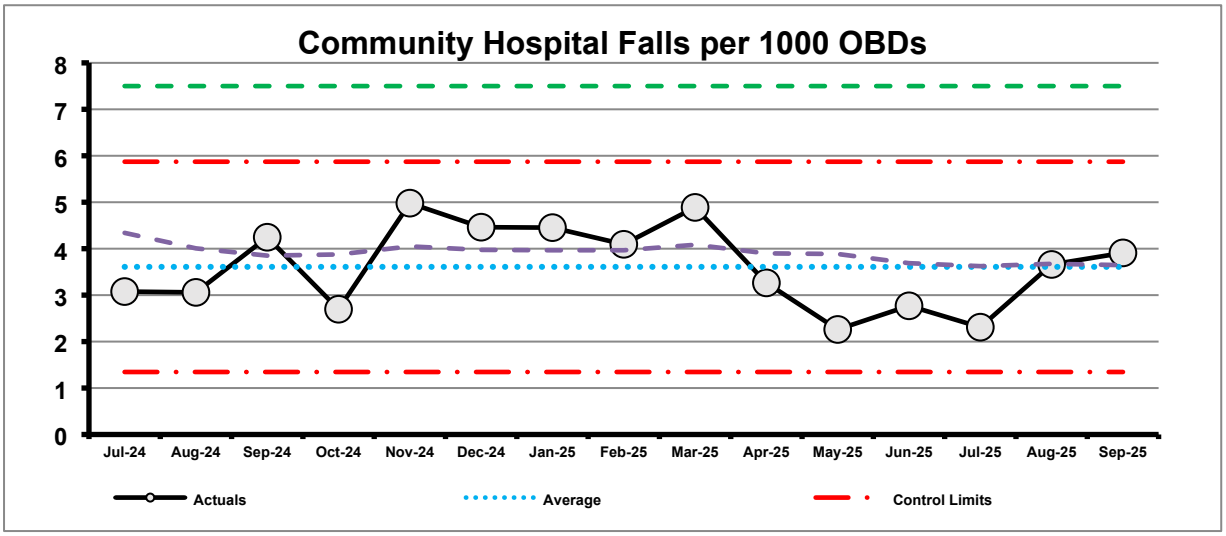
Background

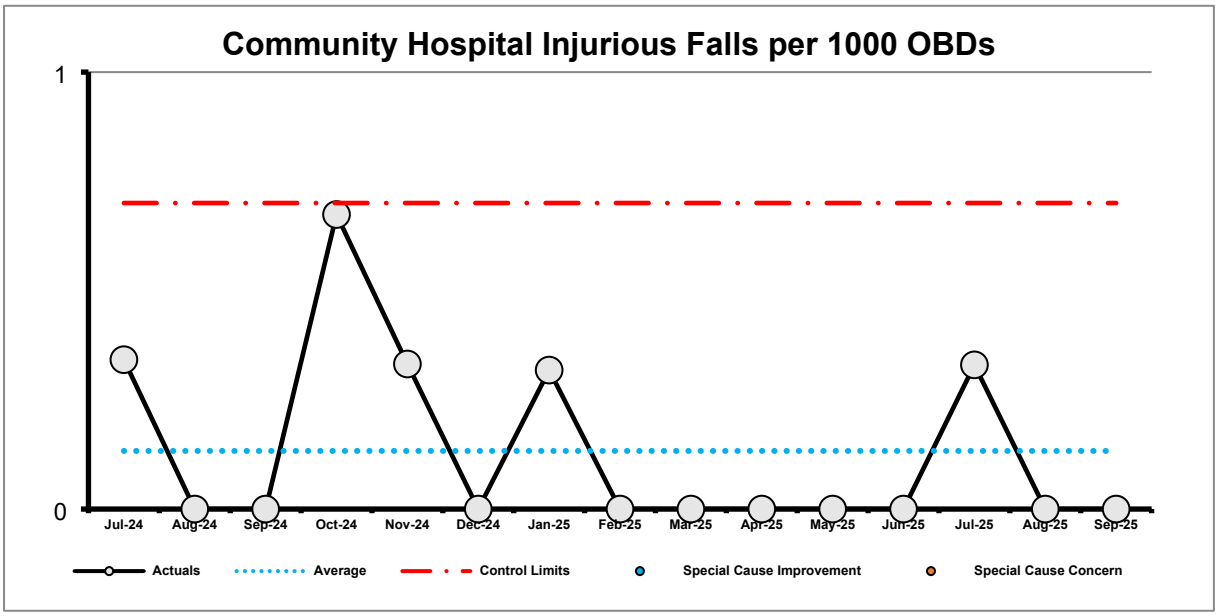
Falls take place in many services, but most falls take place in our community hospitals where the patients have additional levels of frailty and health related conditions which pose additional risk of falling whilst unwell and in an unfamiliar environment.

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





Narrative

Injurious falls within community hospitals are seen. Whilst levels remain low benchmarking with other similar organisations is currently not available. This is due to the removal of LCHS from the national benchmarking data set for cost savings. A similar benchmarking process for LCHS through model hospital remains in development. A quality improvement plan is underway within the community hospitals. This is monitored through Falls Prevention Group for LCHG and has seem a number of initiatives within the service and better alignment with group best practice roles. Enhanced Therapeutic Observations in Care is also under review for LCHG and will incorporate Community hospitals in its phased approach should this model be agreed.

SPC

Community Hospital Falls per 1000 OBDs

SPC shows the Community falls per 1000 OBDs has not varied significantly in this period.

Community Hospital Injurious Falls per 1000 OBDs

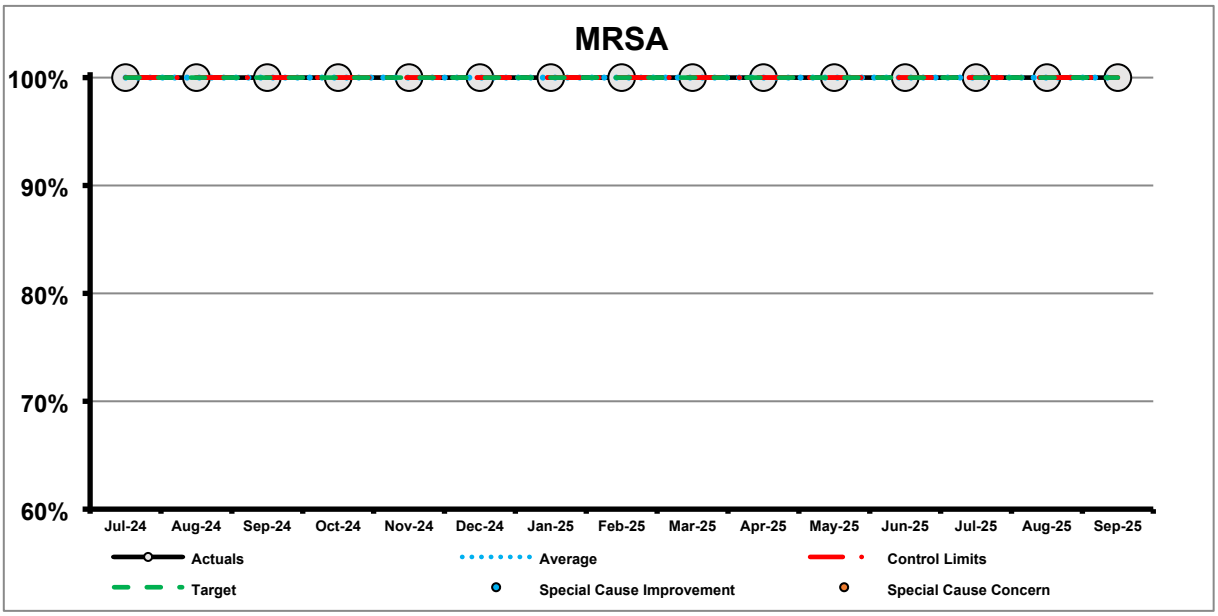
SPC for Community Hospital Injurious falls per 1000 OBDs has not varied significantly in this period.

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 132 patients admitted across all sites, 12 patients were eligible for MRSA screening, of which all 12 were screened.

SPC

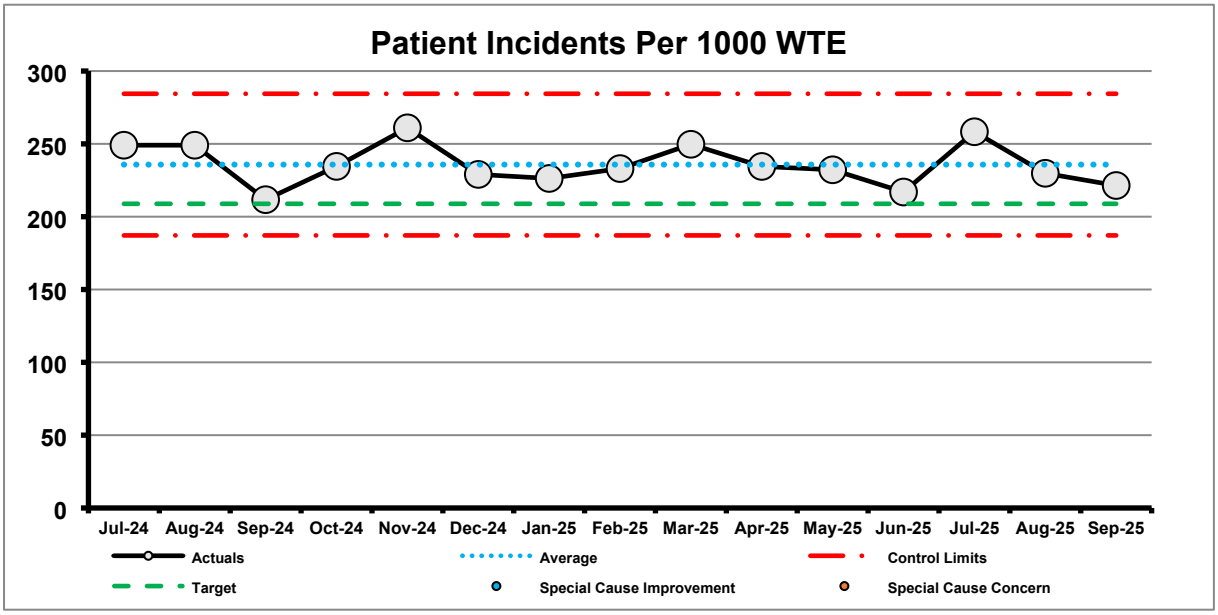
SPC shows MRSA screening compliance has not varied over the period.

Patient Incidents

Background
From 18 June 2017 NHS Improvement moved from six monthly reporting and began publishing monthly data by reporting organisation on the numbers of incidents reported to the National Reporting and Learning System (NRLS).

Benchmarking / Target
LCHS has been consistently a high reporter of incidents using the Datix system.

Current Performance



Narrative

- The graph shows LCHS patient safety incidents per 1000 WTE from 1st July 2024 to 30th September 2025.
- At the time of reporting:
  - CYPSS & IUEC are meeting trajectory around overdue Datix. The remaining divisions are taking actions to realign to trajectory by weekly quality review meetings with leadership oversight.
  - Duty of a candour continues to be tracked weekly. There continues to be improvement in the timeliness of Duty of Candour compliance.
  - There are zero Never Event investigations ongoing, nor have any been declared.

Actions

Each Service Line reviews the incidents monthly at their Quality Scrutiny Group meetings to identify any trends and themes.

The themes are considered to support triangulation of themes from incidents, claims, serious incidents, complaints, and other quality datasets.

Upgrade and redevelopment of the Datix system to Datix IQ is currently being implemented to bring LCHS in line with ULHT partners.

SPC
Patient Incident SPC has not varied significantly in the period.

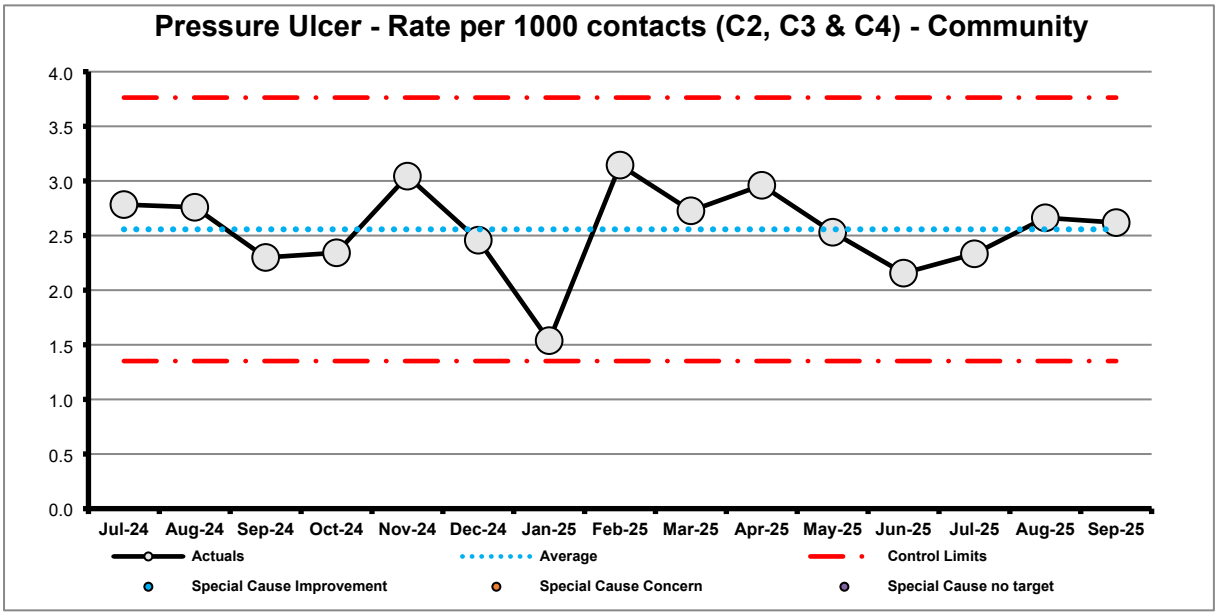
Community Pressure Ulcers – Rate per 1,000 contacts

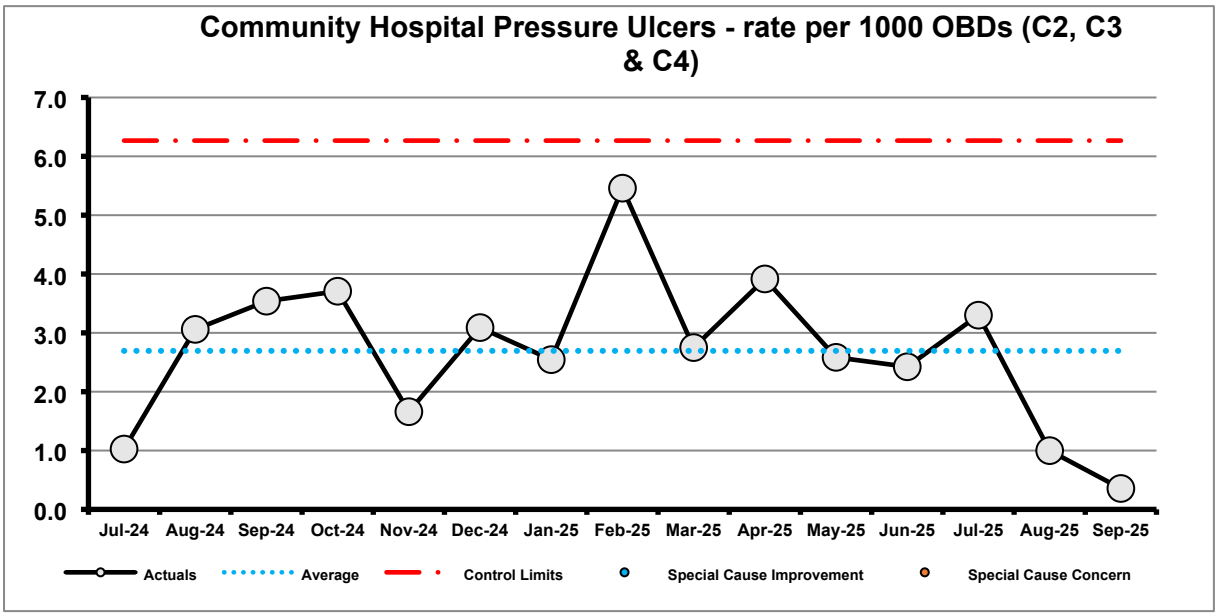
Background
All pressure ulcers grade's 3 and 4 are classified and recorded as serious incidents. There is no distinction between avoidable and unavoidable in cause.

Reduction in patient harm related to pressure damage is the highest priority objective for the Lincolnshire Safeguarding Adults Board.

The Lincolnshire System Quality Group have agreed their first quality priority to be pressure damage – eradication of harm, standardising and improving care.

Current Performance





Narrative for Community:

Pressure Ullcers per 1000 conatacts have slightly reduced in September and are still within 2.5 per 1000 contact. Work continues at a team level to look at targeted support.

Narrative for Community Hospitals:

Significant fall in Community Hospitals and are an area that we are focusing on and number of projects in place. We are seeing a downward trend and will continue to monitor.

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.

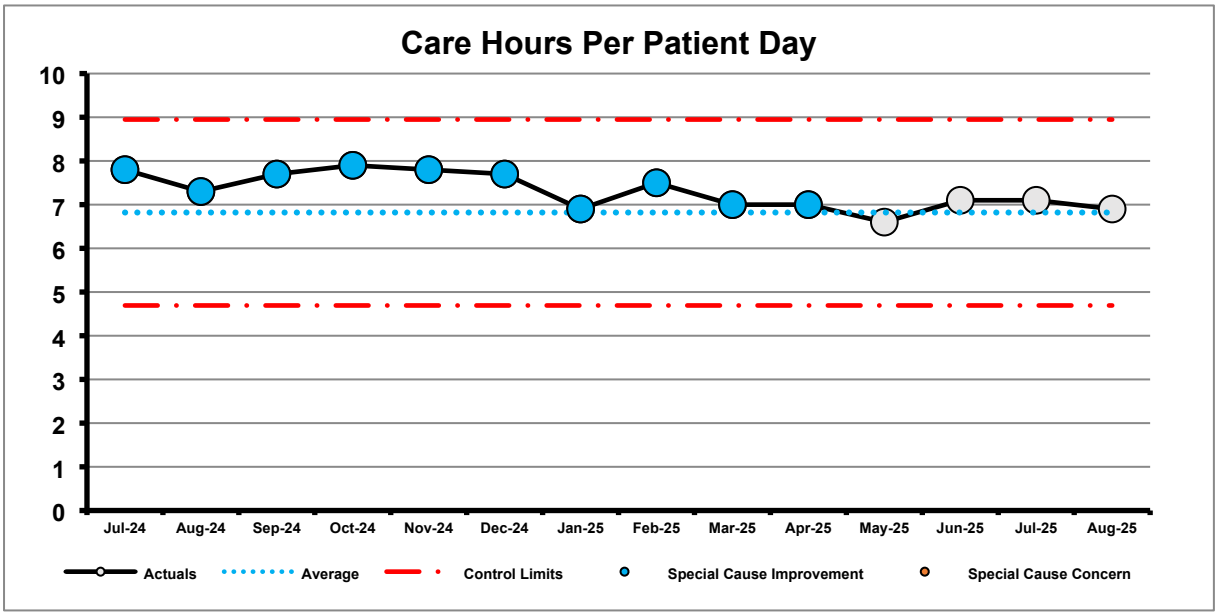
Care Hours Per Patient Day (CHPPD)

Background
Care Hours per Patient Day (CHPPD) is a simple calculation derived from dividing the number of actual care hours provided by the number of inpatients in a 24-hour period used as measure across inpatient areas.

While it is recognised that the needs of patients using these community services are often quite different, the CHPPD measure provides a representation of the number of care hours available to patients and is a measure that enables wards/units of a similar size, speciality, and patient group to be compared.

Target
There is no agreed target, but the CHPPD rate should be considered alongside other quality and safety metrics contributing to safe staffing.

Current Performance



Narrative

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 through 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

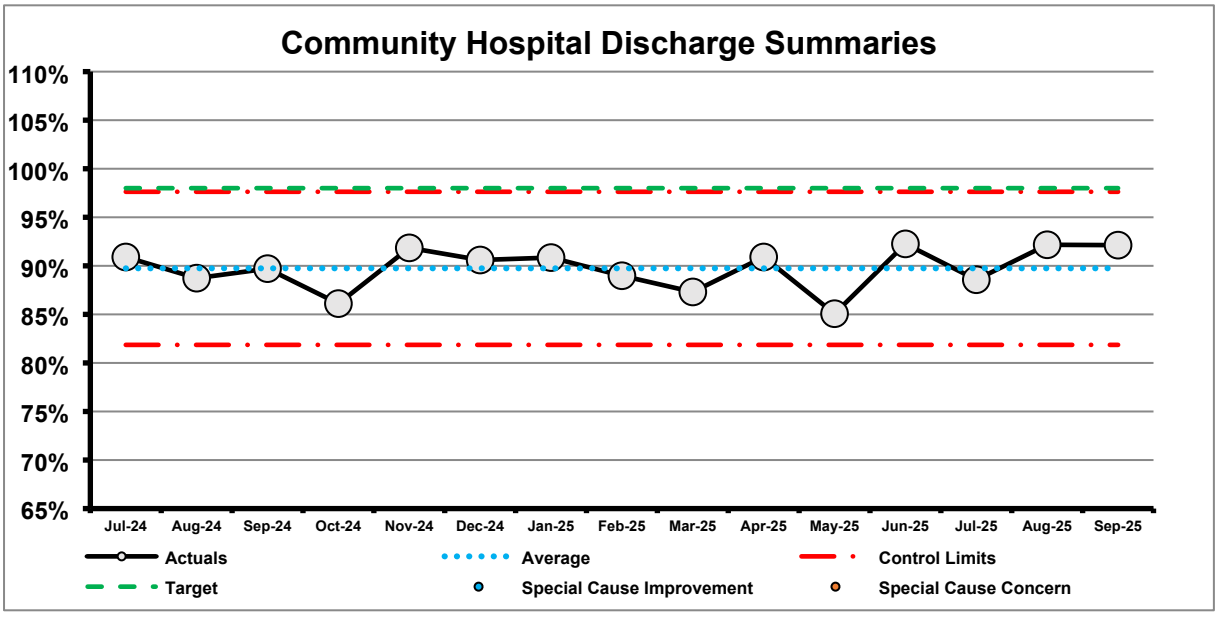
Care Hors per Patient Day and has not varied significantly in August. We are still waiting for September's data.

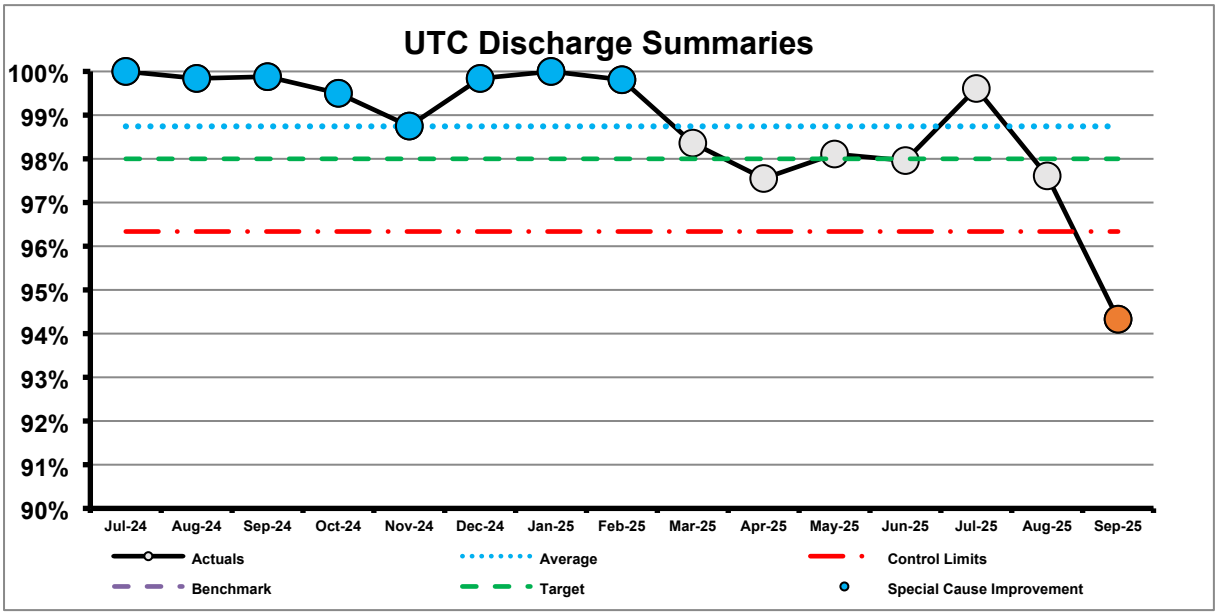
Discharge Summaries

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. Focused piece of work to start to look to increase this over next 3 months.

Urgent Treatment Centres

September has seen a slight decrease in discharge letters being sent to GPs in a timely manner, the hotspots are Louth UTC and Skegness UTC. We are currently doing a deep dive in to this, and this will be present on the narrative next month, The remaining UTCs remain at acceptable percentages of letter's being sent

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, showing special cause concern in September 2025.

Overdue & Reported Datix

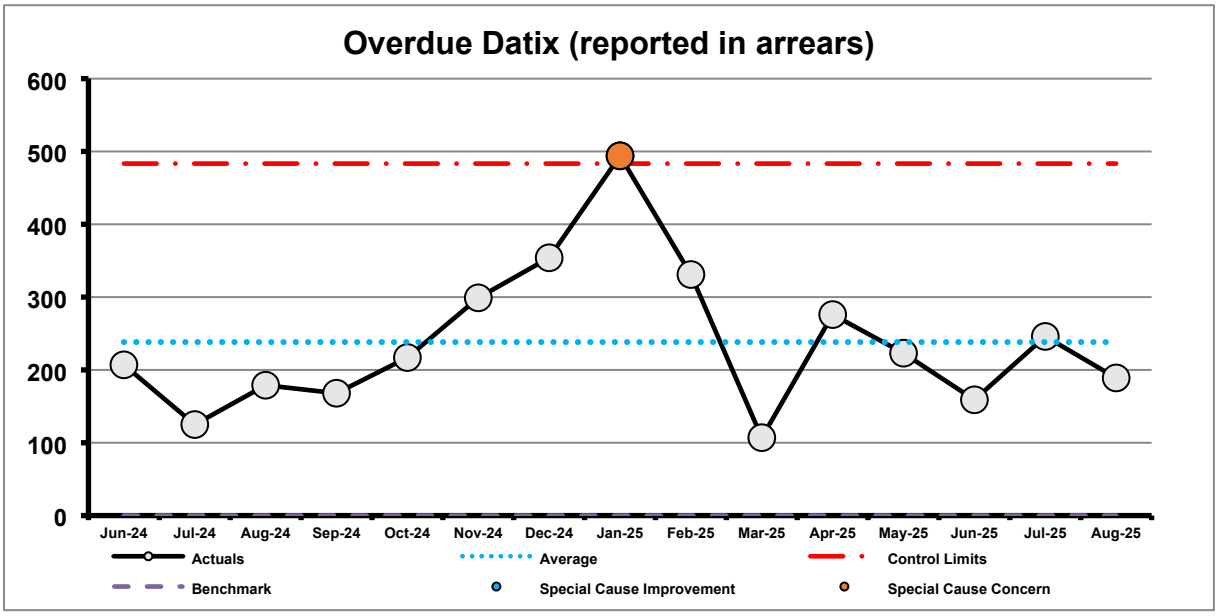
Background
When a Datix is raised to alert or escalate an incident (IR1 form) – it is imperative that the details are reviewed and considered in terms of any immediate actions that have or should be taken particularly regarding patient and staff safety.

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)

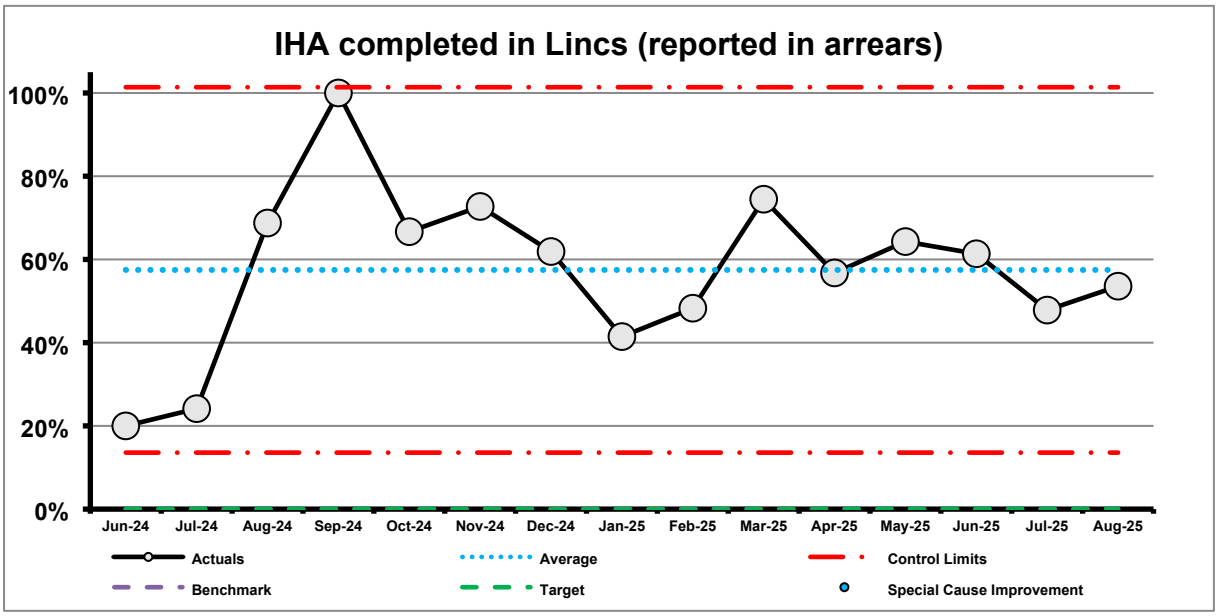
Background

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



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 in March 2025 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 August, 28 children were in cohort to be assessed in Lincolnshire, and 15 received an initial health assessment within 20 working days of them becoming looked after. Although the CIC team actively follows up on late and overdue requests, delays often stem from social workers not completing the necessary paperwork on time and limited appointment availability and travel time for necessary home visits.

SPC

The SPC for IHA Performance has not varied significantly in the period.

Environmental Cleanliness

Background
The cleaning company contract with provider OCS through NHSPS shared services began in 2022.

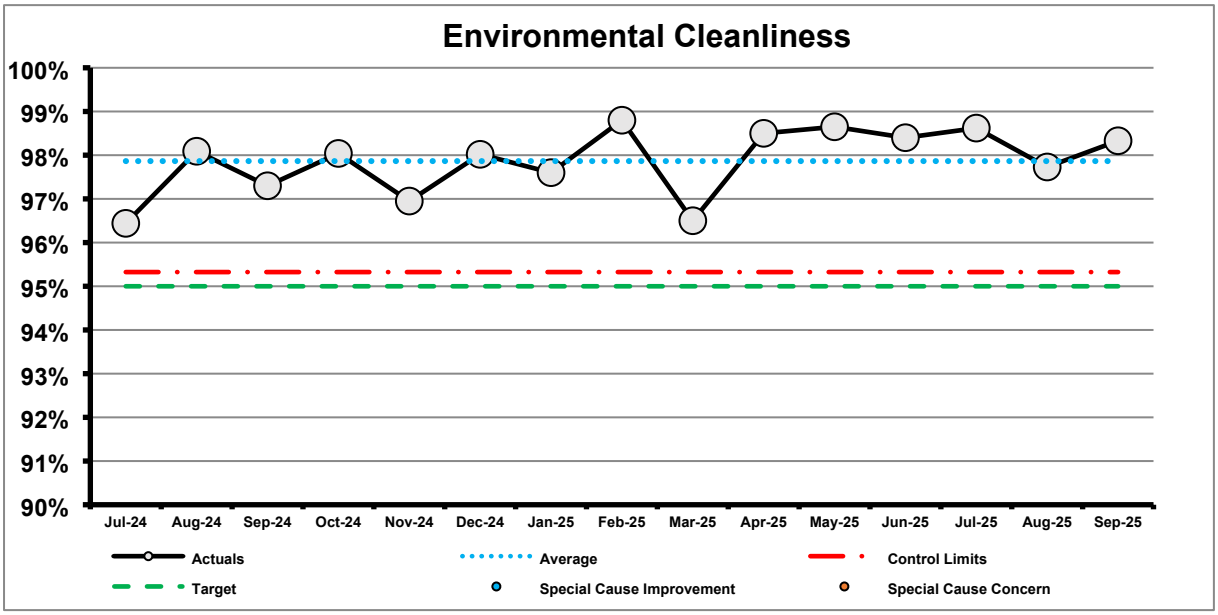
The requirements of the new National Standards of Healthcare Cleanliness that were published at the end of April 2021 have been rolled out across all LCHS community premises by OCS as well as being adopted by NHSPS and the in-house teams at the hospital sites.

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 98.33% 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

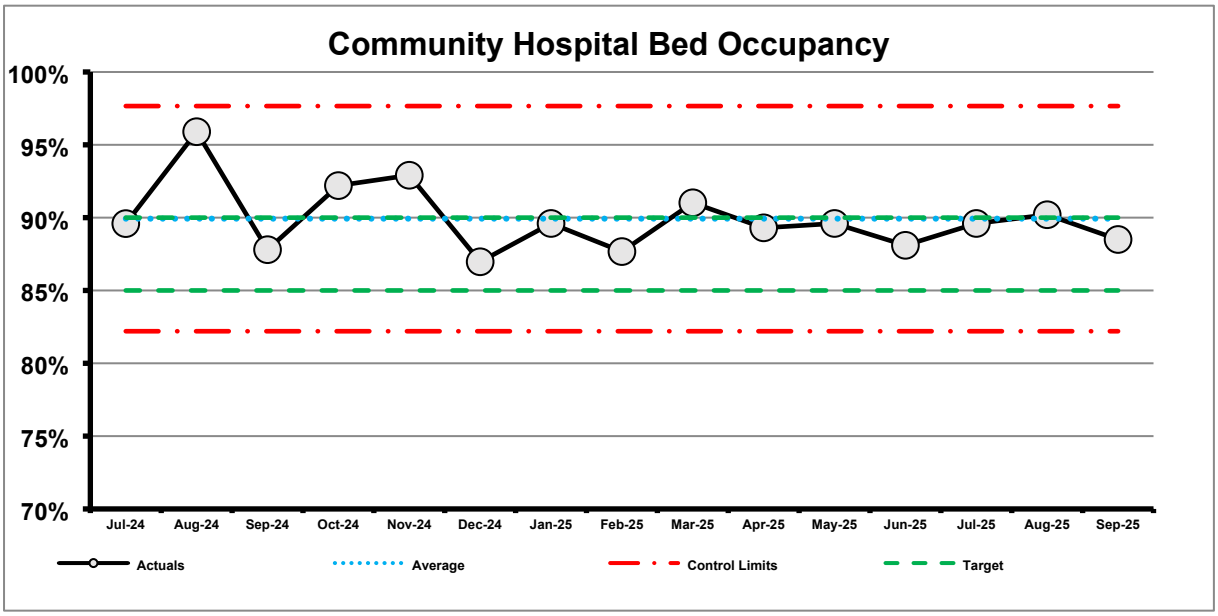
Background

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



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. Occupancy has slightly dipped to 89%.

SPC

SPC shows the Community Hospital bed occupancy performance has not varied significantly over this period.

Average Length of Stay

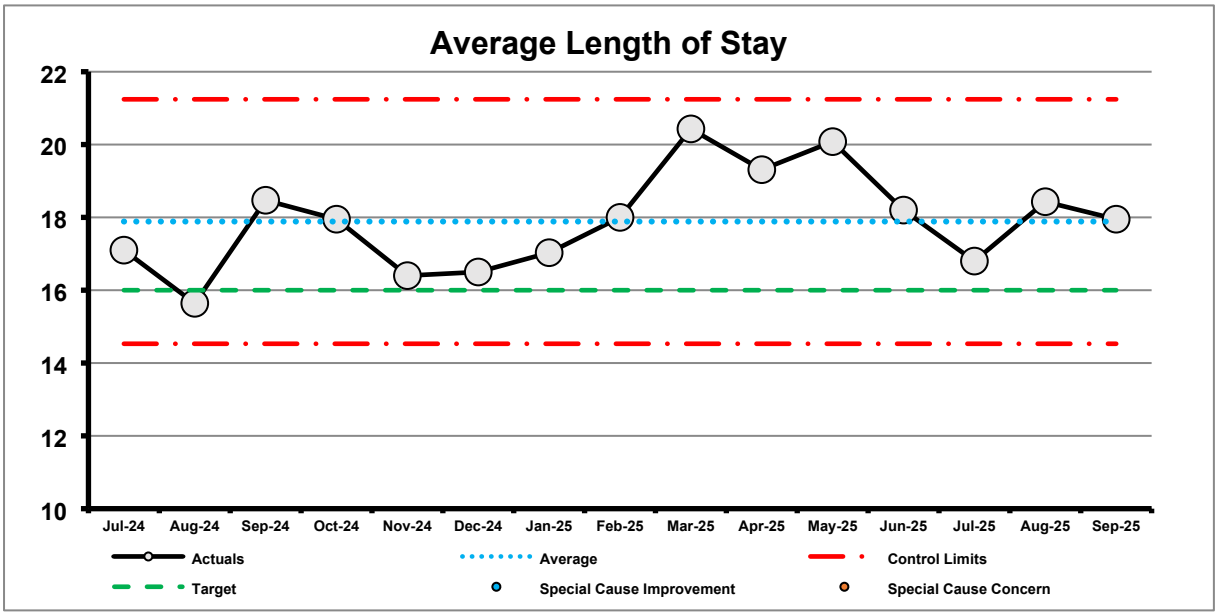
Background

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. We have one patient who has been unable to leave hospital due to not having suitable accommodation for their needs, this has affected the length of. The team have been supporting this patient find a suitable home and we are hoping they will be leaving within the next few weeks.

SPC

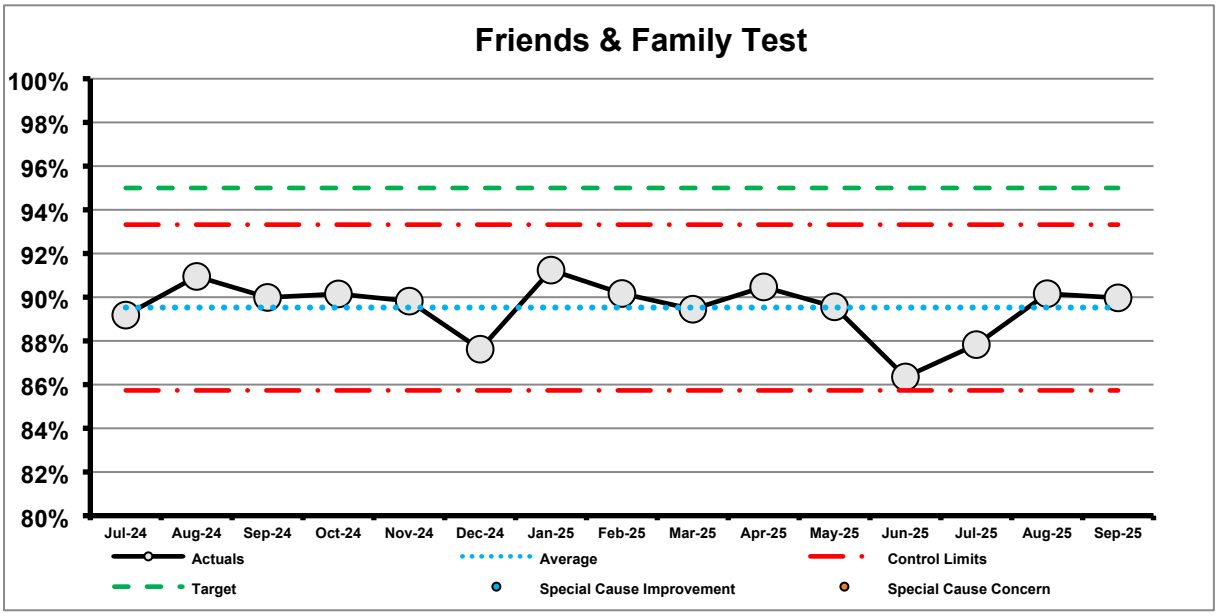
Average length of stay SPC has not varied significantly in this period.

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 September (89.97%) shows a slight decrease on last month's performance activity (90.16%).

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

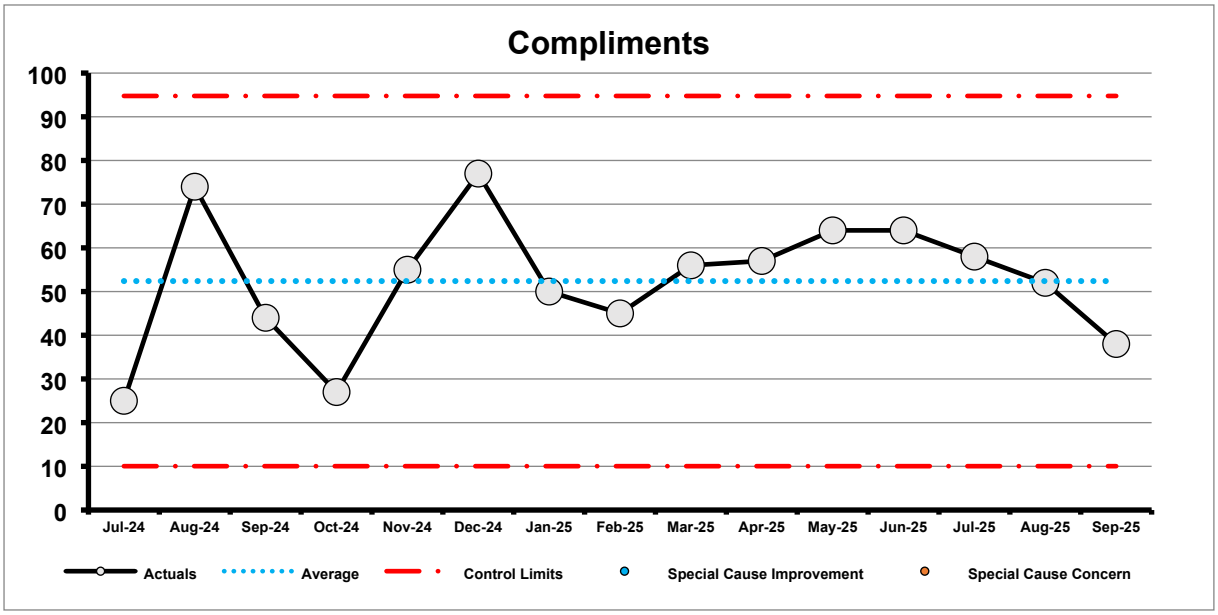
Background

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 from 52 to 38 in September, however there are outstanding Compliments to be logged. The Compliments that have been logged are mainly Community Hospitals (19) Children's and Specialist Services (8), Collaborative CC (1) and Urgent Care (3). The pals and complaints team also received 7 this month.

SPC

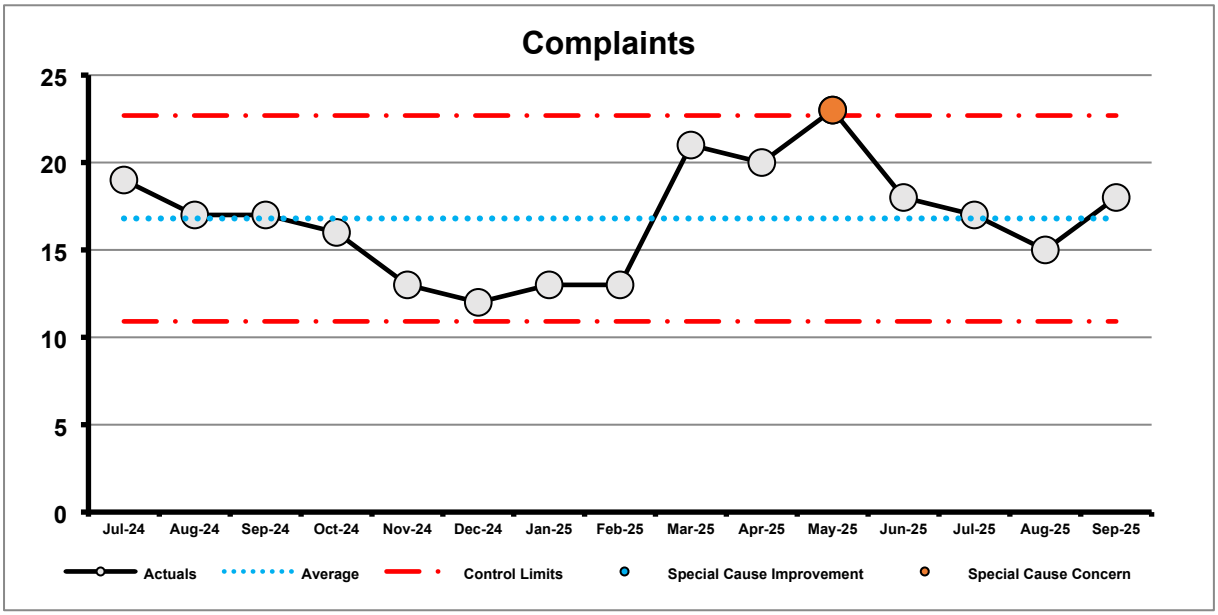
SPC shows that compliments have not varied significantly in the period.

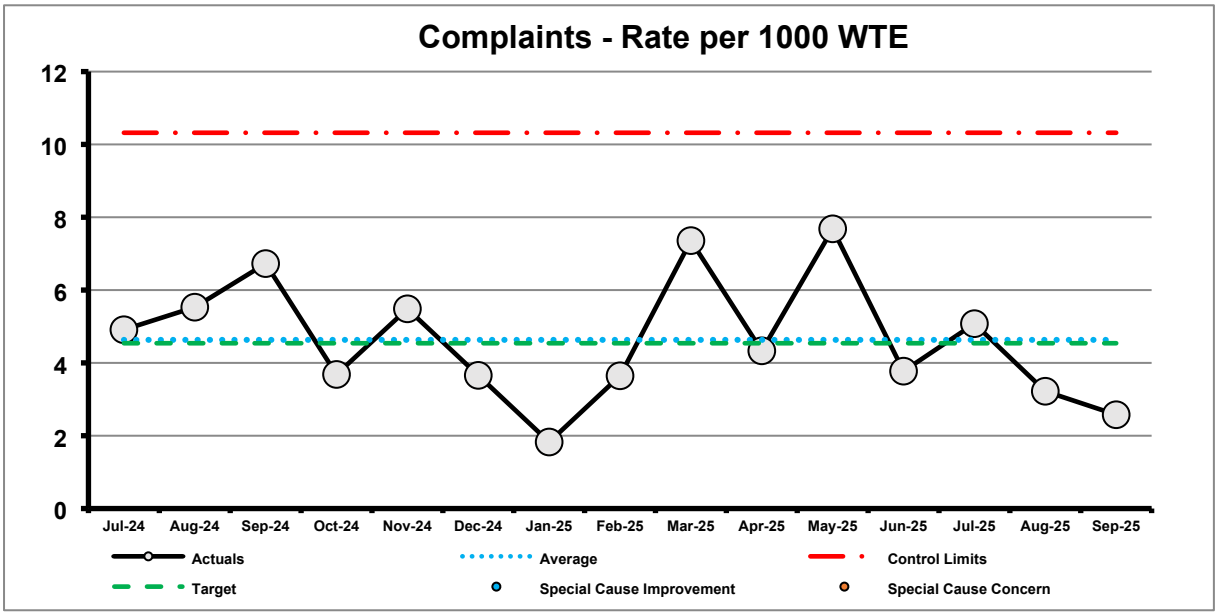
Complaints

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.

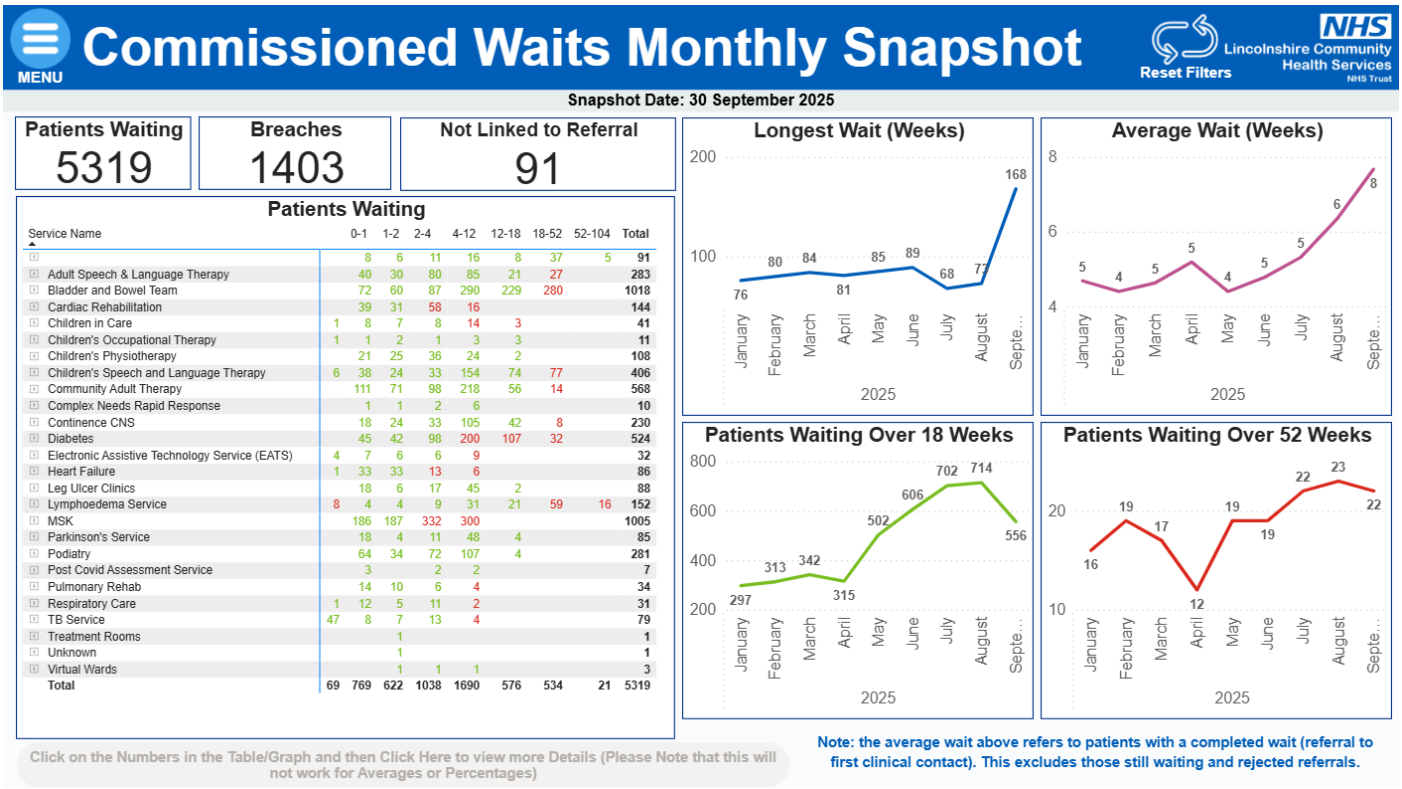
SPC

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.



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 September 2025, 15 services have patients waiting in excess of the service's maximum target wait time including Lymphoedema who have 16 patients waiting longer than 52 weeks. 89.6% of patients are waiting less than 18 weeks. 0.4% of patients across services are waiting more than 52 weeks.

The Lymphoedema Service are working to establish a clinic in Sleaford. This expansion will enable an additional 20–25 appointments per week, helping to reduce current wait times. Following a review of the contract and service specification, patients with Lipoedema will now be redirected to their GP Practice, along with appropriate treatment advice. Work has also commenced on developing a pathway in collaboration with the Lower Limb Service. This aims to support the assessment and garment fitting for patients with mild to moderate lower limb lymphoedema following triage.

The agreed target waits for those services currently utilising the clock are outlined below.

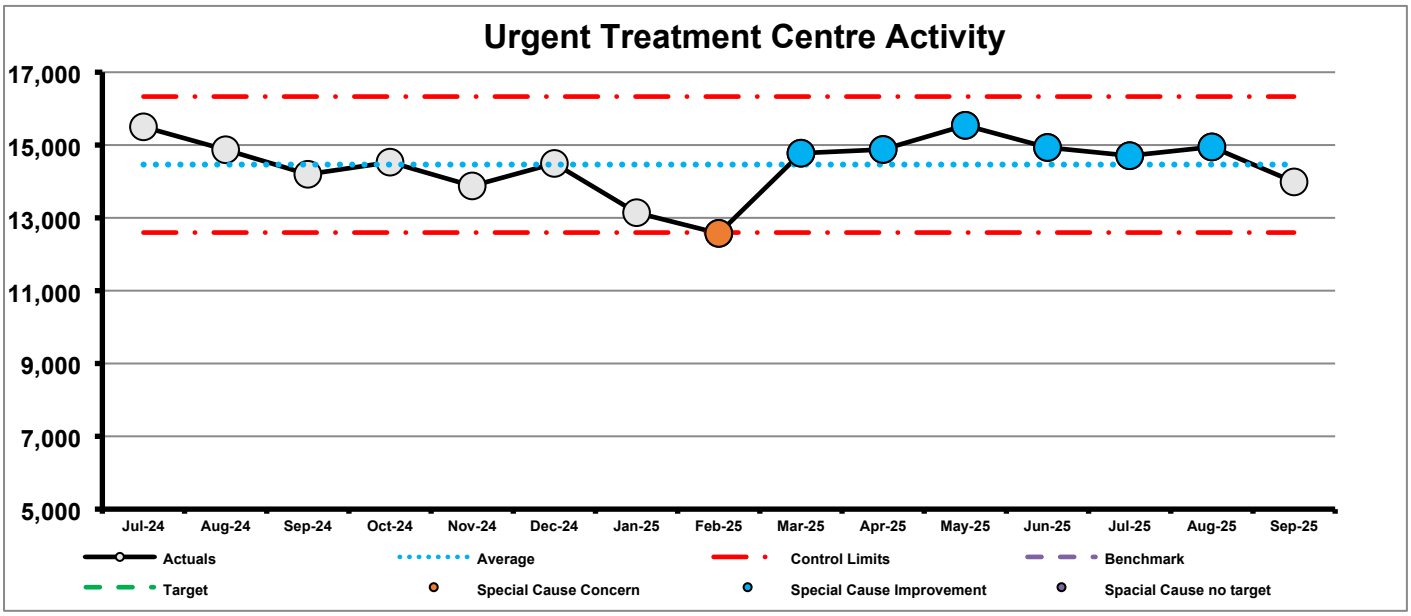
Service	**Target Wait**
Adult Speech and Language Therapy	18 Weeks
Bladder and Bowel	6 Weeks
Cardiac Rehabilitation	10 Working Days
Child Therapy	18 Weeks
Children in Care	20 Working Days
CNS Continence	18 Weeks
Diabetes	4 Weeks
Electronic Assistive Technology Service	6 Weeks
Heart Failure	2 Weeks
Musculoskeletal 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 September 2025, UTC attendances slightly declined from August, however they remain consistent with activity seen in for the same period in 2024. While this reflects a minor reduction, activity levels remain within expected seasonal norms and are consistent with national trends across urgent care services. Seasonal variation continues to be a key driver of UTC demand, with local data closely mirroring national patterns.

Looking ahead, a modest decline in attendances is anticipated, particularly at coastal sites, as seasonal visitor numbers decrease heading into winter. This is consistent with trends seen in other coastal regions nationally. In preparation, we are closely monitoring attendance data to support agile service delivery. This enables us to identify demand fluctuations early and optimise staffing and resource allocation, maintaining safe and effective care.

Despite short-term fluctuations, UTC activity has remained stable since September 2024, demonstrating the effectiveness of our strategic planning and proactive demand management. As we transition into winter, our focus remains on responsive service delivery to ensure patient needs continue to be met efficiently.

Nationally, there is a broader upward trend in urgent and emergency care attendances, highlighting the increasing pressure on services. UTCs play a vital role in managing patient flow and alleviating strain on emergency departments, reinforcing their importance in supporting overall system resilience.

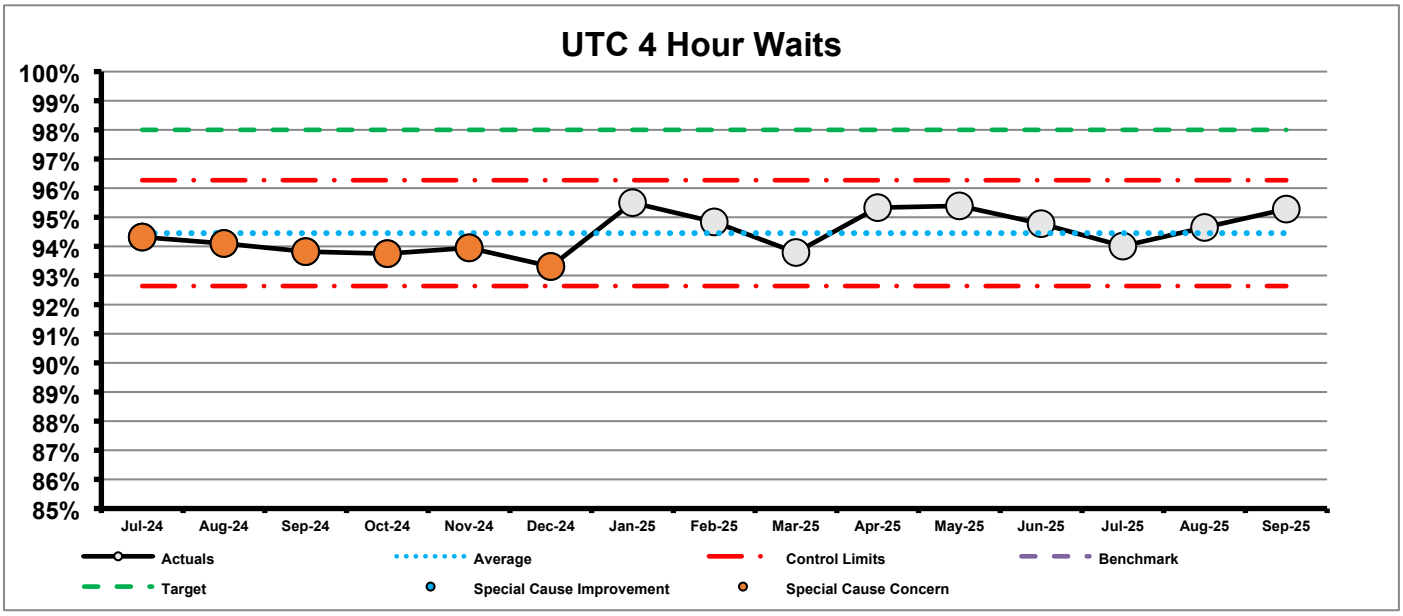
SPC

UTC activity performance has shown Special cause improvement in August 2025. UTC activity moved into normal variation in September 2025.

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

In September 2025, performance across the Urgent Treatment Centres saw a slight increase, with 95.28% of patients seen within the 4-hour standard. This sustained performance reflects continued efforts to improve patient flow and care delivery, supported by system-wide collaboration.

A key contributor to this progress is the increased consistency across UTC sites, enabled by proactive shared learning and operational alignment. Local UTCs continue to perform above the national average for 4-hour wait times—demonstrating the commitment of clinical and operational teams to delivering high-quality care in the face of ongoing system pressures.

While the local performance target of 98% remains aspirational, all sites are engaged in targeted improvement efforts. These include innovative service models, real-time pathway optimisation, and enhanced cross-sector collaboration. Structured initiatives are in place to close the gap, and gradual progress is being observed.

However, challenges persist—particularly at co-located UTCs in Lincoln and Boston—where external system pressures continue to impact delivery. Key issues include:

- Delays in specialty referrals (e.g. orthopaedics)
- Limited access to diagnostics (x-ray, pathology)
- Hospital bed pressures affecting admissions and discharge

These reflect broader national challenges across urgent and emergency care. In response, UTC teams are working closely with acute and system partners to escalate concerns and implement mitigation strategies. These include:

- Daily breach validation
- Early identification of delays
- Streamlined escalation to specialty services

These measures have been effective in maintaining performance above national averages, which in many areas continue to fall below 90%.

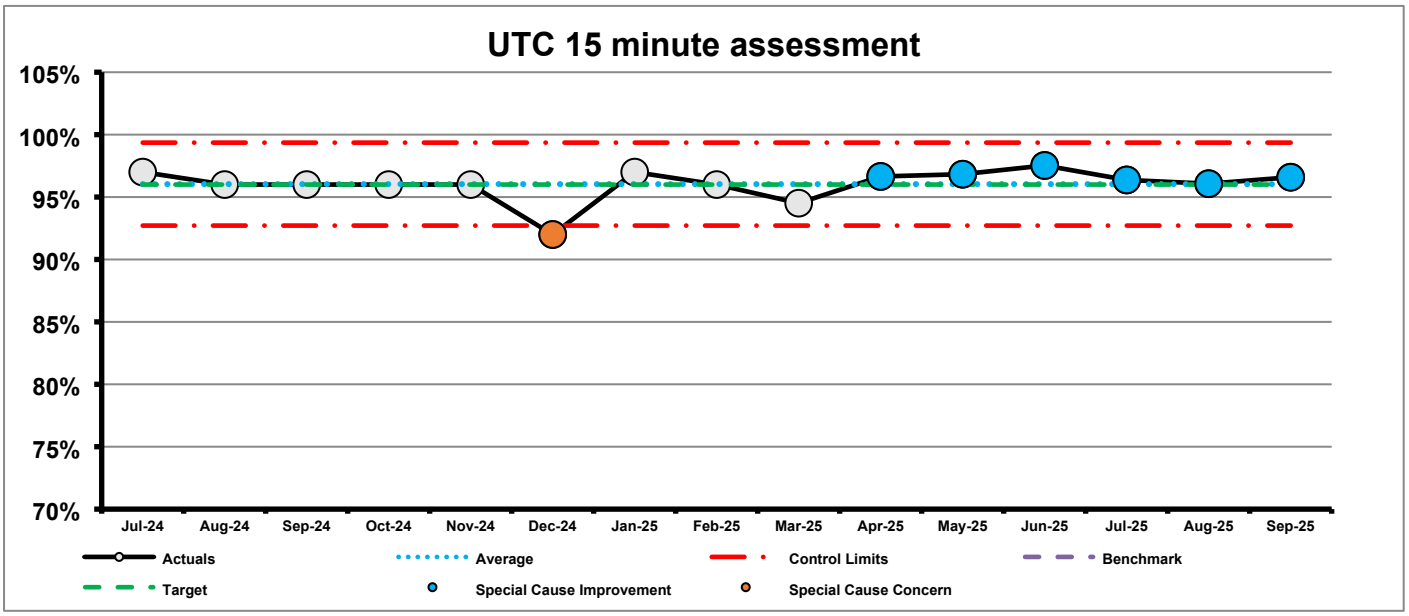
SPC

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.



Narrative

The Urgent Treatment Centres (UTCs) continue to deliver excellent performance in 15-minute initial patient assessments, with September achieving 96.59% which is slightly increased from the previous month. This still continues to exceed 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

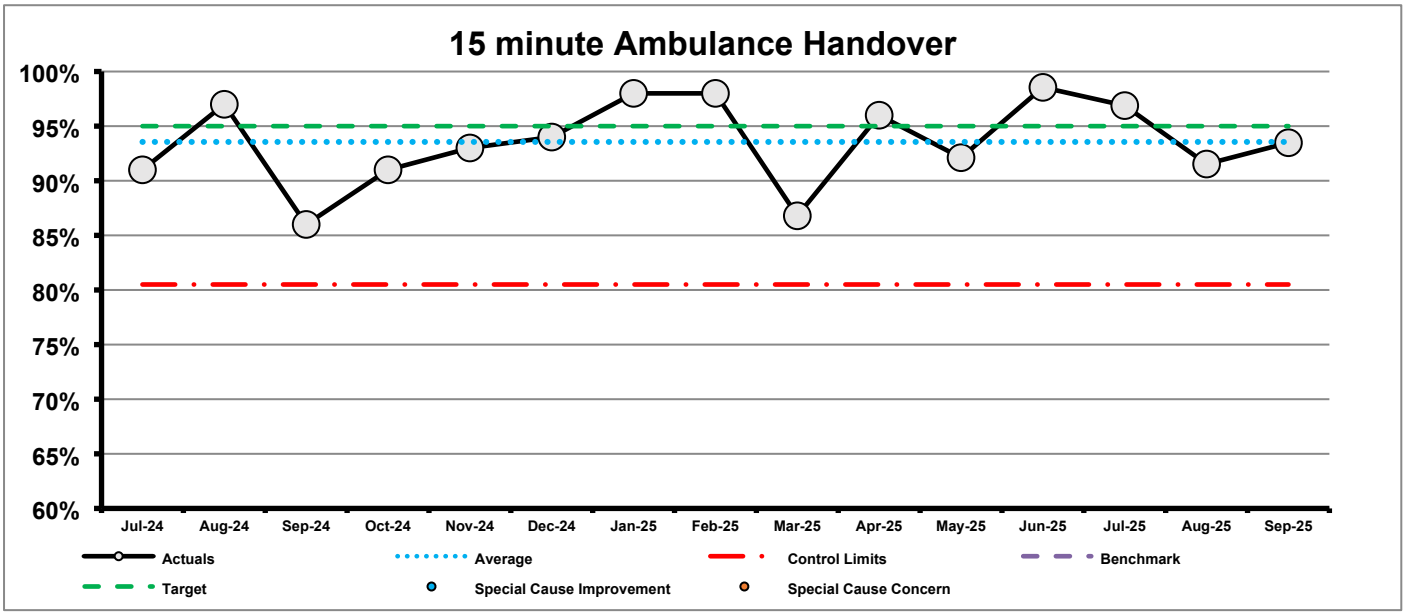
SPC

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 September 2025, 93.48% of ambulance handovers were completed within 15 minutes—an increase from the previous reporting period.

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

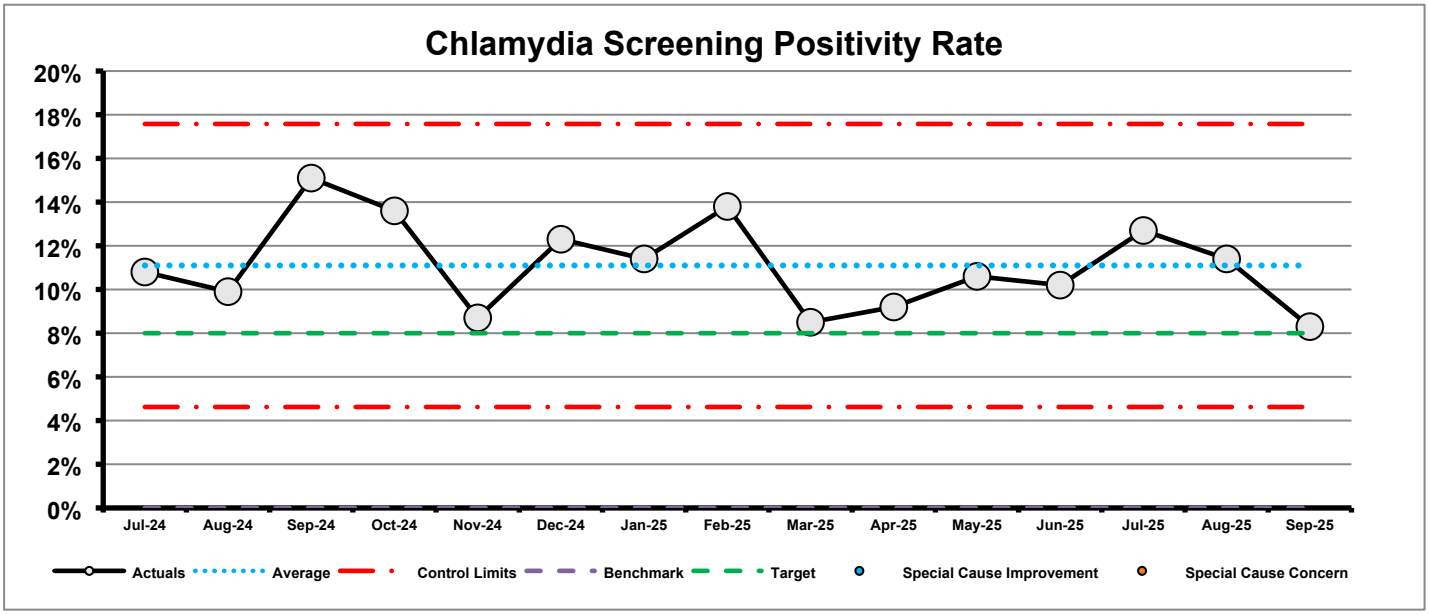
SPC

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.

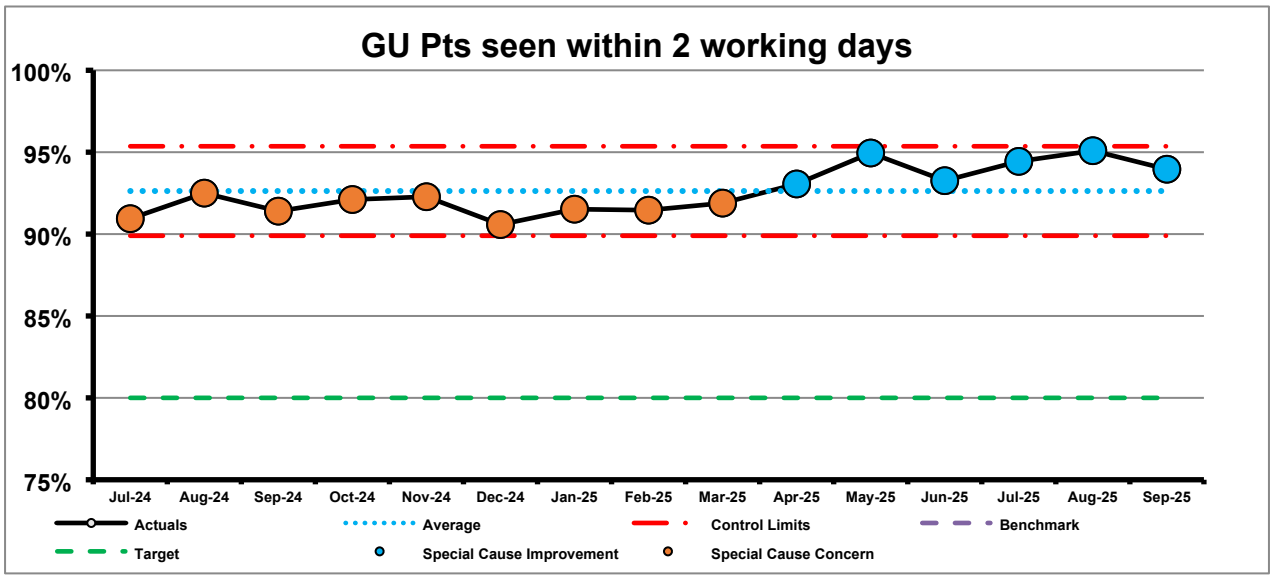
Actions

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



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.

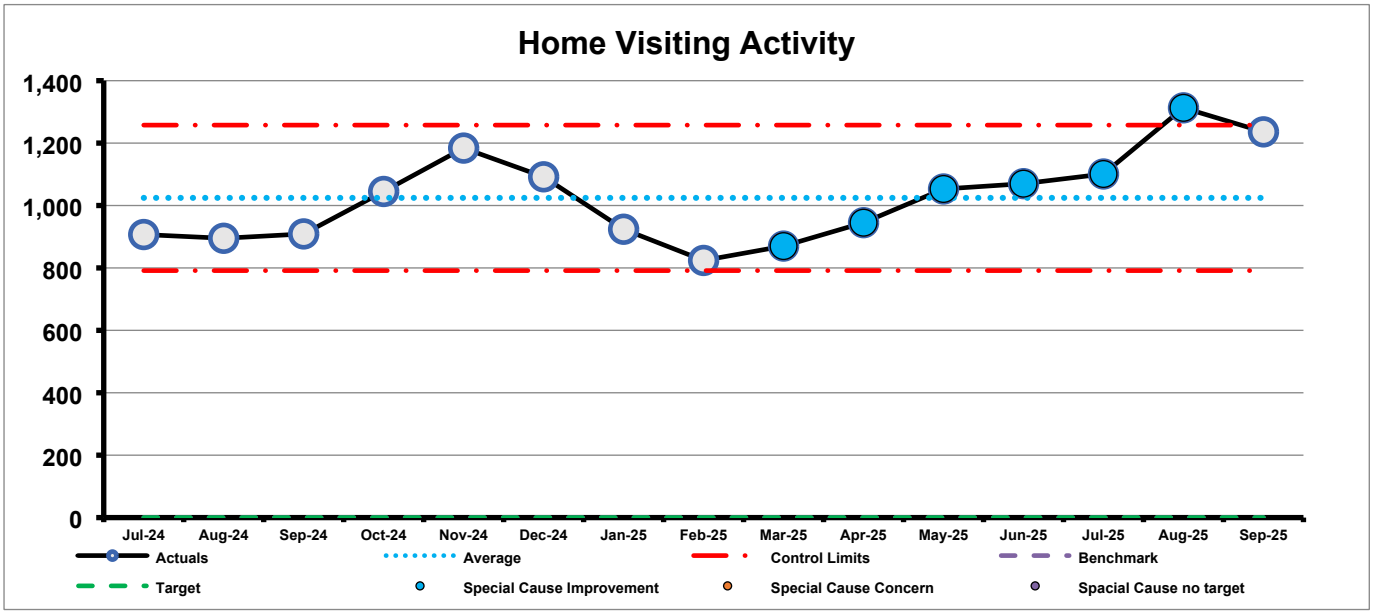
Home Visiting Report

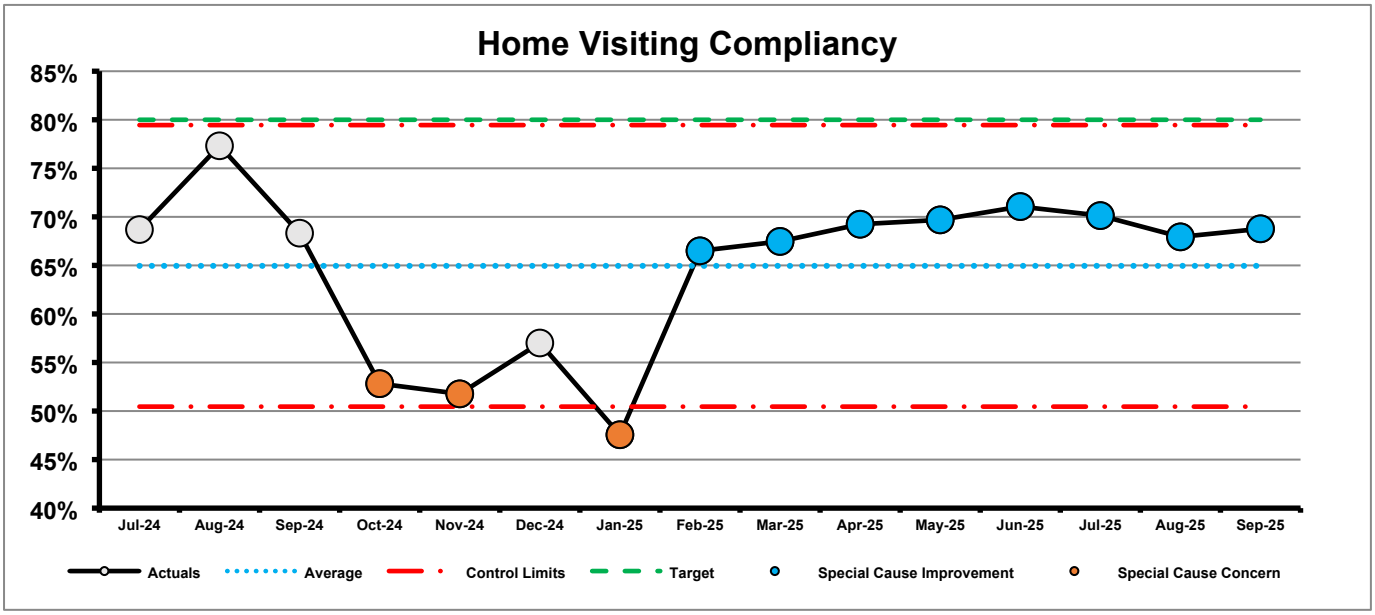
Background

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

These 1236 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 and ability to maintain this. We now have a process in place to support breach validation.

SPC

Home Visiting activity moved into normal variation in September 2025.

Compliance has not varied in the period and remains in Special cause improvement.

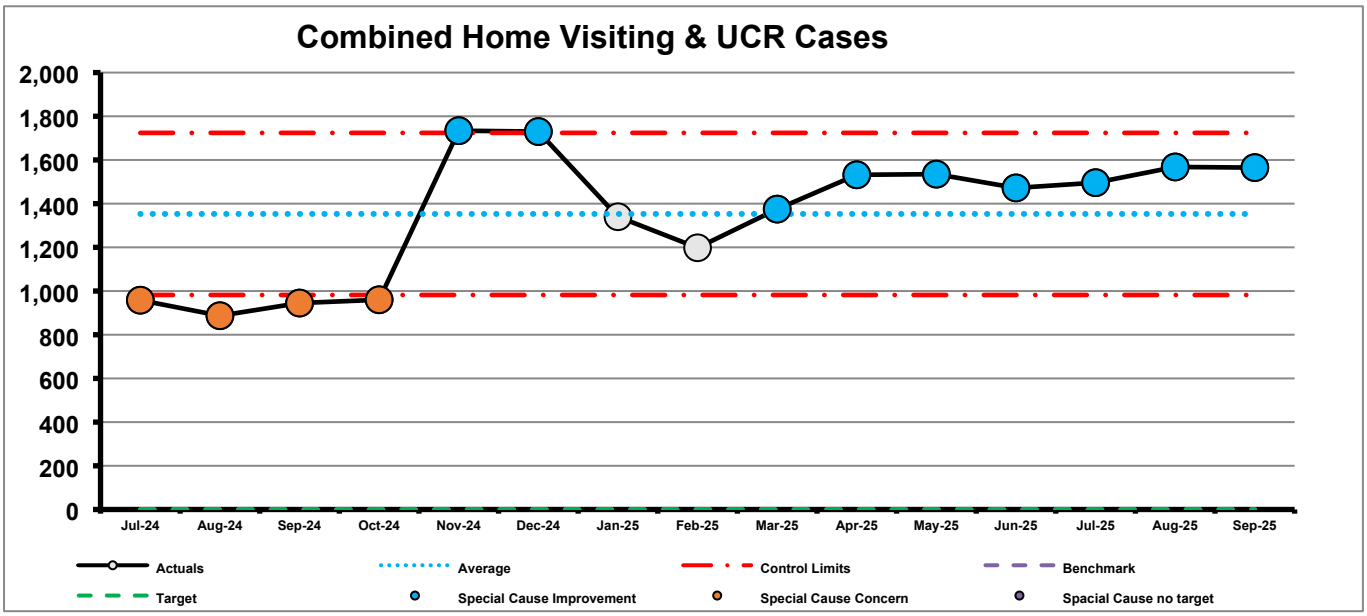
Urgent Community Response

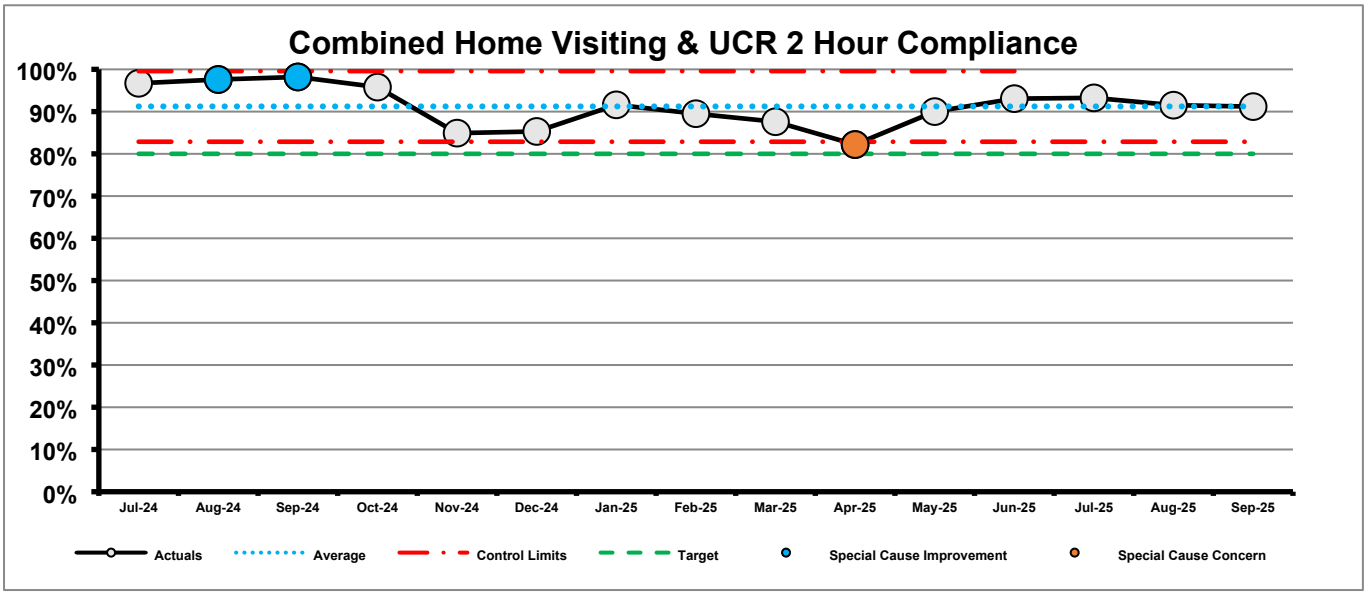
Background

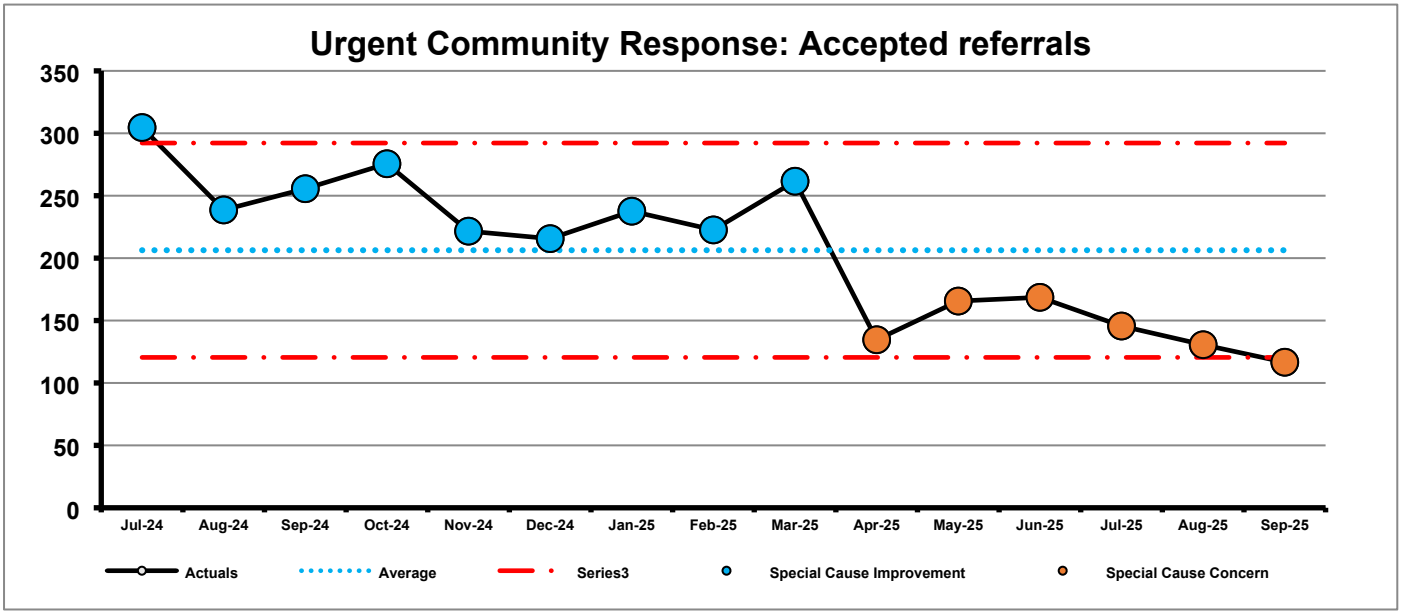
Urgent Community Response is a nationally directed service. The Urgent Community Response Team receives referrals from a variety of sources to support urgent response care services.

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.







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 September this was 1565. The compliance is achieved by measuring the time between the referral being made and the initial assessment (completed in CAS). A compliance of 91.18% 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 stayed in normal variation in the period.

Combined Home visiting & UCR cases remain Special cause improvement and has been in Special cause improvement since March 2025.

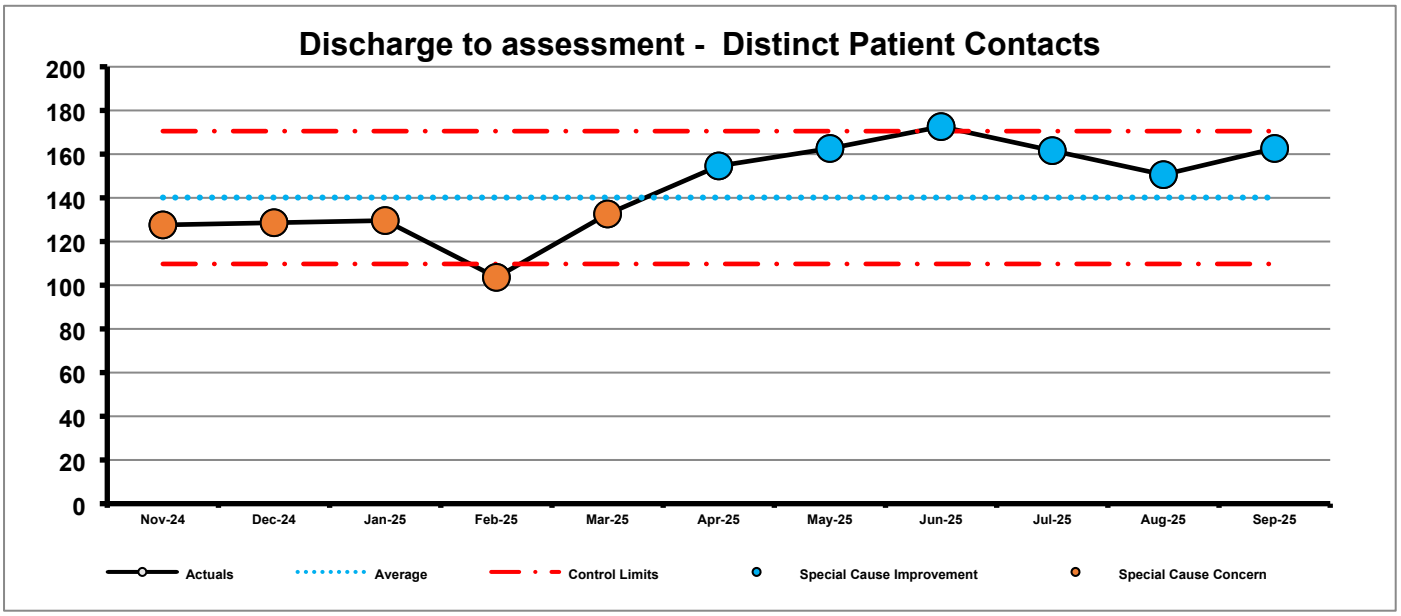
Urgent Community response accepted referrals remain special cause deterioration and has been in Special cause deterioration since July 2025.

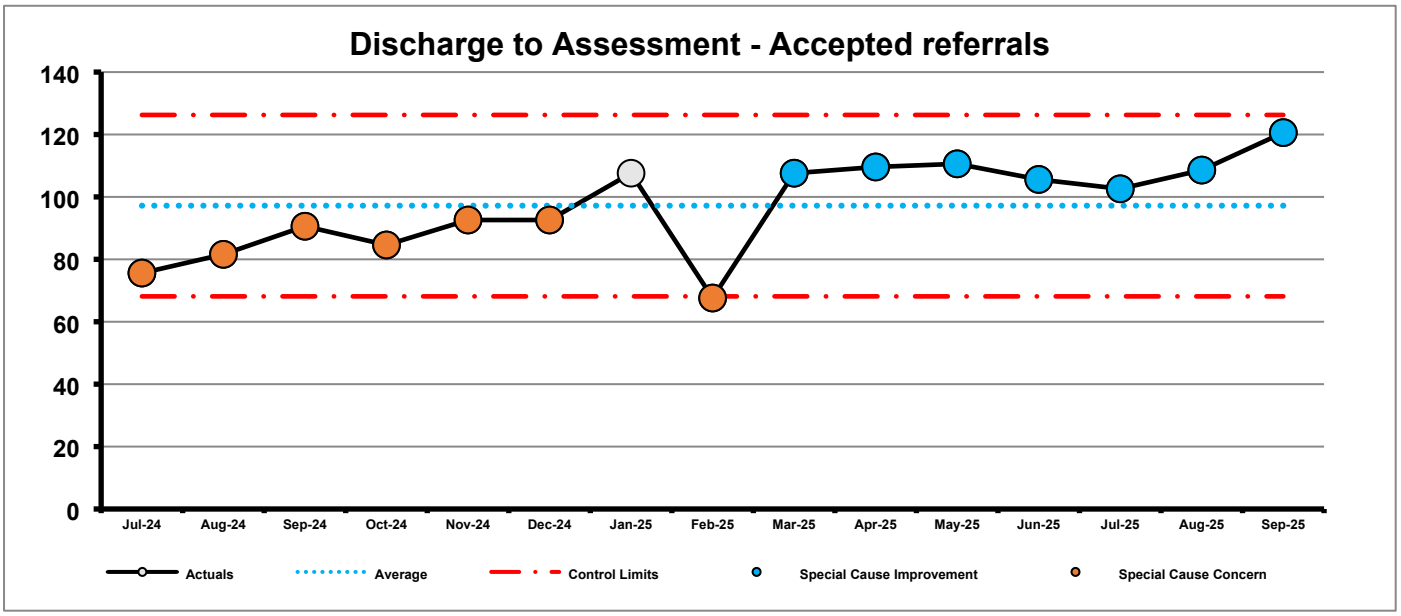
Discharge To Assessment

Background

The Discharge to Assessment programme has been introduced to expedite patients to leave acute care and return to their own home for reablement.

The service works closely with Adult Social Care and supports patients with a wide range of needs.





Narrative

The number of referrals accepted into the Pathway 1 D2A service further increased in September, remaining above average. The number of distinct patient contacts also increased.

D2A continues to work to promote earlier discharge from acute and community bed stock, commencing new ways of working (such as earlier community ‘pull’ from the acute stroke and community hospital wards). Work continues, with the aim of promoting timely discharges from acute sites, via the acute therapy and discharge hub teams.

SPC

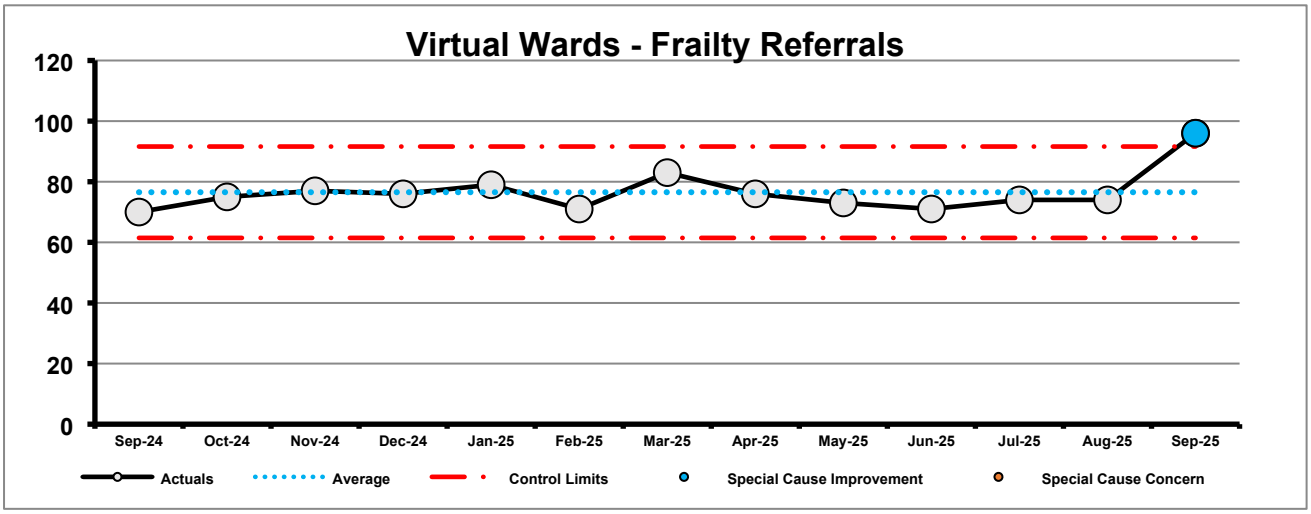
The number of distinct patient contacts remain above average and has remained in special cause improvement since August 2025.

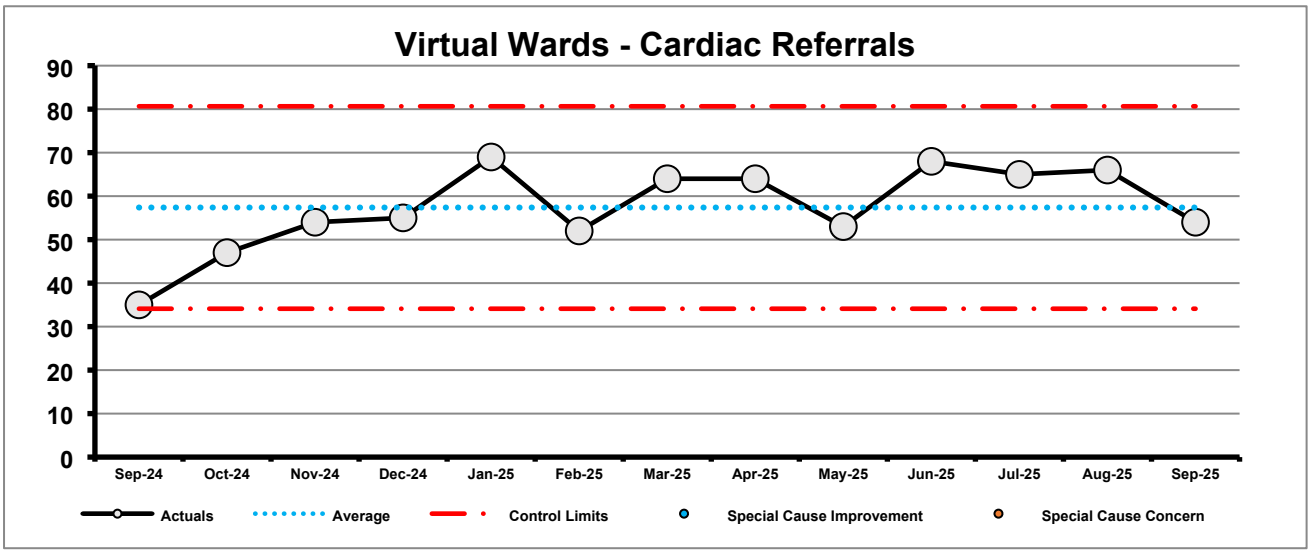
The number of D2A accepted referrals has moved into Special cause improvement and remains above average. The Number of D2A accepted referrals has moved into Special cause improvement in March 2025

Virtual Wards

Background

The Trust's current virtual ward offering includes frailty, cardiology and respiratory. The service closely collaborates with ULHT, and patients are cared for in the community, with guidance from ULHT consultants.





Narrative

Reporting continues to encompass frailty, respiratory and cardiology virtual wards. OPAT & SDEC data is being progressed with ULHT. FBI are supporting the virtual ward team, cross referencing the different reporting that currently takes place (e.g., NHSE, SHREWD and internal reports) to make sure that the data is consistent and that all virtual wards are included in all our reporting.

To be noted the number of beds for Frailty have increased from 20 to 25 as we continue to flex the 172 beds across the pathways to ensure capacity meets demand. This will be increasing further as the 10 Parkinson's beds have been moved from the Integrated Acute medical ward to Frailty but has not been represented in Virtual Ward performance data yet.

SPC

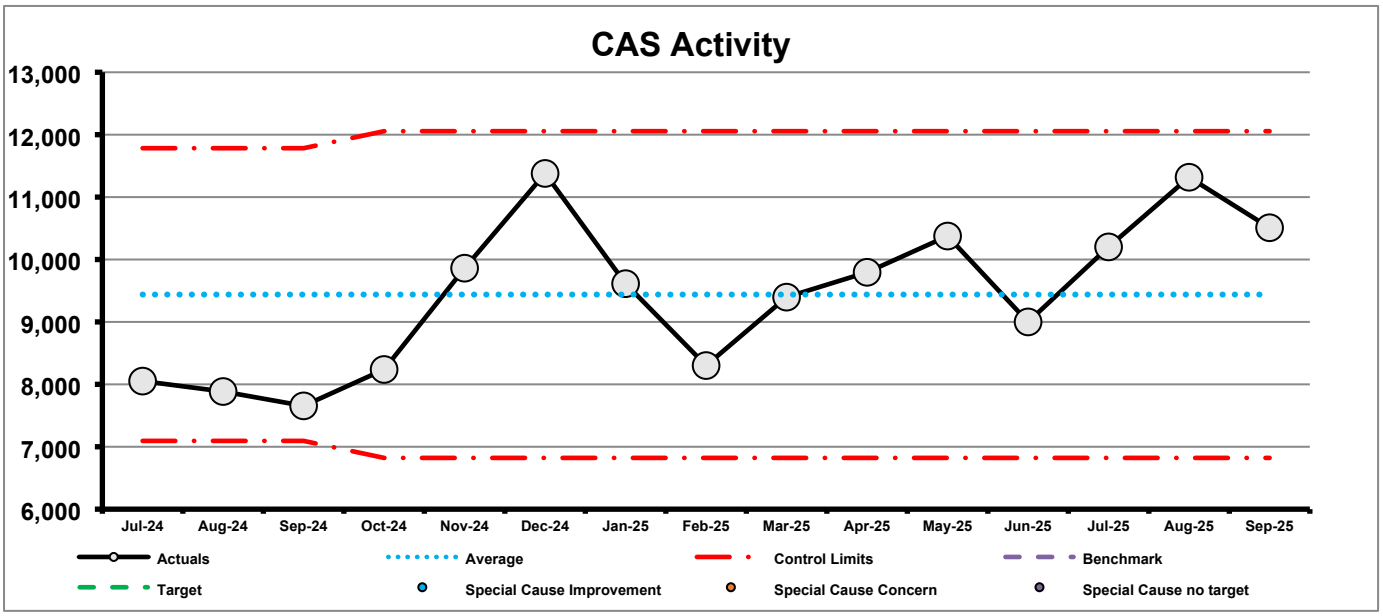
The number of referrals to the frailty virtual ward shows special cause improvement for September.

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

September activity has shown a slight decrease on last month but remains 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. CAS activity for September was significantly higher than for the same period last year. We continue to monitor activity closely and anticipate that activity will continue to grow as we enter the historically busier months over the winter period 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.
- Increasing the number EMAS CAD referrals through approved automated ITK codes from EMAS
- Collaborative working with PSPA

There have been ongoing discussions with the ICB regarding the return of interim dispositions from DHU to CAS.

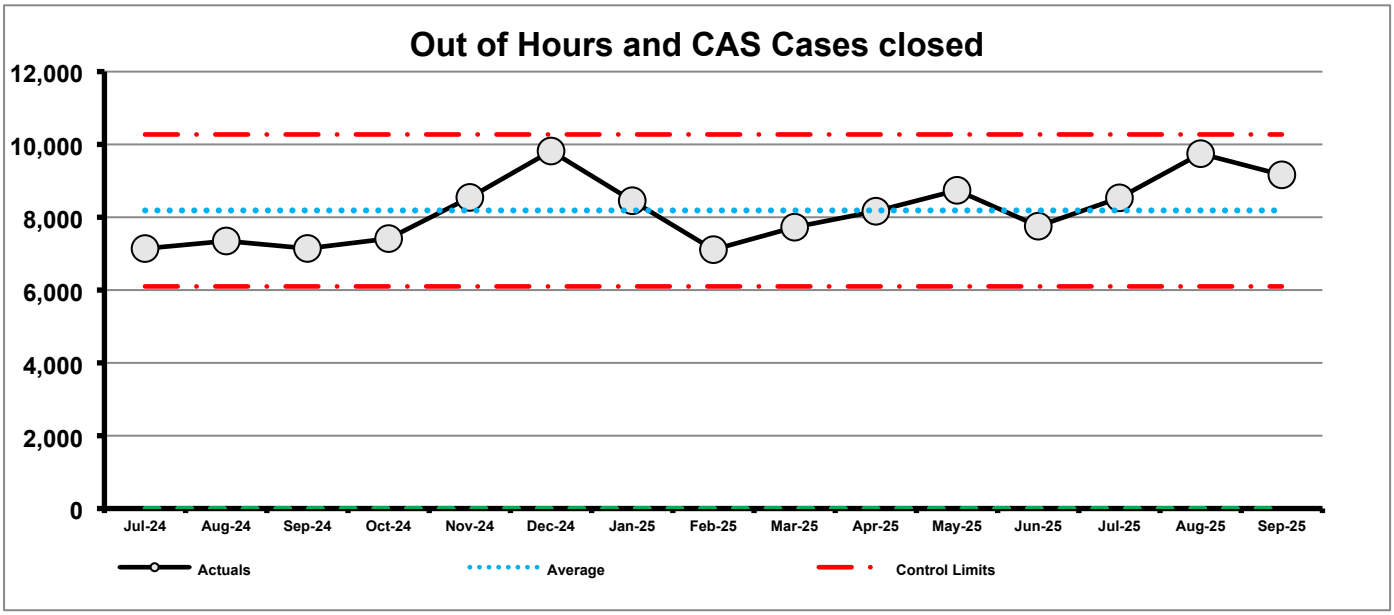
SPC

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).

September activity has slightly decreased from last month but is still above the expected average. It is also an increase on the same period for last year. Some of this additional activity may be due to DHU contract changes which have resulted in the return of some 111 dispositions to Lincs CAS, and additional activity from UCR cases now being medically assessed by CAS.

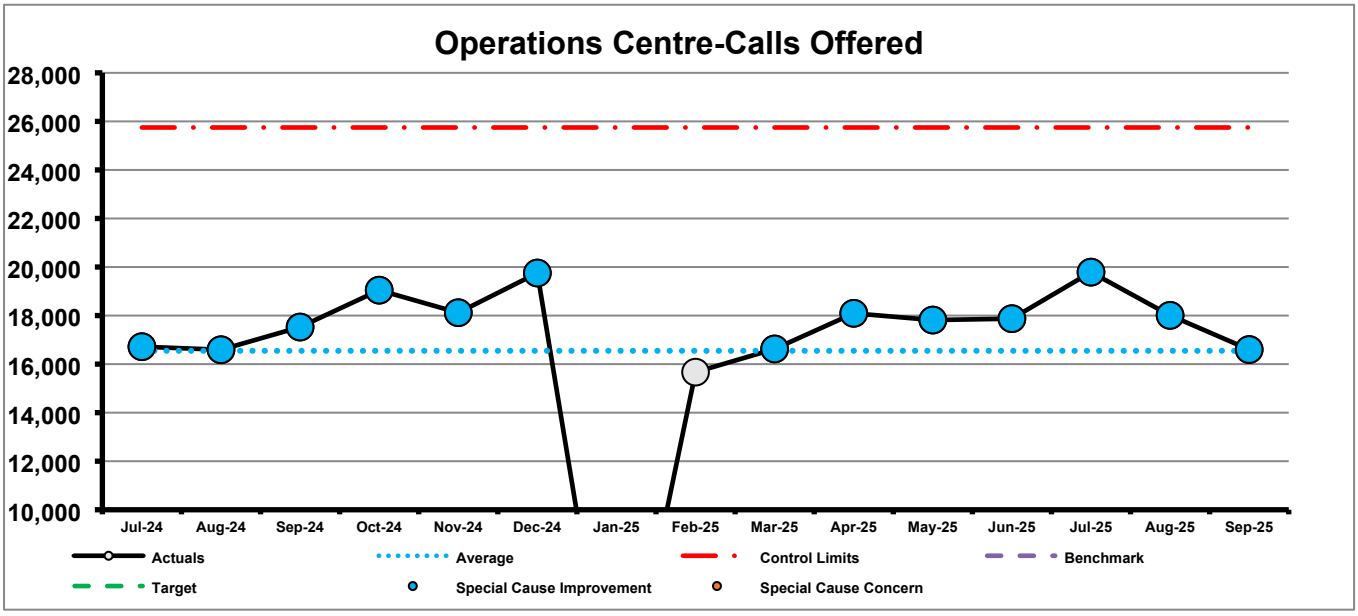
SPC

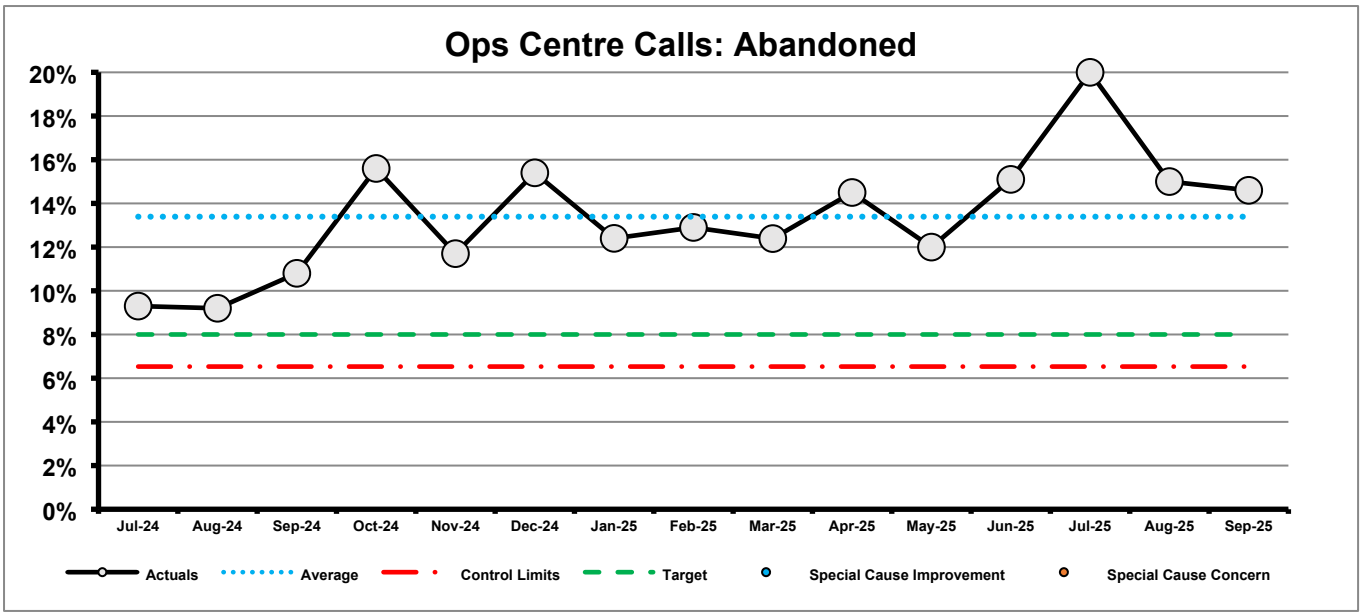
OOH & CAS Cases Closed has not varied significantly in the period.

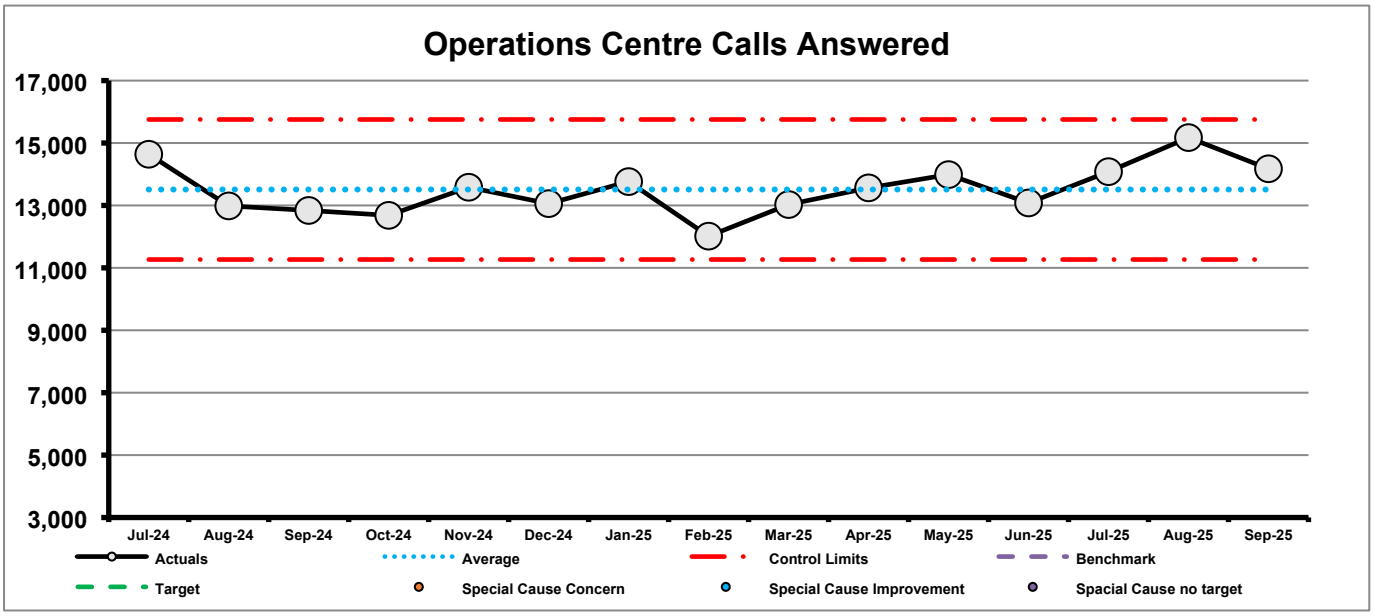
Operation Centre Calls Metrics

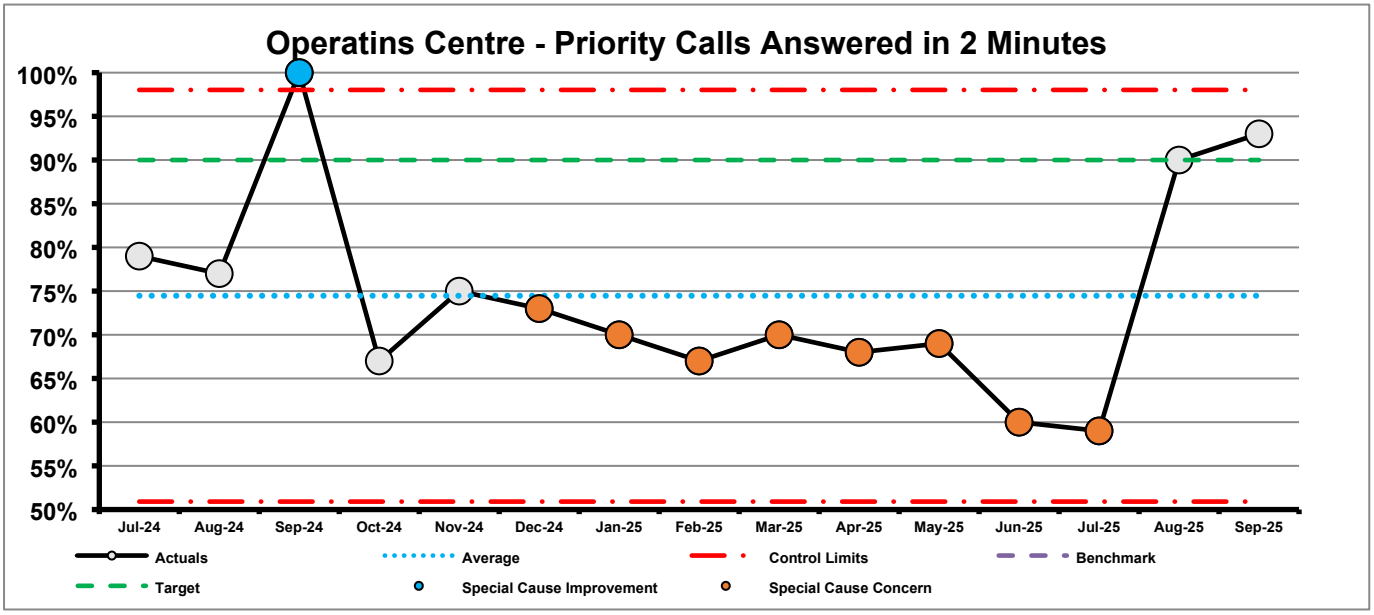
Background

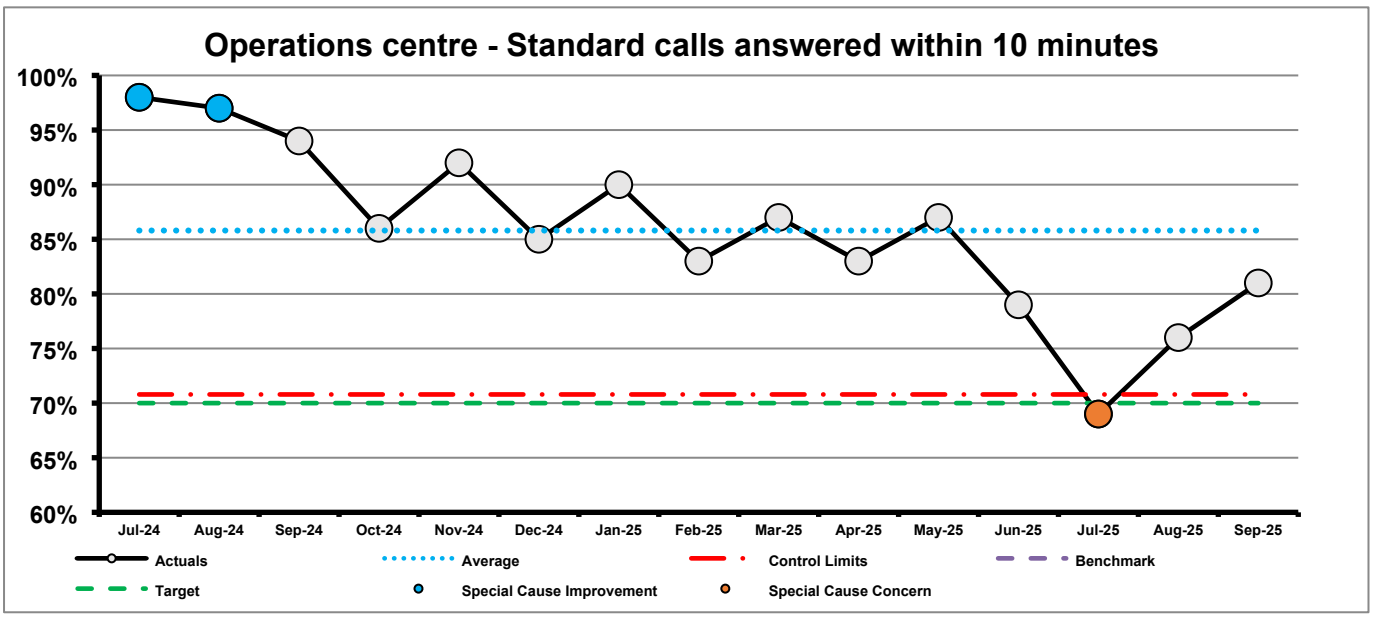
The Operations Centre was opened in December 2016 and provides a 24/7 multi-disciplinary team for LCHS. It was developed on the principle of a 'one call does it all' model and is a critical service that holds the Trust's services together e.g., community nursing, community hospitals, urgent care, transitional 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.

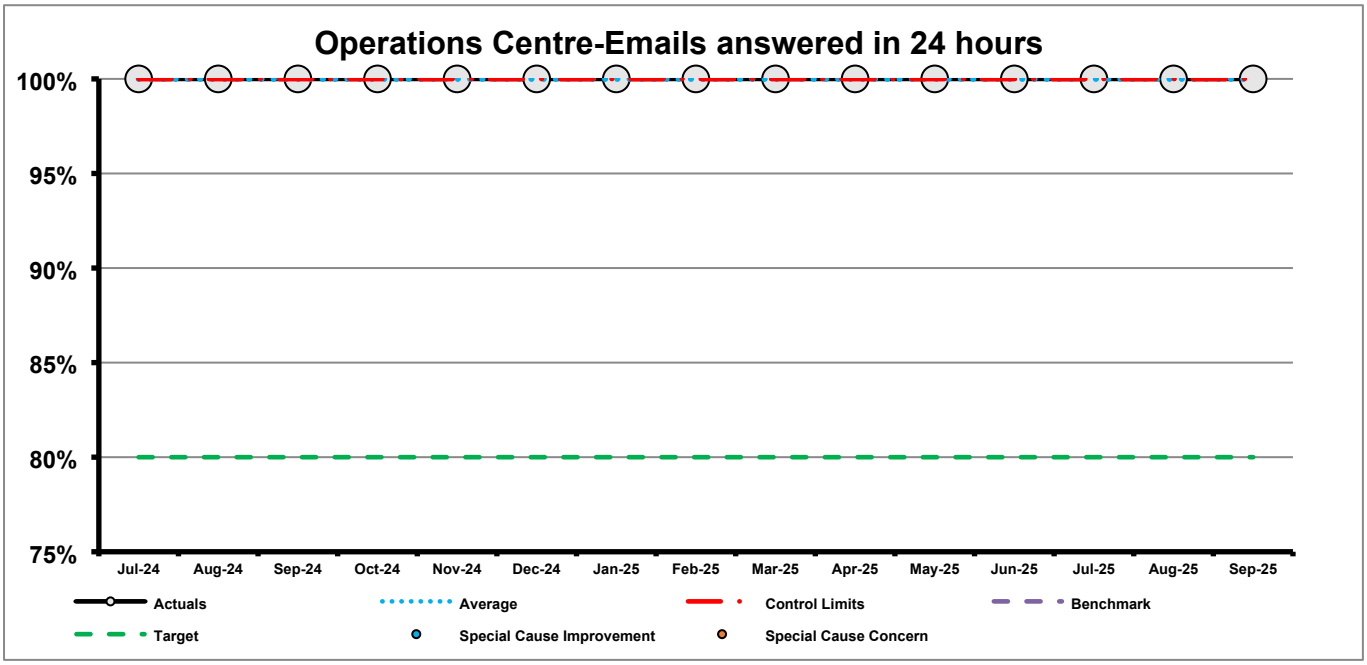


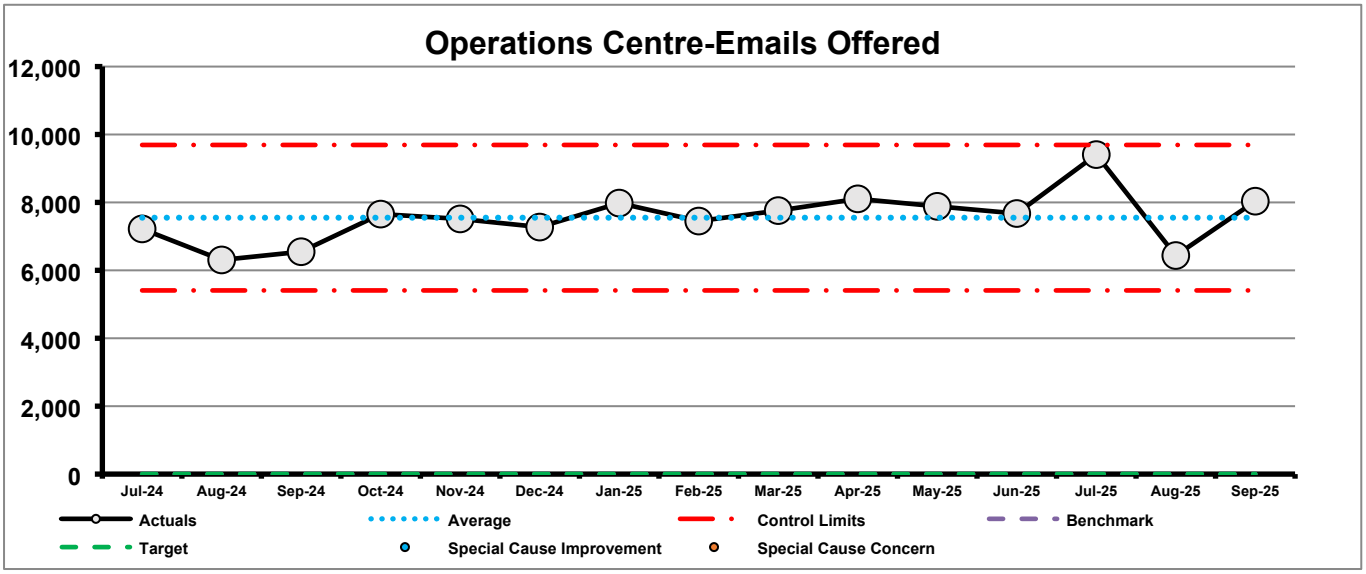



Operations Centre Calls Answered
17,000
15,000
13,000
11,000
9,000
7,000
5,000
3,000
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Actuals
Average
Control Limits
Benchmark
Target
Special Cause Concern
Special Cause Improvement
Spacial Cause no target


Operatins Centre - Priority Calls Answered in 2 Minutes
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Actuals
Average
Control Limits
Benchmark
Target
Special Cause Improvement
Special Cause Concern


Operations centre - Standard calls answered within 10 minutes
100%
95%
90%
85%
80%
75%
70%
65%
60%
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Actuals
Average
Control Limits
Benchmark
Target
Special Cause Improvement
Special Cause Concern





Operations Centre Performance – September 2025

- **Call Volumes: 16600** calls received in September, an **18% YoY increase**. Email volumes also remain high, increasing MoM.
- **Service Levels:**
  - **Priority Calls: 93% answered within SLA** – continued success due to operational changes and achieving monthly targets for the 2nd month in a row.
  - **Standard Calls: 82% answered within SLA**, exceeding targets and increasing by 6% MoM
- **Operational Agility:** The new dynamic call and resource management processes introduced have delivered continued benefits and sustained a positive impact, ensuring **priority and standard call SLAs and email SLAs were met in September.**
- Our average time to answer was just **50 seconds for Priority calls** and **only 5 minutes 5 seconds for standard calls** against a target of 2 minutes and 10 minutes, respectively**.**
- This still requires consummate levels of monitoring and intervention by managers, our senior service advisors and training and audit officers are also involved in answering calls and supporting with emails,
- The focus remains on assessing whether this performance can be sustained while balancing day-to-day workload.

- **Workforce & Resilience:** Recruitment has been completed to restore staffing to template levels ahead of winter demand. **Three new staff members joined in September**, expected to reduce pressure on the existing team and mitigate burnout risk.

Summary: September reflects a strong operational performance, hoping this can continue over the winter period and beyond, focus remains on supporting the staff to answer calls within the SLA and reduce overall waiting time.

SPC

Operation centre – calls offered moved into special cause improvement in March 2025.

Ops Centre Calls Abandoned moved into special cause improvement in August 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) moved into normal variation in August 2025.

Ops centre Standard calls (answered within 10 minutes). Moved into normal variation in August 2025.

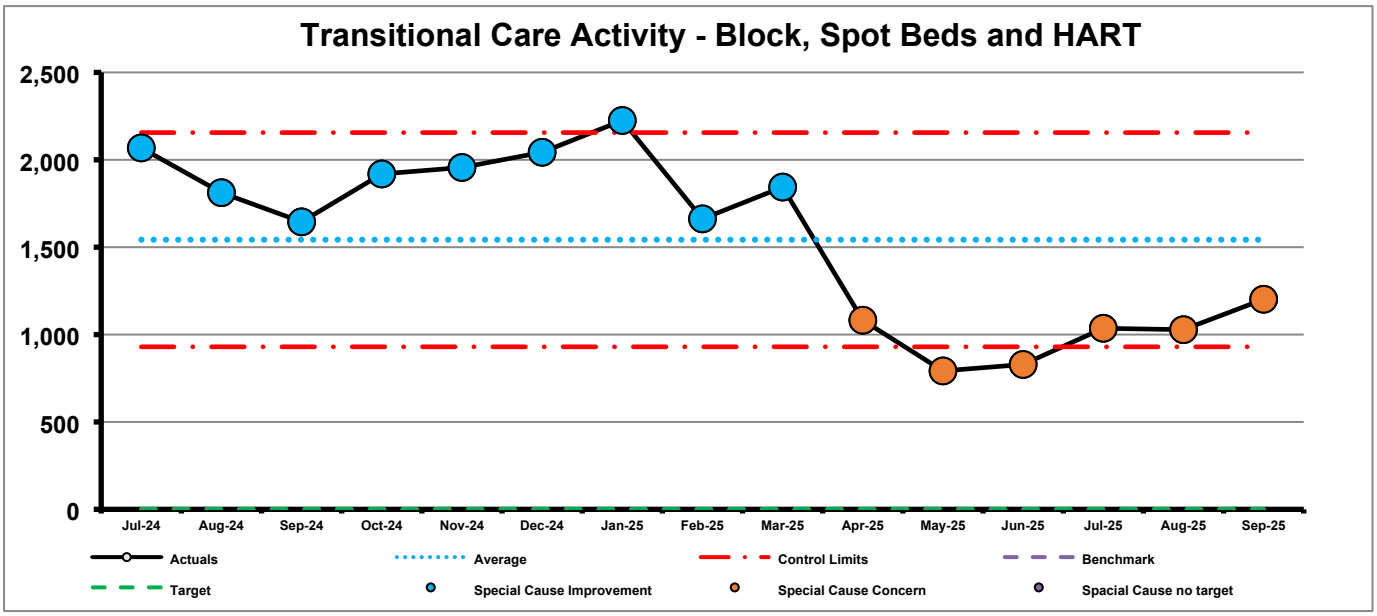
Ops centre Emails answered within 24 hours has not shown any significant change in the period.

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.



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: the procurement process was concluded mid-August. 35 block contract beds are currently in use. 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 moved into special cause deterioration and has been in in special cause deterioration since May 2025.

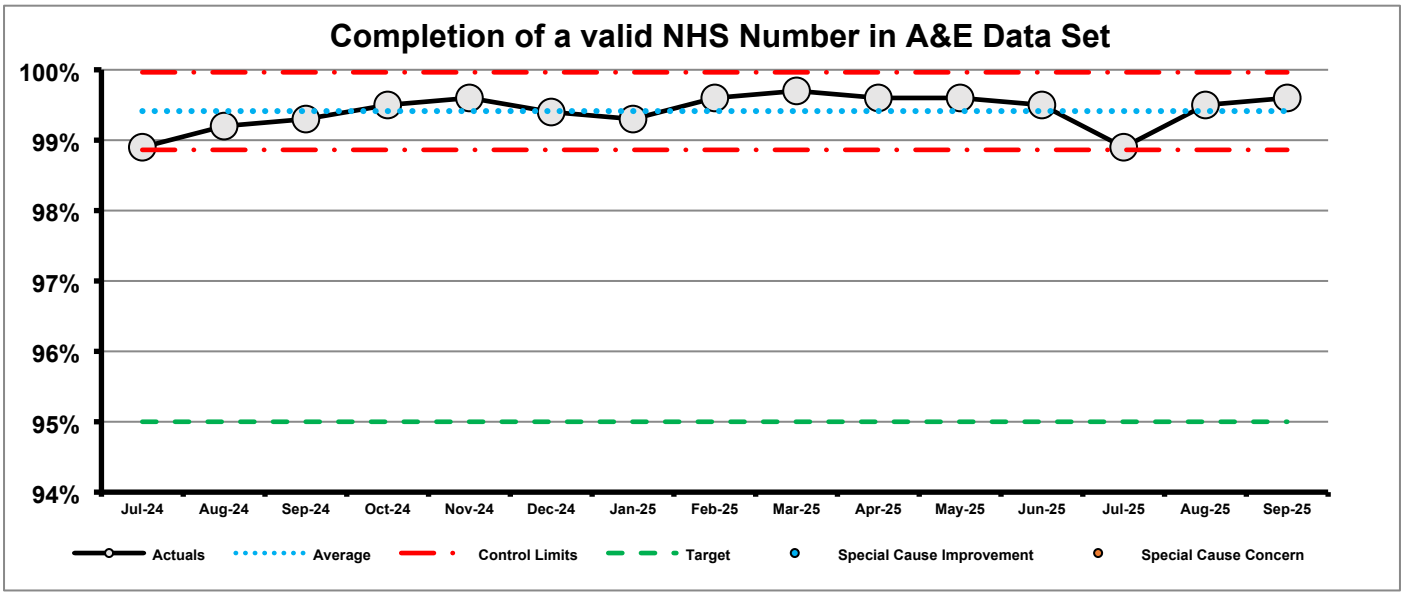
Completion of a Valid NHS Number in A&E Data Set

Background

The Data Quality Dashboards are a national resource to support the improvement and completeness of data flows by reporting on the validity of key data items in Secondary Uses Service (SUS) in accordance with published data standards. The information is provided by The Health and Social Care Information Centre and the areas applicable to LCHS are:

- Accident and emergency

The dashboards are reviewed against the national attainment and any data items that fall below the national attainment rate are highlighted for consideration and action planning.



Narrative

The latest available data demonstrates the completion of a valid NHS number for A&E Data Sets. The Trust maintains a high level of compliance – above 98% since April 2021. This is higher than the national average.

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

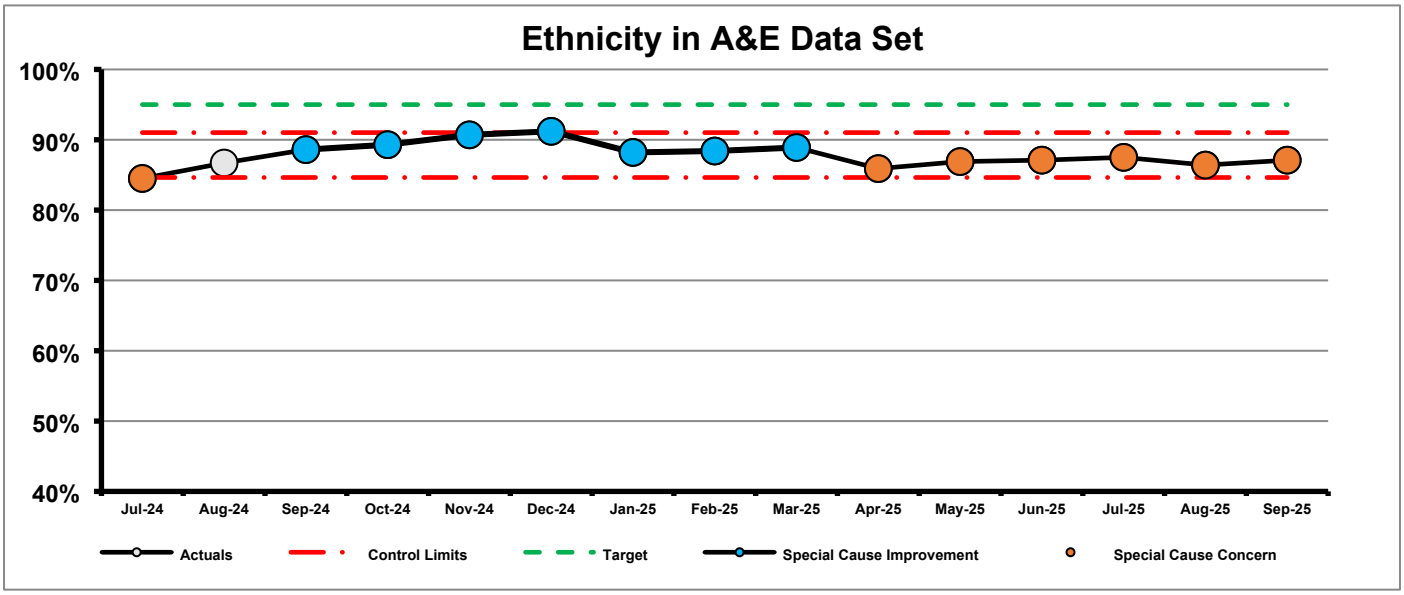
Completion of a valid NHS number for A&E datasets has not varied significantly since June 2024 and is consistently capable of achieving the 95% target.

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.

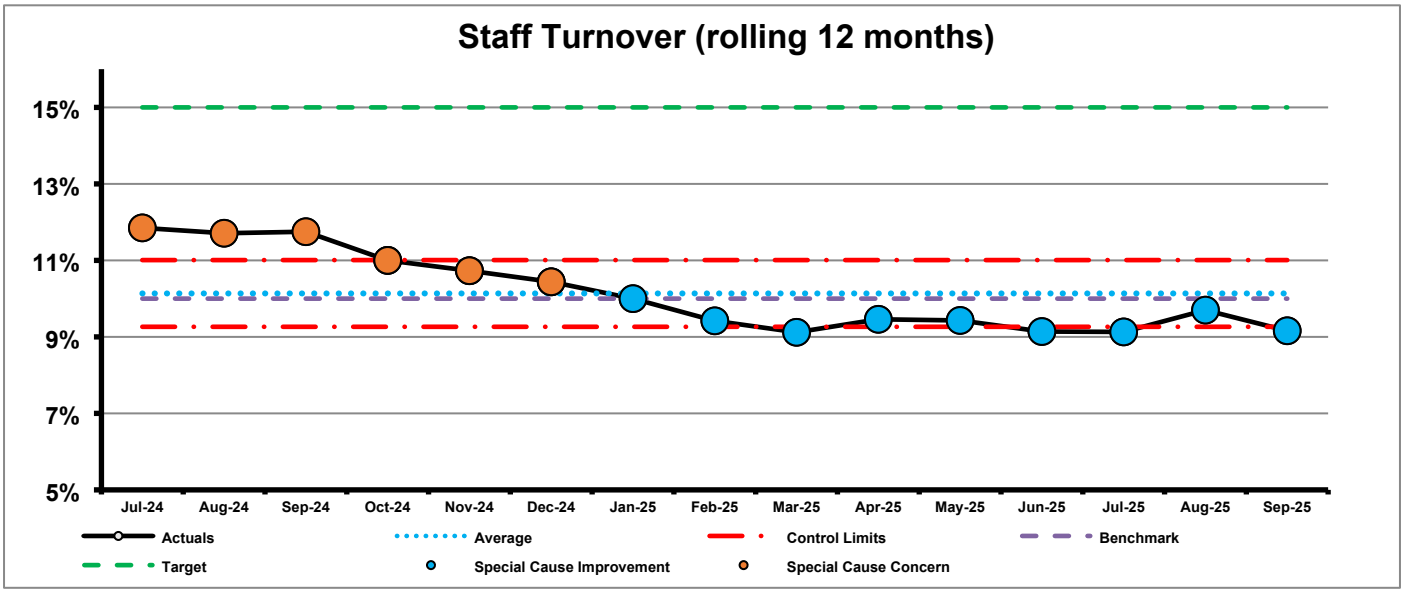
SPC

Ethnicity in A&E dataset has shown special cause concern since April 2025. 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 9.16% 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 January 2025 and is consistently capable of achieving the 15% target.

Financial Performance Summary

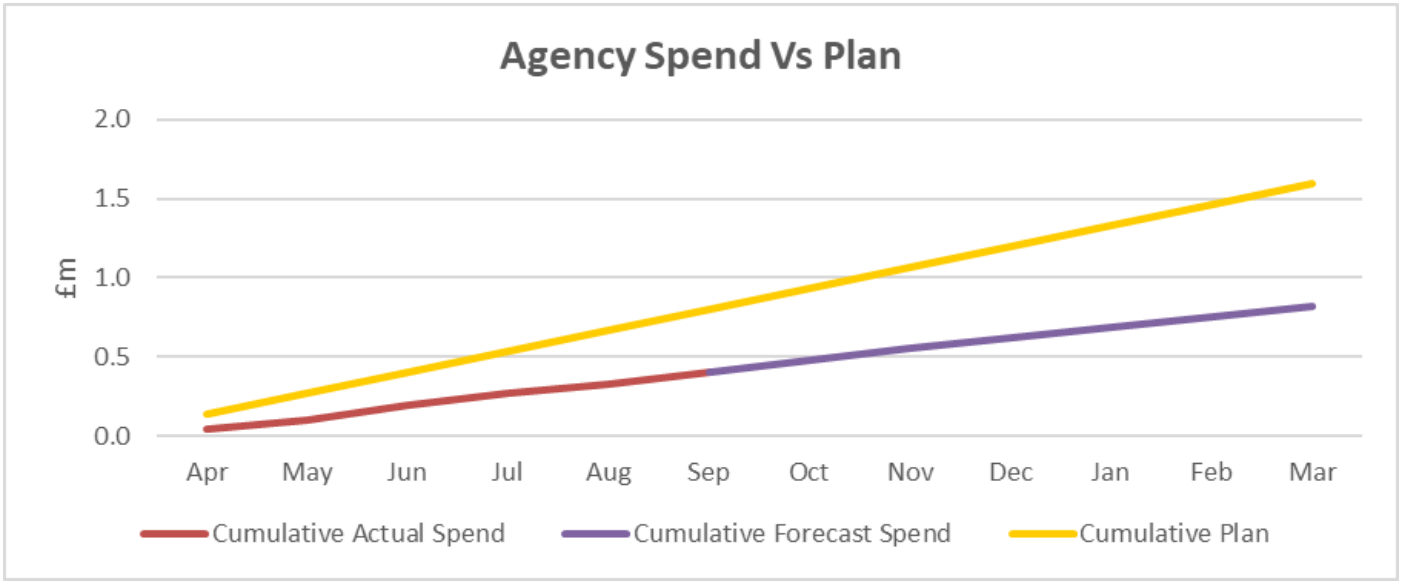
Financial Summary Table (Month 6)

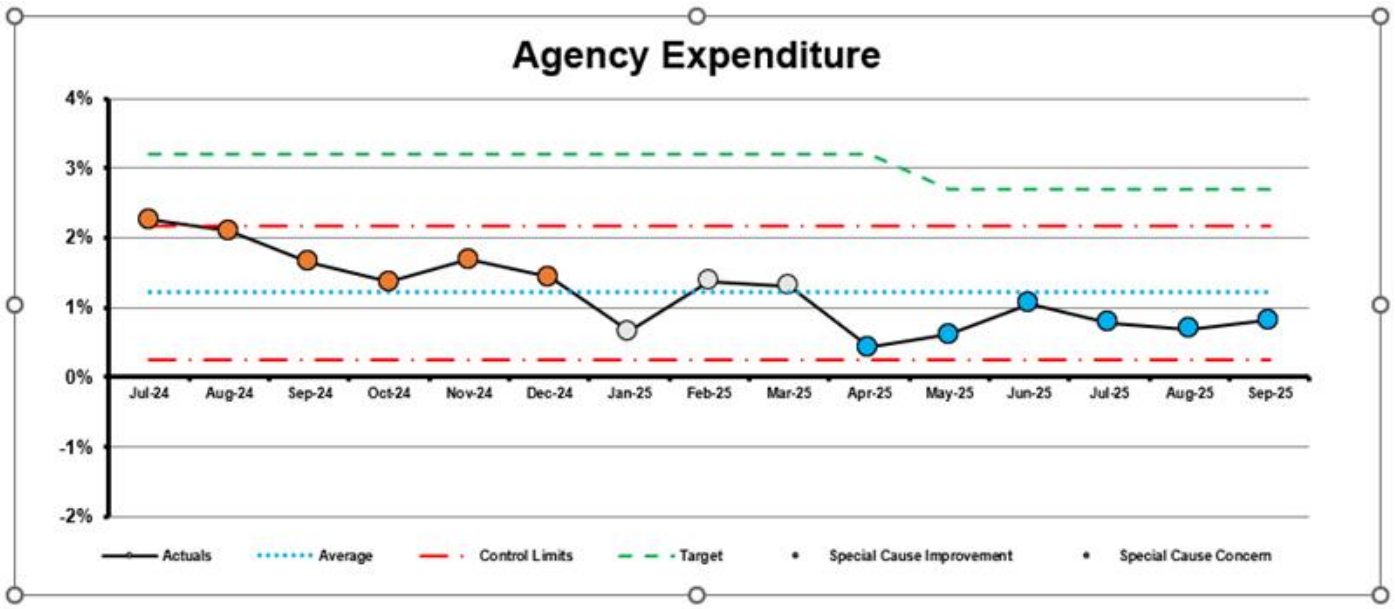
Description	Narrative
Position in September	£-306k deficit
Position YTD	£-2340k deficit
Position FOT	Breakeven
CIP in September	£728k against plan of £496k
CIP YTD	£2.092m against plan of £1.769m
CIP FOT	£8.968m against plan of £9.489m
Agency in September	£72k against plan of £133k
Agency YTD	£402k against plan of £800k
Agency FOT	£1.2m against plan of £1.6m
Capital in September	£39k against plan of £342k
Capital YTD	£1.9m against plan of £2.5m
Capital FOT	£3.3m against plan of £3.3m
Cash	£18.9m against forecast plan of £24.8m

Agency Expenditure

Background

In 23/24 agency spend was £2.6m, the 24/25 outturn represented a 47% reduction in cost of agency in a year, with continued focus on reducing overall temporary staffing spend in 2025/26.





Narrative

- M06 agency spend was £73k compared to £133k plan, this was a favourable result in month and works towards the temporary staffing CIP.
- Nursing agency accounted for 21% of total spend YTD, the increase in M6 relates to corporate agency.
- Full Year Agency Spend Plan is £1.6m, YTD there are savings of £398k against plan.

SPC

Agency expenditure has not varied significantly in the period.

Efficiencies Plan (CIP)

Background

This information represents year-to-date delivery against the planned Cost Improvement Plan (CIP).

Cost Improvement Headlines

	Plan Month 6 £000	Actual Month 6 £000	Variance Month 6 £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		Rejected at Board, replaced with other schemes
Vacancy Factor - Ops	-£71,204	-£148,218	-£77,014	-£427,223	-£947,649	-£520,426	-£854,446	-£2,100,498	-£1,246,052	Low	
Agency/Bank Reduction	-£112,439	-£130,417	-£17,978	-£674,635	-£411,160	£263,475	-£1,349,270	-£1,161,160	£188,110	Medium	
Approved Cost Pressures	£13,889	£4,557	-£9,332	£83,334	£58,787	-£24,547	£166,667	£131,523	-£35,144	Low	
Bank Sickness Reduction	-£21,917	£0	£21,917	-£131,500	£0	£131,500	-£263,000	-£131,500	£131,500	High	Increases already identified bank savings
Pay T&C's	-£5,222	£0	£5,222	-£15,667	£0	£15,667	-£47,000	-£31,333	£15,667	High	Sprint work - awaiting further detail
CFO Corp Target	-£16,132	-£20,453	-£4,321	-£48,396	-£62,920	-£14,525	-£145,187	-£138,670	£6,517	Medium	Portion remains unidentified
Chief Medical Corp Target	-£12,755	£0	£12,755	-£38,265	£0	£38,265	-£114,796	-£59,556	£55,240	Medium	Portion remains unidentified
CIO Corp Target	-£35,791	-£26,528	£9,263	-£107,373	-£203,969	-£96,596	-£322,120	-£442,967	-£120,847	Low	
Chief People Corp Target	-£29,973	-£4,767	£25,207	-£89,920	-£4,767	£85,153	-£269,760	-£4,767	£264,993	Medium	Portion remains unidentified
Estates & Facilities Corp Target	-£97,395	-£11,150	£86,246	-£292,185	-£64,418	£227,767	-£876,556	-£124,418	£752,138	Medium	Portion remains unidentified
Chief Nurse Corp Target	-£14,960	£0	£14,960	-£44,881	-£8,084	£36,797	-£134,643	-£32,084	£102,559	Medium	Portion remains unidentified
Chief Exec Corp Target	-£9,918	£0	£9,918	-£29,754	-£854	£28,900	-£89,263	-£10,854	£78,409	Medium	Portion remains unidentified
Corp Affairs Corp Target	-£8,084	-£1,537	£6,547	-£24,253	-£1,537	£22,716	-£72,759	-£1,537	£71,222	Medium	Portion remains unidentified
Clinical Governance Corp Target	-£6,290	£0	£6,290	-£18,869	£0	£18,869	-£56,606	£0	£56,606	Medium	Portion remains unidentified
Current unidentified/opportunities Operational	£0	£0	£0	£0	£0	£0	-£1,173,437	£0	£1,173,437		
Current unidentified/opportunities Corporate	£0	£0	£0	£0	£0	£0	£0	-£506,555	-£506,555	High	Unidentified
Closure of 2x Community Wards	£0	£0	£0	£0	£0	£0	-£921,626	-£214,842	£706,784	Low	One ward approved, one rejected
Vacancy Factor - Corp	-£13,349	-£116,558	-£103,209	-£80,094	-£469,455	-£389,361	-£160,187	-£728,613	-£568,426	Low	
Wholly Owned Subsidiary	£10,000	£0	-£10,000	£60,000	£0	-£60,000	-£878,932	-£878,932	£0	High	Sprint work - awaiting further detail
1.5% Reduction across services	-£64,243	-£77,804	-£13,561	-£385,455	-£398,378	-£12,922	-£1,541,821	-£1,188,462	£353,359	Medium	Over 85% identified
Bank interest over plan	£0	-£8,664	-£8,664	£0	-£118,708	-£118,708	£0	-£238,708	-£238,708	Low	Expected bank interest over plan
Operational Technical CIP	£0	£0	£0	£0	£0	£0	£0	-£1,515,000	-£1,515,000	Low	
2025-26 CIP Programme	**-£495,783**	**-£541,539**	**-£45,755**	**-£2,265,137**	**-£2,633,113**	**-£367,976**	**-£9,488,934**	**-£9,488,933**	**£0**		

Recurrent	-£425,119	-£272,655	£152,464	-£1,841,154	-£1,156,088	£685,066	-£8,640,968	-£4,531,083	£4,109,884
Non-Recurrent	-£70,664	-£268,883	-£198,219	-£423,983	-£1,477,025	-£1,053,042	-£847,966	-£4,451,295	-£3,603,329
	-£495,783	**-£541,539**	**-£45,755**	**-£2,265,137**	**-£2,633,113**	**-£367,976**	**-£9,488,934**	**-£8,982,378**	**£506,555**

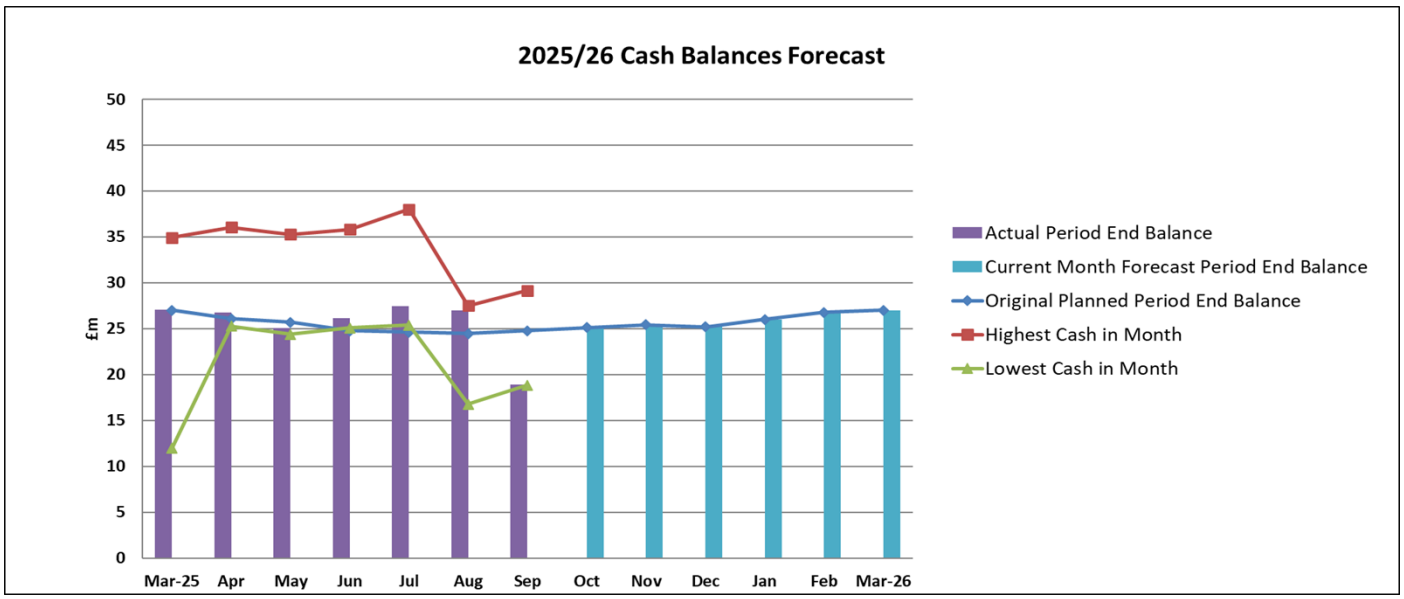
- 2025/26 CIP Target is £9.5m
- Month 6 delivery was £0.05m favourable to plan. Largely related to the improvement in temporary staffing efficiencies that were previously offsetting vacancy savings.
- Red schemes have remained the same from M5, where further schemes were identified; plus schemes e.g. closure of one community ward, were taken forward.
- Forecast reflects £0.5m currently unidentified, a significant movement from £4.2m unidentified in M4. This is due to the ongoing work to review and reforecast CIP for 25/26, alongside work that will support 26/27 CIP

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:



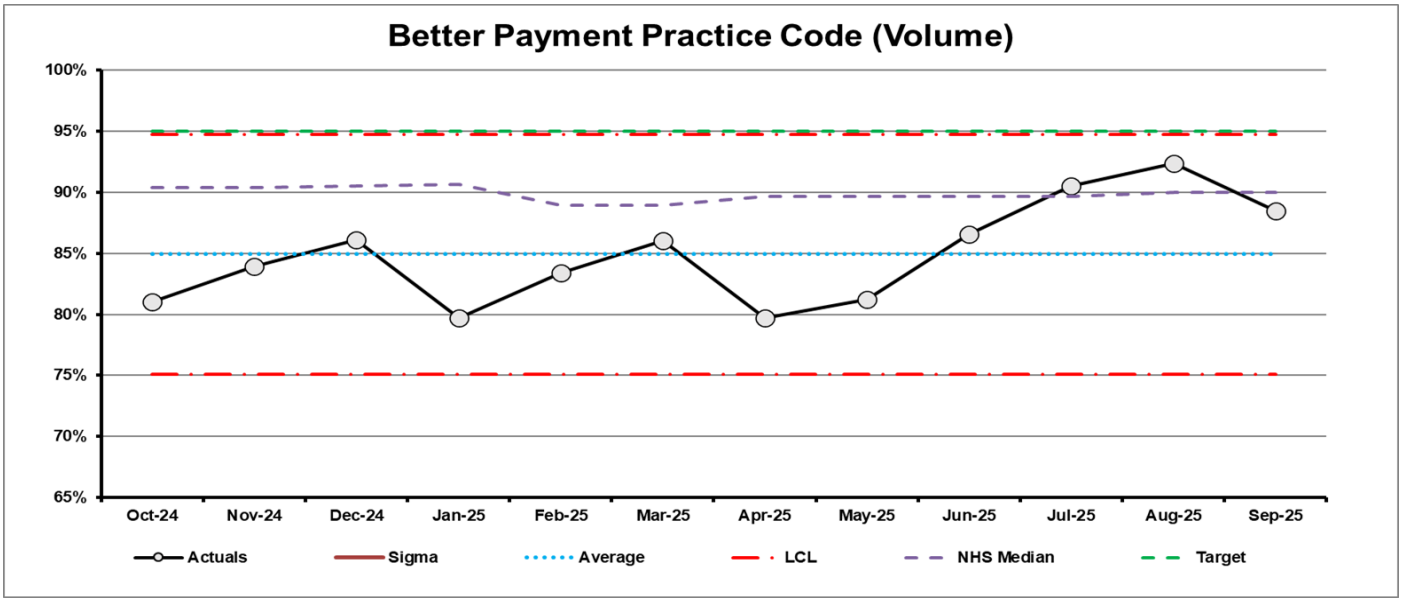
Narrative

- The LCHS cash balance for M6 was £18.94m, this is lower than forecast (£24.8m) due to delayed of receipt of M6 ICB income to support Group cash position (circa £10m). This will be paid prior to year-end.

Better Payment Practice Code

Background

This metric represents the performance of our invoices paid within the agreed terms. The target Better Payment Practice Code (BPPC) is 95%.



Narrative

- Number of invoices for September at 88.5%. This is due to the majority of the chasing being conducted by Finance Officers who left employment in July/August. The Finance team have recruited to these posts, and once the new staff are in place it would be expected that this figures improve.
- 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.

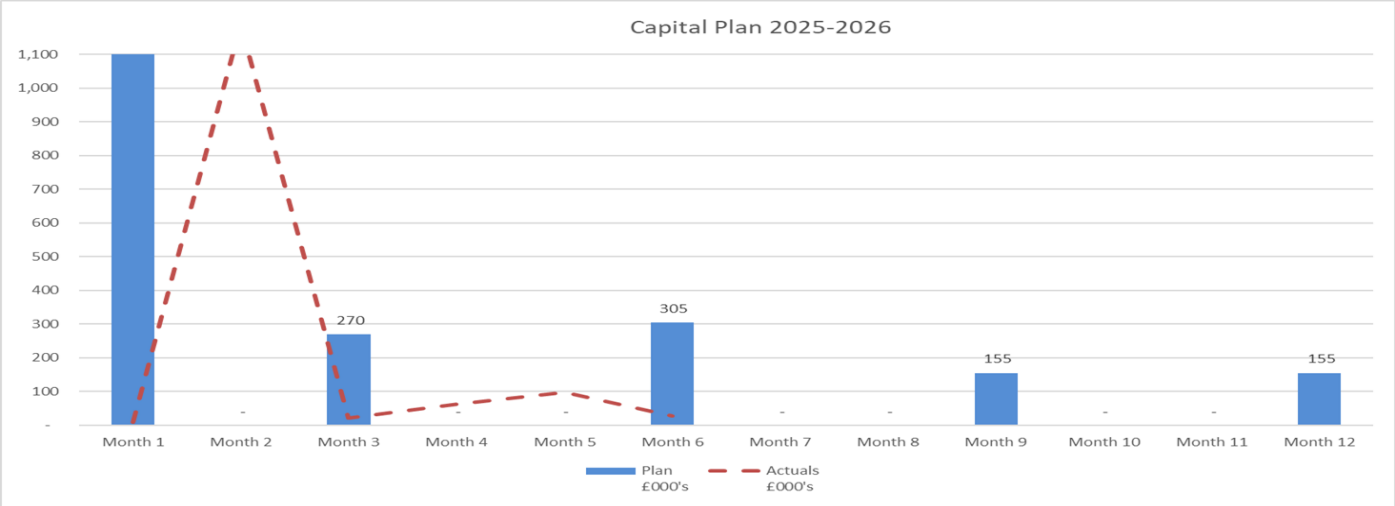
SPC

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.



Narrative

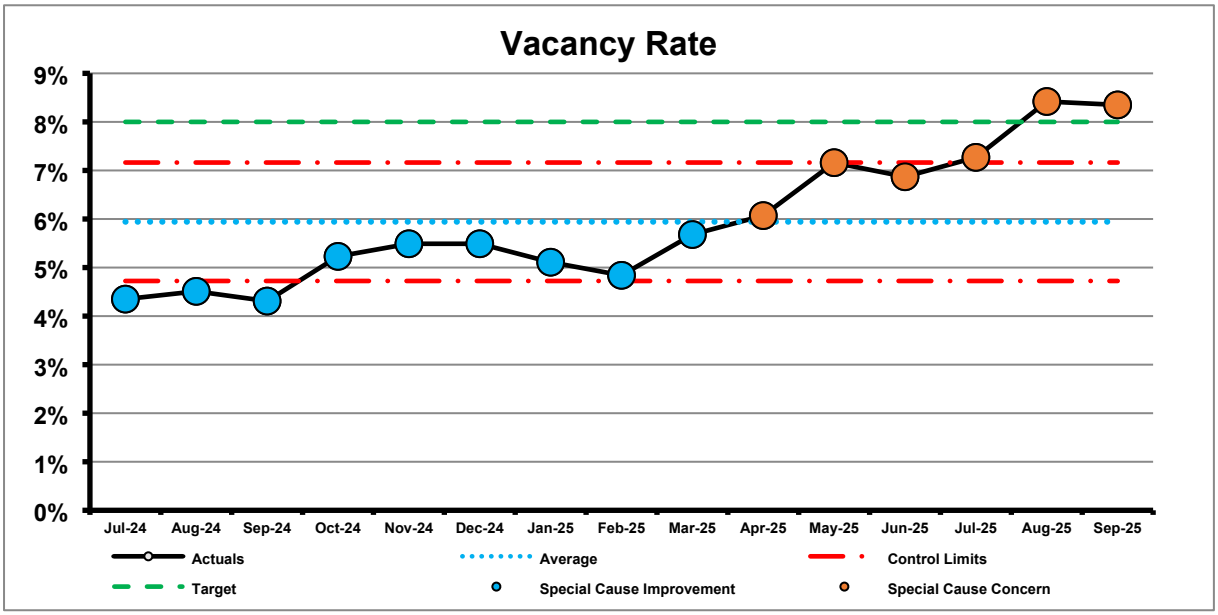
- The LCHS capital plan for the financial year totals c£3.3m, £2.3m of capital allocation and £1m of PDC funding.
- Month 6 spend equated to £39k. The Plan assumed that the IFRS lease adjustments would transact in Month 1, the forecast was adjusted to incur in Month 2 and has been largely transacted. The Plan assumes the remaining capital spend would be incurred quarterly.
- There is a YTD underspend (£0.6m) against plan, which largely relates to the IFRS16 adjustment forecast to be adjusted in M7, alongside some delays in spend from plan.
- The year to date spend has been incurred in the following areas (bracketed numbers are full year plan)
    - Information Management & Technology - £24k (£265k)
    - Estates investment schemes - £15k (£62k)
    - Clinical Equipment schemes - £162k (£558k)
    - IFRS16 - £1.2m (£1.45m)
    - PDC – £484k (£1m)

Vacancy Rate

Background

The Vacancy Rate target for LCHS is 8%.

Current Performance



Narrative

The vacancy rate has decreased in September from a high in August, which is mainly due to the MARS scheme taking effect with the successful applicants leaving and the corresponding budgets still to be adjusted.

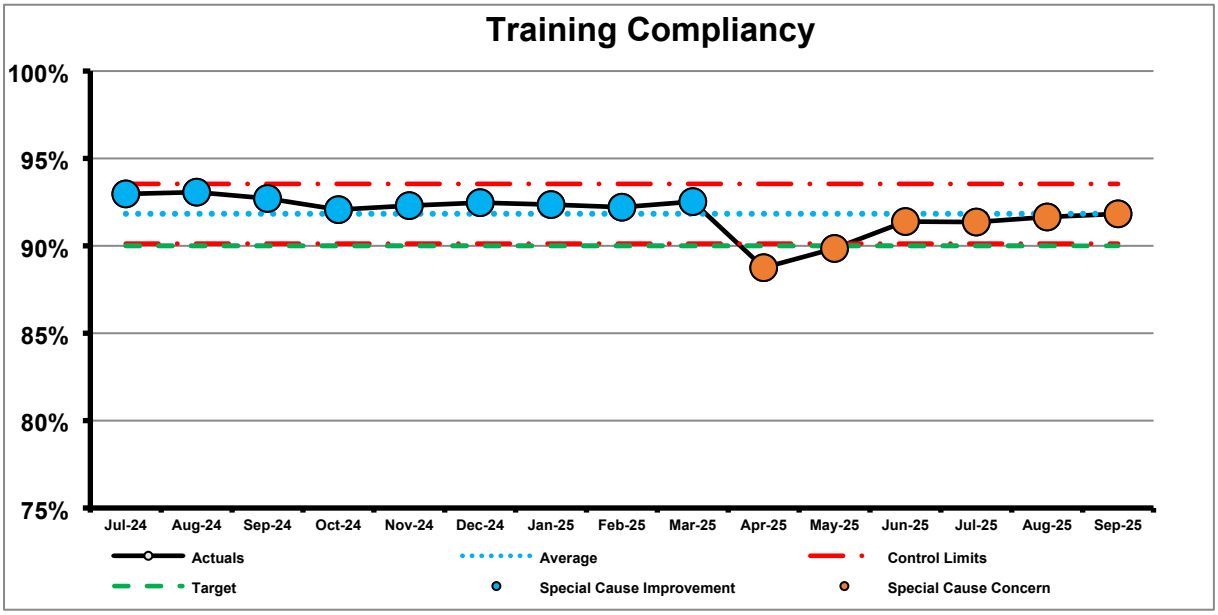
SPC

The vacancy rate shows special cause concern since May 2025 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 position



Overall mandatory compliance as of 30th September 2025:

The overall mandatory training compliance rate which includes all core and role specific modules has increased to 91.83% 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 95.38% which exceeds the national/local target of 90%.

All Divisions have increased this month or remain stable and all, except IUEC who sit just below, have **overall** compliance above the national/local target of 90%.

Children's, Young People's, and Specialist Services	93.93%	↑
Collaborative Community Care	91.03%	↔
Corporate Services	96.66%	↔
Integrated Urgent and Emergency Care	88.01%	↑
Operational Business Services	94.53%	↑
Operational Leadership	94.71%	↑
System	96.78%	↑

SPC

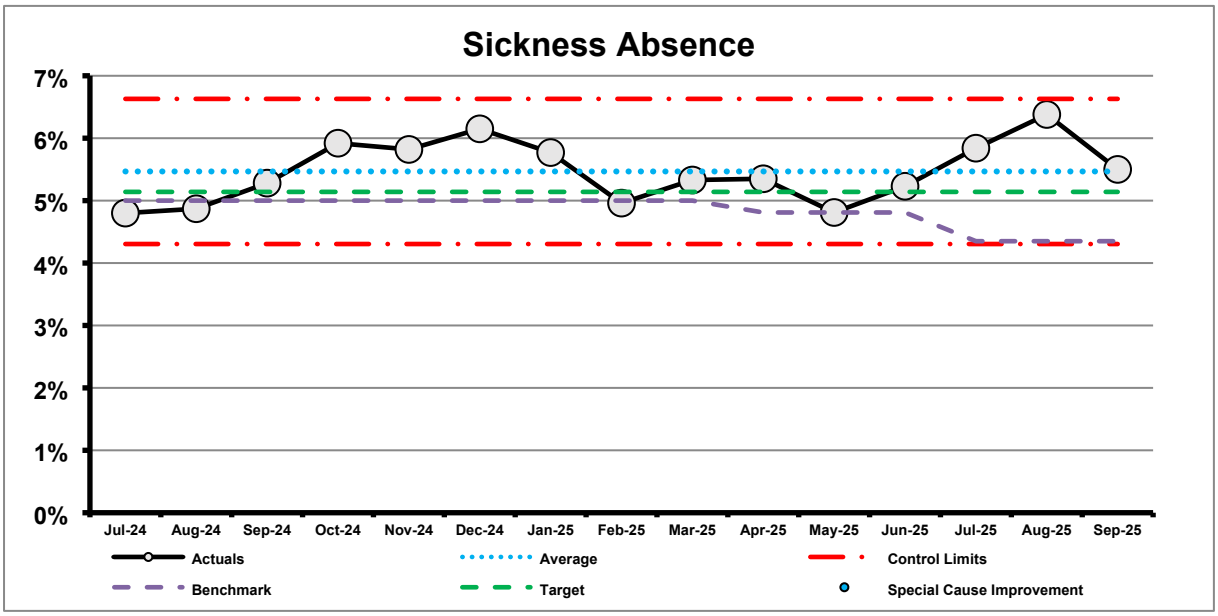
Mandatory Training compliance has shown special cause concern since April 2025. The measure is inconsistently capable of achieving the 90% target but is expected to achieve target more often than not.

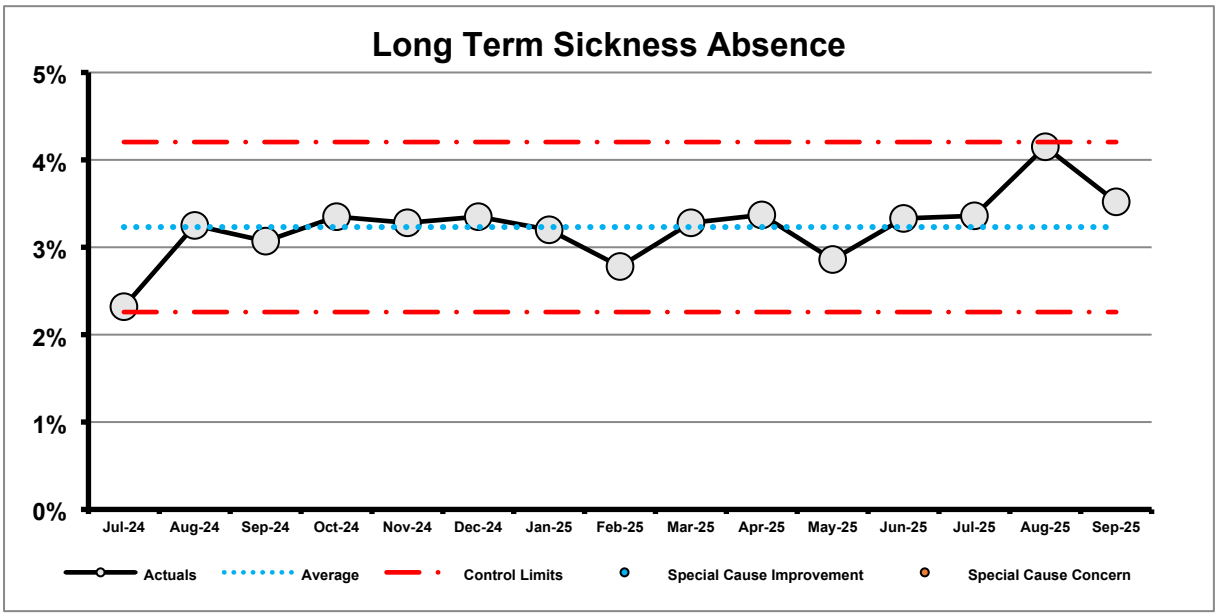
Sickness Absence

Background

The Trust target for total sickness absence is 4.35%.

Current Performance





Narrative

The overall sickness levels in September have decreased to 5.50% when compared with 6.38% in August however, this remains over the target of 4.35%.

Overall Absence	Divisions	Total Absence for the Month	Increase or decrease on the previous month
Planned Care	CYPSS	5.43%	Decrease
	CCC	4.96%	Decrease
Unplanned Care	IUEC	7.25%	Decrease

	OBS	9.32%	Increase
Stand-alone Divisions	Corporate	3.18%	Increase
	System	1.20%	Increase

The top three reasons accounting for overall sickness absence in September were anxiety, stress, and depression (39.66%), other musculoskeletal (11.71%) and Gastrointestinal Problems (5.87%), which remains consistent with previous months.

Long Term

The long-term sickness level in September has also seen a decrease to 3.52% from 4.15% in August, which is a green light in accordance with the new workforce targets as it is a decrease on the previous month.

Long Term Absence	**Divisions**	**Long Term Absence for the Month**	**Increase or decrease on the previous month**
Planned Care	CYPSS	4.01%	Decrease
	CCC	2.95%	Decrease
Unplanned Care	IUEC	4.37%	Decrease
	OBS	6.90%	Decrease
Stand-alone Divisions	Corporate	1.66%	Decrease
	System	0.00%	Remained the Same

The top three reasons for long term sickness absence for September were: Anxiety/stress/depression (56.22%), other musculoskeletal (10.48%) and Benign and malignant tumours at (5.25%). All reasons being consistent with the data for August.

Short Term

The short-term sickness level in September has seen a decrease to 1.98% from 2.23% in August, which is a green light against the new workforce targets due to it being a decrease against the previous month.

Short Term Absence	**Divisions**	**Short Term Absence for the Month**	**Increase or decrease on the previous month**
Planned Care	CYPSS	1.42%	Decrease
	CCC	2.01%	Decrease
Unplanned Care	IUEC	2.89%	Decrease
	OBS	2.42%	Increase
Stand-alone Divisions	Corporate	1.51%	Increase

	System	1.20%	Increase

The top three reasons for short term sickness absence in September were: anxiety/stress/depression (19.39%), Cold, Cough and Flu (15.14%), other musculoskeletal (11.83%), 2 of the 3 reasons have remained consistent with the data from previous months.

Actions

- Absence summit meetings have been held in August, September and October, delivered by the HR team to all SLT operational leads, CSL's and CTL's across LCHS in order to fully analyse the data, identify trends and opportunities to improve and intervene.
- 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.
- Monthly Absence workshops have been planned by the HR team to be held between September and December for all leaders and managers, new and existing to attend.
- 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 in the period and is inconsistently capable of achieving the target.

Workforce Dashboard

September 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	489.14	60.10	10.94%	10.46%	0.82%	5.43%	1.42%	4.01%	93.93%	96.46%	90.80%
Collaborative Community Care	753.03	723.14	29.89	3.97%	7.75%	0.72%	4.96%	2.01%	2.95%	91.03%	89.15%	81.23%
Corporate Services	232.58	199.38	33.20	14.27%	14.42%		3.18%	1.51%	1.66%	96.66%	85.78%	91.11%
Integrated Urgent & Emergency Care	429.09	378.27	50.82	11.84%	6.28%	0.26%	7.25%	2.89%	4.37%	88.01%	97.41%	90.54%
Operational Business Services	114.32	104.25	10.07	8.81%	10.92%	0.68%	9.32%	2.42%	6.90%	97.17%	93.64%	
Operations	14.44	12.40	2.04	14.13%	16.13%					94.53%	66.67%	50.00%
System	14.00	24.31	-10.31	-73.62%	15.09%		1.20%	1.20%		96.78%	76.00%	100.00%
Total	**2,106.70**	**1,930.88**	**175.82**	**8.35%**	**9.16%**	**0.57%**	**5.50%**	**1.98%**	**3.52%**	**91.83%**	**92.23%**	**86.30%**

Corporate September 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
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%**

LCHG Scoring

Lincolnshire Community and Hospitals NHS Group

LCHG Score

1. Field Scoring

Each metric is scored based on 3 criteria as per the table below

Score	Target	Trajectory	Plan
0	Above Target	Stable or Improving	Above Plan
0.5	No Target Set	-	No Plan Set
1	Below Target	Deteriorating	Below Plan

2. Total Metric Score

The total score is the sum of the 3 criteria, uplifted to fit a range of 1 - 4

3. Colour Bandings

Range	Colour	Description
1.00 - 2.00	Green	Performing Well/On Track
2.01 - 2.99	Warm Amber	Slightly Below Expectations
3.00	Burnt Orange	Performance Concern
3.01 - 4.00	Red	Underperforming

4. Aggregation

Section scores are calculated based on the average score of all metrics in that section. With the section score being rated using the same logic above

Metric Scoring Example

Lincolnshire Community and Hospitals NHS Group

Metric Name	Value	Target	LCHG Score
Acute - #NOF 48 hrs	29.41%	90.00%	3.50
Acute - #NOF 36 hrs	11.76%		3.00
Acute - eDD issued within 24 hours	91.42%	95.00%	2.50
Acute - Actions from National clinical audits have been or will be completed within agreed timescale	100.00%	100.00%	1.50

Above is an example of 4 metrics with different scores

Acute - #NOF 48 hrs is flagged as red due to the metric being below target and having a deteriorating trajectory

Similarly #NOF 36 hrs is below trajectory but due to the lack of target scores slightly lower but would still be flagged within reporting

Acute - EDD scores 2.5 because whilst the metric is below target, it has a consistent trajectory with no signs of deteriorating

Acute - Actions from clinical audits is flagged as green as the metric is above target and does not have a deteriorating trajectory

Select Report

Report Summary Page

Lincolnshire Community and Hospitals NHS Group

Acute - Trustwide	Acute - Workforce	Community - Trustwide	Community - Workforce	Community - Pre-Hospital	Acute - Front Door	Acute - Planned	Acute - Unplanned	Community - Planned
1.90	2.30	1.90	2.30	1.83	2.36	2.80	1.50	2.00

Metrics Out of Range

Section Name	Org Name	Metric Name	Value	Target	LCHG Score
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 104+ Day Waiters	111	10	3.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - Hospital Average LoS (Elective)	3.52	2.80	3.50
Acute - Workforce	United Lincolnshire Teaching Hospitals	Acute - Overall percentage of completed mandatory training	92.86%	93.00%	3.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - Partial Booking Waiting List	43727	4524	3.50
Community - Workforce	Lincolnshire Community Health Services	Workforce - Vacancy Rate	8.35%	6.99%	3.50

Information on Scoring Methodology

Report Summary Page

Metrics Out of Range (cont.)

Section Name	Org Name	Metric Name	Value	Target	LCHG Score
Community - Planned	Lincolnshire Community Health Services	52 Week Waits %	99.62%	100.00%	2.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	Acute - % Triage Data Not Recorded	0.24%	0.00%	2.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	Acute - >12hr Trolley Waits	946	0	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 18 week incompletes	53.62%	84.10%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 28 days faster diagnosis	74.32%	75.00%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 31 day first treatment	87.30%	96.00%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 52 Week Waiters	2012	0	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 62 day classic	61.80%	85.39%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 65 Week Waiters	23	0	2.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	Acute - Ambulance Conveyances Delayed >59 mins	318	0	2.50
Acute - Trustwide	United Lincolnshire Teaching Hospitals	Acute - Complaints investigated and responded to within agreed timescales	83.00%	100.00%	2.50
Acute - Workforce	United Lincolnshire Teaching Hospitals	Acute - Number of Vacancies	6.02%	6.00%	2.50
Acute - Workforce	United Lincolnshire Teaching Hospitals	Acute - Sickness Absence	5.37%	5.00%	2.50
Acute - Trustwide	United Lincolnshire Teaching Hospitals	Acute - Summary Hospital Mortality Indicator (SHMI) (rolling year data 5 month time lag)	107.50	100.00	2.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	Acute - Under 4 hour performance	74.90%	78.00%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - Waiting List Size	69630	58965	2.50
Community - Trustwide	Lincolnshire Community Health Services	Friends & Family Test	89.97%	90.00%	2.50
Acute - Front Door	Lincolnshire Community Health Services	UTC - 15 Minute Ambulance Handover	93.48%	95.00%	2.50
Acute - Front Door	Lincolnshire Community Health Services	UTC - Monthly 4 Hour Waits	95.28%	98.00%	2.50
Community - Workforce	Lincolnshire Community Health Services	Workforce - Overall Compliance	91.83%	90.00%	2.50
Community - Workforce	Lincolnshire Community Health Services	Workforce - Sickness Rate	5.50%	4.81%	2.50

Information on Scoring Methodology

Report Performance Dashboard

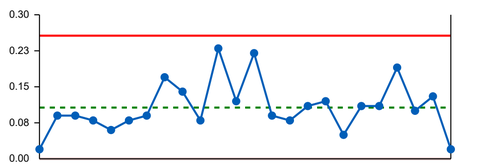
Lincolnshire Community and Hospitals NHS Group

Acute - Trustwide

Acute - Falls per 1000 bed days resulting in moderate, severe

United Lincolnshire Teaching Hospitals — Target: 0.19

Activity Volume

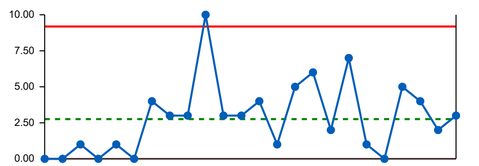


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
0.22	0.09	0.08	0.11	0.12	0.05	0.11	0.11	0.19	0.10	0.13	0.02

Acute - Pressure Ulcers category 3

United Lincolnshire Teaching Hospitals — Target: 4.30

Activity Volume

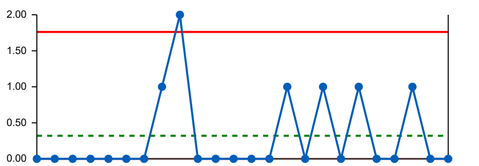


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
4.00	1.00	5.00	6.00	2.00	7.00	1.00	0.00	5.00	4.00	2.00	3.00

Acute - Pressure Ulcers category 4

United Lincolnshire Teaching Hospitals — Target: 1.30

Activity Volume

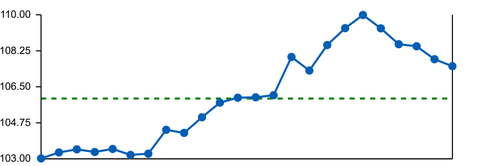


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
0.00	0.00	1.00	0.00	1.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00

Acute - Summary Hospital Mortality Indicator (SHMI) (rolling y

United Lincolnshire Teaching Hospitals — Target: 100.00

Activity Volume

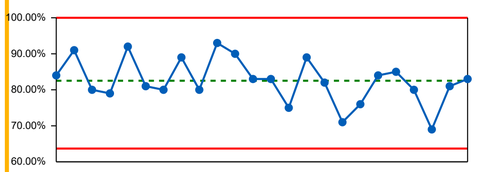


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
105.99	106.09	107.95	107.29	108.53	109.35	109.99	109.34	108.57	108.47	107.84	107.50

Acute - Complaints investigated and responded to within agre

United Lincolnshire Teaching Hospitals — Target: 100.00%

Activity Volume



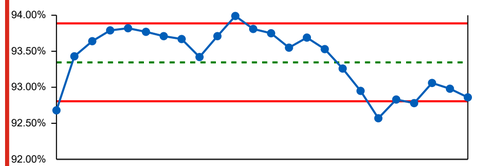
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
83.00%	75.00%	89.00%	82.00%	71.00%	76.00%	84.00%	85.00%	80.00%	69.00%	81.00%	83.00%

Acute - Workforce

Acute - Overall percentage of completed mandatory training

United Lincolnshire Teaching Hospitals — Target: 93.00%

Activity Volume

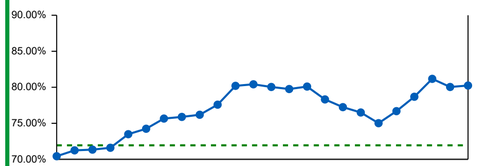


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
93.75%	93.55%	93.69%	93.53%	93.26%	92.95%	92.57%	92.83%	92.78%	93.06%	92.98%	92.86%

Acute - Staff Appraisals

United Lincolnshire Teaching Hospitals — Target: 80.00%

Activity Volume

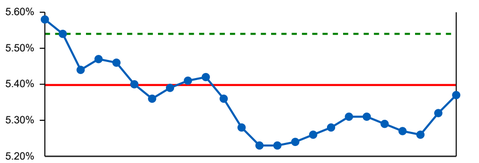


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
80.04%	79.76%	80.10%	78.31%	77.25%	76.50%	75.02%	76.68%	78.69%	81.17%	80.04%	80.25%

Acute - Sickness Absence

United Lincolnshire Teaching Hospitals — Target: 5.00%

Activity Volume

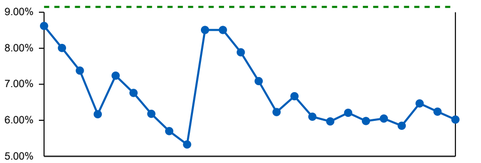


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
5.23%	5.23%	5.24%	5.26%	5.28%	5.31%	5.31%	5.29%	5.27%	5.26%	5.32%	5.37%

Acute - Number of Vacancies

United Lincolnshire Teaching Hospitals — Target: 6.00%

Activity Volume

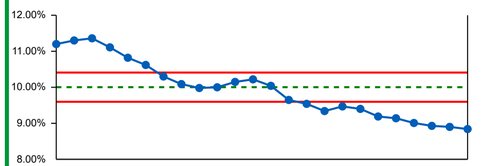


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
7.09%	6.23%	6.67%	6.10%	5.97%	6.21%	5.98%	6.05%	5.85%	6.47%	6.24%	6.02%

Acute - Staff Turnover

United Lincolnshire Teaching Hospitals — Target: 9.00%

Activity Volume



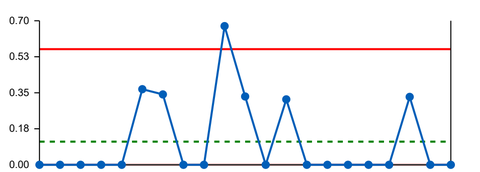
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
10.04%	9.65%	9.54%	9.34%	9.47%	9.40%	9.19%	9.14%	9.01%	8.93%	8.90%	8.84%

Community - Trustwide

Community Hospital Injurious Falls per 1000 OBDs

Lincolnshire Community Health Services — Target: 1.38

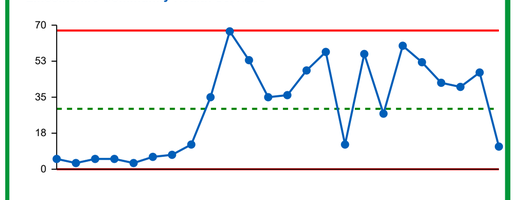
Activity Volume



Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
0.67	0.33	0.00	0.32	0.00	0.00	0.00	0.00	0.00	0.33	0.00	0.00

Quality - Pressure Ulcers Category 3

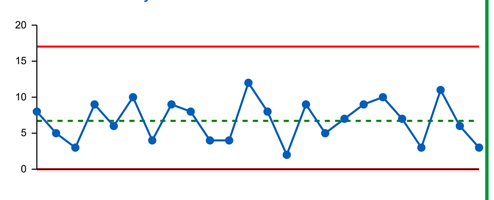
Lincolnshire Community Health Services



Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
36	48	57	12	56	27	60	52	42	40	47	11

Quality - Pressure Ulcers Category 4

Lincolnshire Community Health Services

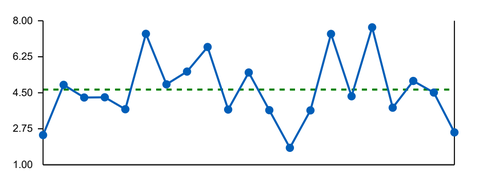


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
8	2	9	5	7	9	10	7	3	11	6	3

Complaints - Rate per 1000 WTE

Lincolnshire Community Health Services — Target: 2.62

Activity Volume

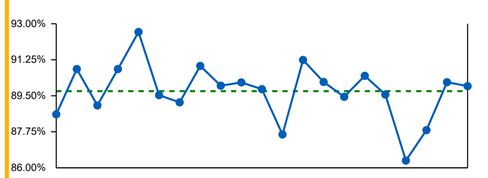


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
3.68	5.49	3.66	1.83	3.65	7.36	4.33	7.68	3.77	5.08	4.51	2.58

Friends & Family Test

Lincolnshire Community Health Services — Target: 90.00%

Activity Volume



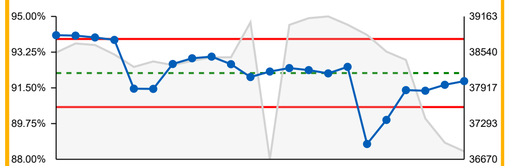
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
90.15%	89.82%	87.62%	91.24%	90.17%	89.45%	90.47%	89.56%	86.35%	87.83%	90.16%	89.97%

Community - Workforce

Workforce - Overall Compliance

Lincolnshire Community Health Services — **Target: 90.00%**

Activity Volume

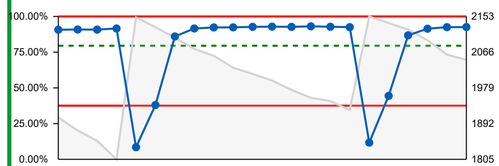


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
92.03%	92.30%	92.47%	92.37%	92.21%	92.53%	88.75%	89.93%	91.39%	91.36%	91.65%	91.83%

Workforce - Appraisals

Lincolnshire Community Health Services — **Target: 80.00%**

Activity Volume

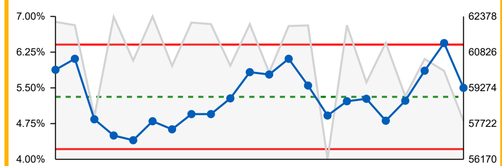


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
92.75%	92.84%	92.71%	93.04%	92.81%	92.47%	11.75%	44.45%	86.80%	91.46%	92.48%	92.57%

Workforce - Sickness Rate

Lincolnshire Community Health Services — **Target: 4.81%**

Activity Volume

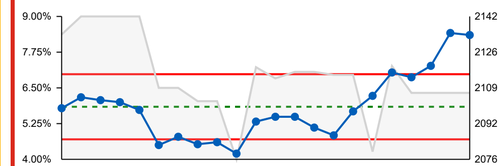


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
5.83%	5.78%	6.11%	5.55%	4.92%	5.22%	5.27%	4.81%	5.23%	5.86%	6.44%	5.50%

Workforce - Vacancy Rate

Lincolnshire Community Health Services — **Target: 6.99%**

Activity Volume

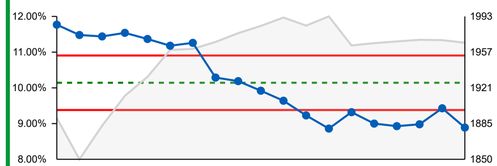


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
5.32%	5.49%	5.49%	5.11%	4.84%	5.68%	6.22%	7.04%	6.87%	7.27%	8.42%	8.35%

Workforce - Turnover

Lincolnshire Community Health Services — **Target: 15.00%**

Activity Volume



Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
10.29%	10.19%	9.92%	9.64%	9.23%	8.86%	9.32%	9.00%	8.93%	8.98%	9.43%	8.89%

Community - Pre-Hospital

LCHS - Admissions Avoided

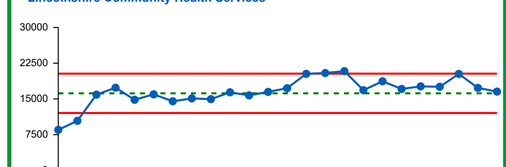
Lincolnshire Community Health Services



Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
3845	4497	4547	4629	3755	4152	3786	3932	3897	4511	3827	3675

LCHS - Bed Days Saved

Lincolnshire Community Health Services

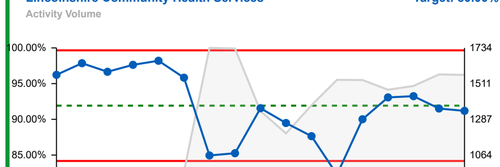


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
17251	20272	20446	20819	16836	18713	17106	17641	17540	20258	17312	16540

IUEC - 2 Hour Response

Lincolnshire Community Health Services — **Target: 80.00%**

Activity Volume



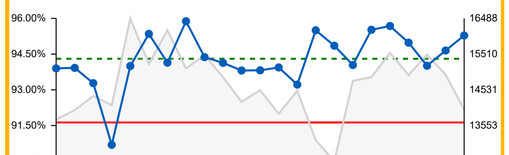
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
95.83%	84.95%	85.26%	91.56%	89.49%	87.64%	82.27%	90.02%	93.07%	93.25%	91.52%	91.18%

Acute - Front Door

UTC - Monthly 4 Hour Waits

Lincolnshire Community Health Services — **Target: 98.00%**

Activity Volume

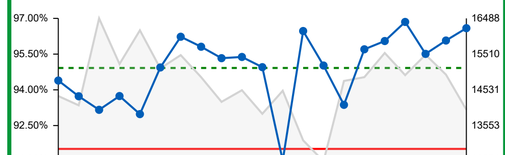


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
93.82%	93.94%	93.22%	95.50%	94.85%	94.04%	95.52%	95.68%	94.98%	94.01%	94.65%	95.28%

UTC - 15 Minute Triage Compliance

Lincolnshire Community Health Services — **Target: 95.00%**

Activity Volume

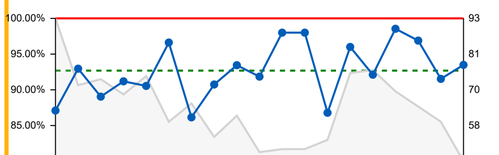


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
95.38%	94.95%	91.03%	96.47%	95.02%	93.37%	95.70%	96.05%	96.85%	95.51%	96.07%	96.59%

UTC - 15 Minute Ambulance Handover

Lincolnshire Community Health Services — **Target: 95.00%**

Activity Volume

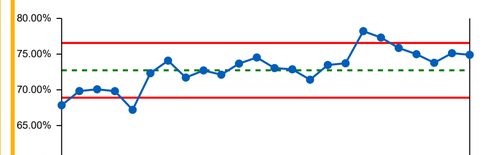


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
90.74%	93.44%	91.84%	98.00%	98.00%	86.79%	96.00%	92.11%	98.55%	96.88%	91.53%	93.48%

Acute - Under 4 hour performance

United Lincolnshire Teaching Hospitals — **Target: 78.00%**

Activity Volume

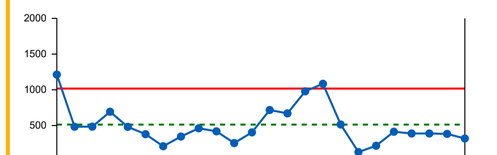


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
73.04%	72.87%	71.41%	73.47%	73.72%	78.21%	77.32%	75.86%	74.98%	73.78%	75.13%	74.90%

Acute - Ambulance Conveyances Delayed >59 mins

United Lincolnshire Teaching Hospitals — **Target: 0**

Activity Volume

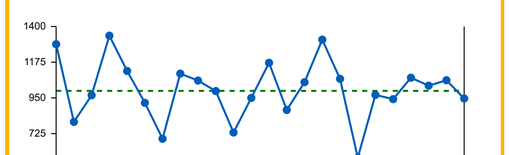


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
717	670	978	1085	514	128	217	413	388	388	383	318

Acute - >12hr Trolley Waits

United Lincolnshire Teaching Hospitals — **Target: 0**

Activity Volume

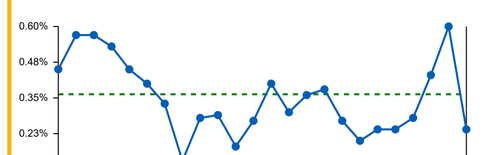


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1171	874	1049	1317	1070	573	969	942	1077	1027	1061	946

Acute - % Triage Data Not Recorded

United Lincolnshire Teaching Hospitals — **Target: 0.00%**

Activity Volume



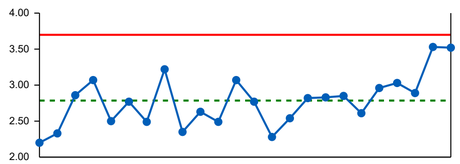
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
0.40%	0.30%	0.36%	0.38%	0.27%	0.20%	0.24%	0.24%	0.28%	0.43%	0.60%	0.24%

Acute - Planned

Acute - Hospital Average LoS (Elective)

United Lincolnshire Teaching Hospitals — **Target: 2.80**

Activity Volume

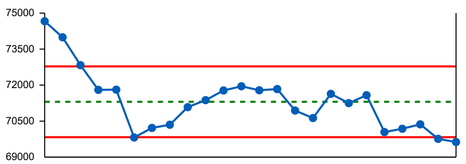


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2.77	2.28	2.54	2.82	2.83	2.85	2.61	2.96	3.03	2.89	3.53	3.52

Acute - Waiting List Size

United Lincolnshire Teaching Hospitals — **Target: 58965**

Activity Volume

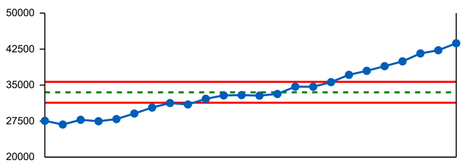


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
71839	70940	70628	71636	71248	71582	70044	70185	70366	69763	69630	

Acute - Partial Booking Waiting List

United Lincolnshire Teaching Hospitals — **Target: 4524**

Activity Volume

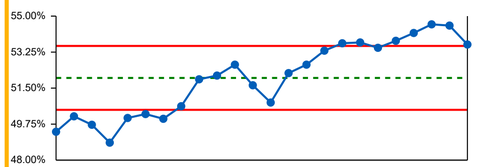


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
32823	33164	34684	34661	35622	37147	37969	38948	39943	41605	42275	43727

Acute - 18 week incompletes

United Lincolnshire Teaching Hospitals — **Target: 84.10%**

Activity Volume

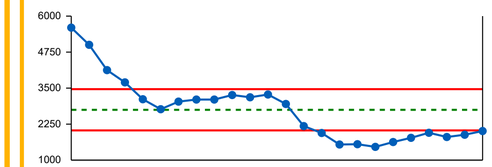


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
52.23%	52.64%	53.32%	53.68%	53.72%	53.46%	53.80%	54.18%	54.60%	54.54%	53.62%	

Acute - 52 Week Waiters

United Lincolnshire Teaching Hospitals — **Target: 0**

Activity Volume

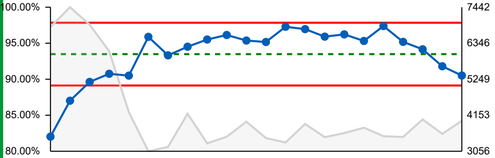


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2181	1944	1543	1552	1461	1629	1775	1951	1805	1882	2012	

Acute - 65 Week Waiters

United Lincolnshire Teaching Hospitals — **Target: 0**

Activity Volume

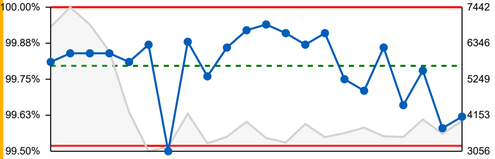


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
201	120	53	30	29	10	17	16	13	9	23	

Acute - 104+ Day Waiters

United Lincolnshire Teaching Hospitals — **Target: 10**

Activity Volume



Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
69	72	85	90	76	78	71	98	97	103	120	111

Acute - 28 days faster diagnosis

United Lincolnshire Teaching Hospitals — **Target: 75.00%**

Activity Volume

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
79.50%	80.50%	79.70%	75.20%	80.30%	78.00%	72.50%	75.80%	77.70%	76.00%	74.32%	

Acute - 31 day first treatment

United Lincolnshire Teaching Hospitals — **Target: 96.00%**

Activity Volume

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
93.00%	91.80%	93.80%	87.30%	92.90%	91.60%	89.80%	89.10%	90.70%	92.50%	87.30%	

Acute - 62 day classic

United Lincolnshire Teaching Hospitals — **Target: 85.39%**

Activity Volume

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
62.30%	66.40%	68.90%	62.00%	59.80%	71.30%	61.70%	65.90%	65.00%	60.90%	61.80%	

Acute - Unplanned

Acute - Average LoS (Non Elective)

United Lincolnshire Teaching Hospitals — **Target: 4.50**

Activity Volume

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
4.73	4.39	4.52	4.59	4.66	4.52	4.61	4.55	4.49	4.34	4.30	4.40

Community - Planned

18 Week Wait

Lincolnshire Community Health Services — **Target: 65.00%**

Activity Volume

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
95.37%	95.17%	97.29%	96.96%	95.92%	96.23%	95.31%	97.38%	95.19%	94.16%	91.80%	90.51%

52 Week Waits %

Lincolnshire Community Health Services — **Target: 100.00%**

Activity Volume

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
99.92%	99.94%	99.91%	99.87%	99.91%	99.75%	99.71%	99.86%	99.66%	99.78%	99.58%	99.62%

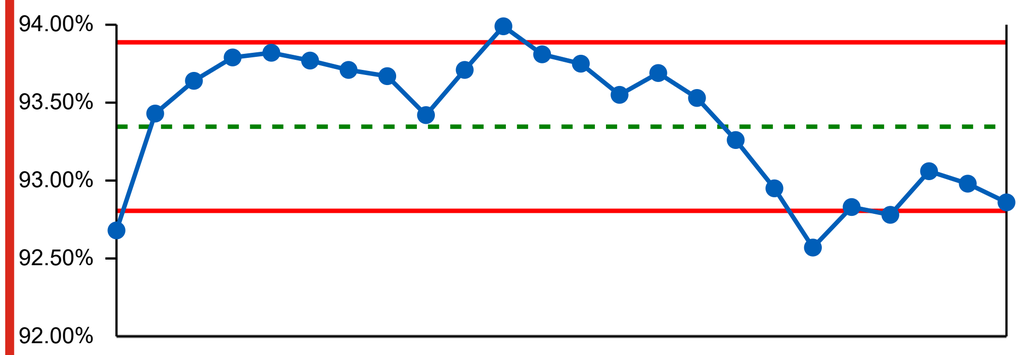
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - Overall percentage of completed mandatory training

United Lincolnshire Teaching Hospitals **Target: 93.00%**

Activity Volume

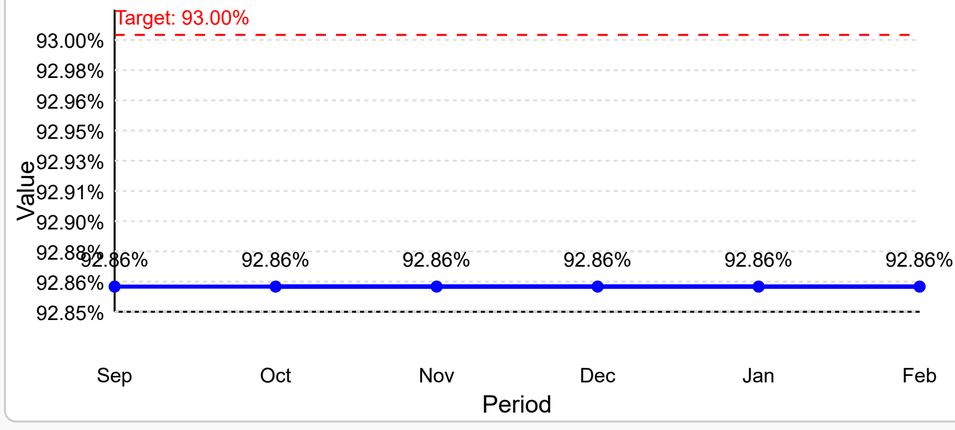


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
93.75%	93.55%	93.69%	93.53%	93.26%	92.95%	92.57%	92.83%	92.78%	93.06%	92.98%	92.86%

• Offer of 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).

Forecast



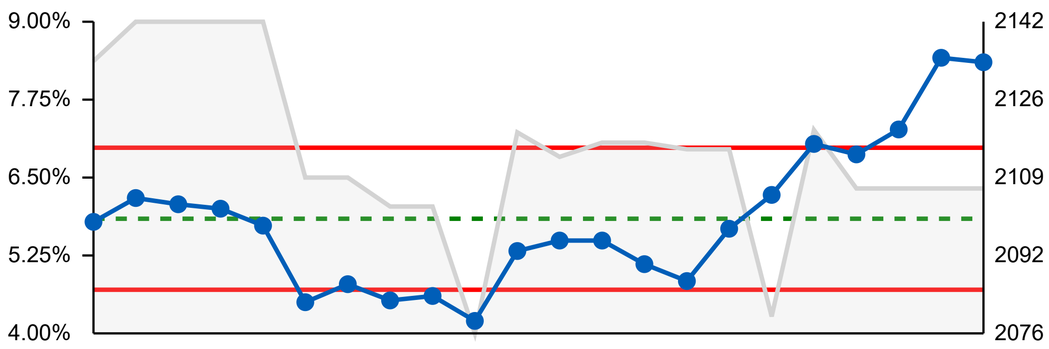
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Workforce - Vacancy Rate

Lincolnshire Community Health Services — **Target: 6.99%**

Activity Volume

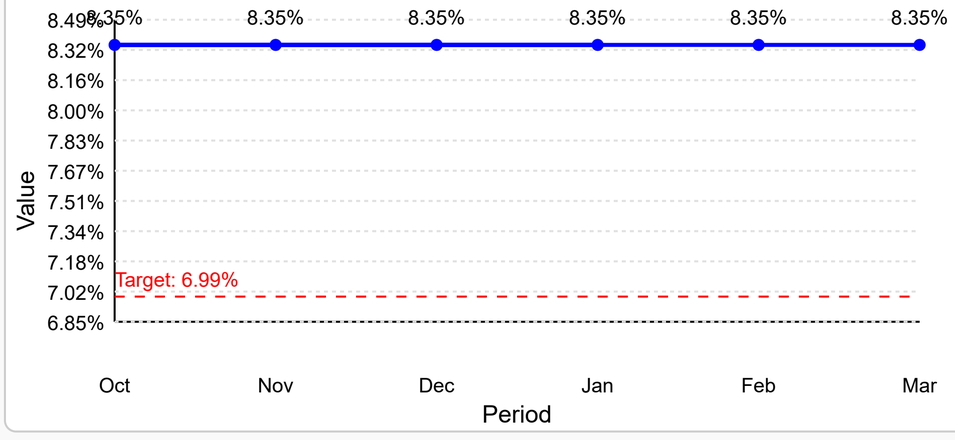


Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
5.32%	5.49%	5.49%	5.11%	4.84%	5.68%	6.22%	7.04%	6.87%	7.27%	8.42%	8.35%

The vacancy rate has dropped slightly from a high in August, this is mainly due to the MARS scheme taking effect with the successful applicants leaving and the corresponding budgets still to be adjusted.

No comment Available

Forecast



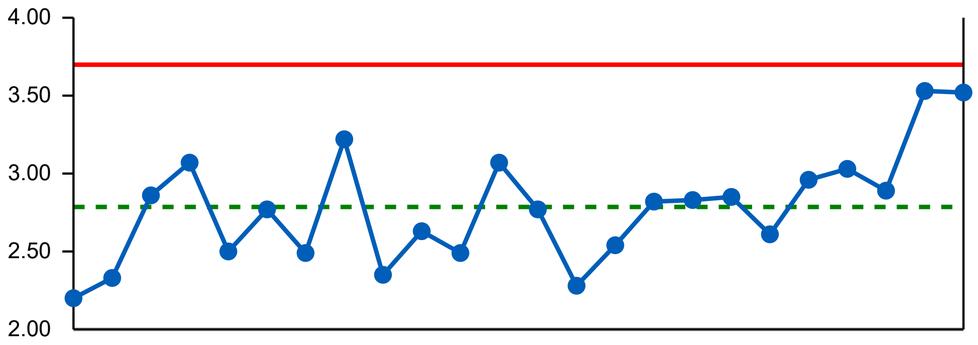
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - Hospital Average LoS (Elective)

United Lincolnshire Teaching Hospitals **Target: 2.80**

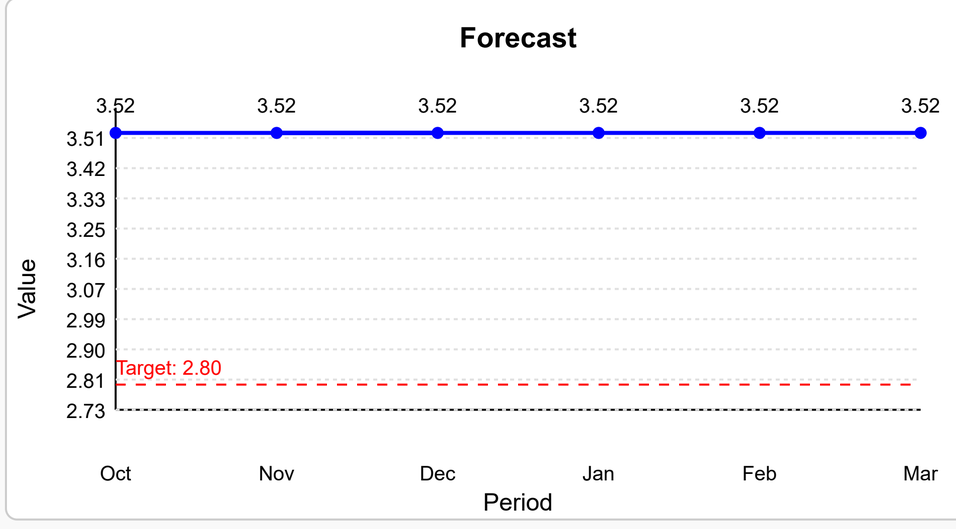
Activity Volume



Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2.77	2.28	2.54	2.82	2.83	2.85	2.61	2.96	3.03	2.89	3.53	3.52

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 inaccurate coding of day case patients which has led to distorted representation of data, misaligning reported figures with established elective care criteria.

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 investigating specific services/sites who have seen an increase to assess on the accuracy of coded information.



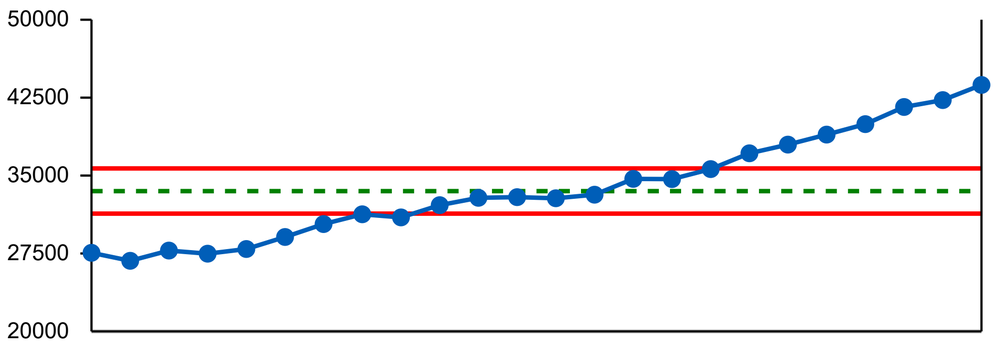
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - Partial Booking Waiting List

United Lincolnshire Teaching Hospitals — **Target: 4524**

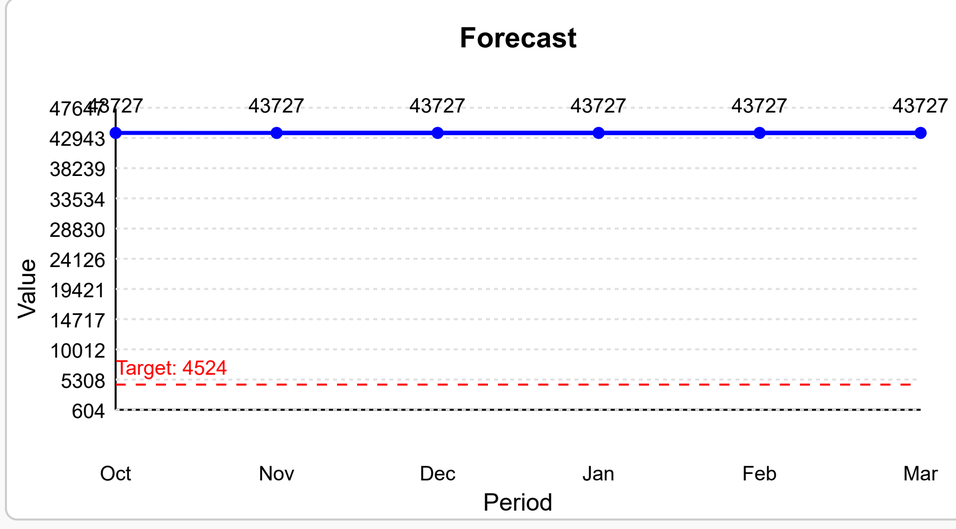
Activity Volume



Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
32823	33164	34684	34661	35622	37147	37969	38948	39943	41605	42275	43727

The organisation has several competing priorities. The current focus is on the long waiting patients (> 65 and >52 weeks) and urgent suspected cancer patients The current PBWL demand outweighs the current capacity which is being impacted by available capacity and resources.

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 further revised to decrease clinic cancellations, improve capacity and vacant slots. Clinic Scheduler x2 in post. Digital room booking system support clinic scheduling and maximise capacity back to procurement phase as initial system not fit for ULTH purpose.



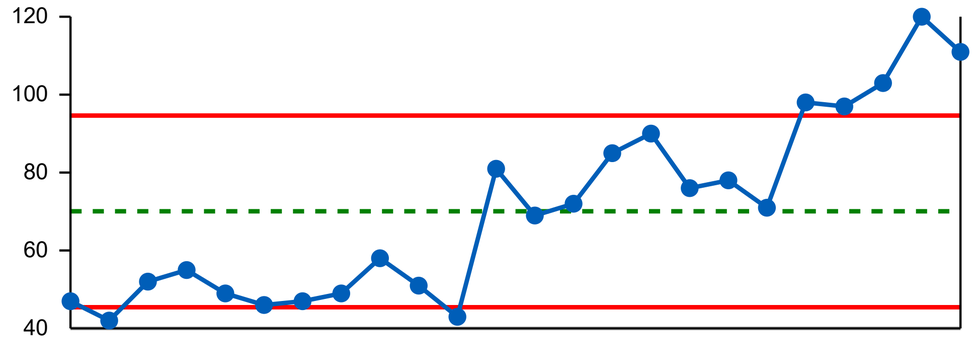
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - 104+ Day Waiters

United Lincolnshire Teaching Hospitals **Target: 10**

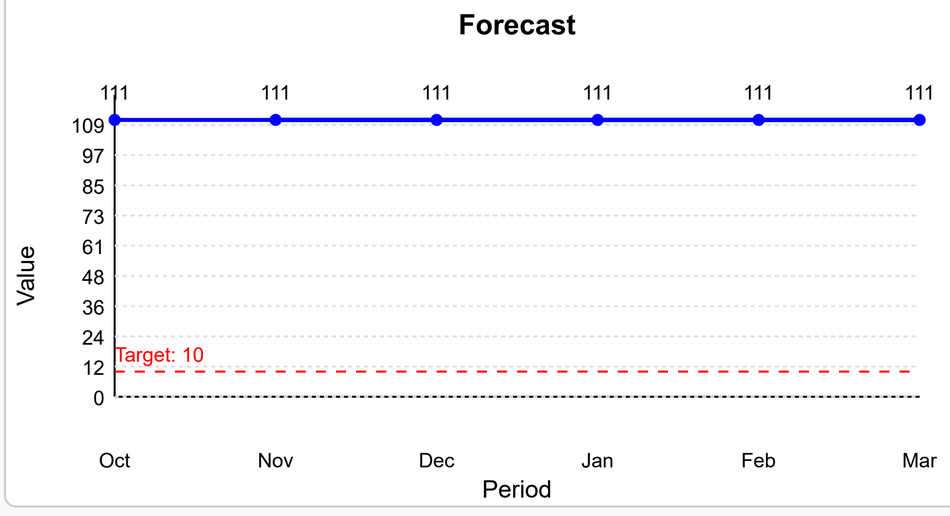
Activity Volume



Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
69	72	85	90	76	78	71	98	97	103	120	111

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 16.2% 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.

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.



NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Strategy Delivery
Q1 Assurance Report (2025/26)

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*11.1*
Report title	*LCHG Strategy Delivery Q1 Assurance Report (2025/26)*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Assurance*
Accountable Director	*Daren Fradgley, Group Deputy CEO, Chief Integration Officer*
Author(s)	*Sameedha Rich-Mahadkar Group Director of Strategy, Improvement and Redesign* *Pauline Bazette, Planning and Business Frameworks Support Lead*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial*
Prior approval process, if applicable	*This report was discussed and approved at ELT on 9 October 2025*
Financial implications, if applicable	*N/A*
Action / decision required	*Review and approve the Q1 report which demonstrates delivery against LCHG 5-year Strategy.*

Assurance Rating Key:

Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are uncertain or possibly insufficient*
Red: Limited or No Assurance	*Effective controls are not in place or are insufficient to manage the risk identified and / or appropriate assurances are not available. Immediate action is required to address the gaps, weaknesses or non-compliances identified*

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:	*x*
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:	*x*
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 report presents a new approach to provide assurance against the delivery of the Trust Strategy.

The report will be produced every quarter to provide a holistic assessment of progress against the delivery of the LCHG strategy whilst considering information from the Board Assurance Framework (BAF), annual plan progress update and associated KPIs from the Integrated performance reports.

The overall assurance rating for Q1 is substantial, indicating effective controls and appropriate assurances are in place.

Strategic Pillar 1: Our Patients – Better Care

Key progress includes improvements in patient safety, infection control, and patient experience. FFT scores are high (ULTH 88.6%, LCHS 90.9%) and Care Opinion engagement is strong (98% response rate). Operational challenges persist in A&E (73.78% performance) and RTT (54.6%), with cancer pathway delays and diagnostics capacity issues. Financially, £15.1m in CIP savings were achieved, and £23m was secured for decarbonisation. Estates compliance actions are underway following limited assurance.

Key actions include enhancing flow programmes, expanding diagnostics, streamlining cancer pathways, and accelerating estates compliance.

Strategic Pillar 2: Our People – Better Opportunities
Training compliance exceeds 90%, and appraisal rates are near target. The medical workforce has grown by 27% since 2022. Leadership programmes and Just Culture initiatives are progressing. Staff recognition is high, with 1,300 award nominations and long service celebrations.

Risks include rising vacancy rates, high sickness absence, and WRES/WDES disparities.

Actions focus on recruitment, manager support, inclusive leadership, and ESR automation.

Strategic Pillar 3: Our Populations – Better Health
Transformation efforts include successful left-shift models and pathway redesigns. Health inequalities are addressed through 44 champions and a co-production taskforce. Digital innovation is advancing with EPR, EDMS, and OPTICA pilots. Sustainability efforts include a Green Plan and £23m for decarbonisation.

Challenges include workforce capacity, estates delays, and digital resource constraints.

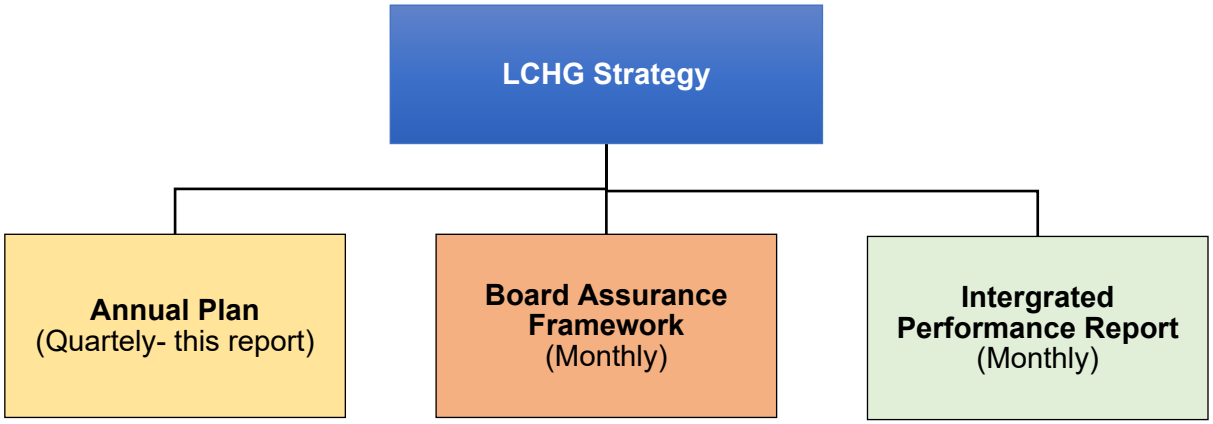
Actions include recruitment prioritisation, planning acceleration, and broadening research participation.

Conclusion
We are making strong progress in delivering against our strategic aims, particularly in patient safety, workforce development, and digital transformation. Continued focus is required on urgent care performance, diagnostics, and estates compliance to maintain momentum across all strategic pillars.

LCHG Strategy Delivery - Q1 Assurance Report (2025/26)

Background:

We separately monitor progress against the Annual Plan goals, Board Assurance Framework risks and Key Performance Indicators to report whether expected progress is being made within that quarter. There are already established mechanisms that the Trust Board utilises to receive updates on how the Trust is progressing against the requirements of the strategy. These are set out in the diagram below which also shows the frequency of reporting.



The report provides a holistic assessment of progress against the delivery of the LCHG strategy whilst considering information from the Board Assurance Framework (BAF), annual plan progress update and associated KPIs from the Integrated performance reports. The following sections describe our strategic aims, what we set out to achieve in 2025/26, our key strategic risks, followed by a summary of key highlights against each strategic aim and key areas of improvements and associated actions.

Pillar 1 (Our Patients)- Q1 Strategic Assessment against delivery of ambitions set for 2025/26

Strategic Aim	Strategic Objective	What we will achieve in 2025/26?	Board Assurance Framework Strategic Risks
Patients: Timely, high quality and affordable care in the right place	1a: Improve patient safety, patient experience and deliver clinically effective care	Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm, improved IPC practices and reviewing external reports and assessments of our services Identify areas where services do not meet best practice requirements and deliver demonstratable improvement in those areas. Focus on improving the top three patient feedback themes: Communication, appointments and clinical practice	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	Utilise best practice from HVLC/GIRFT, deliver a number of planned care improvement programmes to maximise patient experience and flow to support elimination of 52 week wait and 18-week RTT Deliver a number of improvement programmes and projects focussed on unplanned care pathways, that deliver a reduction in A&E waiting times, and improve category 2 ambulance response times Better utilise our Community Diagnostics Centres and increase % of patients receiving diagnostic test within six weeks to support plans to address elective/ cancer backlogs and diagnostic waiting time	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	Robust CIP and productivity monitored through our LCHG Productivity, Improvement and Transformation Forum (PITOF) Embed a culture of Quality Improvement	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	Manage our backlog maintenance liability and deliver our capital programme Optimise property and space utilisation and improve functionality Improve our internal resilience across all services	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

		Fully integrate group working across acute, community, private and system where possible	or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny

Key Highlights

1. Clinical Safety

Clinical safety remains a key priority for the Trust. Medication safety continues to be a concern, particularly regarding the omission or delay of time-critical drugs. This is being addressed through the Patient Safety Incident Response Framework (PSIRF), with harm reduction identified as a priority workstream. Performance against the paediatric sepsis pathway remains below standard. In July, only 44% of children attending ED received IV antibiotics within the recommended one-hour window (target: 90%). Thematic analysis identified barriers such as difficult cannulation, diagnostic delays, and uncertainty around intramuscular administration. Harm reviews have been completed for all affected cases, with no harm identified.

2. Infection Prevention and Control (IPC)

The Trust has seen a rise in healthcare-associated infections (HCAIs), including MRSA, C. difficile, MSSA, E. coli, and Norovirus. IPC audits have highlighted gaps in catheter care, peripheral line management, and environmental cleanliness. These are being addressed through targeted action plans.

- **Outbreaks**: 67 outbreaks were recorded in 2024–25, with Norovirus cases increasing by 340% year-on-year.
- **Antimicrobial stewardship**: ULTH has been identified as a regional outlier in broad-spectrum antibiotic use. An AMS Strategy Group has been established to lead improvement efforts.

3. Safeguarding

Safeguarding activity continues to increase across both adult and children's services.

- **Children**: There has been a rise in care and protection plans, with complex cases involving domestic abuse, FGM, and exploitation.
- **Adults**: Pressure ulcers and discharge planning remain recurring themes. MARAC referrals and DoLS applications are increasing. While compliance is improving, variation persists across services.

4. Patient Experience

Patient experience metrics remain broadly positive.

- **Friends & Family Test**: ULTH reported 88.6% positive responses; LCHS 90.9%.
- **Care Opinion**: 713 stories received with a 98% response rate.

- **Complaints**: ULTH received 1,273 complaints (mainly communication and treatment); LCHS received 204 (access and care). Patient stories are actively used in governance forums to support learning.
- **Realtime feedback**: Surveys are ongoing in oncology, discharge, urgent care, and immunisation pathways.
- **Duty of Candour**: Verbal compliance is at 97%, written at 85%. Patient Safety Alerts compliance was 100% in July.

5. Clinical Effectiveness

Both Trusts maintained 100% participation in national clinical audits.

- **Outliers**: ULTH was flagged in epilepsy, bowel cancer, and paediatric diabetes audits.
- **Positive performance**: Pilgrim Hospital achieved 100% compliance in neonatal retinopathy screening.
- **Practice improvements**: Progress noted in Parkinson's medication timing, antimicrobial prescribing, and paediatric handover processes.

6. Operational Performance

Urgent and Emergency Care

- Operational pressures across urgent and emergency care pathways remain significant. In July, the Trust recorded an overall A&E 4-hour performance of 73.78%, below the trajectory of 78%. Type 1 performance was particularly challenged at Lincoln County Hospital (55.94%) and Pilgrim Hospital (58.37%), with delays in ward discharges and late identification of long-stay patients impacting flow and capacity.
- Despite these pressures, there was a slight improvement in 12-hour trolley breaches, which reduced to 1,027 from 1,077 in June. All breaches have undergone harm reviews, with no significant harm identified. Discharge lounges at Lincoln and Pilgrim continue to operate 24/7, supporting ED flow and timely transfers.
- Ambulance handover delays remain a concern, with 388 handovers exceeding 59 minutes. High patient acuity (21.46% with NEWS ≥4) and late afternoon surges continue to contribute to crowding. Performance against the Fractured Neck of Femur (NOF) 48-hour theatre target improved to 67.95%, though theatre and staffing constraints persist.
- Positively, the non-elective length of stay (LOS) decreased to 4.34 days, below the target of 4.5 days. However, weekend discharge rates remain low, and daily discharge planning continues to be a focus.

Elective and Cancer Pathways

- Referral to Treatment (RTT) performance remains below national expectations, with 54.6% of patients treated within 18 weeks in June. However, the Trust reported zero patients waiting over 104 or 78 weeks, and only 13 patients over 65 weeks. The number of patients waiting over 52 weeks reduced to 1,805, following three months of increases.
- The total waiting list stood at 70,366 at the end of June, with sustained pressure in ENT, Trauma & Orthopaedics, Ophthalmology, Gynaecology, and Gastroenterology. These specialties remain the focus of targeted recovery and transformation efforts.

- Diagnostics (DM01) performance was 75.96% (target: 99%), with Ultrasound and Audiology identified as the most challenged modalities. Recovery plans and additional capacity are being explored. Cancelled operations on the day improved slightly to 1.76%, though 40 patients breached the 28-day rebooking standard due to scheduling pressures.

Cancer pathway performance remains variable:

- Faster Diagnosis Standard (28-day): 77.7% in June, showing recovery after a dip in April.
- 31-day first treatment: 90.7% (target: 96%).
- 31-day subsequent surgery: 48.6% (target: 94%), impacted by theatre and pre-op delays.
- 62-day classic pathway: 65% (target: 85.39%).
- 104+ day waiters: Increased to 103 patients, with colorectal, lung, and head & neck pathways most affected.

To support recovery, the Trust continues to hold Intensive Support Meetings across tumour sites and has implemented additional theatre slots and pathway reviews.

7. Financial Performance and Productivity

The Group remains committed to delivering a breakeven position for 2025/26, underpinned by a robust £79.3m Cost Improvement Programme (CIP), the largest in the Trust's history. CIP and productivity initiatives are fully embedded across operational and strategic planning.

At Month 4, ULTH reported a £10.6m deficit, in line with plan, and delivered £13.7m in CIP savings, exceeding target by £0.7m. LCHS reported a £1.7m deficit, £0.1m favourable to plan, with £1.4m in CIP savings, also ahead by £0.1m. Group-wide, £15.1m in savings have been achieved, £0.9m ahead of plan. The Trust's cash position remains strong at £36.8m, £1.9m above forecast.
CIP delivery is being driven through four key mechanisms:

- **Workforce Controls**: Recruitment of 80 HCSWs is underway to reduce temporary staffing reliance. Enhanced vacancy controls, job planning, and real-time dashboards are supporting proactive workforce management.
- **Operational Efficiency**: Improvements in clinic and theatre utilisation, alongside expanded use of insourcing, outsourcing, and Patient Initiated Follow-Up (PIFU), are helping reduce delays and unnecessary activity.
- **Digital Transformation**: Rollout of EDMS and EPR is progressing, with EDMS expected to deliver £2.9m in savings. Infrastructure upgrades, including Windows 11 deployment, are supporting digital maturity.
- **Governance and Oversight**: The Productivity, Improvement & Transformation Oversight Forum (PITOF) provides strategic leadership, with regular reporting to Finance & Performance and Audit Committees. Post-investment evaluations are being embedded to assess ROI and impact.

8. Estates

The Trust continues to invest in estate safety and sustainability. Discharge lounges at Lincoln and Pilgrim Hospitals operate 24/7, supporting ED flow. Infrastructure risks—particularly fire safety, water hygiene, and ventilation—are under close review.

- £7.1m in ICB funding and £2.9m internal allocation are supporting backlog maintenance.
- A £23m award has been secured for decarbonisation works at Pilgrim Hospital under the Green Plan.
- An external audit of Planned Preventative Maintenance (PPM) has been commissioned following a limited assurance rating.
- Capital spend is currently £4.6m behind plan due to earlier approval delays, now resolved.
- Red-rated risks across the community estate are being actively addressed, with targeted investment in high-priority areas.

Strategic Aim 1 (Patients) Summary

LCHG continues to deliver improvements in patient safety, experience, and financial sustainability. CIP delivery is ahead of plan, patient feedback remains positive, and estates investment is progressing. However, urgent care and cancer pathway performance remain below target, and diagnostics are under pressure.

Areas for Improvement & Actions:

- **A&E and RTT performance**: Below trajectory; implement targeted flow improvement programmes and expand discharge lounge utilisation.
- **Cancer pathways**: Low compliance in 31-day subsequent surgery and 62-day targets; increase theatre capacity and streamline pre-op processes.
- **Diagnostics**: DM01 performance at 75.96%; prioritise capacity expansion in Ultrasound and Audiology and optimise CDC utilisation.
- **Estates compliance**: Limited assurance on PPM; accelerate audit response actions and embed space impact assessments in change processes.

Pillar 2 (Our People)- Q1 Strategic Assessment against delivery of ambitions set for 2025/26

Strategic Aim	Strategic Objective	What we will achieve in 2025/26?	Board Assurance Framework Strategic Risks
People: Develop, empower and retain great people	2a: Enable our people to fulfil their potential through training, development and education	Support our Divisions to provide all staff with an appraisal, clear objectives and clear relevant statutory and mandatory training Increase the number of staff involved with research activity across LCHG Harness new roles, integrated roles and rotational roles where there is further opportunity for productivity or integration through a 'grow our own' approach and maximising the apprenticeship levy Ensure all staff have the correct training and support available to them to fulfil their role as a leader.	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
	2c: Nurture compassionate and diverse leadership	Continue our focus on upskilling leaders by strengthening their leadership knowledge, training and awareness of their responsibilities through active engagement with the 'basics brilliantly' and 'leading functional teams' training Work to be an employer of choice by developing our one desired culture of Civility and Respect through: a. Embedding the 'Just Culture' principals and developing an inclusive culture across the Trust. b. Actively listening to our staff experience through the National Staff Survey. c. Working closely with our Staff Networks Creation of a 'Hot Spot' Dashboard which includes cultural elements including turnover, vacancies, complaints, datix, HR cases, FTSU concerns, sickness which will highlight cultural positions	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
	2c: Nurture compassionate and diverse leadership	Continue our focus on upskilling leaders by strengthening their leadership knowledge, training and awareness of their responsibilities through active engagement with the 'basics brilliantly' and 'leading functional teams' training Work to be an employer of choice by developing our one desired culture of Civility and Respect through: a. Embedding the 'Just Culture' principals and developing an inclusive culture across the Trust. b. Actively listening to our staff experience through the National Staff Survey. c. Working closely with our Staff Networks	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

		Creation of a 'Hot Spot' Dashboard which includes cultural elements including turnover, vacancies, complaints, datix, HR cases, FTSU concerns, sickness which will highlight cultural positions	
	2d: Recognising our people through thanks and celebration	Hold celebratory events through our awards programme and long service programmes to say thank you to our staff and celebrate their achievements and service to the NHS.	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

Key Highlights

9. Training, Development and Education

- **The Mandatory training Core Learning Rate of 93.06% (ULTH) and 94.94% (LCHS)** is **exceeding our overall target of 90.00%**. Compliance will continue to be monitored to ensure that we remain in line with our overall trajectory. The biggest challenge is ensuring staff have protected time to complete role specific mandatory training. **Targeted support is being provided to staff with ≤50% compliance**.
- **Appraisal rates for June 2025 against a Q1 target of 80% were 79.71% (ULTH) and 84.48% (LCHS)**. At ULTH work continues to educate leaders on the process required to update ESR. **Targeted support is being provided to teams with ≤50% compliance**.

10. Continuously Improve and Innovate

- **The National Staff Survey and Quarterly Pulse Survey** are reviewed quarterly alongside the free text comments post thematic review. Divisional action plans are formulated to support closing the feedback loop.
- In June 2025 **70.99%** of doctors have signed off job plans for the 2025/26 job planning cycle against a target of **95.00%**. This is **the highest sign off compliance rate by the end of Q1** since the Trust commenced job planning reporting.
- Over the past 24 months **Consultant recruitment has increased by a net 31 WTE and middle grade workforce by 34 WTE**. Since the medical recruitment team was introduced in July 2022 **the medical workforce has increased by 251 WTE, an increase of 27.00%**. Consultant recruitment priority focus continues and there is a strong pipeline in place to clear our middle grade workforce vacancy position.
- There are **59 individuals acting as Principal Investigator (PI)** for an active research study in June 2025**. HLO target will be 70** different individuals. In June 2025 there are **108 studies and 60 studies in follow-up and potentially due to close**. **There is a risk this may reduce the numbers of individuals acting as PI.**

- **We have developed our Quality Improvement Enabling Plan 2025–2030** to empower staff across LCHG by: Equipping every colleague with the skills, confidence, and support to lead and contribute to improvement, through tailored training, coaching, and structured development programmes. It fosters a culture of curiosity, collaboration, and continuous learning; embedding improvement into everyday practice, leadership behaviours, and personal development plans.

11. Nurture Compassionate and Diverse Leadership

- A leadership programme is in development across Group currently and will be launched in October 2025.
- Just Culture briefings continue to be offered across the Group and embedded within new Group policies.
- ELT Live sessions are proving popular with recent sessions being viewed by 3000 staff
- Workforce Race Equality Standards (WRES) 2024/25 annual reports noted increases in data related to the relative likelihood of white staff being appointed from shortlisting across all posts as well as the increase of staff experiencing bullying, harassment and abuse from patients and relatives, staff or managers. These remained below the national average, but work required has been identified to improve the situation.
- Workforce Disability Equality Standards (WDES) 2024/25 annual reports noted development of an action plan following data analysis. There was an increase, above national average associated with staff likely to enter formal capability processes.
- Sickness absence has plateaued in ULTH (5.27% against Q1 target of 5.28%) and slightly increased in LCHS (5.23% against Q1 target of 4.96%). There is a continued focus on supporting managers and leaders in absence processes and mandated 'People Management Essentials' training.
- Turnover rate for June 2025 is 9.01% (ULTH) and 9.14% (LCHS) against a target of 9.00%. Work ongoing with colleagues to support vacancy reduction and reduce the impact of staffing and associated operational pressures.
- Vacancy rate for July 2025 is 6.47% (ULTH) which is an increased rate to last month. Monitoring will continue in 2025/26 to ensure recruitment to roles/services directly impacting patient care. Vacancy rate is 8% (LCHS) against a target of 8%. 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 took place to align the budgets and establishment. This work has now been completed with the budget/finance system and ESR fully balanced.

12. Thanks and Celebration

- **Group Staff Awards** received a **record-breaking circa 1300 nominations** this year with the event being held in October 2025.

- **Long Service Awards** celebrated 45 LCHS clinical and support staff receiving certificates for 20, 30 or 50 years of NHS service.

Strategic Aim 2 (People) Summary
Progress is evident in training compliance, workforce growth, and cultural engagement. Leadership development is underway, and staff recognition is strong. However, workforce pressures persist, and cultural indicators require attention.

Areas for Improvement & Actions:

- **Vacancy and turnover**: ULTH vacancy rate rising; strengthen recruitment pipelines and review retention incentives.
- **Sickness absence**: Above target in LCHS; enhance manager support and roll out mandatory absence management training.
- **WRES/WDES indicators**: Capability process disparities and staff experience concerns; develop targeted action plans with Staff Networks and embed inclusive leadership practices.
- **Job planning**: 71% sign-off rate; increase support for clinical leaders and automate ESR updates to improve compliance.

Pillar 3 (Our Populations)- Q1 Strategic Assessment against delivery of ambitions set for 2025/26

Strategic Aim	Strategic Objective	What we will achieve in 2025/26?	Board Assurance Framework Strategic Risks
Population: Improve our population health	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	Deliver left shift transformation through the Alliance Care Group, focussed on key specialties OPAT/IV Therapies, Stroke, Dermatology, Weight Management, Respiratory, Rheumatology, Therapies Rehab, Paediatrics, cataract surgery, ENT surgery, Neurology Transform acute wards to community wards to improve pathways of care Strengthen integrated working with Primary Care/GPs/PCNAs and provider partners through collaboration in the Alliance Division Develop our estates strategy for rationalisation and develop business cases for maternity and theatres	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	Embed a BAU population health-based approach to service change and transformation that supports a reduction in health inequalities across our population Deliver the LCHG Health Inequalities Action plan Embed CDC pathways into primary care Deploy neighbourhood health model	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	Become a paperlite digital Group, deliver our Digital Strategy and Implement an Electronic Prescribing system Upgrade our technological infrastructure and provide our people with real-time data to support high quality care delivery Enhance our organisational digital capability and skills through training Develop a new LCHG Research Strategy which will support additional research opportunities and improvements in patient care Attract and increase number of clinical academics and principle investigator opportunities across our workforce to build a strong R&I culture within LCHG and with the University of Lincoln Host system wide provision of Digital and Business Intelligence	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	Robust CIP and transformation delivery monitored through our LCHG Productivity, Improvement and Transformation Oversight Forum New Board-approved Green Plan for LCHG which provides a clear roadmap toward the net zero 2024 target, increasing staff understanding and awareness of the green agenda Develop a sustainability dashboard to provide clear baseline carbon footprint measure and track progress Produce Adaptation Risk Assessments for both ULTH and LCHS	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

Key Highlights

13. Transform Clinical Pathways and Rationalise our Estates

- **Estates and Facilities** experiencing ongoing pressures in respect of space with new requests received. There is some concern about changes undertaken without impact assessment and work is taking place to ensure space awareness is forming part of the change process.
- Capital programmes of **work delayed in respect of Pilgrim ED** but **risks were being managed**. Planning for capital works in maternity environments at Pilgrim and Lincoln continues with plans to support bids should national investment become available.
- Patient experience will be improved through **rollout of electronic menus on 1st August 2025** along with appropriate volumes of meals being produced for wards.
- **Scotter Ward** remedial work underway to address historical structural issues for areas of concern and act in accordance with recommendations. **Appropriate monitoring measures are in place**.
- **TB Service Fragile Service Risk Review impact** had been seen in **reducing waiting lists** and **improving the backlog** and the **ambition to move to a multiple MDT approach**. Lessons learnt from the process could be applied to other reviews.
- **Children's Speech and Language Service Redesign** recognition of **underinvestment** by the ICB and LCC. Action to manage the waiting list with the service redesign being in line with the left-shift approach. **Improved access** through a move from clinic bases to family hubs and integration with local authority hubs. **Delivery timeframe is January 2026**.

14. Move from Prescription to Prevention

- **Alliance Steering Group**: Both planned and unplanned care programmes are progressing positively. Key achievements include the successful implementation of the transitional bed model and intermediate care transformation. Financially, the programmes have delivered £531k in cost improvement savings year-to-date. Risks remain around workforce capacity and transitional bed procurement, but mitigation strategies are in place. Left shift programme is focused on shifting care from acute settings to community-based and preventative models. Rheumatology has been selected as the blueprint for large-scale transformation, with

a comprehensive service redesign underway. Scoping is also progressing in other specialties including Dermatology, CYP, Diabetes, and Women's Health. The programme is strategically aligned with NHSE's 10-Year Plan and LCHG's objectives, with expected benefits in patient experience, operational efficiency, and workforce redesign

- **Target Operating Model Group** workstreams in place for the large services, transfer of teams and functions, contract transfers and contracts with other providers. Shift in focus from the workforce element to the large service changes due to national direction of travel for ICBs. Undertaking due diligence to support the changes and ensure delivery. Alignment of PCNAs as a legal entity would support further engagement.
- **End of Life Due Diligence** undertaken appropriately and development of the service would continue with appropriate clinical engagement in place for the pathway work.
- **To deliver LCHG Health Inequalities Action Plan** there are now 44 Personalisation and Health Inequalities Champions across the Group. Key challenges such as ethnicity coding have been resolved, and a co-production taskforce is being established to drive patient engagement. The programme is now focused on developing care group-specific plans and embedding health inequalities into operational delivery.
- **To improve LCHG Healthy Inequalities Maturity Matrix Scores** between September 2024 and March 2025 there has been an **overall improvement**. An updated action plan has been developed.

15. Enhance our Digital and Research and Innovation Capacity

- **Electronic Patient Record (EPR) Project** moved into initiation stage following contract award to Nerve Centre. Staff are being recruited to key roles with Programme Director now in post. Challenges around resource and accommodation are being addressed. BadgerNet for maternity is now live across ULTH with challenges resolved through training and roll out of additional equipment.
- **Electronic Document Management System (EDMS) Accelerated Programme Plan** business case signed off. Possible to accelerate programme of work, delivering in 12 months through the purchase of additional scanners. Additional capital cost will be offset by providing transformation capacity more quickly and positively impact bottom line of circa £2.9m.
- **Flow & Discharge Improvement Programme – OPTICA pilot is now live** on the Lincoln Site with Pilgrim due to go live in October. Community module is due to come online post the winter period. System data will also be available to the Local Authority, further supporting discharge and allowing sight of areas of pressure.
- **Research and Innovation Group** first meeting held. Work underway to develop a new 5-year strategy in line with the 10-year health plan, alongside expanding research and innovation wider than medics.

16. Drive Forward our Improvement, Efficiency and Sustainability Agenda

- **Booking Centre Update** work being undertaken by PWC is progressing positively and considering existing and future digital solutions to ensure compatibility.

- **Intermediate Care Improvements (Newton**) commenced diagnostic period work which would be followed by recommendations.
- **Green Plans** are due at Board in September for approval. Network of Green Champions launched in April 2025 with over 50 active champions from across the Group. Work underway to develop a sustainability dashboard to track progress.

Strategic Aim 3 (Populations) Summary
Transformation programmes are progressing, with left-shift models and community care redesign delivering early benefits. Digital and sustainability initiatives are gaining momentum, and health inequalities work is embedded across care groups.

Areas for Improvement & Actions:

- **Workforce capacity for transformation**: Risk to delivery; prioritise recruitment for transitional bed models and community services.
- **Left Shift Programme**: Pace of implementation of Integrated neighbourhood Teams (INTs), risk of stakeholder disengagement affecting system-wide transformation due to Impact of the ICB Target Operating Model (TOM) on timelines and delivery. A new system wide Neighbourhood Health Board implemented to work with key system partners to drive agenda.
- **Estates delays**: Pilgrim ED works behind schedule; expedite planning approvals and strengthen project oversight.
- **Digital programme risks**: EPR and EDMS face resource challenges; secure accommodation and staffing to maintain delivery timelines.
- **Research engagement**: PI numbers may decline; broaden participation beyond medical staff and promote research opportunities across roles through the development of an R&I strategy

NHS
Lincolnshire Community and Hospitals NHS Group

NHS Oversight Framework 2025/26 – Q1 publication

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4th November 2025*
Agenda item number	
Report title	*NHS Oversight Framework 2025/26 – Q1 publication*
Report purpose:	• *Information* • *Discussion*
Accountable Director	*Daren Fradgley, Group Chief Integration Officer / Deputy Group CEO*
Author(s)	*Shaun Caig, Associate Director of Performance & Information*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Reasonable assurance*
Prior approval process, if applicable	*ELT, Finance & Performance Committee*
Financial implications, if applicable	*N/A*
Action / decision required	*The Board is asked to:* • *note the new framework, the current segmentation assigned for Q1 2025/26 and associated metric performance*

Assurance Rating Key:

Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are uncertain or possibly insufficient*
Red: Limited or No Assurance	*Effective controls are not in place or are insufficient to manage the risk identified and / or appropriate assurances are not available. Immediate action is required to address the gaps, weaknesses or non-compliances identified*

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings	
People: Better Opportunities – Develop, empower and retain great people:	

2a: Enable our people to fulfil their potential through training, development and education	
2b: Empower our people to continuously improve and innovate	*X*
2c: Nurture compassionate and diverse leadership	
2d: Recognising our people through thanks and celebration	
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*X*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	
3c: Enhance our digital, research & innovation capability	*X*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	

Executive Summary

Further to the 2025/26 NHS Oversight Framework that was published at the end of June 2025 (NHS England » NHS Oversight Framework 2025/26), the first set of league tables were published on Tuesday 9th September 2025 (a paper summarising the approach and initial position was shared with ELT on 10th July 2025 followed by an update on 11th September 2025). Subsequent updates went to ELT on 16th October 2025 and Finance & Performance Committee on 23rd October 2025.

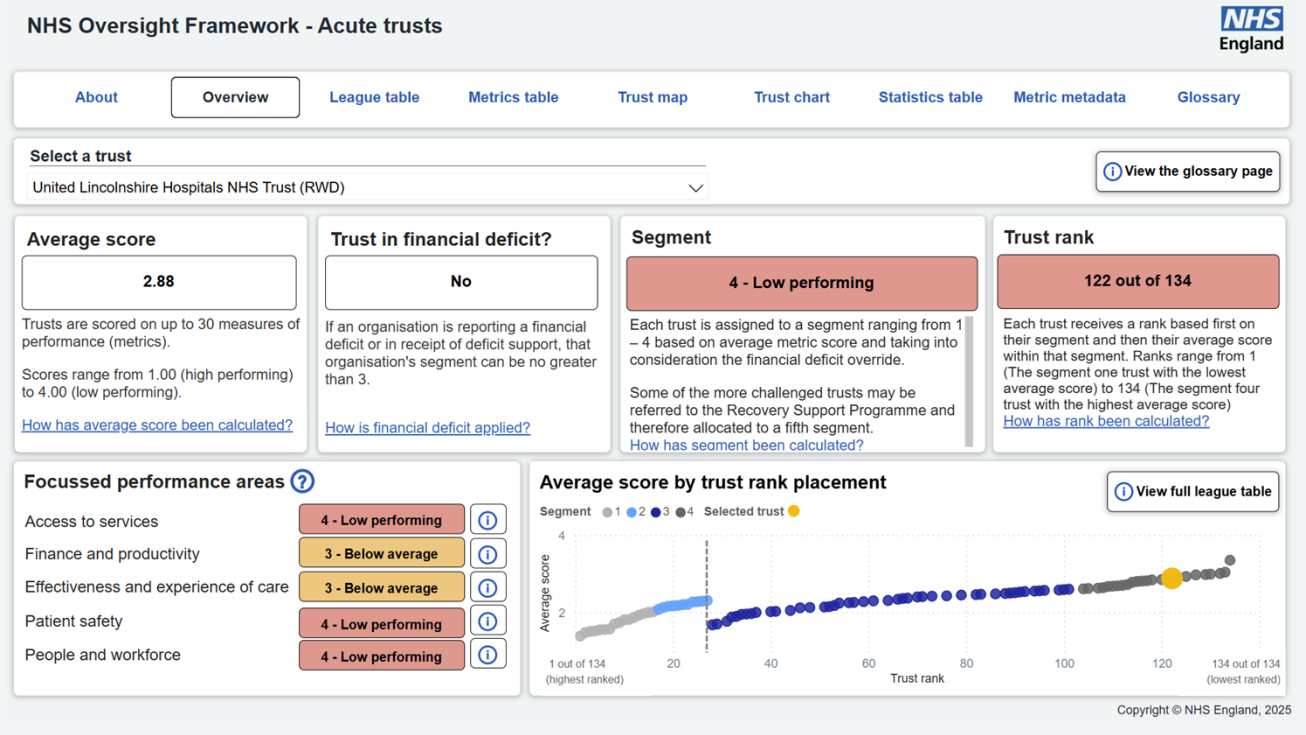
The published position for Q1 2025/26 is as follows:

Trust	Trust Type	Segment	Score	Rank
ULTH	Acute - Large	4	2.88	122 out of 134
LCHS	Community	3	2.54	41 out of 61

Source: Acute (NHS England » Acute trust league table) or Non-Acute (NHS England » Non-acute hospital trust league table)

Further detail on performance of domains and metrics is captured below from the National Dashboards (Acute Data Dashboard and Non-Acute Data Dashboard)

ULTH:



Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q1 2025/26	65.96	percent	3.13	81 out of 118	71.12	75
Access to services	Cancer care	Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	Q1 2025/26	75.38	percent	3.12	79 out of 118	76.88	80
Access to services	Elective care	Difference between planned and actual 18 week performance	Jun-25	-0.40	percentage points	2.30	92 out of 131	0.99	0
Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Jun-25	54.60	percent	3.68	117 out of 131	60.72	
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Jun-25	3.14	percent	2.90	50 out of 80	1.11	
Access to services	Elective care	Percentage of patients waiting over 52 weeks for elective treatment	Jun-25	2.57	percent	2.85	73 out of 131	2.40	1
Access to services	Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q1 2025	76.00	percent	2.53	62 out of 123	76.00	78
Access to services	Urgent and emergency care	Percentage of emergency department attendances spending over 12 hours in the department	Q1 2025/26	18.09	percent	3.85	117 out of 123	8.36	

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Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Jun-25	1.00	days	3.16	91 out of 126	0.70	
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2023		score	2.00			
Effectiveness and experience	Patient experience	Summary Hospital Level Mortality Indicator	Apr 24 - Mar 25		score	2.00			
Finance and productivity	Finance	Combined finance	Q1 2025/26		score	1.00			
Finance and productivity	Finance	Planned surplus/deficit	2025/26	0.00	percent	1.00	12 out of 134	-1.62	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 3 2025	0.00	percent	1.00	54 out of 134	0.00	
Finance and productivity	Productivity	Implied productivity level	To M12 2024/25 vs 2023/24	-1.02	percent	3.59	116 out of 134	2.91	

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.06	out of 10	3.71	121 out of 134	6.42	
Patient safety	Patient safety	Number of MRSA infections	Jul 24 - Jun 25	3.00	count	2.63	55 out of 134	3.00	0
Patient safety	Patient safety	Rate of C-Difficile infections	Jul 24 - Jun 25	1.13	rate	2.50	48 out of 134	1.22	1
Patient safety	Patient safety	Rate of E-Coli infections	Jul 24 - Jun 25	1.38	rate	3.69	117 out of 134	1.16	1
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	6.59	out of 10	3.57	115 out of 134	6.88	
People and workforce	Retention and culture	Sickness absence rate	Q4 2024-25	5.49	percent	2.66	85 out of 134	5.21	

<u>Areas for improvement</u>:

All Access to Services domain metrics, especially

- “percentage of patients waiting 18 weeks or less for elective treatment” (June 2025 performance 54.60% against an average of 60.72%, ranked 117 out of 131)
- “percentage of emergency department attendances spending over 12 hours in the department” (Q1 performance 18.09% against an average of 8.36%, ranked 117 out of 123) – please see “Potential changes to data” notes below

Effective and experience

- “average number of days from discharge ready date to actual discharge date” (June 2025 performance 1.00 days against an average of 0.70 days, ranked 91 out of 126)

Finance and productivity

- “Implied Productivity level” (to M12 2024/25 vs 2023/24 performance -1.02% against an average of 2.91%, ranked 116 out of 134)

Patient Safety

- “NHS Staff survey – raising concerns sub-score” (2024 performance 6.06 out of 10 against an average of 6.42 out of 10, ranked 121 out of 134)
- “Rate of E-Coli infections” (Jul24-Jun25 performance 1.38 rate against an average of 1.16 rate, ranked 117 out of 134)

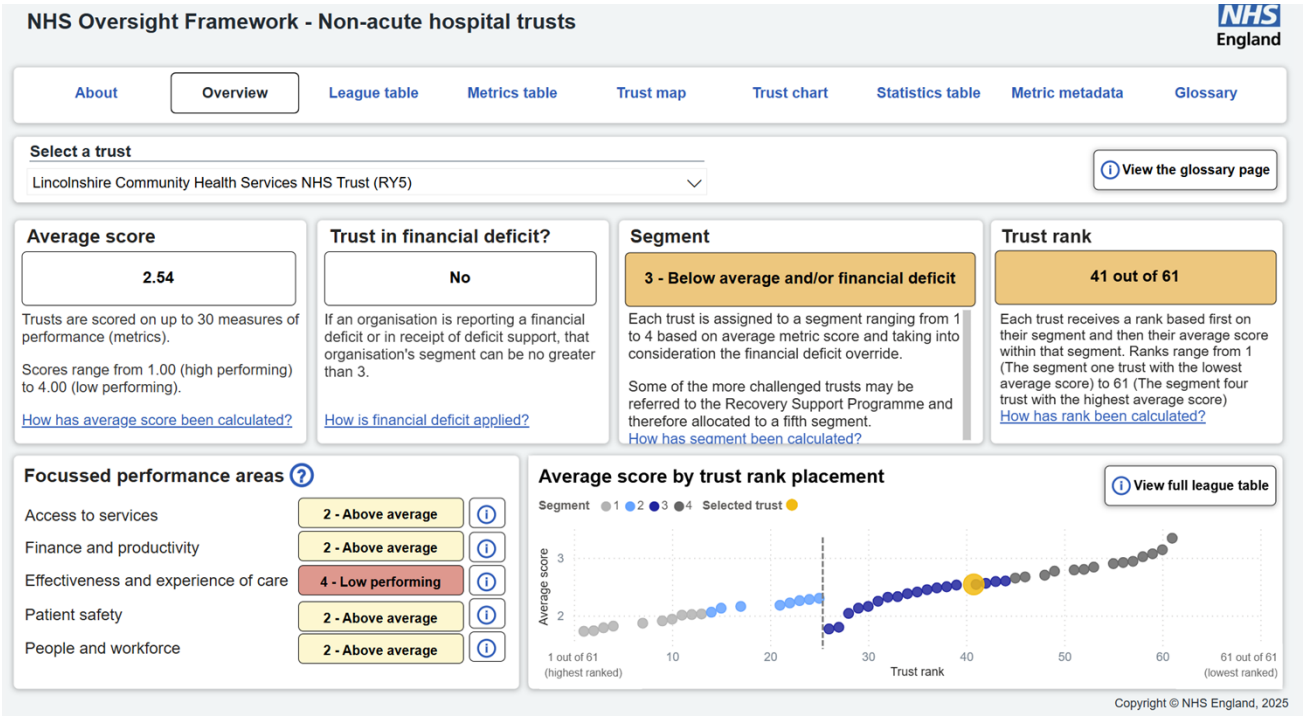
People and Workforce

- “NHS staff survey engagement theme sub-score” (2024 performance 6.59 out of 10 against an average of 6.88 out of 10, ranked 115 out of 134)

<u>Areas performing well</u>:
Finance and productivity

- “Combined finance” (Q1 metric score of 1)
- “Planned surplus/deficit” (2025/26 0% against an average of -1.62%, ranked 12 out of 134)
- “Variance year to date to financial plan” (Month 3 2025 performance of 0% against an average of 0%, ranked 54 out of 134)

LCHS:



Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Jun-25	0.36	percent	2.18	16 out of 41	0.70	
Effectiveness and experience	Effective out of hospital care	Urgent Community Response 2-hour performance	Q1 2025/26	39.21	percent	4.00	37 out of 37	85.58	70
Finance and productivity	Finance	Combined finance	Q1 2025/26		score	1.00			
Finance and productivity	Finance	Planned surplus/deficit	2025/26	0.00	percent	1.00	15 out of 61	0.00	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 3 2025	0.32	percent	1.00	4 out of 61	0.00	
Finance and productivity	Productivity	Relative difference in costs	2023/24	113.16	percent	3.39	46 out of 60	105.39	

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.86	out of 10	2.20	25 out of 61	6.81	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	7.01	out of 10	3.00	41 out of 61	7.08	
People and workforce	Retention and culture	Sickness absence rate	Q4 2024-25	4.99	percent	2.00	15 out of 61	5.65	

<u>Areas for improvement</u>:
Effective and experience

- “Urgent Community Response 2-hour performance” (Q1 2025/26 performance 39.21% against an average of 85.58, ranked 37 out of 37) – please see “Potential changes to data” notes below

Finance and productivity

- “Relative difference in costs” (2023/24 performance 113.16% against an average of 105.39%, ranked 46 out of 60)

People and Workforce

- “NHS staff survey engagement theme sub-score” (2024 performance 7.01 out of 10 against an average of 7.08 out of 10, ranked 41 out of 61)

<u>Areas performing well</u>:
Finance and productivity

- “Combined finance” (Q1 metric score of 1)
- “Planned surplus/deficit” (2025/26 0% against an average of 0%, ranked 15 out of 61)
- “Variance year to date to financial plan” (Month 3 2025 performance of 0.32% against an average of 0%, ranked 4 out of 61)

<u>Future changes to data capture</u>
Having reviewed the metrics included within the Oversight Framework and understood our performance, there are two areas of concern with regards to data & submissions.

1. ULTH – “percentage of emergency department attendances spending over 12 hours in the department”
2. LCHS – “Urgent Community Response 2-hour performance”

Both of these areas have been reviewed and resolved, and the right data will pull through in Q2 reporting which is expected to be published in draft mid-November via the NHSE regional team.

Recommendation

The Group Board is asked to **NOTE** the current published results in the Q1 framework and associated segmentation.

NHS
Lincolnshire Community and Hospitals NHS Group

Group Board Risk Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4th November 2025*
Agenda item number	*12.1*
Report title	*Group Board Risk Report*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Assurance*
Accountable Director	*Kathryn Helley, Group Chief Clinical Governance Officer*
Author(s)	*Helen Shelton, Group Deputy Chief Clinical Governance Officer* *Sarah Davy, Group Risk and Datix Manager*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial assurance*
Prior approval process, if applicable	*Sub Committees of the Board*
Financial implications, if applicable	*Not applicable*
Action / decision required	*The Board is asked to:* • *Review the content of the Report. There are no further escalations at this time.*

Assurance Rating Key:

Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are uncertain or possibly insufficient*
Red: Limited or No Assurance	*Effective controls are not in place or are insufficient to manage the risk identified and / or appropriate assurances are not available. Immediate action is required to address the gaps, weaknesses or non-compliances identified*

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*x*
1b: Reduce waiting times for our patients	*x*

1c: Improve productivity and deliver financial sustainability	*x*
1d: Provide modern, clean and fit for purpose care settings	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	*x*
2b: Empower our people to continuously improve and innovate	*x*
2c: Nurture compassionate and diverse leadership	*x*
2d: Recognising our people through thanks and celebration	*x*
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	*x*
3b: Move from prescription to prevention, through a population health management & health inequalities approach	*x*
3c: Enhance our digital, research & innovation capability	*x*
3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	*x*

Executive Summary

The following report includes information pertaining to risks scoring 15 – 25 which are in relation to the highest risks across the Group.

There are 742 (116 LCHS and ULTH 626) active and approved risks reported to lead committees in October 2025, this is an increase of 22 since the September 2025 report.

LCHS

There is 1 Very High risk (20 - 25) reported to the Quality Committee. This relates to:

- 403 - Children SLT Therapy Treatment Delays

There were no Very High risks (20-25) reported to the Finance, People, or Integration Committees in October.

ULTH

The are 7 Very High risks (20-25) reported to the Quality Committee this month, remaining static since the September report, these relate to:

- 4731 - Reliance on paper medical records
- 4746 - Overdue patients on Ophthalmology PBWL - **presented and validated at RRCC in August 2025 for increase in score to 5x4=20,** (previous score 4 x 4=16).
- 4879 - Recovery of planned care cancer pathways
- 5016 - Patient flow through Emergency Departments
- 5101 - Delivery of paediatric epilepsy pathways-across acute and community
- 5200 - Backlog of Paediatric Cardiology clinics
- 5450 - Risk of Gastro service not being viable due to current fragility of Consultant workforce

Following Risk Confirm and Challenge meeting the following Very High risk was closed:

4947 – Inability to meet NICE medicines reconciliation targets

There are 4 Very High risks (20-25) reported to the People Committee this month, remaining static since the September report:

- 4844 – Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service
- 4996 - Consultant workforce capacity (Haematology)
- 4997 – Service configuration (Haematology)
- 5093 – Procurement service staffing levels

There are 6 Very High risks (20-25) reported to the Finance and Performance Committee this month, remaining static since the September 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)
- 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

There are 2 Very High risks (20-25) reported to the Integration Committee this month, an increase of 1 since the September report, these relate to:

- 5563 - Neurology – Service sustainability
- 5711 - Risk to our transformation programme due to changes within the ICB (**New Risk validated at Risk Register Confirm and Challenge** on 15th October, Score **agreed 5 x 4 = 20)**

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 Risk 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 742 (116 LCHS and ULTH 626) active and approved risks reported to lead committees in October 2025, this is an increase of 22 since the September 2025 report.

2.2 LCHS

There is 1 risk with a current rating of Very High risk (20-25) and 10 rated High risks (15-16) reported to lead committees this month. **Table 1** below shows the number of active risks by current risk rating and proportion of the overall Trust risk profile:

Very low (1-3)	**Low** (4-6)	**Moderate** (8-12)	**High** (15-16)	**Very high** (20-25)
3 (-) (3%)	**37 (+6)** (32%)	**65 (+1)** (55%)	**10 (+1)** (9%)	**1 (-)** (1%)

2.3 ULTH

There are 19 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 (-) (8%)	**156 (+1)** (25%)	**345 (+12)** (54%)	**59 (-)** (10%)	**19 (+1)** (3%)

Strategic objective 1a: Improve patient safety, patient experience and deliver clinically effective care

2.4 LCHS

There is 1 Very High risk, and 4 High risks recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	Title	Risk score	Division	Progress Update	Date of latest review
403	Children SLT Therapy Treatment Delays	20	Children, Young People, and Specialist Services	Pre-school pilot commenced with a soft launch – too early to note any change. As such there is no change to score.	02/10/25

2.5 ULTH

There are 7 Very High risks and 22 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	22/09/2025
4746	Overdue patients on Ophthalmology PBWL	Very high risk (20-25)	Surgery	Process remains ongoing with updates through Patient Safety Group. **Risk validated at RRC&C in August for increase in score to 5x4:20 Very High Risk.** Increased number of incidents being reported weekly which demonstrates increasing risk**.**	19/09/2025
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
5016	Patient flow through Emergency Departments	Very high risk (20-25)	Medicine	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.	15/09/2025
5101	Delivery of paediatric epilepsy pathways-Acute Paediatrics & Community	Very high risk (20-25)	Family Health	Business case has been written - to be submitted for 2026/27 funding – await outcome of business case submission. Conversations ongoing with tertiary provider regarding clarity of service offer.	23/09/2025

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	Cardiology Service is delivering additional Saturday clinics in Sept and Oct 25 to increase capacity to complete clinic reviews which has resulted in decrease in backlog of clinics. Once completed will revert to "business as usual" and optimistic it will be sufficient to maintain the clinic backlog at acceptable level with a view to review and reduce / close the risk.	19/09/2025
5450	Risk of Gastro service not being viable due to current fragility of Consultant workforce	Very high risk (20-25)	Medicine	Work not started for moving Gastro service into community. 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	22/09/2025

Updates from the previous report:

- **4947 – Inability to meet NICE medicines reconciliation targets** – Risk reviewed at the August Risk register Confirm & Challenge meeting and the decision made to close the risk and merged with 4844 which covers this risk and provides mitigations.

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	Approval for 3 long-line agency scrub nurses for a period of 3 months started on 29th September. Nursing establishment has been adjusted for 9 theatres however there are still occasions where requests are made to staff additional theatres. Risk to be reviewed for potential reduction due to current changes.	09/10/2025

Strategic objective 1c: Improve clinical outcomes Improve productivity and deliver financial sustainability

2.8 **LCHS**

There are no Very High risks, and 1 High risk recorded in relation to this objective.

Update from previous report:

- 805 – **CIP (Efficiency) Requirement 2025/26** - New risk validated at August RRC&C meeting, agreed score of 4x4:16 High Risk.

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	Current active communications with ICO- regulator. Changes to processes are being discussed and implemented. Resource needs have been reviewed and temporarily increased. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	01/09/2025
4664	Exceeding the agency cap due to the cost of reliance upon temporary clinical staff	Very high risk (20-25)	Corporate	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	22/09/2025
4839	Lack of pharmacy capacity for Intravevenous Immunoglobulin (IVIG)	Very high risk (20-25)	Clinical Support Services	Interview and successful appointment for B7 Pharmacy Technician – planned start date mid-October Further interviews for 8a and 8b towards the end of September. Following recruitment and onboarding will be able to review risk score and reduce. Once team embedded will be looking to close risk.	22/09/2025
5020	Reliance on agency / locum medical staff in Urgent & Emergency Care	Very high risk (20-25)	Medicine	Robust recruitment plan International recruitment Medical Workforce Management Project	15/09/2025
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. Development of future programme of cost improvement.	22/09/2025

ID	Title	Risk level (current)	Division	Progress Update	Date of latest risk review
				Additional resource supported in Financial Improvement. Further pipeline opportunities being developed. Discussions with system partners and regional colleagues on specific issues.	

Strategic objective 1d: Provide modern, clean and fit for purpose care settings

2.10 **LCHS**

There are no Very High risks, and 2 High risks recorded in relation to this objective.

Update from previous report:

- 799 – **Potential for a Major Fire** - New risk validated at August RRC&C meeting, agreed score of 4x4:16 High Risk.

2.11 **ULTH**

There are no Very High risks and 12 High risks, recorded in relation to this objective.

Update from the previous report:

- 5695 – Risk of maintenance of specialist equipment was not being followed - **New Risk validated at September Risk Register Confirm and Challenge Meeting, risk score 4x4:16 agreed.** Following an internal audit, it was identified that the maintenance of specialist equipment was not being followed relating to oxygen and suction delivery in ward and departments across the Trust. Over 1000 pieces of equipment for PHB have been replaced with ongoing delivery across both main sites.

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 rating	Risk reduction plan	Date added to register and latest review:
4996	Staffing - insufficient consultant workforce to meet demand. Particular areas of concern: 1. Lymphoma tumour site cover 2. Haemostasis/haemophilia (single consultant Trust wide) 3. Pilgrim Consultant cover 4. Clinical governance lead 5. HoS/clinical lead	Very high risk (20)	Recruitment of further substantive consultants - April 2025 Service review undertaken – progressing left shift to GP Surgeries for low grade CLL and MGUS	18/09/2025

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 2 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. Weekend working change in practice effective from 09/08/2025.	22/09/2025
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.	18/09/2025

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 Long term absence staff being reviewed for temporary redeployment. Invoicing vacancy filled. Storekeeper vacancy progressing through TRAC process following approval from VCP.	22/09/2025

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 are 2 Very High risks (20 - 25), and 8 High risks (15 -16) recorded in relation to this objective. A summary of the Very High risks 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	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. Recruited to one vacancy, commencing on 1st September, still carrying one vacancy. Outsourcing companies contacted and working up pathways. Team will return to 4 consultants by October however significant backlogs and PBWL risk remains.	22/09/2025
5711	Risk to our transformation programme due to changes within the ICB	Very high risk (20-25)	Corporate	**New Risk validated at Risk Register Confirm and Challenge on 15th October, Score agreed 5 x 4 = 20** The current position is monitored and mitigated through the following strategic and leadership engagement forums: -BLET -LLG -System exec to exec -ICB Board (include partner chief execs -Group Board - weekly chief executive meetings - target operated model board (TOM) - Executive one to one's Given the pace of change and the current vagueness of the ICB cluster operating model it is difficult to quantify the future controls possible until the cluster executive team is in place. It is anticipated the announcement will be made during October on these roles and then formalised next steps planning can take place.	15/10/2025

<u>Update from previous report:</u>

Following a deep dive of the People Committee risks the following risks have been transferred to Strategic Objective 3a.

- 4780 – **Significant deficit in stroke consultant staffing** – High Risk (4x4:16)
- 5564 - **Risk of operational pressures to Hospital Out of Hours due staffing and increase of wards** – High Risk (4x4:16)
- 5480 - **Risk of depleted workforce in diabetes-DSN** - High Risk (3x5:15)

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 no High risks (15 - 16) recorded in relation to this objective.

Update from previous report :

783 **– TB Service Provision - Capacity & Demand** - score decreased to 3x4=12 Moderate Risk (previously 4x4=16 High Risk). This was due to the ongoing work by the TB working group to get through the backlog of patients on the waiting list, which have reduced from 20 weeks to 3 weeks. Following cost improvement plans, Band 6 and Band 3 substantive staff are in post which supported the workload. The working group are now looking at more digitisation and pathway improvements going forward.

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 742 (116 LCHS and ULTH 626) active and approved risks reported to lead committees in October 2025, this is an increase of 22 since the September 2025 report.

3.2

LCHS

There is 1 Very High risk (20 - 25) reported to the Quality Committee. This relates to:

- 403 - Children SLT Therapy Treatment Delays

There were no Very High risks (20-25) reported to the Finance, People, or Integration Committees in October.

ULTH

The are 7 Very High risks (20-25) reported to the Quality Committee this month, remaining static since the September report, these relate to:

- 4731 - Reliance on paper medical records
- 4746 - Overdue patients on Ophthalmology PBWL
- 4879 - Recovery of planned care cancer pathways
- 5016 - Patient flow through Emergency Departments
- 5101 - Delivery of paediatric epilepsy pathways-across acute and community
- 5200 - Backlog of Paediatric Cardiology clinics
- 5450 - Risk of Gastro service not being viable due to current fragility of Consultant workforce

There are 4 Very High risks (20-25) reported to the People Committee this month, remaining static since the September report:

- 4844 – Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service
- 4996 - Consultant workforce capacity (Haematology)
- 4997 – Service configuration (Haematology)
- 5093 – Procurement service staffing levels

There are 6 Very High risks (20-25) reported to the Finance and Performance Committee this month, remaining static since the September 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)
- 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

There are 2 Very High risks (20-25) reported to the Integration Committee this month, an increase of 1 since the September report, these relate to:

- 5563 - Neurology – Service sustainability

5711 - Risk to our transformation programme due to changes within the ICB

3.4 The Group Board is invited to review the content of the report. There are no further escalations at this time.

Strategic Objective	ID	Group Risk Type	Risk Lead	Committee Responsible	Opened	Rating (initial)	Division	Service	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
1a: Improve patient safety, patient experience and deliver clinically effective care	403	Physical or Psychological Harm	Farbrace, Kylie	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)	13/09/2022	9	Children, Young People, and Specialist Services	Children's Therapy	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	02/10/2025	Extremely likely (5) >90% chance	Severe (4)	Very High Risk (20-25)	20	[02/10/2025 15:03:22 Ana Morgan] Risk reviewed at CYPSS Quality SMT 2/10/25: too early to note any change from the pilot. No change to score. [04/09/2025 15:05:54 Ana Morgan] Risk reviewed at CYPSS Quality SMT 4/09/25: pre-school pilot started with a soft launch WC 01/09/25. No change to score. [15/08/2025 11:59:07 Ana Morgan] Risk reviewed at CYPSS Quality SMT 7/08/25: still aiming to start in September for the pre-school changes, although there will be a period of adjustment. No change to risk. [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	Low Risk (4-6)	06/11/2025	No change

1a: Improve patient safety, patient experience and deliver clinically effective care	681	Regulatory Compliance	Farbrace, Kylie	(Accountable for), Patient Safety Group (Accountable for)	05/02/2024	20	Children, Young People, and Specialist Services	Children in Care	There is a risk that there is insufficient capacity within the children in care service to meet the current demand for Initial Health Assessments (IHAs) and Review Health Assessments (RHAs). Initial Health Assessment is required within 20 days of a child coming into care. Review Health Assessments are required annually for children over 5 years of age, and twice yearly for children under the age of 5 years.	At the end of 2023 there were 728 children in the care of Lincolnshire County Council, this number continues to increase year on year (increased by 7% from the previous year alone and 18% over the last 5 years). The introduction of the National Transfer Scheme in November 2021 has also triggered a significant rise in Unaccompanied Asylum-Seeking Children receiving support from the service. The number of children and young people placed into Lincolnshire by external authorities also continues to rise significantly putting additional pressure on the team (22% increase over the last 5 years). The current budget for	This means there is a significant increase in the number of children in care in Lincolnshire resulting in an increased demand for IHA and RHAs. These assessments are statutory and the service will be unable to meet the timescales these should be completed within. This will impact on the health needs of children in care living in Lincolshire and delay access to care they may require. The reputation of the service will also be affected if they are unable to meet these statutory assessment timescales. Service user and carer feedback will also be impacted as children have to wait longer	The number of children under the care of Lincolnshire County Council continues to grow year on year increasing the demand for IHA and RHA assessments. The service has only been able to offer the amount of IHA appointments needed to meet this demand at significant cost pressure to LCHS. LCHS are unable to continue to cover this additional financial support needed from 01.04.24. An options appraisal has been completed to identify the increase in funding to meet the increased demand for IHA and RHAs, this is attached to the record.	02/10/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[02/10/2025 15:07:06 Ana Morgan] Risk reviewed at CYPSS Quality SMT 02/10/2025: post out for recruitment for the second time as fixed term; applicants are being shortlisted. Risk score remains high. [17/09/2025 11:51:12 Sarah Davy] Reviewed at RRC&C on 17 Sept agreed to increase in score from 3x4=12 to 4x4=16 High Risk. [05/09/2025 14:02:41 Ana Morgan] Risk reviewed by DDL and CSL: The doctor provided by ULTH on an SLA basis joined the service in February and left July, working only part of that month. The service's bank capacity is variable as it's reliant on the availability of one particular clinician, who has been absent throughout most of the summer period and will continue to be so in September. ULTH are currently out to advert to recruit a permanent doctor for the service (O.75WTE). Initial health assessments are entirely reliant on doctors since they cannot be performed by any other grade within guidance. Demand is	Very Low Risk (1-3)	08/01/2026	Increase in score
1c: Improve productivity and deliver financial sustainability	805	Finances	Taylor, James	Finance Committee (Lead assurance committee)	08/08/2025	20	Corporate	Finance	The Trust fails to deliver the efficiency requirement aspect of its financial plan	Lack of identified efficiency plans; Non delivery of identified schemes; delays in implementing efficiency savings of increased complexity due to system implications	Reputational damage including reduction in the SOF rating and/or lack of financial sustainability going forward, and a failure to meet statutory financial duties	1. Financial plan and budgets approved and delegated. 2. Financial control systems in place 3. Executive oversight at ELT with Executive owned targets for efficiency delivery. Cost improvement planning process overseen by ELT, PITOF and Finance Committee. 4. Benchmarking actively used in identifying opportunities across clinical and corporate areas including estates.	20/08/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[20/08/2025 11:49:42 Rachael Turner] New risk presented at RRC&C meeting 20/08/25. Currently 3.7 million to be underpinned. Finance will continue to review and monitor progress around this. Risk validated at 4x4:16 High Risk.	Moderate Risk (8-12)	20/11/2025	NEW RISK

1b: Reduce waiting times for our patients	773		Farbrace, Kylie	Finance Committee (Lead assurance committee)	13/01/2025	16	Children, Young People, and Specialist Services	Speech and language Therapy (Adult)	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	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.	02/10/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[08/10/2025 15:24:16 Amy Evans] Additional information to support review at CYPSS Quality SMT 2/10/25 - actions to be implemented to reduce further escalation and recovery waiting lists / long waits for therapy to include: Review / update referral form, return referrals where not appropriate / outstanding actions for referrer to be completed, consider screening assessments to support prioritisation, increased provision of self management advice and guidance for P4 priority, increase telephone triage from B7 capacity, reduce planned review for care home patients: for care home staff to self-manage/ re-refer as required, increase virtual clinics / face to face clinics and reduce home visits, 1 x communication assessment day per month per clinician to reduce waits. Current longest wait - 34, with booked appointment. 282 waiting for assessment [02/10/2025 15:10:19 Ana Morgan]	Low Risk (4-6)	08/01/2026	No change

1a: Improve patient safety, patient experience and deliver clinically effective care	714	Physical or Psychological Harm	Farbrace, Kylie	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)	16/05/2024	16	Collaborative Community Care		Patients are not always receiving the correct level of care for pressure ulcers within community nursing settings	Variability in the delivery of care for pressure ulcers across community Lack of consistent senior clinical case review Variable clinical skill set of team members in delivering pressure ulcer care	Deterioration in pressure ulcers Increasing referrals for S42 safeguarding responses Poor patient and family/carer experience ICB/CQC oversight of pressure ulcer care	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	Moderate Risk (8-12)	05/11/2025	No change

1a: Improve patient safety, patient experience and deliver clinically effective care	815		Scott, Ian	Integration Committee (Lead assurance committee)	14/10/2025	20	Corporate	Digital Health	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) are not met and that Digital systems are not implemented safely.	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.	A lack of an established (Digital) Clinical Risk Management System, processes, and resource provision, nationally there have been clinical safety incidents involving digital systems resulting in or contributing to harms and deaths. The risk of harm to our patients through the lack of effective Clinical Risk Management Activities undertaken for individual Health IT system deployments and post-deployment maintenance, ranges in likelihood and severity dependent upon the scope.	In line with LCHG Group Digital: •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 •Chief Digital Clinical Information Officer in post for LCHS •Clinical Safety Officer training has been completed by 9 other staff in LCHS •Digital Clinical Champions in place and agreed to be funded within community from operational budgets 1 day per week	14/10/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[15/10/2025 10:09:44 Sarah Davy] Risk agreed at RRC&C on 15/10/2025 with score of 4 x 4 = 16	Moderate Risk (8-12)	14/11/2025	NEW RISK

2b: Empower our people to continuously improve and innovate	695	Service Disruption	Farbrace, Kylie	People Committee (Lead assurance committee)	12/03/2024	16	Collaborative Community 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	02/09/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[02/09/2025 15:42:04 Angela Wilson] No change to current position. [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	Low Risk (4-6)	04/12/2025	No change

2a: Enable our people to fulfil their potential through training, development and education	754	Physical or Psychological Harm	Kidger, Leanne (Accountable for)	09/10/2024	15	Corporate	Quality	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.	15/10/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[15/10/2025 11:44:48 Ana Morgan] Risk reviewed with Moving and Handling Clinical Lead LK & EP Lead 15/10/25: training has been reviewed by M&H expert and appropriate training packages for each area have been developed. Delivery has commenced following a short pause, and compliance is increasing. To monitor if compliance continues to improve (currently 64.67%) and consider score reduction at next review date. [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	Very Low Risk (1-3)	05/01/2026	No change

1d: Provide modern, clean and fit for purpose care settings	799	Regulatory Compliance	Davey, Keiron	Finance Committee (Lead assurance committee), Fire Safety Group (Accountable for)	04/07/2025	25	Corporate	Estates	if a fire occurs on one of the Trust's work places and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment, Emergency lighting 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.	1. Fire Safety Training not suitable and sufficient, including not role specific 2. Vulnerability of patients 3. Complex environments and layouts 4. lack of Assurance for maintenance and other controls from landlords 5. Flammable material present, including medical gases 6. critical electrical medical equipment present with overload circuits and improper use. 7. Aging premises 8. Human Error 9. Smoking on site and within wards 10. EN (NHPS) Louth, AAP Spalding (NHPS)	physical or Psychological harm	Trust Fire Safety policy National Guidance including HTM, HBN, British standards, ACOP Trust Protocols and Policies Fire Safety Training including managerial role. compliance rates Fire wardens Fire drills Governance committees, FEG, FSG, HS Committee FPC. Annual Fire Safety declaration including PEEP awareness reporting of unwanted Fire alarm activations reports of Fire Regulator from audits conducted Fire risk Assessments	06/08/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[20/08/2025 11:51:57 Rachael Turner] Risk presented at RRC&C meeting 20/08/25. Risk validated at 4x4:16 High Risk. [06/08/2025 14:21:20 Ana Morgan] For review at Fire Safety Group 06/08/25 New Risk to encompass the results if a major fire occurred	Moderate Risk (8-12)	20/11/2025	NEW RISK

2a: Enable our people to fulfil their potential through training, development and education	715	Physical or Psychological Harm	Farbrace, Kylie	People Committee (Lead assurance committee)	16/05/2024	16	Collaborative Community Care		The community nursing service is unable to meet the demand of patients within Lincolnshire	Increased demand for service of 8% Care unit allocation above the maximum of 15 care units daily Case load levels above 150 max levels Reduced numbers of DNSPQ qualified staff	Variance in care delivery Ineffective case load management Poor patient experience Reduced complex caseload efficiency Task based service provision with a lack of holistic care planning	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	02/09/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[02/09/2025 16:06:17 Angela Wilson] No change [03/06/2025 15:30:00 Zoe Wills] 03/06/2025 - Holding vacancies for apprenticeships has meant high unavailability in all teams. This has caused reduced capacity. Work ongoing to move VBYV into teams helping support unavailability. [04/03/2025 15:47:25 Zoe Wills] 04/03/2025 - We are currently seeing high unavailability in Sleaford, Skegness and Four Counties. Maternity and sickness rates have gone up impacting on this. Community Nursing Teams are unable to back fill people going of on maternity. [05/11/2024 15:21:59 Zoe Wills] 05/11/2024 - No change currently [08/10/2024 15:09:13 Zoe Wills] 08/10/2024 - paper has gone to ELT and has been backed by the board, awaiting information on if/how this can be financed to increase capacity and value DNSPQ workforce. 6 now DNSPQ students started in September. 6 practice teachers are now on the course	Low Risk (4-6)	03/12/2025	No change

1d: Provide modern, clean and fit for purpose care settings	649	Regulatory Compliance	Davey, Keiron	(Accountable for), Fire Safety Group (Accountable for)	12/09/2023	15	Corporate	Estates	There is a risk that the Trust cannot demonstrate statutory compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO). If Lincolnshire Fire & Rescue Service (LFRS) carries out an inspection and finds the Trust to be systemically non-compliant with fire safety regulations and standards it could result in regulatory action and sanctions, with the potential for financial penalties and disruption to services if sites are required to close	Inadequate fire protection of both active and passive measures, maintenance, training, policy and procedures	Loss of facilities, injuries to patients and staff. financial penalties and disruption to services including loss of service	1. LCHS Fire Safety Operational Meeting 2. Planned Preventative Maintenance PPM 3. Fire Risk Assessments 4. Fire Safety Training 5. Fire protection system tests 5. Fire Emergency Plans 6. Yearly Fire audit 7. Appointed Authorising Engineer (AE) for Fire 8. Inpatient Fire evacuation plans and tests 9. Test Fire drills. 10. National Policy via HTM, HBN and Guidance 11. Policy and Protocols 12. Governance via FEG, FSG and trust HS Committee	04/07/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	[04/07/2025 11:32:13 Keiron Davey] reviewed description of risk to include sanctions by Fire Safety Regulators and consequences. additional control measures also included to include policy protocols, and over sight by FEG, FSG and HS Committee etc [14/04/2025 09:16:44 Russell Fordham] No change to the score or risks in this period and monthly and quarterly fire operational meetings are being attended by NHSPS to try to resolve the actions identified in the safety noticed severed on them. [17/02/2025 09:58:03 Russell Fordham] No change to score within this time frame. NHSPS have had several other Fire infringements notified to them as a organisation for concerns at Louth. ULHT Fire team and risk assessors are currently working to support on several concerns and attendance to Monthly Fire Safety Meetings are being undertaken. [11/10/2024 15:37:34 Dan Dring] After a conversation with Mike Parkhill this risk has been moved to	Low Risk (4-6)	24/10/2025	No change

1a: Improve patient safety, patient experience and deliver clinically effective care	792	Physical or Psychological Harm	Farbrace, Kylie	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)	13/05/2025	15	Collaborative Community Care – Community Hospitals	Outpatients Department, Johnson Hospital	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	08/10/2025	Extremely likely (5) >90% chance	Moderate (3)	High Risk (15-16)	15	[08/10/2025 12:44:42 Zoe Wills] 08/10/2025 - Clinic has increased capacity and staff in post and trained. This has resulted in waiting list down to routine - 1 day. and urgent - 0 days [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

Strategic Objective	ID	DCIQ ID	Risk Type	Exec Lead	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	Caroline Landon	Coghill, Piper	Shuck, Joanne	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	09/10/2025	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	[09/10/2025 09:53:58 Nicola Cornish] Awaiting agreement of cabinet for decrease in risk score to reflect the significant reduction in backlog. Once agreed, this will be listed for RRC&C meeting to confirm approval of the score decrease. [22/09/2025 09:39:09 Nicola Cornish] 19/09/2025 - KR The cardiology service is delivering additional Saturday clinics throughout September and October 2025 to increase capacity to complete clinic reviews. This has resulted in a decrease in the backlog of clinics and it is hoped that reverting to 'Business as Usual' once this has been completed will be sufficient to maintain the clinic backlog at an acceptable level. Added the need to review risk the current score to next Specialty Governance agenda. [21/08/2025 14:27:43 Sarah Davy] Right size in case currently being developed with Becky Johnson under guidance of tertiary consultant working in ULTH. Expect submission some time mid 2026/27. [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.	8	30/06/2024	30/06/2025	09/11/2025
1b: Reduce waiting times for our patients	5447	691	Service disruption	Caroline Landon	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	09/10/2025	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.	[09/10/2025 14:11:52 Nicola Cornish] Discussed at Anaesthetics speciality governance meeting on 3rd October. Sam Goy provided an update confirming that the Director of Nursing has given approval for 3 long-line agency scrub nurses for a period of 3 months and they started on 29th September. Nursing establishment had been adjusted for 9 theatres however there are still occasions where requests are made to staff additional theatres. [15/09/2025 15:11:19 Nicola Cornish] Sam Goy reviewed this risk and confirmed there is no change. [29/08/2025 14:16:56 Nicola Cornish] Risk reviewed by Wendy Rojas, no change. [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 12:57:19 Nicola Cornish] Risk reviewed, no change. [07/01/2025 10:42:07 Nicola Cornish] Risk reviewed by Wendy Rojas - no further progress. [28/11/2024 10:06:10 Nicola Cornish] Task and finish group now established to	8	30/06/2025	30/06/2025	09/11/2025
1c: Improve productivity and deliver financial sustainability	4657	7	Reputation	Jayne Warner	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.	01/09/2025	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.	[01/09/2025 13:11:21 Fiona Hobday] PATIENT- Additional resource in team to copy/ support from LCHS staff following departure of team supervisor. STAFF- Work ongoing re new process with NHSE to obtain data. [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.	6	31/12/2025	31/12/2025	01/10/2025

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2a: Enable our people to fulfil their potential through training, development and education	4862	44	Service disruption	Caroline Landon	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)	19/08/2025	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.	[19/08/2025 14:41:06 Rachael Turner] Risk reviewed,we have 9 cons against establishment of 10 but have asked for 15 cons previously as by GIRFT recommendation that's how many we need. Business case written at the turn of the year to this affect but wasn't considered due to system financial constraints. Risk currently to remain open at same risk level. [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	4	30/12/2022	03/06/2024	19/11/2025
2a: Enable our people to fulfil their potential through training, development and education	4996	39	Physical or psychological harm	Caroline Landon	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	18/09/2025	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	[18/09/2025 11:15:16 Gemma Staples] Meeting taken place with Stakeholders progressing left shift to GP Surgery's for low grade CLL and MGUS. [19/08/2025 08:20:43 Gemma Staples] All services are currently under review to establish if there is opportunity to left shift activity to the CDC's. The first services to be reviewed are Low Grade CLL and MGUS Blood monitoring. [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	8	30/09/2023	01/04/2025	20/10/2025
2a: Enable our people to fulfil their potential through training, development and education	5142	65	Physical or psychological harm	Caroline Landon	Thomson, Cheryl	Lentz, Blanche		12/04/2023	20	Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	Within Lincoln and Pilgrim Emergency Departments there is a risk that, given increases in demand/footfall, the current staffing template for middle grade doctors overnight may not provide assurance to maintain patient safety.	Utilisation of on-call Consultant to support dependant on holistic risk. Specialty support and signposting to other directorates and providers. Full capacity protocol and boarding.	4 hour target/12 hour breaches. Time to first assessment. Decision to admit.	24/09/2025	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.	[24/09/2025 13:34:14 Rachael Turner] There is no change currently as going through consultation. Risk score to remain. [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	9	31/08/2023	01/11/2023	24/12/2025

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1d: Provide modern, clean and fit for purpose care settings	4858	12	Service disruption	Mike Parkhill	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.	14/10/2025	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.	[15/10/2025 08:47:06 Rachael Turner] Risk Reviewed - Recommended for closure as it is replicated in Risk IQ 789. This will be discussed at the Estates Confirm & Challenge Group this week. [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	5	31/03/2026	31/03/2026	14/01/2026
1b: Reduce waiting times for our patients	5267	485	Physical or psychological harm	Caroline Landon	Mooney, Mrs Katy	Marsh, David		26/09/2023	16	Medicine	Cardiovascular CBU	Cardiology		If there is a continued delay in processing of Cardiac MRIs, which is impacted by workforce limitations and an existing backlog of scans, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcomes. Cardiac MRI backlog was recorded at 278 as of the 7th April, the oldest scan being 5th December.	1.Paper for outsourcing option submitted to exec team for consideration for sign off (more economical than paying substantive consultants extra contractual rates) to clear backlog. 2. Locally agreed KPI's to outline number of scans to be reported within allocated PAs. 3.Undertaking additional reporting sessions - this will help significantly with the reporting backlog but not solve causal factors. At cost. 4. We now have a Radiographer that can report Cardiac MRI's independently which is approx 8 a week. 5. Additional imaging consultant recruited (starts September 2025)-joint funding from CDC/radiology 6.Backlog monitored weekly and escalated through Divisional Governance structure.	Size of reporting backlog (number/time required) Average time for reporting of scans from date of imaging Locally agreed KPI's to outline number of scans to be reported within allocated PAs-This is being monitored.	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. 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 also are in early negotiations with a consultant from Nottingham to support with our backlog. There is a possibility of mutual aid from Sherwood Forest, but this is in the early negotiations. We have submitted a paper to the Divisional Managing Director for £35,000 for an external company to clear 200 scans from the backlog. [12/12/2024 14:49:24 Rachael Turner] As of Monday 9th December: •There are 266 CMR scans awaiting reporting • The oldest scan awaiting reporting is from 30.09.24 (70 days) With regard to current reporting 'performance', the number of reports per operator over the last week was: • Houghton 26 • Andrews 5 • Disbrow-Carpenter 2 (supervised reports) • Kylintireas 0 [30/09/2024 11:07:44 Rachael Turner] Current backlog has increased to 194 which were waiting to be reported. The oldest scan is from the 8th August.	3	01/07/2024		07/10/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	4855	207	Physical or psychological harm	Caroline Landon	Chantry, Chris	Marshall, Lisa		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.	21/08/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Exploration of creating additional capacity through redesign of clinic facilities, etc. Business case to be re-reviewed and resubmitted for investment round 2026/27.	[21/08/2025 14:05:13 Sarah Davy] Breast was top of ICB cancer risk register last year. Service is essential for Trust to maintain 28 day FDS performance. Risk mitigated through 2025/26 as a result of fixed term ICB SDF investment. Case to be re-reviewed and resubmitted for investment round 2026/27. [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	4	31/12/2021	29/12/2023	21/11/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	5520	753	Physical or psychological harm	Caroline Landon	Landon, Caroline	Constantin, Dr Carmen	Clinical Effectiveness Group	11/10/2024	16	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of ULHT not having a Thrombectomy centre, we have to transport patients to Nottingham. There is a risk of transfer delays for patients with acute neurological presentation suspected to be a stroke having access to a designated thrombectomy centre for consideration of mechanical Thrombectomy. This could lead to more brain cell death, increase risk to life and ultimately poor functional outcomes/severe disability. On occasions delays have been so long the offer of intervention has been withdrawn.	Attempts to streamline pathway to hold crew bring patient to Lincoln for further transfer to Nottingham however not often successful due to pathway delays. [current acute pathway QI project] Escalating to operation centre as soon as Ambulance requested for transfer if original crew already stood down/handed over. Explored option of increasing category allocated to Stroke transfers [Currently CAT2] so far despite regional engagement Ambulance service unable to re-categorise.	Regional meetings - Integrated Stroke Delivery Network M&M meetings [local & regional] Datix incidents reported.	19/08/2025	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	[19/08/2025 12:13:00 Rachael Turner] Risk reviewed, no current changes. It has been advised that other areas are struggling more than us. We are however doing the best in performance based on Nottingham audits in the region. Risk score to remain. [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		19/11/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5101	487	Physical or psychological harm	Caroline Landon	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;	23/09/2025	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.	[24/09/2025 09:21:48 Nicola Cornish] Risk reviewed, no change. Await outcome of business case submission. [21/08/2025 14:03:34 Sarah Davy] Business case has been written - to be submitted for 2026/27 funding. Conversations ongoing with tertiary provider regarding clarity of service offer. [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 risk will now include both Acute and Community Paediatrics and risk 5100 will be presented at Risk Confirm & Challenge in July for closure. [20/05/2025 14:02:04 Nicola Cornish] This issue remains ongoing. The Group Chief Nurse has requested that a paper is written for presentation to Quality Governance Committee setting out the current position and proposals for development of the epilepsy service. [18/02/2025 13:19:19 Nicola Cornish] No progress, still awaiting decision about	8	14/03/2024	16/02/2024	23/10/2025
3c. Enhance our digital, research and innovation capability	4641	18	Service disruption	Daren Fradgley	Fradgley, Daren	Gay, Nigel	Emergency Planning Group	23/11/2021	16	Corporate	Integration and Improvement	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	13/10/2025	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.	[13/10/2025 12:35:08 Rachael Turner] Following collective review the digital team determine that this overarching risk remains a 16 due to the combination of risks that contribute to this higher level risk. The individual risks that support this risk are being regularly updated and contain the detail around the specific actions and mitigations resulting in an overall reduction across a number of risk areas but due to the significance of a digital infrastructure event and the impact on Trust operations, this risk continues to be managed at current level. At this time the downward trajectory would indicate that by the end of this financial year, work will have completed to a point where this overarching risk score will begin to reduce. [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	4	31/03/2023	31/03/2023	13/01/2026
1b: Reduce waiting times for our patients	5381	560	Service disruption	Caroline Landon	Landon, Caroline	Capon, Mrs Catherine		09/02/2024	15	Corporate	Operations	Operations		Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands. Significant RN and HCSW WTE shortfall. No B7 manager in place. B6 jnr sister post is unfunded secondment. No ward clerk. Insufficient housekeeping hours. This means that DL cannot staff each shift witihin budget and relys on temporary workforce and inpatient ward support. RNs and HCSWs act as ward clerk and Housekeeper. The risks are:- service is not well led on every shift contributing to delays, failed discharges, reduced patient capacity and turnover, reduced patient flow impacting on front door, omissions in care, omissions in documentation, errors, patient safety incidents, poor staff wellbeing, Poor patient notes and careflow management, poor patient experience. Improvement to practice very challenged to implement due to temporary staffing. Unable to function within current budget. Reputational damage. Inability to meet CQC requirement from 2021 audit.	Each shift has substantive, bank or ward swap nurse in charge. Staffing issues on the day managed by ops matron. Shifts go to bank and then to agency. Dynamic risk assessment; capping capacity or refusing complex patients. Strategic on call sign off required to close discharge lounge due to staffing. Orientation of temporary staff; Induction materials. limited support and advice from operations centre. RNs and HCSWs complete meal and refreshment service. RNs and HCSWs complete cleaning required outside of 2hrs allocated Housekeeper time. RNs and HCSWs complete ward clerk duties.	Healthroster, Workforce safeguard spreadsheet, 8a lead audit, flo audit, datix, PALS feedback and complaints, e-mail feedback, monthly budget, CQC assurance summary, DL patient flow dashboard, daily delays escalation, complaints, PALS feedback, TSSG, Confirm and challenge process. Sickness rates.	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

Strategic Objective	ID	DCIQ ID	Risk Type	Exec Lead	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	5651	871	Physical or psychological harm	Caroline Landon	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	4	07/05/2026		04/11/2025
1c: Improve productivity and deliver financial sustainability	4664	5	Finances	Paul Antunes Goncalves	Antunes Goncalves, Paul	Picken, David		11/01/2022	20	Corporate	Finance and Performance	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)	22/09/2025	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	[22/09/2025 09:18:03 Rachael Turner] The Trust's financial plan for 2025/26 includes a total agency plan of £12.7m. Against this agency plan, expenditure of £1.2m in August 2025 was £0.2m higher than planned, and expenditure YTD of £7.0m was £1.1m more than planned; the higher than planned agency expenditure position is driven by expenditure on medical and dental agency staffing being £0.9m higher than planned. Although YTD agency expenditure of £7.0m is £4.2m lower than spend of £11.2m in the same period 2024/25, the Trust still requires plans to address this movement from plan. Furthermore, it is noted that NHSE wrote to the Trust on 8 September to offer ULTH enhanced support because the Trust has been identified as a higher risk in delivering their agency spend target. Driving concerns at a regional level is the fact that 1) the Trust had the 3rd highest agency spend of all Trusts in the Midlands in 2024/25 (£22.6m), 2) the Trust YTD continues to have the 3rd highest agency spend in the region in 2025/26 and was overspent against its YTD agency plan at month 4, and 3) the Trust has the highest level of Medical and Dental agency usage in the region.	8	31/03/2023	31/03/2024	22/10/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5533	754	Physical or psychological harm	Caroline Landon	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 have had a suspected TIA within 24 hours [in line with guidelines] this may result in subsequent stroke due to a delay in intervention/treatment. Stroke may cause lifelong disability or death.	Reviewing patients as soon as we can in clinic and arranging investigations to coincide with clinic appointment [limited to imaging slots allocated per day] We convey ambulance referrals to have patients reviewed in ED by ACP team, if adequate space was provided for rapid TIA review there could be hospital avoidance [better patient experience/reduce cost and better patient flow]	Audit delays from referral to physical review in TIA clinic – Stroke Co-ordinator/service manager Recent data provided by Vascular team reports delays to carotid Doppler scans being performed, creating less benefit from surgical intervention which may result in no intervention being completed Datix review of hospital admissions with stroke symptoms post TIA clinic referral and not yet seen	19/08/2025	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	[19/08/2025 12:10:50 Rachael Turner] TIA pathway has begun last week, this is in the early stages of a new process. Risk currently to remain at same score, we will assess again in November. [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		19/11/2025
2a: Enable our people to fulfil their potential through training, development and education	5469	697	Service disruption	Colin Faruharson	Rinaldi, Dr Ciro	Chablani, Manish		21/06/2024	16	Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of Pharmacy struggling to budget and recruit into the role whilst there are budgetary provisions on the medical education side there is a risk that without adequate educators we would fail to deliver the curriculum across the entire clinical years for years 3,4 & 5 which would lead failure of our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	We are currently liasing with the Pharmacy department around the appointment of a part time prescribing skills lead. This would be a 50/50 appointment shared with the pharmacy team	Meeting reviews.	16/09/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[16/09/2025 14:14:36 Rachael Turner] Risk remains the same, no further updates. Multiple talks with LCHS, they to remain in a difficult position to recruit because of job/budget freezes. Awaiting an update from Ashok around an update with any meetings with ULTH pharmacy department. [19/05/2025 12:04:21 Rachael Turner] Risk reviewed, no current change, risk remains at current level. [18/02/2025 15:12:47 Rachael Turner] Currently working with LCHS to have a shared Prescribing Skills Lead. The JD are ready and awaiting for LCHS to advertise from their side. Although funding may be an issue owing to the freeze on new appointments prior to May. [18/12/2024 11:06:27 Rachael Turner] Risk presented at Risk Register Confirm & Challenge 18/12/2024 this will be reduced following recruitment has taken place. Risk score to remain until established post. [26/11/2024 14:59:10 Rachael Turner] We have nearly come to an agreement with LCHS regarding a shared appointment. This is a now a low risk and may not require to be on the register. This risk will be presented at Risk Register Confirm and Challenge in December for a reduction in score. [31/07/2024 13:24:09 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		16/12/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Exec Lead	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
1c: Improve productivity and deliver financial sustainability	4658	17	Reputation	Jayne Warner	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.	08/09/2025	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.	[08/09/2025 10:56:10 Rachael Turner] Risk reviewed, mitigation remains and score is accurate [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	4	28/06/2024	31/12/2025	08/12/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	4741	42	Service disruption	Caroline Landon	Lynch, Diane	Chester-Buckley, Sarah	Patient Experience Group	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	18/09/2025	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	[18/09/2025 11:19:33 Gemma Staples] Further investment is still required to remedy this risk. [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 meeting it was agreed to combine this risk with 5180. [24/07/2024 11:38:27 Gemma Staples] Clinical Lead appointed due to start August 2024. SACT Lead appointed to, HR checks in progress, therefore no start date as yet. [23/04/2024 13:04:41 Gemma Staples] Risk reviewed and no further update [05/04/2024 10:41:51 Gemma Staples] Risk reviewed. No further update [05/04/2024 10:38:06 Gemma Staples] Consultant Oncologist workforce capacity [18/01/2024 11:26:42 Gemma] Oncology rightsizing paper currently being written. [14/09/2023 16:04:46 Rose Roberts] Ongoing [28/06/2023 14:43:05 Rachael Turner] Following this risk being discussed at RRC&C meeting, the question was raised around the number of patients currently waiting to be seen (including overdue) These are as follows: Oncology PBWL numbers as at 29/5/23:	4	31/03/2023	31/03/2023	18/12/2025
1d: Provide modern, clean and fit for purpose care settings	4701	85	Reputation	Caroline Landon	Chantry, Chris	Ugjohn, Emma	Family Health	13/01/2022	15	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.	21/08/2025	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.	[21/08/2025 14:12:43 Sarah Davy] Currently being picked up through Suzanne Nicholson and Estates work. [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.	6	31/03/2025	31/03/2025	21/11/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Exec Lead	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	5306	713	Physical or psychological harm	Caroline Landon	Cooper, Mrs Anita	Rambani, Reena	Patient Safety Group	28/08/2024	20	Clinical Support Services	Path Links (Pathology)	Microbiology (Pathology)	Trust-wide	As a result of the inadequate resource of Microbiologists provided via the service contracted from NLAG, there is inadequate specialist input to ULH for complex cases or reviews on the correct use of high risk treatments used. This would lead to patient care being unsafe and can result in harm including death. It would also lead to extended hospital stays, readmissions, poor bed flow affecting access to Acute NHS care, increased morbidity and increases risk of antimicrobial resistance as a Public Health threat which harms our patients further. There are severe restrictions to prescribers accessing Microbiologist Specialist advice as it is now limited to Registrars, Consultants, Advanced Nurse Practitioners and GP 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 anti-microbial consumption trends in a timely manner.	Currently being directed through Consultant Antimicrobial Pharmacist within own working hours and remit as and when they are able to do so. Being flagged at various forums. Regular communication and reminders about availability of Antimicrobial team and guidelines and any resources available. Draft Business case for Microbiologist Consultant currently in progress.	Through antimicrobial consumption and surveillance Audit results Specialist time input from Antimicrobial Team Survey Pending Infection prevention & control surveillance and audits	09/09/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Trust to review Microbiologist contracting - as a matter of urgency – Ian Fulloway – December 2025 Antimicrobial Guidelines being revised to for both ULTH and NLAG – Balwinder Bolla – March 2026	[09/09/2025 15:18:14 Gemma Staples] Risk reworded and remains the same due to limited resources and demand remains the same. [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,	4	30/11/2025	01/06/2025	09/12/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	4868	64	Physical or psychological harm	Caroline Landon	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.	20/08/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Use of tamper proof boxes/trays being purchased. 2. The only control to prevent the risk is to prepare the injections prior to administration (within 30 minutes) as per guidance (National and Trust). 3. If the practice is to continue, the prepared products should be labelled to include the recommended information. A procedure should be developed indicating the process to follow to ensure the medicines drawn up are discarded at the end of the day.	[20/08/2025 10:07:58 Rachael Turner] Risk discussed as part of the RRC&C Deep Dive, conversations have started with the anaesthetic team. Policy is being in looked at to be in line with national guidelines. Looking at closing this by end of January. Key will be monitoring compliance. [19/08/2025 14:37:49 Lisa Hansford] MSO in discussion with clinical team to explore opportunities for improving safety and security of process. [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	4	30/09/2022	31/03/2023	19/11/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5433	646	Physical or psychological harm	Caroline Landon	Upjohn, Emma	Marshall, Lisa		08/05/2024	8	Family Health	Women's Health and Breast CBU	Gynaecology		As a result of insufficient EPAU scan capacity to meet the demand, there is a risk that patients may not be offered an appointment in a timely manner. National and local recommendation is that patients should be seen within 24 hours but patients are currently waiting up to 2 weeks. This increased waiting time may cause psychological harm during a very emotional and worrying time for a patient but can also result in physical harm as not all treatment options may not be open to the patient by the time they are seen.	24 hour emergency service via GAU Patient information around signs and symptoms to be aware of and who to contact for advice and help. Offer scan capacity at either site. Review of referral criteria along with Lead EPAU Consultant. Weekend scanning where possible if agreed within Division as overspend to support to reduce demand. EPAU nurse currently undertaking sonography course to support improved scanning availability and efficiency within the service.	Complaint data PALS enquiries Patient and staff feedback	23/09/2025	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.	[26/09/2025 09:23:58 Nicola Cornish] The EPAU nurse is currently undertaking ultrasonography training and once completed this will provide some additional support however this will not fully address the capacity issues. [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	4	31/05/2025		23/12/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Exec Lead	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	5617	854	Physical or psychological harm	Caroline Landon	Upjohn, Emma	Rayner, Gemma	Workforce Strategy Group	24/03/2025	20	Family Health	Women's Health and Breast CBU	Obstetrics	Trust wide	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.	05/09/2025	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.	[05/09/2025 14:51:44 Nicola Cornish] Business case was presented to CRIG and the uplift of 12.2WTE was approved. Awaiting formal confirmation of this decision prior to commencing recruitment. [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		05/12/2025
2b: Empower our people to continuously improve and innovate	4935	58	Service disruption	Caroline Landon	Farquharson, Colin	Wright, Jo	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	25/09/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruitment to vacant posts.	[26/09/2025 15:10:25 Nicola Cornish] Risk reviewed, no further update. [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.	4	31/10/2022		25/12/2025
2b: Empower our people to continuously improve and innovate	4905	48	Physical or psychological harm	Caroline Landon	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.	09/10/2025	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	[09/10/2025 11:39:13 Gemma Staples] Risk reviewed and remains the same. Declined request for additional winter funding to increase Therapy capacity to support additional acute beds eg 7A at Pilgrim. [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 due to vacancies 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	9	30/09/2023 18/12/2023		09/01/2026

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1a: Improve patient safety, patient experience and deliver clinically effective care	5495	725	Physical or psychological harm	Caroline Landon	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
1c: Improve productivity and deliver financial sustainability	4839	328	Finances	Caroline Landon	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 Intravevenous 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	22/09/2025	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	[22/09/2025 15:19:19 Gemma Staples] Interview and successful appointment for B7 Pharmacy Technician – planned start date mid October Interview for 8b 26th September Interview for 8a 29th September Following recruitment and onboarding will be able to review risk score and reduce. Once team embedded will be looking to close risk [20/08/2025 10:01:13 Rachael Turner] Risk discussed as part of the Deep Dive at RRC&C, as soon as posts are filled we will be looking at closing risk. This will continue to be monitored. [19/08/2025 13:39:37 Lisa Hansford] Vacancies going through Trac. Once staff in place. Risk can be reduced. [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 Gemma Staples] 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	4	01/10/2021	31/03/2023	22/10/2025
1d: Provide modern, clean and fit for purpose care settings	5334	533	Physical or psychological harm	Caroline Landon	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 be picked up as part of overall refurb at Pilgrim. [04/04/2024 10:33:53 Nicola Cornish] Risk reviewed, no change. [31/01/2024 13:01:35 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024. Need to know frequency when this is happening. Agreed currently that this sits at a 4x4: 16 High Risk. Link to be added around regulations.	6	01/01/2025		24/10/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	4843	57	Physical or psychological harm	Caroline Landon	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	4	01/10/2021	31/07/2023	17/07/2025
3c: Enhance our digital, research and innovation capability	5245	19	Service disruption	Daren Fradgley	Fradgley, Daren	Humber, Michael		30/08/2023	20	Corporate	Integration and Improvement	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.	15/08/2025	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.	[16/09/2025 14:21:37 Rachael Turner] Work continues to mature the Rubrik backup capability, with recovery testing now occurring on a regular basis. Risk score should remain as is due to the continued targeting of backups by threat actors in malicious cyber attacks. [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	10		30/08/2024	15/11/2025
2a: Enable our people to fulfil their potential through training, development and education	5154	88	Regulatory compliance	Colin Farquharson	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	19/08/2025	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	[19/08/2025 14:35:13 Lisa Hansford] Awaiting outcome of NMAFF approval 22nd August [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	8	31/03/2025		19/11/2025

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3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	5563	782	Physical or psychological harm	Caroline Landon	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	22/09/2025	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.	[22/09/2025 09:39:46 Charles Smith] Risk remains the same. Now significant 65wk cohort challenges with breaches likely in September. Outsourcing companies contacted and working up pathways. Team will be back to x4 consultants by October however significant backlogs and PBWL risk remains [19/08/2025 14:37:04 Rachael Turner] Risk currently remains the same, we have recruited to one of the vacancies who start of the 1st September but still carrying 1 vacancy and we have continued issues that even at full establishment working is too small for the influx that we get in. [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 has been had with ICB. Neurology is a difficult area to recruit. Risk validated at 4x4: 16 High Risk	8	19/12/2025		22/10/2025
1d: Provide modern, clean and fit for purpose care settings	5136	10	Physical or psychological harm	Mike Parkhill	Davies, Chris	Temlison, Vincent	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.	06/10/2025	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	[06/10/2025 10:43:49 Rachael Turner] Risk has been re-drafted with a new Moderate scoring. Risk will be agreed at Estates Governance and then this risk will be presented at Risk Confirm and Challenge for closure and new updated risk agreed. [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	10	28/03/2024		06/01/2026
1d: Provide modern, clean and fit for purpose care settings	5234	510	Service disruption	Caroline Landon	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	19/08/2025	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	[19/08/2025 16:07:52 Gemma Staples] Currently awaiting quotes from Estates so no further update. [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	4	26/08/2024		19/11/2025

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3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	5535	784	Physical or psychological harm	Caroline Landon	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	Caroline Landon	Bassi, 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.	02/10/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1) Chief pharmacist ward visits monthly - Lisa Hansford - Dec 2025 2) Rolling safe and secure audit programme for quarterly visits - Lisa Hansford - Nov 2025 3) Explore support from clinical governance team - Lisa Hansford/Jeremy Daws - Nov 2025 4) Development of a robust action plan and audit trail - Lisa Hansford - Nov 2025	[02/10/2025 11:02:13 Lisa Hansford] SOP for ward pharmacy staff visits completed and approved at pharmacy governance. Safe and secure audit tool has been reviewed and updated. [20/08/2025 10:11:58 Rachael Turner] Risk presented as part of RRC&C Deep Dive, we are hoping to get traction on this risk and once changes embedded we will look at closing and creating a new risk around ward areas. We are making sure we are engaged with all Quality process of medicines management in place. Audits are being looked at across the Group that they are fit for purpose with support from clinical governance audit team. [19/08/2025 14:32:15 Lisa Hansford] Chief pharmacist visited wards, which highlighted serious ,medicines management concerns. In addition to concerns raised by CQC visits to ED PHB and Lincoln. [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	4	20/06/2024		02/01/2026
1a: Improve patient safety, patient experience and deliver clinically effective care	4746	121	Physical or psychological harm	Caroline Landon	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	19/09/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Need to ensure future sustainability once recovered.	[06/10/2025 14:43:22 Rachael Turner] process remains ongoing with updates through PSG [20/08/2025 10:39:00 Rachael Turner] Risk presented at RRC&C for increase in score. Increases are occurring in incidents, this is being seen weekly, which demonstrates that the risk is rising, this is reflected in Datix. Risk validated for increase in score to 5x4:20 Very High Risk. [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 this. 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	4	31/07/2021	30/06/2022	19/10/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	5614	825	Service disruption	Caroline Landon	Fulloway, Mr Ian	Woods, Mr Michael		04/03/2025	16	Clinical Support Services	Diagnostics CBU	Audiology	Trust-wide	As a result of Increasing demand on referrals to the service, the Paediatric Audiology Service not meeting the Paediatrics Quality Standards and the consequence of the requirement to attain UKAS IQIPS accreditation, due to insufficient staffing, capacity and lack of soundproofing rooms (the room at Boston has recently been condemned after IQUIPS benchmarking visit which has reduced capacity further) there is a risk of 1) an increase in waiting times which is a causing a delay in patients being seen and a delay in treatment which could lead to long term patient harm and risk of litigation and 2) the risk of the Trust not attaining accreditation which could lead to Audiology losing the contract for Paediatric Services in Lincolnshire.	Audiology team are undertaking work to bring the service up to this standard by updating or developing new policies, operating procedures and work instructions to meet the new Paediatric Quality Standard requirements. This is causing capacity pressures as staff are having to be taken out of clinical time due to the work involved in revising the required documents. Team is working to review IQUIPS standards and match requirements to policies and procedures currently in place within the department and to develop the new working practices and quality monitoring processes required. Work will then be undertaken to produce an action plan to put into place any policies, procedures or processes that are not currently embedded in service. Once action plan is complete and revised systems suitably embedded then an application will be placed to UKAS for initial assessment for department's compliance with IQUIPS standards. Clinics are pausing during testing while noise levels abate. Clinic dates have been amended to quieter clinic days. Insert earphones used for greater attenuation of external sounds. Paediatric room layout reviewed to reduce reverberation. Soundfield testing has been stopped at Pilgrim site for paediatric under 5's and defined complex patient group. With other children groups if ear specific information not obtained then patient transferred for testing at Lincoln site in soundproof facilities. Development of business case to provide Gold standard soundproof facilities at Pilgrim site to reduce the need for cross site referral. The service is Investigating an option for temporary Booth's to be leased until proposed building works can be	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.	18/09/2025	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	[18/09/2025 13:21:22 Gemma Staples] No possibility of providing sound proofing to standard for Pilgrim site rooms, Grantham space identified for additional Booth, funding case to be developed, funding source required with appropriate staffing. Potential inclusion for Boston CDC to provide facilities and additional staffing for Boston area patients. Papers still in development to look at demand and capacity required for recovery. Papers going to GLT to raise awareness of the issues within Paediatric Audiology. Additional 13 long waiter children identified to be Datix'd and reviewed. Changes in QIA process slowing recruitment to B6 vacancy. [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	31/03/2026		18/12/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5002	535	Service disruption	Caroline Landon	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 Linconshire - PEOL Re-Design for PEOL services Lincolnshire - ULH Strategy for PEOL ULH Governance - SPC Governance/ CSS CBU/ Cancer Services/ SPC - NACEL report Daily caseload review and triage of caseload using PEOL OPEL reporting measures with sitrep for escalation of risks Daily palliative huddle with key partners to support demand Working as one team across sites to provide pan trust cover Senior leadership for direct support to PEOL at ULHT by addition of deputy lead nurse for PEOL Workforce plan to identify gaps in alignment with national policy and guidance completed	Frequency of referrals outside SPC referral criteria Frequency of referrals that require more information for triage Datix incident / HPF's Complaints/concerns Frequency of patients died/discharged before seen Frequency of patients dying outside Preferred place of death Frequency of first assessment (over 24hrs) from service KPI's. SPC workforce review including staffing deficits and skills gap analysis Daily OPEL level Frequency of support needed by teams from SPC	08/09/2025	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	[08/09/2025 14:54:31 Gemma Staples] Increased absence within SPC CNS and annual leave with no headroom in budget has made staffing challenging and frequently left gaps where there is no face to face service on 1 or more sites. Concerns escalated and best contingency put in place to support most urgent need however, additional risks associated with remote cover only e.g. having to give remote advice and not review patient or have MDT approach to their care. [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	4	30/12/2024		08/12/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5016	22	Physical or psychological harm	Caroline Landon	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	13/10/2025	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Ongoing work in place for long lengths of stay. There is a discharge work progress team in place. 78% performance project currently in place which is supported by the improvement team. Safer Programme in place and SOP is being delivered for Operational meetings in the aim to process discharges and improve flow. Ongoing Care and Comfort project in place to mitigate both harm and risks.	[13/10/2025 08:53:02 Rachael Turner] Risk reviewed, no change to current risk, mitigation remains in place. [15/09/2025 09:11:23 Rachael Turner] Risk reviewed, no change currently. Risk score remains accurate [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. [04/03/2025 15:04:42 Rachael Turner] We are improving our 4 hour standard to enable patients to move through pathway quicker. We are completing AAR's on all 12 hour breaches to enable any learning opportunities. We are changing some pathways, we are going to have a 4 week trial for streaming at Lincoln, this starts	10	02/09/2023 31/03/2024		13/11/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Exec Lead	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	4830	11	Service disruption	Mike Parkhill	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	09/10/2025	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	[09/10/2025 14:42:52 Rachael Turner] Risk reviewed, no current change. Mitigation remains in place and continues to be monitored. [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 risk 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 (KCl) – minimal loss due to quick response: [10/07/2024 11:31:17 Lisa Hansford] no further update [04/04/2024 09:21:11 Lisa Hansford] No further update, all leaks reported to estates [29/12/2023 12:17:18 Lisa Hansford] Leak in dispensary w/c 18th December and stock had to be moved to prevent damage. [26/09/2023 14:12:47 Rachel Thackray] No further update [07/09/2023 14:20:37 Lisa Hansford] 7.9.23 no further update [01/08/2023 14:22:43 Rachael Turner] Risk discussed as RRC&C in July, risk approved to an increase in score to 5x3: 15 High Risk [27/06/2023 09:21:08 Alex Measures] meeting raised risk level to 15	6	30/09/2021	31/03/2022	09/01/2026
1a: Improve patient safety, patient experience and deliver clinically effective care	5095	59	Physical or psychological harm	Caroline Landon	Capon, Mrs Catherine	Chamberlain, Liz (Elizabeth)	Emergency Planning Group, Health and Safety Group	24/02/2023	16	Surgery	Surgery CBU	Vascular Surgery	Pilgrim Hospital, Boston	Due to increased demand for PICC services there is a risk that within the current establishment there is a significant delay to patients. This can delay treatment, hinder flow and cause poorer outcomes for patients. 8 years ago, venous access within the Trust was classed as central lines (internal jugular insertion) and cannulas. Peripheral central catheters (PICC) were undertaken occasionally for oncology patients and portacaths and Hickman lines were done in theatre, as they still are. The vascular ACPs started to learn how to insert picc PICC lines starting from one morning clinic on a Tuesday (supported by the Consultants). The needs for PICC increased and we went to two full day clinics in a week. They were only inserting in pilgrim at that time. It was then determined that Total Parental Nutrition (TPN) needed to be given centrally and not peripherally, and the work load increased two fold. A business case was successful for a 1.0 WTE band 6 venous access nurse to take on the clinics as the work load for the ACPs was also increasing. The Royal College of Radiologists state that a PICC line should be inserted with 72 hours. However, due to the varied nature of why a line is required particulary for urgent cases this has been deemed locally as 24 hours.	At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources.	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	23/09/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business case established with final finance input outstanding to then go to CRIG 6 month secondment for a PICC nurse has been advertised and will require training Give consideration to training of a wider network of clinicians associated with their individual service needs	[23/09/2025 15:08:52 Nicola Cornish] No further progress, a business case is required for expanding the team. [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	1	01/06/2023		23/12/2025
1d: Provide modern, clean and fit for purpose care settings	4648	2	Physical or psychological harm	Mike Parkhill	Parkhill, Michael	Davey, Kelron	Emergency Planning Group, Health and Safety Group	15/12/2021	20	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services. Low level of attendance/completion of fire safety training also contributes to this risk as there there may be significant non-adherence to fire safety policy and procedures which could lead to potential of a major fire.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved by FEG / FSG Sept 2022 - awaiting final approval / signature to be HTM compliant): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - review / protocol in draft, TNA in draft for Fire Safety Team review - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity - Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service - Weekly fire safety team meetings concerning risk assessments and risk register - Capital risk programme for fire - Reporting of local fire safety incidents (Datix) generated through audit programme - Authorising Engineer for Fire - Health & Safety Committee & site-based H&S committees	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms)	25/08/2025	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	[02/09/2025 13:51:10 Rachael Turner] storage of items on corridor has been highlighted with risk from arson, task and finish group to look at challenges formed. actions from group will report to FEG/FSG and FPC. compartmentation works with capital commence this month based upon risk areas [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 remedials and replacement across all three sites continues to make good progress with work being targeted on the basis of risk. Fire Warden numbers across the Trust continue to rise. Due to these mitigations risk proposed for a reduction in score to 4x4:16. [07/11/2024 12:44:43 Rachael Turner] Risk discussed at Fire Safety Group due to current mitigation in place request for risk to reduced to 4x4:16 High Risk. This risk will be presented at RRC&C meeting in December to validate reduction in score. [28/10/2024 11:25:19 Rachael Turner] Risk reviewed, no current change from	10	31/03/2022	31/03/2025	25/11/2025

Strategic Objective	ID	DCIQ ID	Risk Type	Exec Lead	Manager	Handler	Reportable to	Opened	Rating (inherent)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
1a: Improve patient safety, patient experience and deliver clinically effective care	4789	32	Service disruption	Caroline Landon	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 has been staffing challenges so performance has dropped-currently 68% as of December. There is a significant inpatient backlog. Due to the significant drop in performance risk to be presented at February Risk Confirm and Challenge meeting for an increase in score to 4x4:16 High Risk. [08/10/2024 08:54:23 Rachael Turner] Risk reviewed, risk score to remain at	4	01/02/2024	01/02/2024	07/10/2025
2b: Empower our people to continuously improve and innovate	5093	40	Service disruption	Caroline Landon	Bassi, Sangeeta	Baines, Andrew	Workforce Strategy Group	16/02/2023	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of vacancies and long term absence within the invoicing team, purchasing and pharmacy stores team there is a risk that any further absence or leavers will mean the remaining staff don't have the capacity to do the work of all 3 sites which would impact staff wellbeing and all drug ordering across all pharmacy sites (including bulk IV fluids, medical gases, chemotherapy). Inability to complete invoices will negatively impact the Trust finance target to pay invoices within 30 days, with potential of financial penalties, and could result in suppliers putting holds on our accounts rendering us unable to order medicines, this will therefore mean that we would be unable to complete biosimilar switches and meet CIP targets (£1.4m). Recruitment has been further delayed due to VCP to improve the current financial status. Payment beyond 30 days presents a risk of companies levying late payment fees and interest on outstanding amounts.	Band 7 covering the Band 3 gap when needed	Staff Survey Staff Feedback Staff sickness Finance performance on invoice payment Workload CIP tracking Biosimilar switching targets	22/09/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Vacancy fulfillment - QJAs 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	[22/09/2025 15:21:15 Gemma Staples] MARS scheme approved for 0.4wte staff member. Thus reduction in procurement clerk staffing as a result. This affects resilience of team due to part time flexible working of staff members remaining. Further notice received 18th September. Long term absence staff being reviewed for temporary redeployment. Invoicing vacancy filled. Storekeeper vacancy progressing through Trac process following approval from VCP [20/08/2025 10:05:44 Rachael Turner] Risk discussed as part of RRC&C Deep Dive, the control does reduce the risk, although not convenient. Risk score to be reviewed and brought back to RRC&C. This element is part of the whole Pharmacy review. [19/08/2025 13:29:22 Lisa Hansford] Escalation to HR re review of vacancies. Exploring benchmarking of staffing models with other Trusts. [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] QJA 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	4	16/02/2024	16/02/2024	22/10/2025
1d: Provide modern, clean and fit for purpose care settings	4725	466	Reputation	Caroline Landon	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	4	31/03/2022	31/03/2023	30/10/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	4646	66	Physical or psychological harm	Caroline Landon	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	24/09/2025	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.	[24/09/2025 09:28:31 Rachael Turner] Risk continues to be monitored with accurate controls. No current change. Risk score remains at current level. [12/06/2025 10:19:08 Rachael Turner] ED still not following process which is going outside of safety measures, which causes a negative effect on the NIV audit. This remains to be at both Lincoln and Pilgrim but more so at Pilgrim, Patient safety incidents continue to be reported around appropriate usage, equipment, exclusion/inclusion criteria for treatment, ongoing monitoring and usage of an already robust NIV pathway to Respiratory teams. A study day was put on for ED staff, however not been able to move forward as for national standards they need to be exposed to starting off NIV and have a competency. ED are currently looking into how they can put in place this competency. In the meantime the teams need to follow the current policy which is not happening. Due to this this risk needs to remain at current High Risk score of 16. [29/04/2025 14:38:43 Rachael Turner] Escalation has been made, we agreed that NIV & ED meetings need to be set again due to lack of engagement.The policy remains until education is delivered. Three more attempts will be made for these meetings if this fails this will be escalated again to PRM. [04/02/2025 14:39:07 Rachael Turner] We have made no more progression with engagement through ED, however we are re-reviewing KPIs against national standards for NIV. Also reviewing dashboard to identify gaps in knowledge in ED. [27/11/2024 12:16:28 Rachael Turner] NIV provision being reviewed with the implementation of a study day for staff in ED at band 6 and 7, this will be followed by a competence pack whereby staff will be required to set up 5 NIV and be signed off by staff on respiratory. The NIV in a non itu setting SOP is being reviewed to consider options for commencement of NIV in ED. There continues to be significant issues with failure to recognise type 2 respiratory failure in ED	4	31/12/2024	24/12/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5216	362	Physical or psychological harm	Caroline Landon	Cooper, Mrs Anita	Brown, Paula		14/07/2023	12	Clinical Support Services	Cancer Services CBU	Radiotherapy	Trust-wide	As a result of various staffing issues including: Lack of engineer staff for equipment maintenance; Lack of radiotherapy physics staff for weekday and bank holiday run-ups; Lack of radiotherapy physics staff for on-call run-ups; Reduced radiographer numbers; Key staff members leaving the Trust; Increased workload in radiotherapy and radiotherapy physics. There are risks of delivering the necessary patient workload and not always being able to start treatment on time, Increased cancellations. poor morale, long term sick leave and staff leaving their post which could lead to an inability to meet cancer waiting times target, increasing waiting lists, poorer patient experience, poorer patient outcomes and impact commissioning of new equipment.	1) Continue to pro-actively manage activity and capacity to mitigate workload; delaying patients where necessary 2) Review possible breaches to avoid 3) Train additional staff to help with pressured parts of the service where possible 4) Maximise use of existing technologies	Cancer Waiting Time targets Datix Incidents Staff sickness Staff Survey Cancellation of appointments Activity reporting	09/09/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	We will seek funding for some supernumerary salary support for radiation engineers in the coming years – Patrick Downes – April 2026 Business Cases will be developed to meet service needs – Patrick Downes – April 2026 Review duties and service needs to balance staffing against service needs. This could lead to a business to recognise the need for more staff due to service demand - Patrick Downes – 30 November 2025 Recruit to vacant posts as soon as possible - Patrick Downes - December 2025 Staffing review - Patrick Downes - November 2025	[26/09/2025 08:58:35 Gemma Staples] Risk reviewed and reworded. [17/09/2025 13:58:27 Gemma Staples] Risk approved as a 4x4(16) at RRC&C on 17/09/2025 with the request that waiting times be included into the risk detail. [09/09/2025 10:25:14 Gemma Staples] Recruitment of 3 BS radiographer post underway, 1 starting 15th September with 2 others going through the recruitment process. Radiotherapy physics staffing still ongoing due to job matching delays [19/08/2025 14:56:31 Gemma Staples] CSS Cabinet agreed to request to increase from a 3x4 to a 4x4. To be presented at RRC&C in September. [01/07/2025 10:07:05 Gemma Staples] Job matching slow resulting in delays in recruitment. 2 staff members have left in radiotherapy physics. CRIG process for radiographer posts delayed resulting in reduced recruitment for other posts. Capacity is being managed based on staffing numbers. Request for the risk to be increased from a 3x4 to a 4x4. To go to cabinet for agreement and then to RRC&C for approval. [02/04/2025 16:17:40 Gemma Staples] Risk is still live and due to the trust recruitment restrictions is now even more of a problem due to the delays/blocks in recruiting staff. [07/01/2025 12:43:34 Gemma Staples] Brachy physicist upgraded, other staffing still ongoing through strategy meetings and waiting for ICB SDF bids to be approved for some additional roles. [10/10/2024 13:40:42 Gemma Staples] Review of staffing level on-going. Engaging with Ashley Broom to look at structure mapping. Upgrading of brachy physicist to brachy lead in progress. Radiotherapy strategy is now being evaluated through working groups to address actions which includes staffing with a view to submitting BC's when allowed to assist with staffing issues. [23/09/2024 09:42:00 Gemma Staples] Following review at CSS Confirm & Challenge meeting this risk has been combined with 5462	4	30/09/2025		09/12/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	4879	28	Physical or psychological harm	Caroline Landon	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)	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	8	31/03/2023	31/03/2023	11/08/2025

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2a: Enable our people to fulfil their potential through training, development and education	5691	905	Service disruption	Caroline Landon	Fulloway, Mr Ian	Clapham, Mrs Sarah	Patient Safety Group	19/08/2025	16	Clinical Support Services	Diagnostics CBU	Radiology	Trust-wide	As a result of reduction in staffing levels within PACS team attributable to MARS which was 1WTE 8A (with 20+ years of experience), and unfilled vacancies. This will have a significant adverse impact on service delivery across the Trust, affecting the delivery of safe patient care caused by the inability to deliver on vital projects such as Boston CDC, PACS / Web V and CRIS upgrades, importation of images to and from external parties, irefer, Phillips ROCC project, EPR, and the inability to produce data supporting monitoring of diagnostic Waiting times, inability to produce billing reports resulting in loss of income. (this list is a small representation and not exhaustive of the current PACS team workload) Due to staffing issues and unsustainable workload there has not been the capacity to be able to cross train appropriately. Requiring the team to function on the basis of defaulting back to individual strengths in order to keep the service running, resulting in numerous single points of failure within the PACs team	All posts that are unaffected by MARS will be advertised as the QIA system allows. (No controls are in for the posts that have been approved by MARS as unable to replace).	Datix Patient complaints Patient experience Waiting list Staff absence Patient attendance for appointments	19/08/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit into the vacant posts that have not been affected by MARS - Sarah Clapham - February 2026	[17/09/2025 12:48:31 Gemma Staples] Risk approved at RRC&C on 17/09/2025 as a 4x4(16) with the request to include how many WTE we are short by, update risk of VCP approval and the additional updates Sarah provided. [19/08/2025 12:23:03 Gemma Staples] Risk approved at CSS Cabinet as a 4x4 on 19th August 2025.	4	31/08/2026		19/11/2025
1c: Improve productivity and deliver financial sustainability	5020	6	Finances	Caroline Landon	Hamer, Fiona	Lentz, Blanche	WORK	02/09/2022	20	Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	13/10/2025	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[13/10/2025 08:55:37 Rachael Turner] Risk reviewed, no change currently, mitigation remain sin place. [15/09/2025 09:10:31 Rachael Turner] Risk reviewed, no change currently. Risk score remains accurate [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	10	02/09/2023		13/11/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	4731	33	Physical or psychological harm	Caroline Landon	Landon, Caroline	Landon, Caroline	Patient Safety Group	13/01/2022	20	Corporate	Operations	Operations	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review December 2023) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Clinical Records Group - Now led by Deputy Medical Director.	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	13/10/2025	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.	[13/10/2025 11:23:43 Rachael Turner] Request made by digital for this risk to remain open from ops perspective. [22/09/2025 09:24:09 Rachael Turner] Presenter not available for RRC&C, this will now be deferred to October meeting for closure. [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.	4	30/06/2018	31/03/2025	13/11/2025

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2a: Enable our people to fulfil their potential through training, development and education	5467	695	Service disruption	Paul Antunes Goncalves	Babu, Suresh	Chablani, Manish		21/06/2024	16	Corporate	Medical Director's Office	Medical Education	Lincoln County Hospital	As a result of the respiratory teaching at Lincoln currently being delivered by a locum consultant (via bank), who has previously indicated they wish to retire and as there are no consultant job planned or capacity. This could result in the Trust failing our contractual requirements which would bring into question our newly gained status as a teaching hospital.	No controls in place at the moment. This risk has been escalated up to the head of Respiratory by Dr Babu DME as per Dr Chablani's request.	Workforce	04/06/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, include undergraduate teaching as a part of the job plan of a few consultants to share the workload and provide resiliance. Investment into staff and education	[04/06/2025 13:49:40 Rachael Turner] Risk reviewed at RRC&C currently awaiting for confirmation until reduction, this will be monitored and be brought back for reduction [28/05/2025 16:53:27 Rachael Turner] Risk proposed to be reduced to 3x4:12 Moderate Risk, the locum consultant did not leave, however still a risk as may leave. Risk to be presented as part of Deep Dive at RRC&C for reduction in score. [19/05/2025 12:00:19 Rachael Turner] Risk to be presented as part of the Deep dive for RRC&C in May for reduction. [18/02/2025 15:17:11 Rachael Turner] A different locum consultant in place who is the specialty lead and is delivering the teaching. Contract is reviewed on an annual basis. Risk to be presented in March RRC&C meeting for reduction in score [18/12/2024 11:28:22 Rachael Turner] Risk presented to Risk Register Confirm and Challenge 18/12/2024. Until post filled this risk will remain at current level. [26/11/2024 15:03:32 Rachael Turner] Another locum consultant has been appointed to this position for the next year. This is now a low risk. This risk will be presented at December Risk Confirm and Challenge to validate reduction in score. [31/07/2024 13:21:11 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		04/09/2025
1d: Provide modern, clean and fit for purpose care settings	5272	455	Physical or psychological harm	Caroline Landon	Mooney, Mrs Katy	Miller, Mrs Sally		06/10/2023	12	Medicine	Cardiovascular CBU	Cardiology	Lincoln County Hospital	As a result of the current Cath Labs coming to end of life and Lincoln Cardiac catheter lab not being connected to the emergency power supply at Lincoln County Hospital, power cuts and faults due to breakage may occur. This would lead to potentially being unable to offer a PPCI service (primary percutaneous cardiac intervention) and possible risk of patient harm, death or possible implications around infection if a patient is undergoing a procedure at a time of a power cut. Parts not being able to be sourced may put inpatients for angioplasty and pacing procedures at risk and cause significant disruption across the service In addition, Cardiology is trying to build a case for a 3rd lab due to lack and ability and being able to maintain emergencies and piece of work is being undertaken on lab efficiency to help inform the case for. Currently there is nowhere currently on the Lincoln site for a 3rd lab A large proportion of patients waiting for TAVI (Trans Catheter Aortic Valve Implantation) die of the waiting list, we require the 3rd lab to improve and maintain the TAVI service. Replacing a lab can take up to 3 months, which puts increasing pressure on the remaining labs in place.	Temporary electrical fix via Estates-UPS-however there have been mechanical failures which has required Estates to manually to change it over. Estates had a third party assess the UPS switch-this needs to be re-wired but are currently awaiting a date for this to be carried out. Both of the Cath Labs will need re-wiring. Estates have stated they cannot provide power in the event of national grid power outage. Business Continuity Plan Cath Lab-short term power cut would look at utilising Thrombolysis. Prolonged power outage we would need to request mutual aid from those that offer PPI in neighbouring organisations. -Maintenance of labs done by Siemens, however contract comes to an end 2027. -Monthly testing carried out by estates on generators. -Risk of Cath Labs has been escalated to board level. -Project group for new Cath Lab now in place	Monthly audit internally (Cath Lab) Incidents of power outage raised on Datix. Log of jobs raised to Siemens recorded. Financial efficiency project in progress.	16/09/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Estates reviewing Lincoln site space. Job has been raised around electrics 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. -Efficiency Project -Case being developed for replacement of existing labs alongside options appraisal for the possibility of attaining a third lab.	[16/09/2025 14:35:45 Rachael Turner] Risk reviewed and remains at current level. This risk to be merged with existing Cath Lab risks on register to create one risk. [13/06/2025 10:58:55 Rachael Turner] No current change, risk score remains. [12/03/2025 14:02:25 Rachael Turner] Both labs have had the switch over completed, the new technology lets the Cath Lab acquire. We need to understand how long we can acquire for, how long to charge etc. We now have machine capable of screening but if we do not have the data to support the acquisition this could still lead to a risk if a patient was being treated. As there is 1 generator there is the question of whether there is one single place of failure. We need this to be confirmed with Estates. An email has been sent to Estates for confirmation, update to be provided once we hear back. [26/02/2025 13:25:10 Rachael Turner] Risk discussed as part of RRC&C Deep Dive, risk to be reviewed for reduction in score due to work around of fixing electrical supply which has reduced the likelihood of risk. This risk will be reviewed and brought back for a reduction in score [02/12/2024 09:10:52 Rachael Turner] Both labs were tested this morning (29th November) simulating a power cut. Lab 2 worked as planned. During the simulated power cut screening was provided by the 3 phase UPS. When power was restored by estates lab2 reverted back to normal operation. In Lab1 the simulation was repeated. Cath lab 1 did not perform as expected. During the simulated power cut the machine did not switch over to the UPS as expected. The power supply was struck in what Siemens call emergency by-pass. This is the same situation that happened during the last proper power cut where the pacemaker case had to be stopped mid case. There is an automatic switch in the circuit that is supposed to detect a loss in power and then switch over to 3 phase UPS. It is our understanding is that it is this automatic switch that has caused the failure.	1	31/12/2023		16/12/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5491	701	Physical or psychological harm	Mike Parkhill	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.	06/10/2025	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	[06/10/2025 15:49:49 Rachael Turner] Risk reviewed 06.10.25, no change to 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		06/01/2026

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3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	5480	683	Service disruption	Caroline Landon	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.	09/09/2025	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.	[09/09/2025 13:11:39 Rachael Turner] Risk transferred to Integration Committee and strategic objective updated to 3a. [13/06/2025 10:55:21 Rachael Turner] Risk reviewed, some members of staff have returned from maternity. Currently risk remains at current risk score. [19/03/2025 12:08:09 Rachael Turner] Confirmation received that 90% do not have access. Risk increased to 5x3:15 High Risk. [26/02/2025 13:04:37 Rachael Turner] Risk presented at RRC&C 26/02/25, need confirm whether 90% or more do not have access to diabetic nurse, if this is the case risk will be increased to 5x3. [05/02/2025 09:34:13 Rachael Turner] Risk reviewed. Risk description, controls and risk reduction plan updated to reflect current position. Due to ongoing depleted workforce risk to be presented at Risk Confirm and Challenge in February for an increase in score to 5x3:15 High Risk. [28/01/2025 09:44:14 Rachael Turner] Due to current position of depleted workforce risk to be reviewed for increase in risk score. Meeting booked for 31/01/25 to review risk, following this risk to be agreed at CBU governance to then be presented at Risk Confirm and Challenge in February to validate increase in score. [09/01/2025 12:44:47 Rachael Turner] Risk currently remains unchanged. No change to risk score. [09/10/2024 12:14:17 Rachael Turner] This risk remains ongoing. This has been escalated to the Quad in relation for maternity cover.	2	05/07/2025		09/12/2025
1c: Improve productivity and deliver financial sustainability	5672	883	Finances	Paul Antunes Goncalves	Antunes Goncalves, Paul	Sargeant, Paula		17/06/2025	25	Corporate	Finance and Performance	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: - Detailed CIP reporting via the CIP tracker supported by QIA process at Productivity, Improvement, Transformation Oversight Forum (PITOF). - Programme Management Office (PMO) monitors full programme & dedicated Head of Financial Improvement. - Care group overall accountability through GLT	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 now meet as a group and allows confirm & challenge across the group. Monthly Reports into Integration Committee and Finance Committee.	22/09/2025	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. - Continual exploration of new opportunities. - SRO's assigned - Additional resource supported in Financial Improvement.	[22/09/2025 09:21:30 Rachael Turner] "Actions Taken & Next Steps: The Cost Improvement Programme, along with other key performance requirements has been brought back into full focus within the Group. •GLT meetings (planned and extra) have been taken over in August to discuss how improvements to delivery and assurance across all performance aspects is achieved. •Care Group meetings, led by Group Chief Operating Officer (Surgery, Medicine and Family Health) and Group Chief Clinical Governance Officer (Community and Alliance), involving Finance leads have completed a line-by-line review of all schemes planned in August. •Care Groups, via GLT discussions, have submitted further CIP opportunities, together with areas of concern and where additional support is required. •The focus in PRM's in August have been CIP assurance on delivery and next steps. This resulted in a further line-by-line review during these meetings to ensure all key leads were sighted on the current position and risk. •Corporate PRMs have commenced, including Estates and Facilities, to ensure there is full oversight of the cost improvement programme for 2025/26. An opportunities pack has been compiled with suggested SRO's, shared with ELT for review & next steps. •PRM outcomes have resulted in areas of escalation for areas where CIP is off plan (See below). PRM outcomes in relation to CIP: Surgery – Escalation to a further Exec-led meeting based on CIP forecast and assurance. Medicine – Escalation to Group CEO based on financial (CIP and Financial Run-Rate) and workforce performance. Alliance - Escalation to an offline finance review, led by Group Chief Financial	4	01/04/2026		22/10/2025
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	4778	94	Physical or psychological harm	Caroline Landon	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	19/08/2025	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	[19/08/2025 12:14:43 Rachael Turner] We are planning by April 26 to adjust Navenby and move stroke there, this is ongoing work so risk to remain at current level. [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	6	31/03/2025	28/02/2023	19/11/2025

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1a: Improve patient safety, patient experience and deliver clinically effective care	5450	659	Physical or psychological harm	Caroline Landon	Mooney, Mrs Katy	Highfield, Kimmi		05/06/2024	12	Medicine	Specialty Medicine CBU	Gastroenterology	Trust-wide	The capacity of the Gastroenterology Consultant workforce is reducing due to individuals wishing to take resign, retire or partially retire and return with reduce job planned activity. This is impacting the inpatient and outpatient activities of the service. However, as the drive to resign/retire/reduce job planned activity focuses on removal of all inpatient and on-call activity as a 'must' the primary impact is being felt in these area's. If the Consultant Medical workforce for Gastroenterology depletes further and/or does not recruit to vacancies within the workforce, the service will not be able to maintain a two site Gastroenterology inpatient cover, outpatient/ cancer performance and Upper GI Bleed On Call service.	-Recruitment - full time Gastroenterology gaps are out with Agency and on TRAC for NHS Locums. The Business Unit manage the gaps proactively and will put out a variation of gaps (for example, ward cover only) to seek cover for the gaps in the service. -When on-call bleed rota not covered at one site calls are diverted to the other, however this mitigation provides a lower level of service. -Management of UGI Guidelines policy. -Guidelines on Management of Upper Gastro-Intestinal Bleeding (UGIB)	Workforce gaps Capacity of the service Cover of rota's (inpatient ward cover and on-call bleed cover)	22/09/2025	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.	[22/09/2025 09:49:51 Charles Smith] Risk remains at current level with no change for now. [19/08/2025 17:01:38 Rachael Turner] Risk remains at current level with no change to risk scoring. [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. Rotas: bleed gaps covered at Lincoln. We have had consultants returned from sickness. [01/04/2025 14:38:14 Rachael Turner] Risk remains in current position but with further update to be provided around current recruitment. [05/03/2025 09:18:37 Rachael Turner] Risk reviewed, risk remains in current position at the same risk score. [04/02/2025 14:42:02 Rachael Turner] Risk reviewed, risk remains in fragile position currently still awaiting feedback from Trust/ICB. [08/01/2025 12:17:07 Charles Smith] Risk reviewed - No substantial update to current provision. No feedback from Trust/ICB on next steps re: investment cases [10/12/2024 14:52:10 Rachael Turner] Risk reviewed, one more consultant has started at Pilgrim with another possible for late 2025. Workforce business case has been submitted. Risk score remains and unchanged. [22/11/2024 10:23:18 Rachael Turner] Guidelines on Management of Upper	8	05/06/2025		24/10/2025
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	5598	853	Physical or psychological harm	Caroline Landon	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	[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
1d: Provide modern, clean and fit for purpose care settings	5695	906	Physical or psychological harm	Colin Farquharson	Bardan, Ela	Bardan, Ela		19/08/2025	20	Corporate	Medical Director's Office		Trust-wide	As a result of an internal audit identifying that the Trust policy on maintenance of specialist equipment was not being followed and needed to be addressed, work has been undertaken and identified that a significant proportion of devices are beyond their stated manufacturer lifespan and require removal and replacement. There is a risk that ageing and inadequately maintained equipment may fail or malfunction which could lead to harm to patients, disruption to clinical services, and operational delays. In addition, this poses a risk of regulatory action in response to the Trust not meeting statutory requirements in respect of regulation 12 and 15 from the Health and Social Care Act 2008 and Medical Device Regulation (MDR 2017/745) which would also lead to a reputational risk. There is a financial risk in that unplanned use of resource will likely be needed to mitigate the risks to patient safety, regulatory compliance and reputational risk. This contributes to the risk of failure to deliver the Trust's CIP target in full for 2025-26.	1.Devices deemed to be unsafe have been removed from use at audit point and portable suction devices were made available for clinical areas use, if needed. Some filters that were not fit for use were replaced then and there. This supports operational efficiency 2.24/07 Placed urgent compliant orders to support the replacement of devices at Pilgrim Hospital, Boston. 3.17/07/2025-24/07/2025 – Negotiated discount to have a cost avoidance of £48,964.76 +VAT against NHS Supply Chain, with an annual CIP saving for the next 7 years of £13,859,34 + VAT per year, giving a total of £97,015.41 saved over this period, to address the future finance risk. 4.Engagement with key stakeholders to accelerate actions while ensuring safety and considering financial implications.	Audit Datix incidents Patient complaints / PALs Review of all equipment	17/09/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1: Financial resource has been identified to purchase replacement medical devices for Boston only. This should lead to replacement of all affected devices by the w/c 25 August 2025.Completion Date – August 2025 Action 2: Work is underway to raise finances needed to take mitigating action following receipt of the Lincoln audit findings. This remains a work in progress.Completion Date -TBC Action 3: Place an order for replacement devices at Lincoln and roll-out removal and replacement of deficient devices at Lincoln –Completion date- September 2025. Action 4: Clinical Engineering to submit a Quality Impact Analysis (QIA) to the Vacancy Control Panel (VCP) to secure approval for the recruitment of four Band 3 and two Band 4 Clinical Engineering Technicians. These roles are essential to manage the increased volume of medical gas equipment that Clinical Engineering is now responsible for across ULTH going forward. This will ensure	[17/09/2025 13:40:26 Gemma Staples] Risk approved as a 4x4(16) risk at RRC&C on 17/09/2025.	4	19/08/2026		17/12/2025

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3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	5564	783	Physical or psychological harm	Caroline Landon	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	23/09/2025	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.	[23/09/2025 09:11:04 Rachael Turner] We are currently working on an updated case of need for more staffing in the overnight period (and to expand into weekend days). We have been having meetings with Suresh Babu (medical lead for resident Dr education) Jonathan Thomas Thompson (clinical service manager, acute medicine) and others to try and get a medical Dr for the overnight period. Our one FY1 Dr comes to us from the surgical rotation. We have submitted a QIA and an options appraisal. We are working with Rosella Gugliotta on our Service improvement project to try and prevent routine work being left over from the day and coming to us at night. Rosella is currently working with the top 2 wards (Dixon and Hatton). We have very good engagement from Anthony Norman (gastro consultant) and Teressa Lee (Hatton ward sister). Unfortunately, we have experienced a loss of our reporting pages on Nerve Centre, meaning we have no means of re auditing the wards to gage any improvements made. We believe this loss was an unfortunate error during the engagement process with Nervecentre for our new EPR system. We have raised it at a meeting with the Tranch 1 lead for EPR (Janine Alli-Balogun) and digital nurses. We have submitted it as an incident to the digital service desk and emailed Tracey Swift as advised at our meeting and hopefully we will get a swift resolution. Once able to re audit and gage improvements we will move on to work with other wards with the plan being to roll this out pan trust in the not-so-distant future. [09/09/2025 13:10:41 Rachael Turner] Risk transferred to Integration Committee and strategic objective updated to 3a. [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	8	19/12/2025		23/12/2025
1c: Improve productivity and deliver financial sustainability	5389	559	Finances	Caroline Landon	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.	03/10/2025	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.	[03/10/2025 16:28:54 Rachael Turner] We are currently working on an updated case of need for more staffing to allow us to expand into weekend days, however as CRIG will not hear anything without an agreed source of funding this is very slow going and incredibly frustrating. The deputy COO, is currently trying to find funding. A QIA has been created (with Louise Hobson from PMO) for the risks of stopping weekend working, as was requested by Nick Mulholland (Deputy Chief Nurse for Quality and Safety). This is going to be heard at the QIA panel meeting on October 14th (QIA number 2025-513) [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		03/01/2026
3c. Enhance our digital, research and innovation capability	5648	870	Physical or psychological harm	Daren Fradgley	Fradgley, Daren	Humber, Michael	25/04/2025	20	Corporate	Integration and Improvement		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.	13/10/2025	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.	[15/10/2025 10:05:17 Rachael Turner] Risk discussed as part of RRC&C Deep Dive, risk score remains at an appropriate level. [13/10/2025 14:03:30 Rachael Turner] While there are currently many mitigations and manual workarounds in place, that enables the organisation to operate and work more efficiently with paper based health records and stand-alone digital health systems, such as digital tracking of paper based case notes and use of back office systems. The Trust EPR is moving into delivery as is the EDMS which will digitise paper records. [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		13/01/2026

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1d: Provide modern, clean and fit for purpose care settings	5498	726	Regulatory compliance	Mike Parkhill	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	10/09/2025	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.	[10/09/2025 12:49:06 Rachael Turner] Paper to GLT due to be represented on 19th Sept. Grant secured for 2 helipads, complete refurbishment. Funding - annual cost for staff, maintenance etc. [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		10/12/2025
3c: Enhance our digital, research and innovation capability	5519	739	Regulatory compliance	Daren Fradgley	Fradgley, Daren	Evans, Thomas		08/10/2024	16	Corporate	Integration and Improvement	Digital Services (ICT)	Trust-wide	As a result of the lack of an established Digital Clinical Risk Management system (Health IT system), processes and resource resulting in non-compliance with the Digital Clinical Safety Standards DCB0129 and DCB0160 (the Standards mandated by NHSE to ensure the safe manufacture, development, deployment, and use of Health IT Systems) this could lead to patient safety incidents involving digital systems, resulting in or contributing to patient harm or death. An informal 'best endeavours' approach has previously been taken and digital clinical systems have been deployed that have not fully met the Standards. The Standards also mandate an approach to Clinical Risk Management which continues for the entire lifecycle of the Health IT system, not just prior to initial deployment. Under the standards, the CRMS must have proactive and reactive elements to effectively manage post deployment patient safety concerns / incidents and this element has also previously not existed within at the Trust in any formal way with a lack of formal governance and assurance for clinical safety.	•Previously no defined lead for digital clinical safety established in the Trust. The CNIO has voluntarily taken the lead on Digital Clinical Safety (Trained CSO) within their substantive role, although clinical safety responsibility not outlined in job description / role and responsibilities. However, no resource for non-project/non funded DCSO work = risk •Digital Clinical Safety Officer (DCSO) post recruited into May 2024, as part of EPR programme (not revenue funded = risk). 1 further DCSO post has been included in the resource model for EPR implementation (>2025 funding) however, given the large volume of current in-flight Health IT System projects and legacy systems outside of EPR, this is not an adequate resource. •Digital Clinical Safety Policy now in the organisation (approved at DHG and Corp Gov – awaiting publication on the intranet) •Draft Clinical Risk Management System developed by new DCSO and awaiting Clinical Governance review before formal approval at DHG •Further development of required structures and governance standards to meet/comply with National standards and strengthen our position underway. •Digital Clinical Safety processes / awareness will require significant 'socialisation' to ensure they are effectively embedded. This will include clinical safety training for clinical / digital / operational colleagues as appropriate to their role.	•Number of digital systems without full compliance with the Standards i.e Clinical Risk Management File, Clinical Risk Management Plan, Clinical Safety Case Report, Hazard Logs etc. •Lack of digital clinical safety resource and no policy or standard within the Trust prior to recently created and published policy. •Known new and upcoming digital projects are tracked, and activities aligned to new policy and the National standards. •Previous deployments will require review and a post deployment safety assessment and remain subject to further clinical safety activities under the National standards and guidance	01/09/2025	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	[15/10/2025 10:08:59 Rachael Turner] Risk discussed as part of RRC&C Deep Dive, risk score remains at an appropriate level. [30/09/2025 12:03:22 Rachael Turner] Risk reviewed, score remains. Clinical safety resource remains very limited and supporting a high number of programmes. [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	12	08/10/2025		01/12/2025
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	5710	916	Finances	Daren Fradgley	Fradgley, Daren	Fradgley, Daren		01/10/2025	20	Corporate	Integration and Improvement		Trust-wide	As a result of the size and complexity of our transformation programme there is a risk that we cant mitigate against unplanned delays or complexities which will result in a potential impact on multiple transformation programmes.	1)Internal resources are coordinated by the Strategy, improvement and redesign Directorate and overseen by the productivity improvement and transformation oversight forum, which reports into and Finance and Performance and the Integration Committee. 2)Each transformation programme has a senior responsible officer who is accountable to the governance in item 1. 3)External resources are coordinated by executive sponsors (SRO) and report into the governance in item 1. 4)None transformation cost improvements or quality improvement programmes are monitored through the same governance in item 1, however if they relate specifically to care group actions they fall under the oversight of the performance review meetings.	1)Each programme and associated projects have a delivery plan and benefits map. 2)The larger scale programmes have defined key performance indicators which relate to the expected progress and are monitored monthly. 3)Smaller change programmes including those that have cost improvement benefits are monitored through the performance review meetings.	01/10/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Review and strengthen governance structures to ensure consistent oversight and escalation Lead:Chief Integration Officer Completion date: 3 months (Dec 2025) Action 2. Standardise programme reporting templates to improve consistency and clarity Lead: Director of Strategy, Improvement & Redesign Completion date: 3 months (Dec 25) Action 3. Align outputs from performance review meetings with strategic governance processes Lead: Chief Integration Officer Completion date: 3 months (Dec 25) Action 4. Conduct bi-annual data quality audits on delivery plans and KPIs Lead:Chief Integration Officer Completion date: 3 months (Dec 25)	[15/10/2025 10:34:12 Rachael Turner] Risk presented at RRC&C 15/10/25. Risk validated as 4x4:16 High Risk	8	31/03/2026		01/01/2026

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3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	5711	915	Finances	Daren Fradgley	Fradgley, Daren	Fradgley, Daren		03/10/2025	20	Corporate	Integration and Improvement		Trust-wide	As a result of the ICB's reorganisation into a three county cluster, with fewer senior leaders covering a bigger area there is a risk for the Group that a loss of corporate memory and diluted focus disrupts our ability to deliver our strategy. This could lead to failed delivery of our 25/26 operational plan and loss of progress or regression in our strategic partnerships	The current position is monitored and mitigated through the following strategic and leadership engagement forums: -BLET -LLG -System exec to exec -ICB Board (include partner chief execs -Group Board - weekly chief executive meetings - target operated model board (TOM) - Executive one to one's Given the pace of change and the current vagueness of the ICB cluster operating model it is difficult to quantify the future controls possible until the cluster executive team is in place. It is anticipated the announcement will be made during October on these roles and then formalised next steps planning can take place.	1)The system boards including the ICB Board, the Group Board and the formal joint committees at a system level. 2)Measuring progress and impact at exec to exec monthly meetings.	15/10/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Action 1. Map critical relationships and dependencies to ensure they are actively maintained and not lost during leadership changes. Lead: Director of Strategy, Improvement & Redesign Completion date: 3 months Action 2. Ensure new cluster executives are quickly brought up to speed with local context, priorities, and strategic goals. Lead:Chief Integration Officer Completion date: 3 months Action 3. Enhance joint system governance reporting through improved visibility and alignment across forums such as BLET, LLG, TOM, and the Group Board. Lead: Chief Integration Officer Completion date: 3 months Action 4. Oversee continuity and coordination during the reorganisation period to maintain strategic momentum Lead: Chief Integration Officer Completion date:3 months	[15/10/2025 10:41:00 Rachael Turner] Risk presented at RRC&C 15/10/25, risk validated as 5x4:20 Very High Risk.	12	31/03/2026		15/11/2025
1a: Improve patient safety, patient experience and deliver clinically effective care	5181	358	Physical or psychological harm	Caroline Landon	Lynch, Diane	Rigby, Lauren		23/05/2023	16	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	As a result of inadequate staffing and inadequate space and an increase in available treatments particularly oral treatments, SACT capacity does not meet the demand required which would lead to the Trust being unable to meet our 31 and 62 day cancer targets, psychological distress to patients due to waiting time and staff burn out due to working conditions. Pilgrim does not have a medical day unit (MDU), our SACT services therefore have to run differently to Lincoln. Chemotherapy Suite at PHB has 18 Chairs which could all be utilised for SACT delivery however, as we do not have an MDU these are used for transfusions, picc flushes etc.	OAU used in appropriately at times, patients admitted to wards if time critical. Staff work extended hours Patients waiting 3 weeks or more are escalated to Matron	Datix incidents Complaints / PALS Staff concerns Sickness absence Retention figures 31 & 62 day targets	26/09/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	SACT Pathway to be reviewed - Kate Taft - July 2025 Chairs should be return to pre covid levels - Polly Johnson and Fran Martinez - July 2025 Chemotherapy Case of need for staffing written and awaiting CRIG invitation - Sarah Chester-Buckley - April 2026 Oncology / Haematology Right Sizing paper written and awaiting CRIG invitation - Sarah Chester-Buckley - April 2026	[29/09/2025 14:06:27 Gemma Staples] EMCA benchmarking shows Chemo Suite Needs 14 WTE RN per day and Ingham Needs 17.5 WTE RN – we currently do not have this staffing. Chemo suite Requires additional 100 clinical hours at present to deliver care and Ingham Requires additional 250 clinical hours at present to deliver care per week for what we currently are delivering. [26/09/2025 13:32:45 Gemma Staples] Waiting for establishment review update, waiting for SACT room at Skegness CDC which will help. [17/09/2025 14:12:35 Gemma Staples] Risk approved in the increase of scoring to a 5x3(15) at RRC&C on 17/09/2025. [27/08/2025 13:10:43 Gemma Staples] Risk reviewed against the scoring matrix as a Physical & Psychological harm risk. It was agreed that the severity still sits as a Moderate (3) with the request to increase the likelihood to extremely likely (5) due to the waiting time deteriorating to 3 weeks. [20/08/2025 10:33:54 Rachael Turner] Risk presented at RRC&C 20/08/25 for increase in score.The issue is lack of capacity in service, risk has been there for some time and the number of patients has increased since Covid and the types of treatments available is larger. Increase requested now as likelihood has increased and we are outside of meeting waiting time targets, so contributes to not meeting cancer targets. This is particularly an issue at Pilgrim. This risk is also included in establishment review. This needs to be updated to a patient harm risk as currently listed as regulatory which will effect the scoring. This risk will be reviewed as patient harm risk and brought back to the next meeting. [06/08/2025 14:37:17 Gemma Staples] Agreed at Cabinet on 15/07 for the risk to be increased to 5x3(15). To be presented at August RRC&C meeting. [04/07/2025 10:05:18 Gemma Staples] The position has deteriorated to 3 weeks waiting time so a request for the risk scoring to be increased from a 4x3(12) to a 5x3(15). To go to cabinet for agreement and the to RRC&C. [23/06/2025 08:49:13 Gemma Staples] We are still waiting for the 2 chairs for	4	23/05/2024		26/12/2025
2b: Empower our people to continuously improve and innovate	4997	41	Service disruption	Caroline Landon	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	18/09/2025	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	[18/09/2025 11:16:17 Gemma Staples] Further investment is still required to remedy this risk. [19/08/2025 08:21:39 Gemma Staples] Until there is further investment in the team the risk will remain as we are unable to staff two on call teams to cover both sites appropriately. [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	8	01/04/2023 01/04/2023		20/10/2025

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3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	4780	74	Service disruption	Caroline Landon	Mooney, Mrs Katy	Constantin, Dr Carmen	Medicines Quality Group	16/01/2022	20	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of a significant deficit in stroke consultants levels due to staff leaving/ retiring and stroke service struggling to recruit substantive consultants there is a risk of not being able to maintain effective stroke provision across ULTH. From April 2025 the stroke service will have only one Substantive Consultant, upcoming retirement could result in no substantive Consultant Stroke Physicians in 2028-2029 if continue to not recruit. Reliance on Locum consultants is costly and causes instability in the rota. Locum/Agency/Bank reliance results in limited medical training & supervision for resident doctors, Registrars, ACPs and students – limiting staffing pool for the future & reduces staff experience/satisfaction.	•Utilising a regular pool of locum consultants •Consultant advert out •Attended recruitment drive at medical conference November 2024 •Consultant ACP post •Liaising with Integrated stroke delivery network [ISDN] for possible regional solutions	Datix/incidents/SJR/SI Rota Gaps Budget/costing	19/08/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Convert locum contacts to Bank where possible Action 2. Continue to advertise for consultant stroke physicians Action 3. Continue to liaise with Integrated stroke delivery network [ISDN] for possible regional solutions ?regional rota Action 4. Further consultant stroke practitioner post & support Stroke registrars to become stroke consultants. Action 5. Redesigned stroke pathway.	[09/09/2025 13:31:59 Rachael Turner] Risk transferred to Integration Committee and strategic objective updated to 3A. [19/08/2025 12:25:24 Rachael Turner] Following People Committee feedback, this risk is still ongoing. Currently have two full consultants, we still have four vacant posts for full time (requiring six in total). A job was offered to an applicant but they are coming from overseas, there is potential but nothing concrete so this risk is to remain open. [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	8	31/03/2022	01/07/2024	19/11/2025
2b: Empower our people to continuously improve and innovate	4844	38	Service disruption	Caroline Landon	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 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	22/09/2025	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	[22/09/2025 15:23:07 Gemma Staples] Reports for the ED and Discharge Lounge Pharmacy Pilots complete and sharing reports with CSS, ED and also MQSG. Further actions to be developed from this including opportunity for winter pressure funds Monitoring of the change to weekend working hours ongoing – no patient harms reported to date. Presented to QIA panel 10/9. To continue monitoring and review if any significant events [19/08/2025 13:35:21 Lisa Hansford] Weekend working change in practice effective as of 9th August which was approved through QIA and approved by QIA panel. Effects of are being monitored. [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.	4	29/10/2021	21/06/2023	22/10/2025
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	5169	60	Physical or psychological harm	Caroline Landon	Constantin, Dr Carmen	Constantin, Dr Carmen		09/05/2023	15	Medicine	Cardiovascular CBU	Stroke	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	[06/10/2025 15:24:49 Gemma Staples] Risk reassigned to Stroke / Medicine. [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	3	13/05/2024		04/11/2025

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2a: Enable our people to fulfil their potential through training, development and education	5427	699	Service disruption	Colin Farquharson	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
1a: Improve patient safety, patient experience and deliver clinically effective care	5146	277	Physical or psychological harm	Caroline Landon	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.	23/09/2025	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.	[26/09/2025 09:24:51 Nicola Cornish] Lisa Marshall is completing the ICB weighted value framework template to request additional funding but meeting the required level to be considered at panel is challenging. The guideline for implementation of telemedicine is also being review but additional staffing would be required to deliver a robust level of service. [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.	3	29/02/2024		23/12/2025
1d: Provide modern, clean and fit for purpose care settings	5383	615	Regulatory compliance	Caroline Landon	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	02/10/2025	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	[02/10/2025 09:00:42 Gemma Staples] Risk remains the same. Still awaiting a response from Estates. [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	3	13/02/2025	13/02/2025	02/01/2026

Strategic Objective	ID	DCIQ ID	Risk Type	Exec Lead	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	5003	342	Physical or psychological harm	Caroline Landon	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 for Senior lead to work operationally decreasing the ability to influence, improve and innovate across the Group and partners.	National Policy/Guidance - NICE Cancer service guideline [CSG4] Improving supportive and palliative care for adults with cancer - Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026 - RCN Guidance on safe nurse staffing levels in the UK - NHS Health and Wellbeing Strategic Overview. Creating a health and wellbeing culture - Commissioning guidance for specialist palliative care 2012 ULH Policy Health and wellbeing policies Daily caseload review and triage of caseload using PEOL OPEL reporting measures with sitrep for escalation of risks Daily palliative huddle with key partners to support demand Working as one team across sites increasing team support to improve wellbeing Senior leadership visibility increased Internal and external ask for multi disciplinary support to the SPC team. Education training needs analysis for team completed Workforce plan to identify gaps in alignment with national policy and guidance completed Service improvement gap analysis completed Prioritised 1:1 meetings with individuals and protected time for essential education. Daily check in/out with team. Clear escalation route developed for concerns/risks	Gap analysis for staff education Daily escalation reports with staffing levels and patient caseload numbers Number of referrals to service Number of referrals to assessment outside KPI target Figures for nurse recruitment/retention SPC absence rates Staff feedback on NACEL reports Staff vacancy rates and appraisal rates 1:1 supervision feedback on staff wellbeing	08/10/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business Case written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026	[08/10/2025 12:36:54 Gemma Staples] SPCT staffing continues to be challenging we now have 0.8 WTE band 6 off LTS and band 7 has reduced their hours to 0.8 WTE and is on a phase return. This means we are working at a deficit of between 90 and 93 percent of the MINIMUM safe staffing for specialist palliative care as advised by the Association of Palliative medicine workforce review and is not sustainable or acceptable for patient care or staff wellbeing. We are submitting a datix when there is no CNS on site for the service. [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	8	30/12/2024		08/01/2026

NHS
Lincolnshire Community and Hospitals NHS Group

Group Board Assurance Framework (BAF)

Caring and building a healthier future for all

Meeting	*LincoInshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*12.2*
Report title	*Group Board Assurance Framework*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Assurance* • *Approval*
Accountable Director	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial assurance*
Prior approval process, if applicable	*Consider through Board Committees including Audit Committee*
Financial implications, if applicable	*N/A*
Action / decision required	*The 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 1d, from red to amber;* • *agree the need for any additional action or assurance at this stage*

Assurance Rating Key:

Assurance Rating	Description
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are uncertain or possibly insufficient*
Red: Limited or No Assurance	*Effective controls are not in place or are insufficient to manage the risk identified and / or appropriate assurances are not available. Immediate action is required to address the gaps, weaknesses or non-compliances identified*

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

Executive Summary

Background & Introduction

An effective BAF should guide the agenda setting for a board and its committees and, in turn, should be used as the framework for the board committees to report assurance and / or escalate gaps in assurance to the board in respect of delivery of the group's strategic aims & objectives.

In order to reflect the move to group and to provide a more high-level and concise view of the risks to the achievement of the group's strategic aims & objectives and, in turn, the controls, sources of assurance and any gaps, the LCHG Board had agreed in January 2025 to the introduction of a revised BAF format.

Work to further refine the new style BAF – including the addition of clear timescales and leads for agreed actions – and embed its use within the board and committee cycle will continue over the coming months. Each of the board committees, in turn, will continue to review, challenge and seek assurance in respect of the areas of the BAF for which they have oversight with escalation, as required, to the Group Board.

Work is also underway as a priority to align the underpinning risks on the ULTH and LCHS risk registers to the relevant strategic risks within the BAF.

Summary of the Report

This report provides the second iteration of the BAF in the agreed new format.

BAF entries have been populated with reference to the previous LCHG BAF and with input from relevant executive directors.

The BAF has reviewed by all Committees during September and October and narrative updates provided. During the September Finance and Performance Committee consideration of the assurance rating, in respect of objective 1d, was held with a view that this should be increased from red to amber due to the increased assurances being offered to the committee in respect of estates and facilities. There was recognition that this was supported through the increased quality of reporting, alongside the strengthened assurances being provided.

The BAF has also been received by the Audit Committee during October where it was confirmed that systems and processes were in place and working as expected. The format was confirmed to be relevant and effective for the Group.

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 1d, from red to amber due to the increased assurances being received by the Finance and Performance Committee;

- agree the need for any additional actions or assurances at this stage.

Main body of the report: should not exceed 5 sides of A4, should be prepared using Arial, font 12 and should include the following elements:

Contents

Introduction / Background

Section Headings

Key Points (findings, key risks & issues and any actions already taken)

Conclusion / Recommendations

Board / Committee Action Required

Appendices, if applicable

LincoInshire Community & Hospitals NHS Group (LCHG)

Group Board Assurance Framework (BAF)

As at October 2025

The LCHG BAF

Background & Introduction

An effective BAF should guide the agenda setting for a board and its committees and, in turn, should be used as the framework for the committees to report assurance and / or escalate gaps in assurance to the board in respect of delivery of the group's strategic aims & objectives.

In order to reflect the move to group and to provide a more high-level and concise view of the risks to the achievement of the group's strategic aims & objectives, the LCHG Group Board has agreed to the introduction of a revised BAF format. This report provides the first iteration. Work to further refine the new style BAF and embed its use within the board and committee cycle will continue over the coming months. Each of the board committees, in turn, will continue to review, challenge and seek assurance in respect of the areas of the BAF for which they have oversight.

Scoring the BAF

Risk Scores

The scoring methodology for BAF risks reflect the group's existing risk scoring matrix (as shown in Table 1 below) calculating the impact / severity of the identified risk should it occur by the likelihood of the risk occurring.

Table 1:

	Impact / Severity score & descriptor (with examples)				
Risk type	**1 Minimal**	**2 Noticeable**	**3 Moderate**	**4 Severe**	**5 Extreme**
Physical or psychological harm	Low level of temporary harm (no clinical attention required) affecting individual patients, staff or visitors	Relatively low level of harm (requiring first aid or psychological support) affecting multiple patients, staff or visitors	Significant, temporary harm (requiring clinical treatment but expected to make a full recovery) affecting one or more patients, staff or visitors	Significant long-term or permanent harm affecting individual patients, staff or visitors	Significant long-term or permanent harm affecting multiple patients, staff or visitors
Reputation	Small number of individual concerns raised	Small number of individual complaints raised	Multiple complaints received; negative local media / social media attention	Direct intervention from a regulator; serious complaint from one or more partner organisation; sustained negative national media / social media attention	Fundamental loss of confidence amongst the public, partner organisations and regulators
Service disruption	Manageable, temporary disruption to peripheral aspects of service provision affecting one or more service	Manageable, prolonged disruption to essential aspects of service provision reducing the efficiency & effectiveness of one or more service	Temporary, unplanned service closure affecting one or more service or significant disruption to efficiency & effectiveness across multiple services	Extended, unplanned service closure affecting one or more service; prolonged disruption to services across multiple services	Indefinite, unplanned general hospital or site closure
Regulatory compliance	Technical non-compliance with reasonable justification; no regulator attention	Recommendations for improvement for one or more service	Improvement / warning notice for one or more service; recommendation for independent review; legal action for regulatory / contract breach	Special measures; prohibition notice for one or more service; prosecution	Suspension of CQC registration; Parliamentary intervention
Finances	Some adverse financial impact (unplanned cost / reduced income / loss) but not sufficient to affect the ability of the service / department to operate within its annual budget	Noticeable adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more services / departments to operate within their annual budget	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more business units to operate within their annual budget	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of the organisation to achieve its annual financial control total	Significant aggregated financial impact (unplanned cost / reduced income / loss) affecting the long-term financial sustainability of the organisation

Likelihood score & descriptor (with examples)				
1 Extremely Unlikely	2 Quite Unlikely	3 Reasonably Likely	4 Quite Likely	5 Extremely Likely
Unlikely to happen except in rare circumstances Less than 10% chance	Unlikely to happen except in specific circumstances Between 10-30% chance	Likely to happen in a significant number of circumstances Between 31-70% chance	Likely to happen in the majority of circumstances Between 71-90% chance	Almost certain to happen Greater than 90% chance

Risk Scoring Matrix						
Impact / Severity	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	2	3	4	5
		Likelihood				

Risk Rating	Very Low (1 – 3)	Low (4 – 6)	Moderate (8 – 12)	High (15 – 16)	Very High (20 – 25)

Risk Appetite

How much risk is the Trust prepared to accept for each level of appetite?

Table 2 below provides the group's risk appetite statement and tolerance levels.

Hungry	• This would mean we are willing to take risks such as being innovative or using new technologies	15/16
Open	• Open is when we are willing to consider all potential options and recognises that there will be risk exposure	12
Cautious	• Preference of cautious is to always be safe but we accept there may be some risk exposure	10
Minimal	• Minimal is when we will accept the safest options only	8
Averse	• We will avoid all risk exposure and cease activity	6

Assurance Rating

For each strategic risk, the BAF identifies a number of controls (the actions that are already being taken to manage the risk) and outlines the sources of assurance against these (how it can be determined that the controls are working) and any gaps. For each strategic risk an overall assurance rating is provided using the assurance level definitions set out in Table 3 below. This is intended to assist the LCHG Group Board to assess the level of confidence it can have that appropriate controls are in place and that they are working effectively, that any material gaps in control have been identified and that clear actions, leads and timescales have been agreed to address them.

Table 3:

Assurance Rating Key	
Strength	**Description**
Red	**Effective controls are not in place or are insufficient to manage the risk and / or appropriate assurances are not available to the board**
Amber	**Effective controls are mostly in place and actions have been agreed to implement the remaining controls and / or assurances are uncertain or possibly insufficient**
Green	**Effective controls are definitely in place and the board is satisfied that appropriate assurances are in place**

Action Plan Progress: RAG Rating

Progress with delivery of actions to address gaps in controls and / or assurances will be rated in accordance with the matrix shown in Table 4 below.

Table 4:

Action Plan Progress RAG Rating	
Blue	**Completed & embedded and added to controls or assurances**
Green	**Completed & ongoing and / or not yet fully embedded**
Amber	**In progress & on track**
Red	**Not yet completed / significantly behind agreed timescales**

Group BAF Overview: Strategic Risks

Strategic Aim	Strategic Objective	Strategic Risk
Patients: Better Care – Timely, affordable, high quality care in the right place	1a: Improve patient safety, patient experience and deliver clinically effective care	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny
	1b: Reduce waiting times for our patients	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm
	1c: Improve productivity and deliver financial sustainability	If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients
	1d: Provide modern, clean and fit for purpose care settings	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny
People: Better Opportunities – Develop, empower and retain great people	2a: Enable our people to fulfil their potential through training, development and education	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable, less efficient services and the inability to attract and retain staff
	2b: Empower our people to continuously improve and innovate	If we do not **empower our people to continuously improve and innovate** they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience
	2c: Nurture compassionate and diverse leadership	If we do not **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement
	2d: Recognising our people through thanks and celebration	If we do not continue to **recognise our people through thanks and celebration** then we will be unable to attract and retain staff of the required caliber and experience resulting in services becoming unsustainable / fragile
Population: Better Health – Improve population health	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience
	3b: Move from prescription to prevention, through a population health management & health inequalities approach	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes
	3c: Enhance our digital, research and innovation capability	If we do not **enhance our digital, research and innovation** capability then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale
	3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable

Group BAF: Position Overview as at October 2025

Strategic Aim	Strategic Objective	Strategic Risk	Executive Lead(s)	Board Committee Oversight	Current Risk Score (as at October 2025)	Target Risk Score (March 2026)	Assurance Rating (as at October 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)**	**Amber**	**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)**	**Green**	**Green**
	2b: Empower our people to continuously improve and innovate	If we do not **empower our people to continuously improve and innovate** they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Amber**	**Green**
	2c: Nurture compassionate and diverse leadership	If we do no **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Amber**	**Green**
	2d: Recognising our people through thanks and celebration	If we do not continue to **recognise our people through thanks and celebration** then we will be unable to attract and retain staff of the required caliber and experience resulting in services becoming unsustainable / fragile	Group Chief People Officer	People Committee	**6 (Low)**	**3 (Very Low)**	**Amber**	**Green**
Population: Better Health – Improve population health	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	3b: Move from prescription to prevention, through a population health management & health inequalities approach	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving**	Group Chief Integration Officer	Integration Committee	**9 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**

		population health resulting in less equitable access to services and poorer clinical outcomes						
	3c. Enhance our digital, research and innovation capability	If we do not **enhance our digital, research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (i): **Improve patient safety**, patient experience and deliver clinically effective care
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

8 (Moderate)

⇔

Last Review Date:	~~August~~ ~~October~~ 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	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	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	Underway – Workshop planned for the 8 October to scope what is currently in place and plan next steps. Safe to Safe Campaign planned to roll out during Q3. Update 08/10/25 – Safety Culture Assessment Proposal written and being taken to PSG on the 16/10/25 with upward reporting to the QC. Implementation plan for the Manchester Safety tool underway.
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	With the national launch of the Being Fair Tool which is superseding the Just Culture Tool work is being undertaken to review what this means for the workstream. ~~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 Monthly pressure ulcer assurance meetings continue outcome themes reported to SIG. Oversight also through QA dashboards. Review of data/reporting processes in progress
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 Programme established for community hospitals and community nursing with monthly quality dashboards in

					place Unannounced peer review visit programme commenced. Work is underway to continue to expand and rollout to additional services during Q3/4.
7	Response to internal work and investigations and external visits~~findings from NHSE inspection and other reviews~~ of the group's infection prevention and control practice and interventions~~arrangements~~ to be developed and implemented.	Group Chief Nurse	Deputy Director of Infection Prevention and Control ~~Deputy Chief Nurse~~	31 March 2026	Underway
8	Monthly monitoring and escalation for training noncompliance to Care Groups (CG leads / Safeguarding Operational groups and SVOG). Selective direct emails to noncompliant staff	Group Chief Nurse	Director of Safeguarding	31 March 2026	Ongoing

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of quality & safety agenda and key risks by the Quality Committee and reporting sub-groups (e.g. Patient Safety Group, Maternity & Neonatal Oversight Group, Safeguarding & Vulnerabilities Group), with escalation to the Group Board as required
2	Reporting on quality & safety KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	QIAs reviewed by care groups and executives with Quality Committee oversight
4	Learning from incidents reported to the Patient Safety Group and disseminated across the group
5	Incident themes & trends monitored through the Patient Safety Group
6	Delivery of quality & safety KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
7	Local level and Group Board Maternity & Neonatal Safety Champions in place with reporting to the Group Board
8	Internal & external audit, external reviews and visits provide independent assurance of the robustness of the group's quality governance arrangements
9	Internal audit review of ULTH's management of medical devices undertaken during 2024 / 25 has provided 'reasonable assurance'. Medical Devices Group in place reporting to Patient Safety Group

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	QIAs not universally used across the group
4	The occurrence of repeated or same type incidents suggests processes for learning lessons are not yet fully embedded across the group
5	None identified
6	None identified
7	None identified
8	None identified
9	Medical Devices Group to be renamed to be representative of the LCH group

Actions being taken to address gaps in 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 Update 08/10/2025 – Both Medical Devices Groups have now come together and has been renamed as the LCHG Medical Devices Safety Group.
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~~Update 08/10/2025 – Launch of CG structure September included development of a three posts within the Compliance team that are dedicated to developing and supporting the triangulation of data and learning from all aspects of the Clinical Governance Directorate and ensure that there is a programme of learning in place across the Group.
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	5016	20	Patient flow through ED
ULTH	5101	20	Community and Acute paediatric epilepsy pathway
ULTH	5200	20	Paediatric cardiology backlog
ULTH	5450	20	Gastroenterology consultant workforce
ULTH	4746	20	Overdue patients on Ophthalmology PBWL

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**
LCHS	403	20	Children's SLT treatment delays

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (ii): **Improve** patient safety, **patient experience** and deliver clinically effective care
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

9 (Moderate)

⇔

Last Review Date:	~~August~~ October 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	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	Amber	Amber					

Identified Controls *(What are we already doing to manage the risk?)*	
1	Quality & safety and patient experience priorities and KPIs agreed
2	Patient Experience & Involvement Team in place
3	Established complaints & PALS teams
4	Group Complaints & PALS Policy agreed
5	Improvement Plans developed in response to national patient experience surveys
6	PLACE reviews completed and improvement plans developed

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Quality & safety and patient experience priorities and KPIs being refreshed
2	• Group approach to Patient Panels agreed and being implemented • There are currently workforce gaps in the Patient Experience Team
3	None identified
4	None identified
5	Lack of staff engagement has the potential to lead to a lack of timely implementation of improvement plans
6	PLACE improvement plans in development ~~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~~Completed
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~~Completed
4	Define and enforce timeframes for implementation of improvements identified during PLACE assessments	Group Chief Nurse	Head of Patient Experience	31 March 2026	~~Underway~~Completed

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of patient experience and key risks by the Quality Committee and its reporting sub-group: the Patient Experience & Involvement Group, with escalation to the Group Board as required
2	Reporting on quality & safety and patient experience KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	Patient Stores are heard at the Group Board
4	Patient Experience data is gathered and improvements tracked through the Patient Experience & Involvement Group
5	Delivery of patient experience KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
6	Internal & external audit, patient surveys, PLACE reviews etc. provide independent assurance on the quality of the patient experience

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	None identified
4	Triangulation of patient experience data with other sources of information e.g. complaints, PALS etc. requires strengthening
5	None identified
6	None identified

Actions being taken to address gaps in 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~~ October 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	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	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)	
1	Oversight of clinical effectiveness and key risks by the Quality Committee and its reporting sub-group: the Clinical Effectiveness Group, with escalation to the Group Board as required
2	Reporting on quality & safety and clinical effectiveness KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	Learning from deaths reported to the Clinical Effectiveness Group and disseminated across the group
4	There is oversight of delivery of the clinical audit programme through the Clinical Effectiveness Group with reporting to the Quality Committee as required
5	There is oversight of compliance with NICE guidance through the Clinical Effectiveness Group with escalation to the Quality Committee as required
6	Delivery of clinical effectiveness KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
7	Internal & external audit, external reviews and visits provide independent assurance

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	None identified
4	'Outlier' status has been received for some of the National audit projects
5	None identified
6	None identified
7	None identified

Actions being taken to address gaps in 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	4731	20	Reliance on paper medical records

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1b (i): Reduce waiting times for our patients **(Unplanned Care)**
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm

Current Risk Score & Movement since last review:

15 (High)



Last Review Date:	~~June~~ October 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	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	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 **Proposed revised deadline of 30 November 2025**

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	OPEL triggers regularly used and activated
2	ED activity, flow and LoS regularly reviewed by site teams and issues escalated through the #daily capacity meetings
3	Improvement trajectories in respect of ED performance and expectations agreed for all specialties
4	Suite of metrics in place to measure improvements and focus Care Group leadership teams on discharge target
5	ED performance monitored through the Unplanned Care Group and System Unplanned Care Partnership Board
6	Delivery of ED performance and improvements reviewed through the Care Group PRMs
7	Reporting on ED performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board as required
8	Sustained improvements seen across the UEC pathway: standard currently being delivered

Gaps in Assurance	
1	None identified
2	
3	
4	
5	
6	
7	
8	

Actions being taken to address gaps in 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~~ October 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	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	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 producivity 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)	
1	RTT and cancer improvement trajectories agreed for all specialties
2	Theatre dashboard in place and monitored through the Planned Care Group
3	RTT & cancer performance monitored through the Planned Care Group
4	Delivery of RTT and cancer performance and improvements reviewed through the Care Group PRMs
5	Reporting on RTT and cancer performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board, as required
6	Improved performance: sustained backlog reduction
7	Internal audit review of RTT pathways within ULTH during 2025 / 26 provided 'reasonable assurance)

Gaps in Assurance	
1	IPR is not comprehensive
2	Reports to committee and ELT require improvement
3	
4	
5	
6	
7	

Actions being taken to address gaps in 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~~ October 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	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	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)	
1	Oversight of finance and key risks by the Finance & Performance Committee and reporting sub-groups with escalation to the Group Board as required
2	Reporting on finance KPIs to the Finance & Performance Committee and Group Board through the Integrated Performance Report (IPR)
3	Internal & external audit arrangements in place
4	Internal audit review of performance management and data quality within ULTH during 2024 / 25 provided 'reasonable assurance'
5	Assessment of 'grip and control' undertaken by external parties including through ICB and regulator challenge

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	Internal audit arrangements have been aligned across the group but work remains ongoing to develop a single report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability
4	Internal audit review of overseas and contracts within ULTH provided 'limited assurance'
5	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	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
ULTH	4839	20	Lack of pharmacy capacity for intravenous

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**

			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:	~~September~~ October 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:

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
	Very High	Very High	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	Amber	Amber					

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. Enhanced review of governance systems and structures within risk management and building CAFM (PPM's) has been completed.
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	
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	Completed
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	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	Underway Appointed specification underway
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	Completed
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	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 estate 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	Underway Proposed revised deadline of 31 December 2025
10	Align and update the group business continuity plans to reflect the group infrastructure risks and challenges Update: • All Estates & Facilities BCP's for the acute site are in place. • Fire & Security BCP's for the community sites are in place. • Estates and Health & Safety BCP's to be progressed.	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)	
1	Increased levels of compliance with EFM statutory compliance requirements as demonstrated through internal audits, external condition surveys, AE audits etc.
2	External / independent review processes in place including AE annual audits and quarterly reviews across all HTMs (ULTH) with monitoring of improvement actions through the EFM Cabinet and reporting to the Finance & Performance Committee in the monthly EFM report
3	Premises Assurance Model (PAM) utilised annually to evaluate the effectiveness of premises performance against a set of common domains / SAQs with assurance and / or key risks reported to the Finance & Performance Committee and the Group Board. Comparison of the 2023/24 & 20224/25 PAM evaluation submissions for ULTH show a year on year improvement in compliance across most domains
4	Benchmarking of EFM performance is undertaken against local & national indicators and reported through the governance structure
5	Patient Led Assessment of the Care Environment (PLACE) assessments are undertaken with good levels of compliance in the areas assessed: privacy & dignity, cleanliness, food and general building maintenance and reporting to the Patient Experience & Involvement Group and Quality Committee
6	Oversight of EFM statutory compliance and key risks by the Finance & Performance Committee and relevant sub-groups (e.g. Health & Safety Committee, Infection Prevention & Control Committee, Water Safety Group) with escalation to the Group Board as required
7	Internal audit review of EFM areas provides independent assurance and / or escalation of risks. Internal audit review of the business continuity and emergency planning arrangements within ULTH during 2024 / 2025 provided 'reasonable assurance'
8	Community: AE audit programme for relevant HTMs for LCHS premises in place & progress reported via Estates & Facilities Upward Report

Gaps in Assurance	
1	EFM compliance dashboards not yet fully aligned
3	• Comparison of the 2023/24 & 20224/25 PAM evaluation submissions for LCHS show an improvement 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 •
4	Reliability of LCHS Estates Returns Information Collection (ERIC) scores to be improved
5	Shortfalls in housekeeping staffing levels, due to difficulties in recruiting, have the potential to impact on PLACE scores
6	There is a need for further clarity on the elements of the EFM agenda to be reported to the Finance and Performance Committee and the Integration Committee
7	Internal audit review of planned and preventative estates maintenance within ULTH during 2024 / 25 provided 'limited assurance'

Actions being taken to address gaps in 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	Completed
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

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:	~~September~~ October 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:

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	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	Green	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
2	Monitoring uptake of leadership and development training through monthly performance meetings such as PRM~~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)	
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. Forward reporting schedule shared with People Directorate annually to able to pro-actively list agenda items in sub-groups.
2	Reporting on People KPIs to the People Committee and Group Board through the Integrated Performance Report (IPR). Mandatory training compliance continues to improve
3	Reporting on medical and non-medical education and medical revalidation to the People Committee
4	Reporting on safer staffing (including training and knowledge gaps) to the People Committee
5	Monthly FPAM and PRM meetings take place which review KPIs against targets, and this is reported at overall Trust level at People Committee within the scorecard
6	Internal audit review of the people agenda provides independent assurance and / or escalation of risks. Internal audit review of mandatory training within ULTH undertaken during 2024 / 25 provided 'reasonable assurance'
7	National and regional benchmarking data considered through the People Committee and reporting sub-groups
8	External oversight and assurance in respect of people performance is undertaken through the Lincolnshire People Board/Workforce Committee

Gaps in Assurance	
1	Sub-Groups ensuring that agenda items and upward reports are in line with People Committee annual plan
2	IPR metrics currently being confirmed – have been reviewed within People Directorate and shared, with alignment across LCHS and ULTH in line with Workforce Plans for 2025/26.
3	None identified
4	None identified
5	Alignment to PRM Packs required to ensure consistency of data and reporting by exception
6	Limited oversight of group-wide audit schedule where there is an impact on people. Audit of LCHS areas unclear
7	Oversight of benchmarking data needs to be considered and consistent across all sub-groups – currently in place in line with agenda items and discussion points within Workforce Strategy Group
8	None identified

Actions being taken to address gaps in 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
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	Completed – continues to be embedded 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	Completed – continues to be embedded 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	Completed – continues to be embedded ~~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	Completed – continues to be embedded ~~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)



Last Review Date:	~~September~~ October 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	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	Amber	Amber					

Identified Controls *(What are we already doing to manage the risk?)*	
1	Education, learning and development programmes and KPIs in place
2	Engagement 'Tube Map' – 'Better Together' Programme in place and ongoing including OD support
3	Improved job planning compliance rate to 95% with supporting evidence in place, and a move towards a prospective cycle.
4	Improved Medical & Dental middle tier vacancy rate with a focus on stabilisation and succession planning through fully embedding a revised 'Plan for Every Post' process
5	Quality Improvement (QI) strategy/Quality Management System (QMS) being developed as a key enabler to support innovation/delivery of the group improvement/transformation agenda
6	Creating a culture of research and innovation recognised as a group priority
7	Workforce Planning

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Delivery of action plans and improvements at operational level needs to be incorporated into the Performance Management & Accountability and PRM process
2	Staff awareness at all levels of group strategy, values and approach to innovation and continuous improvement remains ongoing
3	2023 / 24 and 2024 / 25 job plans are still being finalised although significant improvements have been made
4	Division/Clinical Care Groups not yet fully owning the 'Plan for Every Post' process
5	Capacity of staff to engage with improvement agenda to be determined
6	Culture of research and innovation not yet embedded
7	Adverse to plan (M06) within Acute as a result of temporary staffing use, and approved substantive staff levels not included within plan

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	Completed & embedded and added to controls or assurances~~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 4	IPR metrics have been reviewed within People Directorate and shared, with alignment across LCHS and ULTH in line with Workforce Plans for 2025/26. People Committee Scorecard to be refreshed to ensure inclusion of current job planning and medical & dental middle tier rates for assurance purposes 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.	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
7	Shadow Board in place since July 2025 to provide additional level of grip and control with a focus on temporary staff use, continuation of Vacancy Control Process to support risk based recruitment through a Quality Impact Assessment and weekly upward report to ELT, with forecasting included	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	31 March 2026	Underway – on track

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1 2	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.
3 4	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)
5	Oversight of research & innovation has transferred to the Integration Committee

Gaps in Assurance	
1 2	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
3 4	Sub-Groups ensuring that agenda items and upward reports are in line with People Committee annual plan. IPR metrics currently being refreshed
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 & embedded and added to controls or assurances~~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	30 June 2025	Completed – continues to be embedded

			Planning & Reporting		
3 4	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	Completed – 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	20	Service configuration (Haematology)
ULTH	5093	20	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:	~~September~~ October 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	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	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	Completed – continues to be embedded ~~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	Completed – continues to be embedded ~~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:	~~September~~ October 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	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	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	Underway – on track~~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)	
1	Reporting through relevant sub-groups and People Committee on compliance rates for key workforce performance indicators (e.g. Turnover, Vacancies, Sickness, HR Cases, Appraisals)
2	Pulse Survey and NHS Staff Survey results are reported to the Executive Leadership Team, People Committee and Group Board and action plans are monitored through the People Committee with escalation to the Group Board as required. NHS Staff Survey results are currently above average in the 'People Promise' areas. Pulse Surveys are above benchmark
3	Pastoral care award received for recruitment and on-boarding of international nurses
4	Internal audit of people agenda provides independent assurance

Gaps in Assurance	
1	Regular reporting in place for key performance indicators via People Committee Scorecard and Workforce Strategy Group, but there is limited triangulation of wider data sources such as datix, complaints and Freedom to Speak Up Concerns which would highlight cultural trends / issues
2	Monitoring of action plan progress not fully embedded within sub-groups and relevant upward reporting
3	None identified
4	None identified in respect of reward and recognition

Actions being taken to address gaps in 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:	~~September~~ October 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	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	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. Deep dive on the programme included in ASG reporting for September.
2	Transformation of planned and unplanned pathways to be managed through a sub-group of the Alliance Steering Group. 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 being scoped (HI group well-established)
3	Governance structures and QIA processes in support of the transformation programme in place. 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	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, established in June, meets monthly. Currently only with internal group representation and lacks external membership. Movement of ICB to clusters has an impact on key roles and added uncertainty.
2	Pace of change and cultural mindset of working collaboratively needs to be embedded
3	Scale of delivery while implementing a blueprint of transformation for left shift
4	Sub-groups being established with partners supported by the diagnostic by Newton's (commenced in August and is due to run over 8 weeks)
5	Partnership Strategy needs to be refreshed in line with the Group Strategy and Alliance Model (aiming to table at December ~~September~~ Integration Committee)
6	Spectrum of integration options to be formalised for all partners based on Partnership Strategy
7	Embedding of HI as BAU within the Divisions.
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 2025 with terms of reference and sub-groups to be agreed with members (August meeting stood down) First Neighbourhood health board due to meet 21st October with external leaders – this will support the identification of the appropriate external partners to join the alliance steering sub-groups	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 Focus has been on group workstreams being established across left shift to date however the EOL sub-group with external partners is due to launch in November and the Falls work being delivered with LIVES has commenced operational delivery	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	31 July 2025	Will remove gap above when implemented **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. Will go to IC in OctoberDecember **Proposed revised timescale 310 SeptemberDecember 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
5	New Lincolnshire Neighborhood Board to meet on 21st October 2025.
6	
7	
8	

Gaps in Assurance	
1	
2	External partners not yet meeting as part of the Alliance Steering Group but the new Neighborhood Board will be a forum for system partner discussions.
3	PITOF focus has been CIP. Reporting on the 4 Alliance programmes was refined for August to provide a high level update on each programme and will adapt for Sept as the new report templates are introduced.
4	Work streams, KPIs and timelines still being worked up with a digital dashboard being created, to be finalised in Q3
5	
6	
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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	Integration Committee work plan and reporting sub-groups to be established including external partners where appropriate (with support from Newton's for INW) Newton due to present diagnostic findings to ELT (end of October) and to GLT November with system leadership event planned on 7th November followed by update to IC December on the proposed implementation of recommendations	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 INW sub-groups. **Proposed revised timescale October 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	Complete
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
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	Complete

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:	~~September~~October 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	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	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	Embedding the data in decision making in local delivery plan.
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 as an example. ICB changes may pose a risk to sustainability of the linked data set
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 established (complete) ASG arrangements are subject to the outcome of a Board discussion on a proposed system Neighbourhood Board. Representation by PCNA on LCHG governance groups has been confirmed. Neighborhood established now to close the gaps	Group Chief Integration Officer	Director of Integration and Improvement / Deputy Chief Integration Officer	31 July 2025	Complete
2	Health Inequalities action plan is complete. Next phase incudes embedding data in decision making and BAU.	Group Chief Integration Officer	Deputy Director of Strategic Partnerships	30 June 2025	Complete
3	Population Health data packs/intelligence embedded in the improvement methodology approach for left shift and wider transformation activities.~~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	Complete and ~~O~~ongoing

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Health Inequalities Working Group upward report into the new Alliance Steering Group and Integration Committee and Group Board
2	Development of a LCHG Co-production Strategy to support the health inequalities and personalisation agenda and reduce health inequalities – being owned by Chief Nurse/Group Head of Patient Experience and Volunteer Services
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
4	
5	
6	
7	

Gaps in Assurance	
1	Health inequalities action plan completed, approved by Alliance Steering group and Integration Committee August 2025 – Care Group and corporate area plans required.
2	Strategy in development working with Chief Nurse/Head of Patient Experience, ICB Health Inequalities and Personalisation Teams with pilot approach in one of the left shift projects
3	Consistent utilisation of PHM data through all our specialty reviews.
4	
5	
6	
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 September 2025 (ASG stood down in August due to availability of key members) ASG arrangements are subject to the outcome of a Board discussion on a proposed system Alliance Board. Representation by PCNA on LCHG governance groups has been confirmed.	Group Chief Integration Officer	Deputy Director of Strategic Partnerships	31 August 2025	Complete
2	Health Inequalities Action Plan completed and was provided to the Alliance Steering group/Integration Committee in July/August2025. Care group and corporate area plans required.	Group Chief Integration Officer	Associate Director of Partnership	31 July 2025	Underway
3	Communications cascade to be developed (as one of the four Health Inequalities work streams) to increase awareness of the role of the Exec Lead for Health Inequalities and Personalization	Group Chief Integration Officer	Deputy Director of Strategic Partnerships/D	31 July 2025	Complete

			eputy Director of Communications and Engagement		
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:	~~September~~ October 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	2	8(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	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	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	Tactical implementation partner procured up to end March 2026 whilst longer term partner procured. EMAP Implementation Partner now in place. Also using resource via UHL
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	All roles filled for Initiation Stage and now Implementation Stage roles being filled (either tactically with implementation partner resource or strategically via fixed term contract recruitment)
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	Complete and report went to October Digital Oversight Group and Emergency Planning Groupgoing to oversight group

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of digital strategy, digital transformation and key risks by the Integration Committee
2	Digital Maturity Assessment completed
3	Digital Innovations Group established to assess and accelerate safe use of AI technologies
4	Oversight of AGEM IT service transition to LCHG via upward reporting to Integration Committee to manage risk, including agreement of structures.
5	Digital led business continuity exercise to identify improvement and learning, with departments providing assurance to Emergency Planning Group.

Gaps in Assurance	
1	None identified
2	None identified
3	None identified
4	Business as usual service assurance to be aligned to support service development and alignment to standards. Responsibility to move from AGEM to LCHG
5	Output of exercise upwardly reported and actions owned

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 October 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 Group)	~~Completed~~~~Underway and ongoing~~ **~~Proposed revised timescale 31 October 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 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable

Current Risk Score & Movement since last review:

12 (Moderate)



Last Review Date:	~~September~~ October 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	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	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, Care Group CIP's being monitored via PRM's and PITOF in place to oversee other transformation programmes
3	Productivity, Improvement & Transformation Group established and reports into Finance Committee
4	ULTH and LCHS Sustainability & Green Plans approved by Board in September2025, on plan to publish by 31st October 2025 ~~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 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 CIP's continue to be developed in order to bridge the gap
2	
3	Aspyre software contract ends 30th September 2025 – plan for alternative solution in development
4	Green Plan areas of oversight to be agreed by GLT
5	None identified
6	None identified
7	Refreshed Green Plan being drafted for board approval in September 2025. Embedding it within the strategy
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	Extraordinary Care Group, GLT and ELT meetings taking place to identify additiona transformationl/CIP's to close the gap and strenghtne plans for delivery.	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	30 April 2025	**Complete** **Proposed revised timescale 30 September 2025**
2	Interim solution for Aspyre agreed, longer term solution in development in collaboration with digital PMO to ensure we have a common framework across LCHG and utilize AI effectively to support project reporting	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	30 April 2025	**Underway** **Proposed revised timescale end December 2025**
3	Green Plans for LCHS and ULTH approved by Board to be published and shared with NHSE	Group Director of Estates & Facilities	Group Head of Sustainability	31 July 2025	Underway **Proposed revised timescale 31 October 2025**

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of productivity, improvement & transformation by the PITOF, Finance Committee and Integration Committee
2	Sustainability report to the Green Group for oversight and assurance. Upward reporting to the Integration Committee and Group Board
3	Green Plan for LCHS and ULTH approved by Board in September 2025
4	
5	
6	
7	
8	

Gaps in Assurance	
1	
2	None identified
3	
4	
5	
6	
7	
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 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

NHS
Lincolnshire Community and Hospitals NHS Group

Audit and Risk Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*4 November 2025*
Agenda item number	*12.3*

Audit and Risk Committee Upward Report of the meeting held on 20 October 2025

Accountable Director	*Paul Antunes Goncalves, Group Chief Finance Officer*
Presented by	*Neil Herbert, Audit Committee Chair*
Author(s)	*Jayne Warner, Group Director of Corporate Affairs*
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the Audit and Risk Committee;*

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	
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	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	4 November 2025
Report from:	Audit and Risk Committee
Report from meeting held on:	20 October 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Audit and Risk Committee at its meeting held on 20 October 2025 including assurances received and those matters which the committee wish to escalate to the Group Board.

2.0 Matters considered by the committee

2.1 The committee received and considered the following reports on which assurance was received:

a) External Audit Progress Report
b) Internal Audit Progress Report
c) Local Counter Fraud Progress Report
d) Compliance Report
e) Board Assurance Framework
f) Risk Report
g) Policies and Procedures
h) Annual Accounts and Annual Report Lessons Learned
i) Accounting for IFRS16 - leases
j) Audit Committee Annual Report

The External Audit provider advised that preparation had commenced for the 25/26 year end process, it was not anticipated that there would be any changes to the reporting standards. The final submission date was still awaited nationally but would be mid June.

The Internal Audit provider advised that the processes for monitoring audit recommendations and turning around final audit reports for publication had been reviewed with the Group Director of Corporate Affairs. This realignment between the audit team and the internal team was working well.

The Counter Fraud update into the Committee focused on actions being taken to remove investigation delays and the response to the Corporate Criminal Offence of Failure to Prevent Fraud.

The quarterly compliance report offered the latest status in respect of the Data Security and Protection Toolkit across both organisations. The level of waivers being received remained low. The Group Chief Finance Officer highlighted the improvements being made in stock write offs but highlighted that salary overpayments remained an area of challenge and that additional communications across the Group were planned to remind individuals of their responsibilities.

The Group Chief Clinical Governance Officer advised of revised terms of reference for the Risk Register Confirm and Challenge Group and shared the feedback from recent external review by NHS Providers.

The Group Chief Finance Officer advised the Committee of the corrective actions taken in response to identification of an immaterial misstatement during the 24/25 year end audit relating to application of IFRS16 lease accounting. The corrective steps would ensure compliance and prevent future recurrence of the issue. These actions were supported by External Audit and Committee.

An exercise had been conducted to consider lessons learned from the year end process 2024/25. These would be taken forward to support planning for 2025/26.

The Committee continued to offer challenge around the position in respect of overdue policies and procedures. Outside of the meeting an update had been provided with plans to shift oversight to Clinical Governance. Noting that this issue needed to remain visible at board level.

The Committee received and approved the Audit Committee Annual Report for 2024/25 (appended to this report)'

3.0 Matters on which the committee was not assured and has requested additional information and assurance:

3.1 The committee requested additional information and assurance on the following matters:

a) The position in respect of overdue policies and procedures remained a focus for the Committee. The Committee chair had received a briefing from the Group Chief Executive on proposals to support clinical areas with addressing the backlog. The Group Chief Clinical Governance Officer would update at the January meeting.

4.0 Matters for reporting / escalation to the Group Board

4.1 The committee agreed the following matters for reporting / escalation to the Group Board:

a) The position with overdue policies and procedures remained a live escalation in to the Board meeting

5.0 Confirm or challenge of the Board Assurance Framework (BAF):

5.1 The committee considered the BAF and sought feedback on how the revised framework was supporting the work of the Committees and the assurances received. It was agreed that the new framework was working well whilst recognizing the continued development and the ongoing work to embed within the work of the Board Committee reporting groups.

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the matters considered and assurances received from the Audit Committee;

Neil Herbert, Audit Committee Chair

20 October 2025

NHS
Lincolnshire Community and Hospitals NHS Group

Annual Report to the Group Board from the Group Audit and Risk Committee 2024/25

ROLE OF THE COMMITTEE

In 2024/25, in line with all other Committees of the Board, the Terms of Reference were reviewed and amended. Under the agreed terms of reference the Audit and Risk Committee was tasked as follows:

The Audit and Risk Committee's main purpose is to advise the Board on the adequacy and effectiveness of both Trust's systems of internal control and its arrangements for risk management, control and governance processes. In order to discharge this function it is best practise for the Group Board to receive a formal annual report from the Audit and Risk Committee (the Committee). This report summarises the work of the Committee for the financial year 2024/25. This report includes information provided by internal and External Audit.

TERMS OF REFERENCE

During 2024/25, in line with all other Committees of the Board, the Committee's Terms of Reference were reviewed. The terms of reference and membership of the Committee reflect the governance arrangements and the guidance requirements set out in the NHS Audit Committee Handbook. Under the agreed terms of reference the Committee was tasked as follows.

To support the Board by scrutinising the robustness of and providing assurance that there is an effective system of governance and control for

- risk
- the accounting policies and the accounts of the organisation
- the planned activity and results of both internal and external audit
- and assurances relating to the corporate governance requirements for the organisation.

MEETINGS

During the 2024/25 year the Committee was established across the Group and met for the first time as the Group Audit and Risk Committee in October 2024. Prior to the establishment of the Group Committee the Audit and Risk Committee for ULTH and LCHS met to provide assurances in respect of their relevant terms of reference, with meetings taking place on a quarterly basis and quoracy met for each.

During 2024/25 the Committee completed it's full schedule of meetings.

The Committee considered all items necessary to fulfil its role of supporting the Group Board by critically reviewing and reporting on the relevance and robustness of governance structures and assurance processes on which the Board places reliance. During 2024/25 the Board particularly asked the focus of the Committee to include the arrangements which had been put in place for Group working. Following each meeting, an assurance report was provided to the Group Board.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. From October 2024 the Committee was chaired by Mr Neil Herbert.

Details of the Group Committee's membership and attendance from October 2024 is set out below:

Non-Executive Director (Chair)
Non-Executive Director - Finance and Performance Committee Chair
Non-Executive Director – People and OD Committee Chair
Non-Executive Director – Quality Governance Committee Chair
Non-Executive Director – Integration Committee Chair

In attendance
Associate Non Executive Director
Group Chief Finance Officer(Executive Lead)
Group Director of Corporate Affairs
Group Chief Clinical Governance Officer
Internal Audit
External Audit
LCFS

Attendance Group Committee from October 2024

Members	**Oct 2024**	**Jan 2025**
Non-Executive Director (Mr Herbert, Chair)	X	X
Non-Executive Director (Ms Cecchini)	X	X
Non-Executive Director (Prof Baker)	A	A
Non-Executive Director (Mrs Brown)	X	X
Non-Executive Director (Mr Connolly)	A	X

A denotes Apologies given

Attendance Pre October 2024 - ULTH

The ULTH Audit and Risk Committee membership was as follows, quoracy was met for each meeting held during 2024/25 until October 2024

Non-Executive Director (Chair)
Non-Executive Director - Finance and Performance Committee Chair
Non-Executive Director – People and OD Committee Chair
Non-Executive Director – Quality Governance Committee Chair

In attendance
Director of Finance (Executive Lead)
Trust Secretary
Internal Audit
External Audit
LCFS
Deputy Director of Clinical Governance

Attendance Pre October 2024 - LCHS

The LCHS Audit and Risk Committee membership was as follows, quoracy was met for each meeting held during 2024/25 until October 2024

Non-Executive Director (Chair)
Non-Executive Director – People and OD Committee Chair
Associate Non-Executive Director

In attendance
Director of Finance (Executive Lead)
Deputy Director Corporate Governance
Internal Audit
External Audit
LCFS

REVIEW OF BUSINESS

The Audit and Risk Committee's work programme for 2024/25 is set out as an appendix to this report.

OVERVIEW

The Audit and Risk Committee has continued over the last twelve months, to improve the assurance it can give to the Board on

- the adequacy and effectiveness of the Trust's systems of internal control
- it's arrangements for risk management, control and governance processes.

The work programme for the Committee in 2024/25 has focused on

- meeting the organisations requirements to produce and publish a set of audited accounts and annual report
- Internal Audit Annual Plan and Work Programme
- Counter Fraud Annual Plan and Work Programme
- External Audit Programme

The Committee has reported its progress to the Board through upward reports, reporting progress against the delivery of the work plan, as defined by the terms of reference and through this annual report.

The Committee has been well attended by members. The Chair has been actively involved in the agenda setting alongside the Chief Finance Officer

The Committee received regular reports on:

- Board Assurance Framework
- Risk Management
- Compliance with Governance Arrangements
- Policies and Guidelines

INTERNAL CONTROLS AND RISK MANAGEMENT

Assurance Framework

The Board Assurance Framework (BAF) is the key assurance document for the Group. The Audit Committee has scrutinised the BAF at each of its meetings in 2024/25 and has considered the adequacy of the mechanisms and processes surrounding the BAF in place to support the Board in seeking assurance in respect of the strategic objectives. The Committee received the Head of Internal Audit Opinion for both organisations and acknowledged the opinion given in relation to the BAF.

Care Quality Commission Regulation

The CQC has not inspected either Trust in 2024/25. Outcomes from previous CQC visits were captured in the Compliance Reports presented to the Committee. ULTH remains Good for the Well Led Domain (2022). LCHS remains Outstanding for the Well Led Domain (2018)

Both Trusts are clear of any conditions in place in respect of their licence.

Governance Arrangements

The Committee received quarterly reports on compliance with the Group's governance arrangements. The Committee has continued to monitor closely the level of waivers performed and through the Chief Finance Officer worked to see these reduce.

Annual Review of Governance Arrangements

The Committee reviewed as part of the annual update and in light of best practice, changes to the key corporate governance documents of the Group:

- Standing Financial Instructions
- Scheme of Delegation
- Standing Orders

The review of these documents captured the revised governance arrangements to support Group working.

Quality Account

There was no requirement for the Trust Quality Account for 2024/25 to be subject to audit. This report was produced and considered by the Quality Governance Committee and published in line with the required timeframe.

Counter Fraud Service

Each Trust is required to monitor and ensure compliance with NHS Provider Standards for Fraud, Bribery and Corruption regarding its arrangements for counter fraud and corruption work. A key role for the Committee is to provide assurance to the Board that these arrangements are robust.

During the year, the Committee:

- received and recommended to the Board the LCFS Annual report
- approved the Annual Counter Fraud Plan
- reviewed and approved the annual LCFS submission to NHSCFA
- monitored progress against the plan
- monitored reactive and proactive fraud work provided by the LCFS, and received reports on the volume of cases under investigation and subsequent actions taken by management to strengthen control, an area of additional reporting requested but the Committee
- received strategic updates

Internal Audit

TIAA have been the Internal Audit service provider for both Trusts. During the year the Committee:

- Approved the Internal Audit Plans for 2024/25 to address areas of internal control where assurance was sought, to cover mandatory areas as required by NHS Internal Audit Standards and to meet the statutory responsibility to provide a Head of Internal Audit Opinion.
- monitored progress against plan, including consideration of issues arising and high priority recommendations through receipt of regular progress reports
- received and considered the Head of Internal Audit's opinion for 2024/25
- continued focus on overdue audit recommendations

The overall Head of Internal Audit opinion for both organisations was Reasonable Assurance which is consistent with committee expectations based on reports received throughout the year. The Internal Audit providers noted the positive trajectory of the opinion

EXTERNAL AUDIT AND FINANCIAL REPORTING

Both Trust's external auditor for 2024/25 was Mazars.

The Audit Plan set out the work to be undertaken in relation to the 2024/25 accounts and was developed on the basis of a risk-based approach to audit planning. This was received and considered by the Committee.

The external auditors presented their Annual Opinion to the Committee prior to the Board's review of the Annual Accounts for both organisations in June 2025. The Committee considered and recommended the 2024/25 Annual Accounts and Annual reports to the Board.

RISKS

The BAF and Corporate risk register have been reviewed at the committee at each meeting identifying where updates have been required based on assurances received at the Committee. The format of the BAF was revised during the year and the Committee have reviewed the format of the assurance framework and confirmed that it is fit for purpose.

The Audit Committee is an essential element of the Group's corporate governance structure. It works closely with the Assurance Committees and the Chair of each of these committees is also a member of the Audit Committee, which helps provide additional assurance on the adequacy of the Trust's systems and controls.

The Committee has fulfilled its terms of reference and contributed to strengthening internal control within the Trust.

The Committee can provide the Board with assurance that, by addressing its terms of reference, it has scrutinised the levels of controls in place and as necessary applied additional control measures in order to maintain, strengthen and develop systems of control that enable the Trust to be compliant with its legislative and statutory duties. Within year the Committee escalated the concern around the position in respect of policies and guidelines overdue for review.

The focus for the new financial year 2025/26 will be on continuing to support and assure the Board on reviewing and strengthening financial reporting, internal control, risk assurance and governance.

The Committee will focus on the following proposed priorities

- Reviewing and monitoring the output from the NHS providers Well Led review
- strengthening and reviewing new arrangements as they develop within the Cluster ICS
- Meeting the Counterfraud standards
- Improve the control environment as evidenced by Internal Audit opinion
- Ensuring the Trust meets the requirements of the provider licence, code of governance and capability self assessment
- Improved position in relation to historic overdue for review policies and guidelines

Lincolnshire Community and Hospitals NHS Group
Board Work Programme 2025/26

Agenda Item	Lead	Person Responsible	Committee Oversight	Mar	May	Jul	Sep	Nov	Jan	Mar	Purpose of Report	Action
Business Items												
Public Questions	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X		
Ward Accreditation	Group Chief Nurse		N/A	X	X	X	X	X	X	X		Assurance
Declarations of Interest	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X	To note any conflicts of interest on specific agenda items or any changes to Directors' Interests	Assurance
Annual Declaration of Board Interests	Group Chair	Group Director of Corporate Affairs	N/A		X						To review and note any changes to the Register of Directors' Interests	Assurance
Fit and Proper Person Annual Declaration	Group Chair	Group Director of Corporate Affairs	Audit & Risk Committee			X (def. from May)					To receive assurance that all board members remain compliant with the Fit & Proper Person requirements	Assurance
Minutes of the previous meeting	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X	To approve and / or amend the minutes of the previous meeting ensuring an accurate corporate record of the meeting is maintained	Approval
Matters arising from the previous meeting/action log	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X	To ensure all agreed board actions are completed	Assurance
Group Chief Executive Report to the Board	Group Chief Executive	Executive Business Manager	N/A	X	X	X	X	X	X	X	To brief the boards on local and national topical matters, risk issues & mitigations and good news & communication updates	
Group Workstreams Progress Briefing	Group Chief Executive		N/A	X	X	X	X	X	X	X	To receive regular updates on the delivery of the expected benefits of moving to a Group model and the integration of clinical and corporate services	
Celebrating Group Success	Group Director of Corporate Affairs	Deputy Trust Secretary	N/A	X	X	X	X	X	X	X	To hear from Clinical Teams and give clinical teams access to the Board	
Patient/staff Story	Group Chief Nurse	Associate Director of Communications and Engagement	N/A	X	X	X	X	X	X	X	To receive direct feedback on the experience of both patients and staff	
Patients												
Strategic Aim 1 - High quality, timely care in the right place												
Assurance and Risk Report from the Quality Committee	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Quality Committee Annual Report	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Quality Committee ToR and Work Programme	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee		X						To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Safeguarding Annual Report	Group Chief Nurse	Group Director of Safeguarding and Patient Experience	Quality Committee				X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Infection Prevention and Control Annual Report	Group Chief Nurse	Deputy Director of Infection Prevention and Control	Quality Committee				X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Complaints Annual Report	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	Quality Committee				X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Patient Experience Annual Report	Group Chief Nurse	Group Director of Safeguarding and Patient Experience	Quality Committee				X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Assurance and Risk Report from the Finance Committee	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Finance Committee Annual Report	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Finance Committee ToR and Work Programme	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee					X			To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Financial Plan	Group Chief Finance Officer		Finance Committee								To approve the Financial Plan	Approval
Capital Plan	Group Chief Finance Officer		Finance Committee								To approve the Capital Plan	Approval
Contract Award Reports	Group Chief Finance Officer	Deputy Director of Procurement	Finance Committee	X	X	X	X	X	X	X	To approve relevant Contract Awards in accordance with the Trusts' Schemes of Delegation	Approval
Emergency Preparedness Annual Report and EPRR Core Standards	Group Chief Estates and Facilities Officer	Emergency Planning and Business Continuity Manager	Finance Committee			X					To receive and approve the Trusts' annual submission to NHSE on EPRR including any required improvement actions	Assurance
People												
Strategic Aim 2 - Attract and retain talent, build a strong culture												
Assurance and Risk Report from the People Committee	Chair of People Committee	Deputy Trust Secretary	People Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
People Committee Annual Report	Chair of People Committee	Deputy Trust Secretary	People Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
People Committee ToR and Work Programme	Chair of People Committee	Deputy Trust Secretary	People Committee					X			To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Gender Pay Gap Report	Group Chief People Officer	Director of People	People Committee	X						X	To receive the Gender Pay Gap Report	Assurance
Ward Establishment Review	Group Chief Nurse	Deputy Director of Nursing and Midwifery	People Committee				X (def. from May)			X	To approve the outcome of the review of safe staffing and any recommended changes to the establishment	Approval
Responsible Officer Revalidation Report	Group Chief Medical Director	Deputy Medical Director	People Committee				X					
National Staff Survey Results	Group Chief People Officer	Director of People	People Committee		X					X	To receive the results from the annual staff survey & note the planned improvement actions and monitoring arrangements	Assurance
FTSU Annual Report	Group Director of Corporate Affairs	FTSU Guardians	People Committee					X			To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Equality Delivery System Report	Group Chief People Officer	Director of People	People Committee		X					X	To approve the annual EDS submission	Approval
Workforce Race Equality Standard (WRES) Report and Action Plan	Group Chief People Officer	Director of People	People Committee				X				To approve the annual WDES submission	Approval
Workforce Disability Equality Standard (WDES) Report and Action Plan	Group Chief People Officer	Director of People	People Committee				X				To approve the annual WDES submission	Approval
Population Health												
Strategic Aim 3 - Adapting to neighbourhood health needs												
Assurance and Risk Report from the Integration Committee	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Integration Committee Annual Report	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Integration Committee ToR and Work Programme	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee						X		To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Risk and Assurance												
Integrated Performance Report	Group Chief Integration Officer	Associate Director of Performance and Information	Finance Committee	X	X	X	X	X	X	X	To brief the boards on key performance metrics & priorities, risks to delivery & mitigations	Assurance
Group Risk Management Report	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	Audit & Risk Committee	X	X	X	X	X	X	X	To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the Trusts' current risk profile	Assurance
Board Assurance Framework	Group Director of Corporate Affairs	Deputy Trust Secretary	Audit & Risk Committee	X	X	X	X	X	X	X	To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the Trusts' current risk profile	Assurance
Strategic Objectives	Group Chief Integration Officer	Director of Strategy and Planning		X						X	To approve the Group Vision, Strategy & Objectives	Approval
Assurance and Risk Report from the Audit Committee	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee	X	X		X	X		X	To note the matters considered by the committees-in-common and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Audit Committee Annual Report	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee					X			To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Audit Committee ToR and Work Programme	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee	X						X	To approve the changes to board committee terms of reference and work plans following annual review.	Approval
NHS Provider Licence Self Certification	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee		X						To agree the annual Trust Board self certification of compliance with the NHS Provider Licence	Approval
Year End Accounts and Annual Report	Chair of Audit Committee	Group Chief Finance Officer/ Group Director of Corporate Affairs	Audit & Risk Committee			X					To approve and adopt the Annual Report & Accounts	Approval
End of meeting												
Board Work Programme	Group Director of Corporate Affairs	Deputy Trust Secretary	N/A	X	X	X	X	X	X	X	To ensure the boards' consideration of all relevant items of business and, in turn, continued compliance with their statutory and regulatory requirements	Assurance
Any other notified items of urgent business	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X		