Bundle LCHG Board Meeting in Public Session 6 May 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 Public Questions
Group Chair

3 Apologies for Absence
Group Chair

4 Declarations of Interest
Group Chair

5 Minutes of the meeting held on 4th March 2025
Group Chair

Item 5.1 Public Board Minutes March 25

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

6 Group Chief Executive's Report to Board
Group Chief Executive

Item 6 Group CEO update public board May 2025 Final

6.1 Group Model Workstream Progress Briefing
Group Chief Executive

Item 6.1 Group Development Programme Plan Progress Report to Group Board
Item 6.1 App 1 Group Development Delivery Against Plan Monthly Report as at April 2025

6.2 Board and Board Committee Governance
Group Director of Corporate Affairs
To include:
Joint Board and Committee Principles Framework
Board Assurance Map
Board Committee Terms of Reference and updates Workplans

Item 6.2 Work Plans Assurance Map Group Board Front Sheet 6 May 2025
Item 6.2 Board and Committee Joint Working Principles Framework DRAFT
Item 6.2 Assurance Map Oversight and Assurances Roles of Board Committees April 2024
Item 6.2 Audit and Risk Committee TOR 2025-26
Item 6.2 Audit Committee forward reporting schedule 2025-26
Item 6.2 Finance and Performance Committee TOR 2025-26
Item 6.2 Finance and Performance Committee Work Prog 2025-26
Item 6.2 Integration Committee ToR 2025-26
Item 6.2 Integration Committee Work Plan 25-26
Item 6.2 People Committee forward reporting schedule 2025-26
Item 6.2 People Committee TOR 2025-26
Item 6.2 Quality Committee TOR 2025-26
Item 6.2 Quality Committee Work Programme 25-26

6.3 Performance Management and Accountability Framework
Group Chief Integration Officer

Item 6.3 Performance Management and Accountability Framework - front sheet Board May 2025
Item 6.3 LCHG Performance Accountability Framework v3.8

7 Patient/Staff Story

7.1 Celebrating Group Success

Item 7.1 Lincoln - AlignRT

7.2 BREAK

8 Strategic Aim 1 - Patients

8.1 Assurance and Risk Report from the Quality Committee to include the 2024/25 Annual Report

Chair, Quality Committee

Item 8.1 Quality Committee Upward Report March 2025

Item 8.1 Quality Committee Upward Report April 2025

Item 8.1 LCHG Patient Safety Inicident Response Plan 2025-2026 FINAL April 2025

Item 8.1 QC Final Annual Report 2024-25

8.2 Assurance and Risk Report from the Finance and Performance Committee to include the 2024/25 Annual Report

Chair, Finance and Performance Committee

Item 8.2 Finance Committee Upward Report March 2025v1

Item 8.2 Finance Committee Upward Report April 2025v1

Item 8.2 FPC Final Annual Report 2024-25

8.3 Finance Briefing

Group Chief Finance Officer

Item 8.3 Finance Briefing Trust Board Cover M12

Item 8.3 Appendix 1 Finance Briefing Trust Board M12

9 Strategic Aim 2 - People

9.1 Assurance and Risk Report from the People Committee to include the 2024/25 Annual Report

Chair, People Committee

Item 9.1 People Committee Upward Report March 2025v1

Item 9.1 People Committee Upward Report April 2025v1

Item 9.1 People Committee App1 April LCHG Equality Objectives - 03.04.25

Item 9.1 PC Final Annual Report 2024-25

9.2 2024/25 National Staff Survey Results

Group Chief People Officer

Item 9.2 Board Report - NSS 24-25 - 06.05.25

Item 9.2 NSS Appendices 1 and 2 - Board - May 25

Item 9.2 Appendix 3 - Our NHS Staff Survey Results 2024 - LCHS

Item 9.2 Appendix 4 - Our NHS Staff Survey Results 2024 - ULTH

9.3 Board Member Appraisals

Group Chief People Officer

Item 9.3 Board Member Appraisals

10 Strategic Aim 3 - Population

10.1 Assurance and Risk Report from the Integration Committee

Chair, Integration Committee

Item 10.1 Integration Committee Upward Report March 2025v1

Item 10.1 Integration Committee Upward Report April 2025v1

10.2 2025 - 2030 Group Strategy

Group Chief Integration Officer

Item 10.2 LCHG Group Strategy 2025-2030 cover sheet

Item 10.2 group strategy 2025 Version 11

Item 10.2 Staff personas

Item 10.2 LCHG Strategy - Patient Personas
Item 10.2 Appendix 2- LCHG Strategy - Socialisation Communications Plan

10.3 Operating Model
Group Chief Integration Officer
Item 10.3 LCHG Board Update - Alliance Programme April 2025 v1 280425 (002)

11 Integrated Performance Report - ULTH/LCHS
Group Chief Integration Officer
Item 11 Front Sheet Trust Board - IPR
Item 11 Appendix 1 IPR Trust Board April 2025
Item 11 LCHG Interim Report Template FINAL MARCH
Item 11 LCHS Integrated Performance Report -March

12 Risk and Assurance

12.1 Group Risk Management Report
Group Chief Clinical Governance Officer
Item 12.1 LCHG Group Board Risk Report May 2025 v2
Item 12.1 Appendix A LCHS High and Very High Risks May 25
Item 12,1 Appendix B - ULTH Group Board Risks rated High or Very High - May 2025

12.2 Board Assurance Framework
Group Director of Corporate Affairs
Sign off 2024/25 Board Assurance Framework
2025/26 Board Assurance Framework
Item 12.2 LCHG BAF 2024-25 Front Cover May 2025
Item 12.2 LCHG BAF 2024-25 29.04.25
Item 12.2 BAF Group Board Front Sheet 6 May 2025
Item 12.2 Appendix Group BAF as at APRIL 2025

12.3 Assurance and Risk Report from the Audit Committee
Chair, Audit Committee
Item Audit Committee Upward Report - April 25 - NH edit

12.4 NHS Provider Licence Self Certification
Group Director of Corporate Affairs
Item 12.4 NHS Provider Licence Self Cert
Item 12.4 NHS Provider Licence NHS2
Item 12.4 NHS Provider Licence G5

12.5 Board and Board Development Forward Planner
Information item
Item 12.5 Board Work Programme 2025-26
Item 12.5 Board Dev Plan 2025-2026

13 Any Other Notified Items of Urgent Business

14 The next meeting will be held on Tuesday 1st July 2025
EXCLUSION OF THE PUBLIC
In accordance with Standing Order 3.1 and Section 1(2) of the Public Bodies (Admission to Meeting) Act 1960: To resolve that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

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

Minutes of the Public Board in Common Board Meeting

Held on 4 March 2025

Via MS Teams Live Stream

Present

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

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

ULHT
Voting Members:
Mrs Rebecca Brown, Deputy Chair/Non-Executive Director
Mr Jim Connolly, Non-Executive Director
Ms Dani Cecchini, Non-Executive Director
Professor Karen Dunderdale, Group Chief Executive
Mr Daren Fradgley, Group Chief Integration Officer
Mrs Nerea Odongo, Group Chief Nurse
Ms Caroline Landon, Group Chief Operating Officer
Mr Paul Antunes Goncalves, Group Chief Finance Officer
Professor Colin Farquharson, Group Chief Medical Officer

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

In attendance:
Mrs Jayne Warner, Group Director of Corporate Affairs
Mrs Karen Willey, Deputy Trust Board Secretary, ULTH
Mrs Rachel Lane, Corporate Administration Manager, LCHS (minutes)
Mr Nico Batinica, Deputy Director of People
Professor Duncan French, Pro-Vice Chancellor/Head of College of Health and Science, University of Lincoln
Sister Nadiya Mappoura, Burton Ward, ULTH (Item 2.1)
Sister Lucy Jones, Cardiac Cath Lab, ULTH (Item 2.1)
Zoe Wills, Deputy Divisional Lead, LCHS (Item 7)
Jill Edwards, Deputy Lead Nurse Palliative and End of Life Care, LCHS (Item 7)
Carl Ratcliff, Integration Specialist, (Item 7.1)
Sarah Hunter, Consultant Practitioner, ULTH (Item 7.1)
Dr Abduelbaset Elmarimi, Consultant Stroke Medicine, ULTH (Item 7.1)

Apologies:
Mrs Elaine Baylis, Group Chair
Mr Neil Herbert, Non-Executive Director
Professor Philip Baker, Non-Executive Director, ULTH
Miss Claire Low, Group Chief People Officer

126/25	**Item 1 Introduction** The Deputy Group Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream. The Deputy Group Chair also acknowledged that the first signs of Spring were beginning to be seen and expressed a view that it was a good time to reflect on a challenging and difficult winter and thanked all staff members for their hard work during this time.
127/25	**Item 2 Public Questions** **Q1 Received from Vi King** Please can I ask what is being done about the patients not being allocated crews by EMAS, therefore outpatients appointments are missed. Is this down to lack of capacity from EMAS? EMAS do not know why patients are attending, so it could be detrimental to their care when coming for outpatient appointments.

128/25	The Group Chief Operating Officer responded by explaining that outpatient transport was a contract managed by the Integrated Care Board (ICB) with East Midlands Ambulance Services (EMAS) directly, and the Group did not have any involvement with the contract determination of the standards, therefore it was not possible to comment on performance.
129/25	The Group Chief Operating Officer explained that a meeting had been arranged for later in the month with the EMAS Chief Operating Officer to discuss the contract and performance standards the Group would like to see for patients moving forward.
130/25	**Item 2.1 Ward Accreditation** The Deputy Group Chair was pleased to be able to commence the Board meeting with the celebration of achievement of the provision of high quality, safe care through the awarding of ward accreditation.
131/25	Sister Mappouras from Burton Ward at Lincoln County Hospital and Sister Jones and Sister Smith from the Cardiac Cath Lab at Lincoln County Hospital were welcomed to the meeting to celebrate their achievements.
132/25	The Group Chief Nurse introduced the teams who had successfully achieved the Bronze award as part of the quality accreditation programme. Board members were reminded of the core requirements the departments were required to achieve against a range of quality indicators, in addition to presenting a portfolio of evidence to the Quality Accreditation Panel.
133/25	Sister Jones informed Board members that the Cardiac Cath Lab team cared for 2,200 elective and emergency patients each year and the service was available 24 hours a day, seven days a week. Many patients arrived in an acute state, some in cardiac arrest and upon arrival patients were stabilised. The Centre relied on innovative treatment and Sister Jones described the use of equipment which supported patients with coronary artery disease, with Lincoln County Hospital being one of two Centres in the country able to offer this.
134/25	Sister Mappouras explained that Burton Ward was a 20 bedded renal ward that also offered an in-patient dialysis service. An area of improvement was described by Sister Mappourous when high levels of falls had been seen. A “bay watch” system had been introduced where one staff member each shift remained within a bay of cohorted patients most at risk on a rota basis for one hour at a time to reduce falls. All staff had been trained in the expectation, and this had seen a significant decrease in the number of falls within the area.
135/25	The Deputy Group Chair thanked both Sister Jones and Sister Mappouras for sharing the positive stories, demonstrating excellent work within the ward areas. It was noted that the Ward Accreditation programme fostered excellent leadership and improved practice at grass root level.
136/25	The Group Chief Executive thanked the Sisters for attending the meeting and thanked them for their leadership. The Group Chief Executive commented that the example from Burton Ward was a good initiative where an issue had been identified,

	understood and the impact of that on patients to reduce potential harm had been good to see.
137/25	In respect of the Cardiac Cath Lab, the Group Chief Executive expressed a view that it was good to hear of the life supporting services available at the Lincoln site and asked how loved ones and families coped with seeing patients being treated in this way and what the emotional impact was of that. Sister Jones responded that the first patient had been positive of the service and had been well counselled in advance of the treatment taking place. Following this the patient had been in full support of the procedure available, as this had given him his life back. A full rollout of the service was anticipated by October 2025.
138/25	Mrs Wells was pleased to hear of the work of the Heart Centre and liked the “bay watch” system on Burton Ward. This was a simple intervention that had made a real difference for patients and Mrs Wells asked if this had been shared with other areas. Sister Mappouras responded that this had been shared at system meetings and with Quality Matrons and had been effective across the sites.
139/25	The Deputy Group Chair again thanked Sister Mappouras and Sister Jones for sharing the stories and for their leadership noting the positive feedback from the Board. The Deputy Group Chair added that the Ward Accreditation was not an easy process to achieve and both Sisters should be proud of their achievements.
140/25	**Item 3 Apologies for Absence** Apologies for absence were received from Mrs Elaine Baylis Group Chair, Miss Claire Low Group Chief People Officer, Mr Neil Herbert Non-Executive Director and Professor Philip Baker Non-Executive Director.
141/25	**Item 4 Declarations of Interest** There were no additional Declarations of Interest made.
142/25	**Item 5 Minutes of the meetings held on 7th January 2025** The minutes of the meeting held on Tuesday 7th January 2025 were approved as an accurate record.
143/25	**Item 5.1 Matters Arising from the previous meeting/log** There were no outstanding matters arising.
144/25	**Item 6 Chief Executive Horizon Scan** The Group Chief Executive presented the report to the Board, noting that all parts of the Lincolnshire health and care system remained busy and good work continued to cope with ongoing operational pressures.
145/25	The 2025/26 priorities and Operational Planning Guidance had been issued by NHS England towards the end of January. The Group Chief Executive advised that work

	had been ongoing since then to produce the System Operational Plan for 2025/26, which was due to be submitted to NHS England on 27th March 2025. The focus was currently on finances and maintaining the operational performance, quality and patient standards for the population of Lincolnshire.
146/25	The Group Chief Executive explained that over recent weeks several regional and national calls had taken place with regards to planning and at the last meeting it was made clear that systems would have to live within their means in terms of finances. NHS England had been satisfied with the progress and actions taken by the Lincolnshire system, however there had been a larger request for savings to be made in the coming year. The detail of this was currently being worked through to ensure patients could continue to be offered high standards of care.
147/25	In addition, NHS England had published guidance around reforming elective care for patients in early January, work was ongoing to produce a plan which set out the proposals to reform elective care.
148/25	The Group Chief Executive was also pleased to inform those present that ULTH received the Quarter 4 tiering letter in February 2025, on behalf of the NHS National Elective Recovery and Diagnostic Programmes, which confirmed the organisation had been moved out of tiering for elective care and diagnostics. This highlighted the considerable amount of work carried out to improve performance and the positive impacts on patient care.
149/25	In respect of the financial position across the Group, the Group Chief Executive explained that this was not where the Board would have liked it to be and expressed a view that this was a disappointing position. Executive Team colleagues were continuing to work with system partners and a lot of work had been undertaken to recover the 2024/25 position, including a lessons learned review and, approaching 2025/26, the exit run rate would need to be factored into planning discussions.
150/25	Three Community Diagnostic Centres (CDCs) had now been officially opened across the County in Skegness, Lincoln and Grantham with approximately £42million being invested. The facilities contained state-of-the-art elective (planned) diagnostic services, and the Lincoln centre had dedicated training facilities to support the training of future radiographers, directly linking with the Diagnostic Radiography Programme at the University of Lincoln.
151/25	The Group Chief Executive explained that the rollout of Martha's Rule, had continued most recently at Pilgrim Hospital, Boston at the beginning of February 2025. The service built on the existing safeguards already in place in the hospitals to offer a clear and direct way to escalate concerns about a patient's deteriorating condition.
152/25	There had been visits to the organisation during January from the Chief Nursing Officer for England, the Patient Safety Commissioner for England and the Chief Midwifery Officer for England who had presented silver awards to the maternity teams across the ULTH sites. There had also been a Gold award presented to the former Director of Midwifery, prior to her retirement. All of these visits had been positive and allowed time for helpful discussions with colleagues.

153/25	The Group Chief Executive informed Board members that the Executive Team were working with senior leads to develop a Group Operating Model with a focus on population health and an ambition to reduce health inequalities and redesigning clinical services into Care Groups. The purpose of the Group was to do this once and well for the residents of Lincolnshire and beyond and to make the organisation a great place to work and receive care. This would also allow the Group to deliver care in the right place, at the right time and to move to primary of care in the community.
154/25	As part of this work the realignment of services into Care Groups would assist the delivery of more planned care services both in and out of hospital and work was underway with care partners to transform clinical pathways and to rationalise estates. The Group Chief Executive added that an Alliance Care Model had been created which would form a common space to bring both parts of the Group together, whilst also working in a supportive way with partners in the system to look at how to provide services for the residents of Lincolnshire in different ways, whilst responding to their needs.
155/25	The Deputy Group Chair thanked the Group Chief Executive for the comprehensive report, which demonstrated the vast amount of work currently taking place at both organisational and system level.
156/25	Mrs Buik raised the issue of new GP contracts which were being signed and asked if there was any insight as to what that might mean for the Group and the system. The Group Chief Executive responded that it was currently too early to understand the immediate impact across Lincolnshire. However, explained that there had been good dialogue with GP colleagues and the Lincolnshire Medical Council (LMC) in respect of working differently and collaboratively.
157/25	The Deputy Group Chair offered that this report demonstrated that this had been a challenging winder and acknowledged the work to continue to develop, grow and reshape services. On behalf of the Board, the Deputy Group Chair acknowledge the significant achievement with elective and diagnostic work. The Board: • **Received the report and noted the significant assurance provided**
158/25	**Item 6.1 Group Model Workstream Update** 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. There had been some real ownership from Executive Senior Responsible Officers (SROs) across the workstreams and the Group Chief Executive took the opportunity to thank colleagues for driving the work at pace.
159/25	The Group Chief Executive informed the Board that Executive colleagues met on a weekly basis to discuss this and a battle rhythm was now in place in respect of oversight and progress against Group developments. Good progress was being made whilst working within a tight financial envelope.

160/25	Board colleagues were reminded of discussions at the last Board meeting in respect of timescales, and the Group Chief Executive offered that interdependencies across workstreams had not been accounted for and had impacted upon early delivery, therefore adjustments had been made to reflect the timescales and RAG ratings. The Group Chief Executive assured Board members that the ratings would not just be adjusted if the timescales were not met, and if they failed items would be rated as underdelivering.
161/25	The detail in respect of the development of a Group menopause service was also continuing to be worked through and further details were also offered to the Board in respect of staff engagement work currently in place.
162/25	Overall the Group Chief Executive explained that the report demonstrated the amount of work required to develop the Group and to gain momentum in bringing together the acute and community Trusts.
163/25	The Deputy Group Chair thanked the Group Chief Executive for the report and noted that it was important that this work was not rushed by setting unrealistic timescales and agreed that resetting those was the correct way forward.
164/25	Mrs Wells asked how transparent the organisation was being with staff members in terms of timescales. The Group Chief Executive responded that this was an important point, particularly when bringing the two organisations together specifically around culture and this could also cause anxieties and concerns in respect of personal futures. The Group Chief Executive explained that each Executive was sharing details of the work that was about to commence with their teams and the wider organisation. A series of engagement roadshows to meet staff members would be commencing across the Group where the development would be discussed along with the strategic aims and objectives and values.
165/25	Miss Shadlock commented that it would be important to ensure that the timescales were appropriate, specifically in respect of workstream four, communication and engagement. From a Non-executive Director perspective this would be one of the most crucial areas for the public, understanding the work of the Group. The Board: • **Received the report and noted the position in respect of the Group menopause service**
166/25	**Item 7 Patient/Staff Story** The Deputy Group Chair welcomed Zoe Wills, Deputy Divisional Lead, LCHS and Jill Edwards, Deputy Lead Nurse Palliative and End of Life Care, LCHS to the meeting for the Patient Story. The Deputy Group Chair explained that this was a story that some may find distressing which demonstrated poor end of life care, however also reported areas for improvement and some of the actions taking place to achieve this.
167/25	

	The Group Chief Nurse echoed the Deputy Group Chair's comments, adding that this was an important story for the Board to be sighted on and added that there was much that could be learned from this story by the Group regarding how care could have been personalised for John and Wendy and how though system learning, work would be undertaken to ensure end of life care services remained sustainable for the future. There was also a strong theme of bereavement throughout this story.
168/25	John and Wendy's story was then shared via a recording with Board members, who had met over 30 years ago when working in the airline industry. John had rheumatoid arthritis and when they retired, decided to move to Lincolnshire. A routine appointment for a scan had found a small tumour on John's liver and he was subsequently referred to Nottingham for a further scan where a liver ablation was recommended to cure the cancer in November/December 2023. Wendy called the hospital in January 2024 as there had been no communication regarding an appointment and when John eventually had the scan, sadly the tumour was too large for treatment, and he was told his cancer was terminal.
169/25	Wendy explained that John's health soon deteriorated after this, and the community nursing team were soon involved in John's care who had been keen for John and Wendy to complete a Respect Form. John had requested to pass away at home or in a hospice setting. John's care was not documented in his yellow book and Wendy was uncertain of what to do when John's health deteriorated further, now requiring mobility aids and specialist equipment which she eventually ordered herself from the internet. Wendy explained that John wanted to maintain his independence and did not want to be a burden and would not let her push for help.
170/25	On 9th May 2024, John became more poorly and was in a lot of pain, where Wendy then called for an ambulance, however she felt guilty at this due to John's wish to remain at home and the ambulance crew asked if John had a Respect form. John was transferred to hospital and taken to A&E with no consultation with Wendy and John, where he became more agitated. Wendy was told at this point that John was very poorly and thought would need to be given to an end of life plan. Wendy described her shock at this, and she again expressed John's wishes to pass away at home or in a hospice setting. At this point John was moved to a side room to make him more comfortable, two nurses gave John some oxygen and informed Wendy that he would be quiet and resting and left them alone. Shortly afterwards John became more agitated and kept setting off a buzzer, at this point Wendy was shown how to stop it, rather than summoning nurses each time. Wendy asked where the care was at that point and felt like the nurses did not seem to notice that John required more care and attention.
171/25	At this point staff members called a Hospice who said that they needed a referral. By this time, the day shift nurses had started work and a lovely nurse began to look after John, and Wendy felt that was when John was treated like a human being. Transport was arranged for John to be transferred to the Hospice, however by this time John had sadly passed away, alone with Wendy, who went to get a nurse and eventually a chaplain came to see Wendy.
172/25	Wendy expressed her emptiness of going home and telling friends and family that John had passed away. She asked why John had completed a Respect form when it

173/25	was not adhered to. She added that A&E was not a place to die. She also did not know what was happening after John passed away and she could not believe that someone had been treated in that way at end of life. Wendy decided to complain about John's treatment and received what she felt was a "fluffy" letter in return, so she went back to the Complaints team with further questions and was subsequently offered a meeting. Wendy commented that the meetings she had with staff members had been good, people had been open and honest with her and she had felt more reassured, despite wishing that she did not have the memory of the day John passed away.
174/25	Several improvements had been made to end of life care at home and within the palliative care services across the Group, following Wendy's feedback, where a leaflet had been designed for carers, supporting families and the referrals process for hospice and community services had now been improved. Quality audits were taking place and symptom management guidance had been updated for staff, related to end of life care. Work had also been undertaken on the co-ordination of palliative care across the Wards, through patient feedback and education.
175/25	The Deputy Group Chair thanked Wendy for her courage and strength in sharing this story which had been humbling and on behalf the Board, thanked Wendy for providing this learning opportunity for the Group.
176/25	The Group Chief Executive offered sincere apologies to Wendy on behalf of the organisation, and added that the story uncomfortable to hear and was embarrassed by what was not done to support John and that Wendy had to fight for everything, however had thankfully found through this the Deputy Divisional Lead and Deputy Lead Nurse Palliative and End of Life Care who had supported her. The Group Chief Executive said that this type of feedback was what the Board needed to hear, and acknowledged the courage that Wendy had in sharing the story and for reliving her experiences. The Group Chief Executive wished Wendy well and again offered apologies.
177/25	The Group Chief Clinical Governance Officer said that this had been a difficult story to hear, however one of the things coming out from this was the ability to ensure that care was improved for patients at end of life. It was pleasing to hear that Wendy had found good benefit in a face-to-face meeting with clinicians and the complaints team to ensure her questions were answered.
178/25	Miss Shadlock offered that Wendy had been brave to share her poignant story and asked how widely patient stories were shared with the people involved so that they understood the impacts of their actions. The Deputy Divisional Lead explained that the story had been shared with the ICB and other organisations, including East Midlands Ambulance Service (EMAS), due to the Respect form being in place as the crew should have discussed this with Wendy and John prior to the hospital admission.
179/25	As Chair of the Quality Committee, Mr Connolly thanked Wendy for sharing her story and welcomed the actions put in place as the Group came together and looked forward to further developments being seen across the end-of-life pathway, which had to be a priority.

180/25 181/25 182/25 183/25	The Deputy Lead Nurse Palliative and End of Life Care agreed that this was a poignant story and agreed that the Board needed to be aware of these stories adding that some of the suggestions Wendy had made on supporting others in similar situations had been excellent in terms of reducing any risk of this occurring again. The Group Chief Integration Officer thanked Wendy for sharing the story and informed Board members that work was underway within this pathway between system leads and partners in terms of how to get the best care from partnerships, with the system and Group taking a leading role. There was also an important point on ensuring staff had the right tools available to them to have difficult and honest conversations and this would link into the development work that would feed into the Quality and Integration Committees in the near future. The Deputy Group Chair recognised some of the work described, and that assurance would come through from stories such as today's, to demonstrate that robust action was being taken and looked forward to hearing of improvements in the coming months via the complex change pathways. The Deputy Group Chair again thanked Wendy the story today and the Deputy Lead Nurse Palliative and End of Life Care and Deputy Divisional Lead for supporting Wendy and others during challenging times. A lot had been learned from the story in respect of communication, particularly listening and recognising the times when compassion was lacking. The Board: • **Received the Patient/Staff Story**
184/25 185/25 186/25	**Item 7.1 Celebrating Group Success – Stroke Services** The Deputy Chair welcomed Carl Ratcliff Integration Specialist, Sarah Hunter, Consultant Practitioner and Dr Abduelbaset Elmarimi, Consultant Stroke Medicine to the meeting who provided a comprehensive presentation in respect of an impressive piece of systemwide work in respect of stroke services. Details were shared in respect of a one year project with NHSE, where the aim was to improve stroke treatment rates (Thrombolysis). A PowerPoint presentation was provided for Board members which demonstrated the improvement from 8% to 12% treatment and other areas where patient care had been improved. Treatment times had also reduced, as well as the treatment to Ward. The next steps were outlined and a new project with CLEAR/National Stroke team was outlined where it was hoped that this would reduce delays in treatment, patient pathways and address staffing challenges. Dr Elmarimi described some of the current challenges within the stroke services, for example communication breakdowns between departments and ward for patients, space for assessments was often difficult and process waste could be reduced. A pit stop approach had been utilised where there were multiple hands doing multiple tasks utilising the term Code Stroke. Dr Elmarimi made a plea to the Board for stroke services to be reviewed as an urgent priority.

187/25	The Integration Specialist advised that the presentation had set out the importance for improvement in stroke services and where further work was required. This was a success story in respect of how to make change.
188/25	The Group Chief Integration Officer thanked the team for the improvements made and commented that despite the challenges, the response times and outcomes being achieved could be seen and expressed a view that the team should be congratulated. In terms of what was next, the Group Chief Integration Officer advised he would be sponsoring this initiative from a Community perspective and the Group Chief Medical Officer would be doing so from an acute perspective. The Group Chief Integration Officer informed those present that there was capacity within the 2025/26 capital plan to address issues relating to environment and build, secondly the rehabilitation pathway and early supported discharge currently overlapped, and expressed a view that there would be a requirement to have a consistent offer and workforce model which was sustainable for the future going forward. The Group Chief Integration Officer offered that this had Board sponsorship and would also have Committee oversight.
189/25	The Group Chief Medical Officer endorsed the Group Chief Integration Officer's comments and agreed that the team attending the meeting deserved to be congratulated for the achievements. The Group Chief Medical Officer advised that stroke services in general were becoming challenged within the East Midlands region. The transformational work that had been undertaken should not be underestimated and whilst there was still a lot of work to be done, the Lincolnshire Community and Hospitals NHS Group was best placed to be able to address the issues within the current pathway. The Group Chief Medical Officer noted that there were exciting transformational times ahead. The only exception to that could be from a medical workforce perspective.
190/25	The Group Chief Executive acknowledged the excellent work that was being undertaken in this area and outlined that the Executive Team and the Board were in full support of this and were committed to transformational change.
191/25	The Deputy Group Chair thanked colleagues for attending the meeting and for sharing some incredible success advising that the Quality Committee would be monitoring the movement and improvements anticipated over the next 12 months in this area. The Board: • **Received the presentation**
	Item 8 Strategic Aim 1 To Deliver high quality, safe and responsive patient services
192/25	**Item 8.1 Assurance and Risk Report Quality Committee in Common** The Chair of the Quality Committee in Common, Mr Connolly, presented the Committee reports following the meetings held on January 2025 and February 2025 and the reports were taken as read with no formal escalations to be made to the Board from either of these meetings.

193/25	Mr Connolly offered key highlights from the meetings drawing attention to the Clostridium difficile figures which were ahead of trajectory, the Group was a national outlier in respect of antibiotic usage and the Quality Committee had requested further assurance and for a reduction plan to be developed.
194/25	In terms of maternity services, the Board was advised that the organisation had submitted a Clinical Negligence Scheme for Trusts (CNST) status of non-compliance as previously highlighted, this was in respect of safety action four relating to workforce and Mr Connolly advised that the CNST papers were available within the reading room on iBabs for completeness.
195/25	Children in Care had previously been escalated to the Board in respect of fragility of the service and Mr Connolly advised that 10 PAS of clinician time had now been allocated, and the Committee would keep this under review however this remained a risk until long term improvements were seen.
196/25	The Group Chief Clinical Governance Officer advised that within the February Committee report, the Medical Examiner (ME) service was referred to regarding the time being taken for death certificates to be issued. It was noted that there was now a plan in place for the organisation to support this across the system and work was underway with the Lincolnshire ICB to review further system working. The Board: • **Received the assurance reports, noting there were no escalations**
197/25	**Item 8.2 Ward Establishment Review** The Group Chief Nurse presented the report and advised that a data capture exercise had been undertaken across the Group between November 2024 and January 2025. Whilst this had been an annual review for ULTH, this was the first time an establishment review had been conducted for LCHS. The purpose of the exercise had been to determine if the existing ward staffing establishments remained sufficient to meet the needs of the public.
198/25	On assimilation of the datasets and subsequent interrogation, it has been identified there were significant disparities in how the requirements for data-capture across ward areas had been interpreted.
199/25	The Group Chief Nurse therefore advised Board members that there was a lack of assurance as to the conclusions reached within the establishment review and proposed a range of actions and mitigations, as a short-term solution, until such time that a repeat establishment review could be carried out. The Group Chief Nurse would present a refreshed establishment review to the Board in September 2025 at the latest.
200/25	Mr Conolly and Mrs Wells confirmed that this proposal had been discussed and endorsed by both the Quality Committee and People Committee. The Board:

	• **Approved the non-submission of the November 2024 – January 2025 establishment and the proposed actions as detailed by the Group Chief Nurse**
	Item 9 Strategic Aim 2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG
201/25	**Item 9.1 Assurance and Risk Report People Committee** Mrs Wells provided the assurances received by the People Committee, at the meetings held during January and February 2025 and the reports were taken as read.
202/25	At the February meeting a report from the Workforce Strategy Group had been received and it was confirmed that further work was requested to understand levels of work related stress absence across the Group and to understand the impact on wellbeing, work which was already underway.
203/25	With regards to safer staffing, recruitment challenges were acknowledged by the Committee within paediatric speech and language therapy and the audiology impact was sometimes not realised until children were older. This was an area the Committee had expressed an interest in recognising recruitment challenges.
204/25	There had been positive news in respect of recruitment of Health Care Support Workers (HCSW) where an additional 52 staff members had been recruited and a positive update on medical staffing was also received, where there had been a reduction in vacancies and an improved position on job plans at 90% with a trajectory of 95% to achieve by year end.
205/25	At the January meeting, the Committee had been advised that the work of the Talent Academy had been recognised by Buckingham Palace, for the work in respect of apprenticeships and work experience and the team would be attending a Garden Party in May 2025.
206/25	The Committee had also received the Freedom to Speak up Guardian (FTSUG) quarterly report where an escalation had been noted in respect of the time taken for action once issues were raised. The Committee would continue to monitor this.
207/25	The Deputy Group Chair thanked Mrs Wells for the report and was pleased to see the focus of the Committee in respect of work-related stress and the impacts of wellbeing. There was a view that this should be an area of focus throughout 2025/26. The Deputy Group Chair acknowledge the delays relating to FTSU concerns. The Board: • **Received the assurance reports**
208/25	**Item 9.2 Gender Pay Gap Report** The Deputy Group Chief People Officer presented the reports for ULTH and LCHS for final ratification by the Board prior to the 31st March 2025 deadline. There was a requirement to complete two separate reports due to statutory responsibilities and the

	formats of reports and action plans had been aligned and action plans would be addressed across Group.
209/25	For ULTH, as at 21st March 2024, women earned 86p compared to £1 men earned and women held 81.7% of the lowest paid jobs and 63.8% of the highest paid jobs, which was a positive improvement based on the previous year's results.
210/25	For LCHS women earned 91p compared to £1 men earned, which was an improvement based of the previous year's figures and women held 79.4% lowest paid jobs and 89.2% highest paid jobs, again this was a positive improvement.
211/25	In respect of the action plans, this had been broken down into three key areas; actions data and analytics and supporting teams in obtaining comprehensive data to support positive impacts, recruitment and retention and career development, flexible working options, health and wellbeing and career options and medical workforce which was predominantly made up of a male workforce within higher graded consultant roles.
212/25	The Deputy Group Chair thanked the Deputy Chief People Officer for the report and noted that the People Committee had ratified this previously. The Board: • **Approved the publication of the Gender Pay Gap Reports for ULTH and LCHS**
	Item 10 Strategic Aim 3 To ensure services are sustainable, supported by technology and delivered from an improved estate
213/25	**Item 10.1 Assurance and Risk Report from the Finance and Performance Committee** The Chair of the Finance and Performance Committee, Ms Cecchini, provided the assurances received by the Committee at the meeting held in January and February 2025, the reports were taken as read and the following areas were highlighted.
214/25	At the February meeting the financial position had been noted for the Group as £33.3m deficit, which was £24.7m adverse to plan and it was clear that the majority of the deficit was attributed to the ULTH part of the Group. There was evidence that mitigations Executive colleagues and teams had put in place were starting to work, with the slowing of the run rate. CIP (Cost Improvement Programmes) was also behind plan by £1.2m, however there was optimism of delivery for 2024/25, with approximately half of this relating to non-recurrent funding. The Board was advised that at the January Committee meeting, the financial position had formally rated as having no assurance that the plan would deliver in the financial year.
215/25	In respect of Capital, the funding spent at the end of January was £38.2m compared to full year plan of £61m, which was slightly behind plan however there were no concerns of non-delivery.
216/25	

217/25	The forecast outturn position had also been discussed with NHSE and the Committee had been advised that this would likely be a £36.1m deficit for the Group, which was a £29.2m variance against the original plan for 2024/25.
218/25	A funding risk against the CDCs had been identified and a plan would be required to resolve this during the planning round as currently the pricing did not meet the costs.
219/25	Cash continued to be problematic, despite an extra £4m being received from NHSE as well as a VAT claim on treatment of NHS car parking income which had supported the position.
220/25	Ms Cecchini explained that there had been good development of a Group estates report which was received at the February meeting where there had been assurance on the ULTH elements, despite some improvements still to be made. However concern had been raised in respect of the community estate specifically relating to available data and appointed Authorised Engineers reporting to the Committee. A fire enforcement action notice has also been issued against NHS Property Services in respect of County Hospital Louth, and the Estates team was working with NHS Property Services to ensure issues were resolved.
201/25	The Committee had been advised of good performance with the organisation exiting tiering for elective and diagnostics. Urgent and Emergency Care was currently in the upper quartile regionally for delivery, which was a good achievement, however there remained work to do in respect of 12 hour waits and category two ambulance response times.
202/25	In February, the Committee was informed that there were no 78-week waits and that there were 33, 65-week waits at the end of January which continued to move in the right direction.
203/25	A referral had been received from the Integration Committee in respect of community waiting times and lists, and it had been noted at the meeting that there had been waiting list issues on the lymphoedema service, which would be an area of focus moving forward.
204/25	Information Governance reports had demonstrated a concern surrounding a backlog of Subject Access Requests and a plan had been received from the Information Governance team in respect of moving that forward. The Committee had also acknowledged the development of an Information Governance dashboard which had been considered.
205/25	The Deputy Group Chair acknowledged one of the challenges in respect of finances around the 50% non-recurrent funding for CIP which would have an impact on 2025/26, which Executives were currently working through. In respect of performance, the Group Chief Nurse drew attention to the rapid ambulance offloads and provided the Board with some assurance that work was being undertaken to support teams working in a highly pressured area to maintain wellbeing in respect of this.

	The Board: • **Received the assurance report**
	Item 11 Strategic Aim 4 – To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grown our culture of research and innovation
206/25	**Item 11.1 Assurance and Risk Report from the Integration Committee** Mrs Buik provided the assurances received by the Committee at the meeting held in January and February 2025.
207/25	Mrs Buik advised that Estates and Facilities was being viewed through an alternative lens to the Finance and Performance Committee and the key priority for the Integration Committee was to optimise the use of space across the Group, which would also support the development of an Estates Strategy later in the year, once the Clinical Strategy had been finalised.
208/25	The Committee had received stroke updates at both the January and February meetings where assurance had been provided on the ongoing work on the CLEAR project, which had triangulated well with the presentation received at the Board meeting and a further update would be provided at the June meeting.
209/25	From a digital perspective, assurance had been received on a range of projects across the Group, with a focus on four main areas: Electronic Patient Record for both organisations, Electronic Document Management Service and the email tenant migration for ULTH.
210/25	Three reports had been received in respect of health inequalities and there had been assurance relating to system wide working to progress those areas.
211/25	The Alliance Operating Model had been presented and provided assurance on the overall approach. The first milestones would commence next month.
212/25	Two staff stories had been received, both relating to pilot projects with system partners, EMAS and Primary Care focussing on attendance avoidance to avoid admission to Hospital where possible. Positive results had been seen from both pilots and good discussion had taken place with recognition of analysing the impacts with a range of options for patients and making best use of resources. The Board: • **Received the assurance reports**
	Item 12 Strategic Aim 5 – To embed a population health approach to improve physical and mental health outcomes, promote well-being and reduce health inequalities across an entire population
	No items.

213/25	**Item 13 Integrated Performance Reports** The Integrated Performance Reports were taken as read with the Board noting that the reports had been received and reviewed in depth by the Committees. The Group Chief Integration Officer explained that work to amalgamate the two reports had fallen behind due to vacancies within the team.
214/25	There were two areas the Group Chief Integration Officer wished to highlight to the Board. From a ULTH perspective 12 hour waits in ED remained an outlier, despite all other Urgent and Emergency Care (UEC) improvements being seen. Plans were in place to improve this during the next quarter and from an LCHS perspective the report demonstrated an outlier on call answering performance within the Clinical Assessment Service (CAS) and Urgent Community Response, however the Group Chief Integration Officer explained that the target measures were currently too high compared to national expectation for those services which needed to be addressed.
215/25	The Group Chief Integration Officer also highlighted lack of performance in community waiting lists and integrated neighbourhood teams and cancelled appointments. This was being addressed as part of the Performance Review Meeting (PRM) structure and would feed through to Board and Committees in the coming months. The Board: • **Received the Integrated Performance Reports noting the moderate assurance**
	Item 14 Risk and Assurance
216/25	**Item 14.1 Group Risk Management Report** The Group Chief Clinical Governance Officer presented the risk report to the Board noting that there two very high risks from the LCHS perspective, both attributed to the Quality Committee, remaining static from last month.
217/25	From an ULTH perspective, the Quality Committee had sight of nine very high risks which remained static. The People Committee had five very high risks remaining static and the Finance Committee had four, a reduction of three from the last report.
218/25	The Group Chief Integration Officer advised of some realignment of the risks into the Integration Committee.
219/25	The Deputy Group Chair was confident that the Committees were reviewing the risks, and the Quality Committee would be focussing on the very high risks at the March meeting. The Board: • **Accepted the risks as presented noting the significant assurance**

220/25	**Item 14.2 Board Assurance Framework** The Group Director of Corporate Affairs presented the report noting that all assurance Committees had considered the Board Assurance Framework (BAF) during January and February and there had been no change to the assurance ratings.
221/25	The Group Director of Corporate Affairs explained that the Board should note the new format for the BAF following consideration at a Board Development Session; this was under development and at the next meeting the 2025/26 BAF would be considered.
222/25	The Group Director of Corporate Affairs informed those present that Internal Audit had commenced an annual review of the BAF and Risk Register which would be submitted to Committees once concluded. The Board: • **Accepted the Board Assurance Framework**
223/25	**Item 14.3 Assurance Report from Audit Committee** Ms Cecchini provided the key highlights from the Audit Committee meeting held in February 2025, taking the report as read.
224/25	A joint Group report had been received from External Audit and an update had been provided on planning arrangements for year end. Good assurance had also been received that discussions were underway, and a plan was in place to complete the year end audits within the timescales.
225/25	In respect of Internal Audit there were some reports that remained outstanding, and concern was expressed regarding a lack of pace in completion of those. The Committee had been reassured of governance commitments.
226/25	A Local Counter Fraud Specialist report had been received and it had been agreed to move to one single local counter fraud champion, which had been identified as the Deputy Director of Finance, Mr James Taylor.
227/25	Progress on out of date policies remained poor and each Committee was now monitoring this. The Audit Committee was looking to understand the level of risk of how long some of the policies had been out of date. It was clear that this had good Executive ownership however the Committee expressed a view that this needed to filter down to teams/Divisions. The Board: • **Received the Assurance Report**

228/25	**Item 14.3.1 Audit Committee Terms of Reference and Work Programme** The Group Director of Corporate Affairs presented the refreshed Terms of Reference and Workplan for the Audit Committee for information, which had been drafted as prescribed by the Audit Committee Handbook. The Board: • **Received and approved the Audit Committee Terms of Reference and Work Programme**
229/25	**Item 15 Board Forward Planner** The Group Director of Corporate Affairs presented the Board Forward Planner which would manage the business of the Board and would be submitted to each meeting as an information item. Committee Chairs were asked to review the document and feedback any comments outside of the meeting. The Board: • **Received the Board Forward Planner**
230/25	**Item 16 Any Other Notified Items of Urgent Business** No further items were discussed.
231/25	The next scheduled meeting will be held on Tuesday 6 May 2025 via MS Teams live stream.

Voting Members	7 May 24	2 July 2024	3 Sept 2024	5 Nov 2024	7 Jan 2025	4 Mar 2025						
Elaine Baylis	X	X	X	X	X	A						
Andrew Morgan	X											
Karen Dunderdale	X	X	A	X	X	X						
Ian Orrell	X	X	A									
Jim Connolly	X	X	X	X	X	X						
Gail Shadlock	X	X	X	X	X	X						
Chris Gibson	X	X										
Philip Baker	A	A	X	X	X	A						
Neil Herbert	X	X	X	X	X	A						
Rebecca Brown	X	X	X	X	X	X						
Dani Cecchini	X	X	X	X	X	X						
Julie Frake-Harris	X	A										
Colin Farquharson	A	X	A	X	X	X						
Sam Wilde	X	X	X									

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

Group Chief Executive's Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Trust Board*
Date of Meeting	*6th May 2025*
Item Number	*6*

Group Chief Executive's Report

Accountable Director	*Karen Dunderdale, Group Chief Executive*
Presented by	*Karen Dunderdale, Group Chief Executive*
Author(s)	*Karen Dunderdale, Group Chief Executive* *Gemma Coupland, Business Manager*
Recommendations/ Decision Required	*The Board is asked to note the update on the key points from March and April 2025.*

System Overview

a) All parts of Lincolnshire health and care system remain busy, but good work continues in order to cope with the ongoing operational pressures. Since the last Board meeting the system coped well over the Easter Bank holiday period across the urgent and emergency care pathway.

b) The Lincolnshire system submitted the System Operational Plan for 2025/26 on 26th March 2025. NHS England are reviewing all plans and will seek assurance for the delivery of the plan if required.

c) The system ended the financial year 2024/25 with a financial deficit of £26.7m against a break-even position.

d) The last few weeks have been dominated by national announcements since the change in NHS leadership and the appointment of Sir Jim Mackey as the CEO of NHS England. This has led to a number of significant national decisions which include formally abolishing NHSE and integrating it into the Department of Health and Social Care within two years, expecting Integrated Care Boards (ICBs) to make a 50% reduction in their running costs and expecting provider trusts to reduce their corporate cost growth during quarter 3 and explore outsourcing some support services. This is causing a level of anxiety for colleagues and we are working with our staff side representatives and keeping them as well as our workforce briefed as we understand more detail.

e) The HSJ Independent Healthcare Provider and HSJ Partnerships Awards took place in March, where the partnership between United Lincolnshire Teaching Hospitals NHS Trust, Lincolnshire ICB, Lincolnshire Elective Activity Coordination Hub and DMC Healthcare were successful in winning Best Elective Care Recovery Initiative and Best Insourcing Initiative, both of which recognised the project aimed at reducing the dermatology patient waiting list following the Covid-19 pandemic and improving the overall patient experience. The awards recognise the tremendous achievement and shows the close working within the Lincolnshire system and other partners.

f) Following universal agreement across the NHS, from 1st May 2025, staff will no longer be required to repeat statutory and mandatory training when moving between NHS organisations, which will improve staff efficiency and experience. This announcement coincides with the launch of the national people policy framework which provides organisations with a consistent approach of how mandated learning is determined and managed.

g) On 16th April 2025 the Supreme Court delivered a landmark ruling on gender identify. There are currently many details to be worked through on a national level as to how this would impact the Group. Communications have been shared across the group making it clear that all colleagues are welcomed, regardless of gender identity, and that we will continue to create a safe and working environment for all.

Group overview

a) ULTH's year-end financial position is a £18.3m deficit, £11.4m adverse to the planned deficit.

b) LCHS's year-end financial position is a £31k surplus, £66k favourable to the planned position.

c) The ULTH CIP has delivered savings of £40.5m, which is £0.4m favourable to the plan. LCHS CIP has delivered savings of £7.4m, which is £0.4m ahead of plan.

d) Following robust recruitment processes I am pleased to announce that Caroline Landon has been appointed as the substantive Group Chief Operating Officer and Paul Antunes Goncalves as substantive Group Chief Finance Officer. Caroline joined the Group as Interim Group Chief Operating Officer in August 2024, for a 12-month period, and Paul joined in October on a 12-month secondment from his previous role as the Deputy Director of Finance at Nottingham University Hospitals NHS Trust.

e) 9th March 2025 marked five years since the beginning of the Covid-19 pandemic. The Group arranged a series of reflection services to allow

colleagues to take the opportunity to mark this anniversary and to honour those affected, as well as recognising the huge contribution the NHS made during the pandemic.

f) During March 2025 a productive engagement meeting took place with LCHG and the Care Quality Commission (CQC). The CQC provided an update on the developments within their organisation, including the appointment of Sir Julian Hartley as the new CEO. The Group provided a detailed update on performance and the CQC refresh work aimed at supporting improvements across the urgent and emergency care pathways to reduce waiting times and improve quality of patient care.

g) United Lincolnshire Teaching Hospital NHS Trust (ULTH) have been considering the future plans of the old buildings on the front of Grantham Hospitals. To help develop these plans, the Trust ran a public engagement exercise from 17th February until 31st March 2025, which invited views and ideas from local residents, to ensure that the plans are of benefit to the local community. A report on the outcome of this engagement exercise will soon be shared.

h) Following extensive work to make improvements for patients using urgent and emergency care pathways, the Group has reported significant progress. During March we achieved the four-hour A&E performance of 78.2%, which means we are one of the most improved areas within the East Midlands and that our patients are waiting less time to be seen and treated. A 12% improvement has also been seen in ambulance handover times at our acute sites, despite a 20% increase in ambulance activity. This makes us the most improved organisation in the country for this metric. These improvements highlight the strong working relationships between the different departments across the Group.

i) ULTH Electronic Patient Record (EPR) Full Business Case received ministerial approval during March and has subsequently been submitted to the cabinet office for approval.

   Vin Diwakar, NHSE National Director of Transformation visited ULTH at the end of April accompanied by the Director of Digital Transformation and the Director of Technology. The visit provided an opportunity for the Trust to discuss the EPR programme whilst also highlighting the benefits once the system is implemented.

j) During April the results of the NHS Staff Survey (NSS) 2024 were published, which collated the feedback from colleagues across the Group. Work is now underway at Group, Trust and Divisional level to help understand the results and develop action plans. Following the publication, ULTH has been recognised by NHSE for the significant achievement in improvements across

all seven elements of the People Promise and the themes of Staff Engagement and Morale.

k) The 2025 Staff Awards across LCHG are now open for nominations. The awards are an opportunity for the people of Lincolnshire to recognise the dedication and care shown by community and hospital staff working across the county.

l) Over the past two months I have continued to visit teams across many of the sites within the Group to find out more about the work they undertake to provide and improve the care to the residents of Lincolnshire.

NHS
Lincolnshire Community and Hospitals NHS Group

Group Model Workstream Progress Briefing
April 2025

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*Tuesday, 6 May 2025*
Item Number	*Item 6.1*

Group Model Workstream Progress Briefing
April 2025

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

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

Executive Summary

Background & Introduction

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

Current Position including Issues for Escalation

Overall, there has been continued good progress on delivery of the agreed programme milestones, although there has been some slippage in some work streams. This has been due to the need for the group to focus on urgent planning work and also to ongoing internal capacity issues within the relevant teams.

There are no significant concerns to escalate although it should be noted that there are a number of matters on which board approval is required in May 2025 – these matters have been scheduled separately on the board agenda.

Group Board Action Required:

The Group Board is asked to:

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

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

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

Work Stream 2: Accountability, Information & Reporting

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Design, approve and implement an Performance Management & Accountability Framework for the group which: • is aligned to the aims & objectives of the group and strategic partners; • is aligned to the relevant statutory and regulatory standards, requirements and contracts relevant to the trusts and wider group; • flows from ward / patient to board; • is aligned to and supports the board and board committee cycle; • is based on clear metrics with defined performance thresholds reported through a harmonised Integrated Performance Report (IPR) from a group, trust directorate & service perspective; • is balanced across strategy, quality & safety, performance: operational delivery, workforce, finance, governance & risk; • is underpinned by a harmonised accountability & performance review policy & process; • is action focussed in support of delivery and risk mitigation and which reflects best practice as set out in the latest NHSE guidance: 'The Insightful Provider Board'; [**Note:** There is a need to ensure relevant improvement programmes e.g. ULHT Integrated Improvement Plan (IIP) is integral to and not separate from the above process including the alignment of group / trust KPIs]	31 January 2025 **(draft outline)** 28 February 2025 **(socialise)** 3 March 2025 **(approval)** 1 April 2025 **(implementation)** 30 June 2025 **(embedded)**	Aligned PRMs across the group in place from January 2025 Performance Management & Accountability Framework drafted (including a clear process and ratings for escalation / intervention) and approved by GLT on Friday, 4 April 2025 and due to be approved by the board on Tuesday, 6 May 2025 Aligned IPR and KPIs / metrics for 2025 / 26 currently being worked up	
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)**	'Vision for Information' drafted but not yet approved – date to be confirmed Draft team structure developed: • Director of Improvement and Performance role paused (linked to ICB developments) • Director of Digital in post from 1 April 2025	

Work Stream 3: Aligned Governance & Decision-Making

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Board & Committee Governance			
Complete the transition from boards-in-common to a joint or group board (once all appointments have been made to group executive leadership roles and NHSE approval has been received for the appointment of joint or group and trust specific Non-Executive / Associate Non-Executive Directors (NEDs / ANEDs)	30 November 2024 **(complete – joint Trust Board in place)**	**Complete:** Group Board in place. Board Development Programme also in place supported by NHS Providers who have provided some initial observations and recommendations for strengthening the operation of the board – relevant actions incorporated within the group development programme plan. Well Led Assessment also planned for 2025 with NHS Providers support. Terms of Reference for Well Led Assessment drafted – timescale for assessment to be confirmed	
Complete the work to align the board business cycle (work plan)	31 December 2024 **(drafted)** 31 January 2024 **(approval)** **3 March 2025 (revised timescale for approval)**	**Complete:** Board business cycle for 2025/26 approved by Group Board in March 2025	
Complete the work to transition the remaining board committees (Audit & Risk, People / Workforce, Finance & Performance) to work jointly including the development and approval by the trust board of harmonised terms of reference & work plans and the agreement of any changes to the naming convention for these committees. The development of harmonised terms of reference and work plans for all board committees to include a review of: • delegated authority and matters reserved to the Group Board; • membership (reflecting changes to group leadership structures); • reporting up from sub-groups (reflecting any changes to and / or alignment of those groups) • assurance ratings (ensuring these are aligned and consistent with those within the BAF) • the development of an 'Assurance Map' detailing the areas of oversight covered by each of the board committees; not least to avoid duplication and gaps	31 December 2024 **(harmonisation & approval of terms of reference & work plans & transition to new ways of working for all board committees)** 1 January – 31 March 2025 **(implementation)** **6 May 2025 (final terms of reference & work plans submitted to board)** 30 June 2025 **(arrangements fully embedded)**	Committees are now meeting jointly although arrangements need embedding Terms of reference and work plans are being refreshed to reflect the new group strategic aims & objectives and will be shared with the Group Board for approval in May 2025 (together with the 'Assurance Map', 'Board & Board Committee Principles Framework' and revised board & board committee templates) 'Assurance ratings within the BAF have been reviewed and wording updated. Assurance ratings used within reports to the board and board committees being aligned as part of the strengthening of the board & board committee templates Review of reporting sub-groups is almost complete	
Undertake a review of the operation and effectiveness of the Quality Committee nine months on and any required changes to the terms of reference, work plan & associated arrangements. Any learning to be used to inform the transition of the remaining committees to working jointly **[NB.** Independent testing of the operation and effectiveness of all board committees working jointly will be required once embedded. This could be as part of the Internal Audit or planned Well Led Assessment.]	31 October 2024 **(review complete)** 31 January 2025 **(board receipt of & implementation of recommendations)**	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)	'Board & committee principles framework' drafted and due to be submitted to the board for approval in May 2025.	
Develop (or make any required changes) to harmonised board & committee templates (report cover / front sheet, agenda, minutes, upward report & action log) and common report writing guidance in light of the move to group and working jointly. As part of the development or updating of the report writing guidance, consider the need for and introduce a programme of report writing training for key staff and develop an exemplar report front / cover sheet	28 February 2025 **(templates & guidance)** 31 March 2025 **(training plan drafted)** **6 May 2025 (submitted to board)**	Underway – upward report template strengthened to ensure consistency of approach and to ensure it supports and prompts the provision of appropriate assurance to the Group Board from all committees and, in turn, from the groups reporting to the board committees. Action Log template also being strengthened. Report writing guidance drafted and report front sheet amended	

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. The PCN Chief Executive will also join the Group Board as an Associate NED	
Board Development			
Once the group executive leadership team is in post and informed by a board skills & knowledge assessment and aligned to the proposed group executive development programme, develop, agree & implement a Joint Board Development Programme. As an outline, a Board Development Programme may typically include: • board development days / time-outs ensuring dedicated time on key topics and priorities including group development and strategy; • information sharing / briefings (e.g. national policy, regulatory changes, learning and good practice from elsewhere); • board training / compliance requirements; • tailored sessions in response to identified development needs (including those identified from the skills & knowledge assessment or arising from the annual review of board effectiveness or any well led or governance review etc.)	From 1 October 2024 onwards	Board Development sessions being undertaken with NHS Providers support Formal programme for 2025/26 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 to be 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 planned with NHS Providers support – timescale for assessment to be confirmed	

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

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

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Board Reporting Framework (BAF) & Risk Registers			
Phase 1: Complete the work to align the two trust BAFs including a review and alignment of 'assurance ratings' and ensure that each strategic risk is cross-referenced with related risks on the corporate risk registers. **[Note:** Whilst the aligned BAF will reflect risks to the delivery of the strategic objectives which have been agreed for the group and the controls, assurance, gaps and actions may be the same for each organisation, where there are risks which are specific to either ULHT or LCHS, the controls, assurances, gaps and actions to be explicitly referenced for each separate organisation] Phase 2: Consider and agree the 'design' of the aligned BAF for 2025/26 onwards i.e. should the format of the aligned BAF look and feel different for the group? Agree the board committee oversight for each strategic aim & objective Phase 3: Implement the new style BAF	31 October 2024 **(underway)** 21 January 2025 **(Group Board workshop)** 1 April 2024 **implementation of new style BAF)**	Strategic aims & objectives for 2025/26, a revised BAF format and BAF review cycle agreed by the Group Board BAF drafted in new format and being shared with board committees during April and Group Board in May 2025. Work to further refine the new style BAF and embed its use within the board and committee cycle will continue over the coming months 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	
Agree the group risk appetite and ensure this is appropriately referenced within the BAF for each strategic objective	18 March 2025 **(Group Board workshop)**	**Complete:** Group risk appetite agreed by the Group Board and incorporated within the BAF	
Review and standardise the risk register and approach to risk management and risk reporting across the group including the management of Datix	31 December 2024	**Complete:** A new joint Risk Policy was launched on 1 December 2024. Whilst two separate risk registers remain in place there is considered to be a consistent approach to risk management across the group, however, scope being drafted for NHS Provider to review & test the approach. Routine testing of the effectiveness of these arrangements will continue to be undertaken as part of the annual internal audit review of risk management which informs the Annual Governance Statement and as part of the planned Well Led Assessment Risk Register – Confirm & Challenge Group terms of reference and membership refreshed to ensure executive input	
Alignment of Group Meeting Cycle			
Once the work to design and align the board, committee, sub-group and other key trust meetings is complete, develop and update annually a single group meeting schedule (ensuring alignment with the Accountability & Performance Management Framework and performance review meetings)	31 January 2025	**Complete:** Meeting cycle in place. PRMs to be added	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Document Control & Policy Approvals			
Agree and implement a harmonised and strengthened approach to document control and policy approvals for the group	31 March 2025 (policy in place) 31 June 2025 (review of effectiveness of arrangements)	A combined document control policy and process is in place although not yet fully embedded. A recent internal audit of these arrangements recognised that the group is still in transition. Further review to be undertaken as part of the group development work programme	
Review of Key Trust Documents & Governing Instruments			
Complete the review, alignment and approval of key documents & governing instruments to reflect the move to group and changes to the operating model to include but not limited to: • Standing Orders • Standing Financial Instructions • Scheme of Delegation & Powers Reserved for the Boards • Division of Responsibilities Schedule between the Group Chair and Chief Executive • 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	31 March 2025	Interim amendment to Standing Orders made to reflect the appointment of a Group Chief Executive and joint Leadership Team, changes to ELT and GLT decision-making and the proposed move to joint board and committees and any changes to voting rights Division of Responsibilities Schedule drafted and shared with Group Chair & Group Chief Executive. Schedule to be appended to Standing Orders and approved by the Group Board A joint Fit & Proper Persons Policy is in place for the group but will need to be refreshed to ensure alignment with the newly published Board Member Appraisal Framework Performance Management & Accountability Framework drafted and approved by GLT on 4 April 2025 and will be approved by the Group Board on 6 May 2025 Final amendments to the Standing Orders, Standing Financial Instructions and Scheme of Delegation cannot be undertaken until other work stream actions are complete – **suggested revised timescale for completion: 25 July 2025 (Audit Committee) and 2 September 2025 (Group Board approval)**	
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	31 March 2025	This action cannot be completed until other work stream actions are complete – **suggested timescale for completion: 2 September 2025 (Group Board approval)**	
Review and update the Group Workforce Sharing Agreement to reflect the agreed arrangements for broader staff / staff groups from each trust, as required, to work across the group: such arrangements to maintain the existing employment relationship whilst avoiding the need for honorary contracts or secondment agreements	31 March 2025	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	31 March 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	31 March 2025	Strategy drafted and currently being reviewed. Group Board approval scheduled for July 2025	
Develop the Group visual ID / brand ensuring adherence to the NHS Identity Guidelines specifically in respect of partnership branding	21 April 2025	Group visual ID / brand approved and due to be 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	Guidelines and templates being developed – on track in line with timescale for implementation of the group visual ID / brand	
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)	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)	Most communication channels have been merged – 'Group Bulletin' will be the final one and will 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	Toolkit developed in conjunction with the Patient Experience Team. Communication & Engagement Team working with the Improvement & Integration Team to embed the toolkit in to use as part of the service change process	
Continue the ongoing comms on all aspects of group development and benefits realisation as changes occur including the development of FAQs for staff on changes to 'how things work across the group'. **NB.** Case studies and group wide log of engagement activities being maintained including learning from staff listening events	Ongoing	Ongoing	

Work Stream 4: Communications & Engagement cont'd

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

Work Stream 5: HR & Workforce

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
For any consultation process moving staff into group roles from individual trusts, undertake an equality impact assessment in accordance with ACAS best practice	Ongoing	Ongoing process	
Develop a package of individual support for staff who will be affected by the change of the move to group	Ongoing	Arising from the local health & wellbeing survey and outputs from the national staff survey a programme of staff engagement workshops, led by GLT and ELT and covering the group vision, strategy & objectives, group values and behaviour frameworks has been agreed. These workshops are in addition to the existing staff engagement 'Tube Map' & Change Workshops and health & well-being offer in place	
Harmonise contractual policies and processes across the group, working with union colleagues: six priority policies identified and agreed with union colleagues from both trusts in the first instance. Plan and timescale to be agreed for harmonising remaining policies and processes	31 March 2025	Priority policies have been harmonised and formally ratified. The next cohort of policies to be reviewed and harmonised relate to recruitment	
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. Policy approved w/c 17 February 2025	
Move to a group induction using the following blended approach: • Development of joint induction video • Harmonisation of joint face to face induction	31 December 2024 30 June 2025	Group induction video in place. Plan in place to introduce harmonised face to face induction but this has been delayed due to resource / capacity issues within the team	
Ensure all training, progression, career development opportunities, apprenticeships and support are offered consistently across the group – *linked to policy work and supported by aligned of teams and portfolios*	31 January 2025 **(review of portfolios)**	Ongoing & monitored through Workforce Operational Group	
Ensure portability of staff for cross-site working	1 November 2024 **(interim solution)** 1 April 2025 **(long term solution)**	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	Engagement 'Tube Map' and Change Workshops in place & ongoing **(Appendix C refers).** Additional staff engagement roadshows planned as outlined in work stream 5	
Develop proposals for a long term Organisational Development programme to support the transition to group and the new operating model with a focus on: • Directorate leadership development • Executive development • Board development	Ongoing **(Group Board and ELT) Development Programmes)** 31 March 2026 **(Division / Directorate Leadership Programme (The 'Leeds Way') to be embedded**	Board Development sessions are currently being undertaken with NHS Providers support. EDI specific half-day board development session is also being planned with external, expert speakers (authors of *'Too Hot to Handle'*) 12 month ELT Development Programme in place and being supported by Acqua The OD team have commenced the scoping work to support the implementation of the 'Leeds Way'	
Continue to align and develop the group culture including the agreement of one set of group values	31 January 2025 **(outputs & recommendations from 'Better Together' Programme & engagement sessions)** 3 March 2025 **(board approval)**	New group values – Compassionate, Collaborative and Innovative – approved by the Group Board and being implemented w/c 14 April 2025. Underpinning statements for each value currently in development. A staff engagement exercise is also due to be launched on the development of the behavious that underpin each value – 'Our Values in Action'	
Continue to develop the staff health & well-being offer across the group including the introduction of menopause support	31 March 2025 **31 May 2025 (proposed revised timescale)**	The staff health & well-being offer continues to be developed. It has however been identified that there is currently insufficient funding for the development of the menopause service. This is currently being urgently reviewed to determine what funding can be identified to offer the service across the group	

Work Stream 7: Digital

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Develop a digital strategy, infrastructure & capabilities for the group with a focus on digital transformation and new ways of working to include the following specific actions / milestones:	31 March 2025	Strategy developed – first draft submitted to Digital Oversight Group on 11 April 2025. Date for submission to Integration Committee and Group Board for approval to be confirmed	
• 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 contract awarded • Datix in process of moving to cloud. • Group Intranet subject to IG approvals Technical enablement in place through NHS.nes. On track for implementation by deadline	
• move to a single Microsoft 365 teams platform with the migration of ULTH to the national tenancy	31 March 2025	Complete. Work continues to optimise and standardise processes	
• move to a single domain / directory login process	31 March 2025 **(Implementation Plan)** 31 October 2025 **(Full Implementation)**	Underway – on track: • Implementation Plan drafted • Supplier (AGEM) to support implementation	
• move to standardised printing & print codes – significant piece of work – workarounds to be simplified in short term	31 March 2026 **(Full Implementation)**	Underway – on track: • Interim arrangements and process in place between ULTH and LCHS • Joint procurement process to commence Summer 2025	

Work Stream 7: Digital cont'd

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
• transition LCHS from the current AGEM IT support contract to the Group Digital support system	24 January 2025 **(Finalised Plan)** 1 October 2025 **(Full Service Migration – some things may take longer)**	Underway – on track for 1 October 2025 full service migration • Weekly transition meetings taking place • AGEM delivering the new domain which is a key technical enabler • Resource model agreed	
• create a common identity for the Digital Team (linked to the group brand & associated actions)	31 March 2025 30 April 2025 **(agreement of structure)**	Underway – on track: • Director of Digital in post • Structures drafted • Integrated structure to be presented with management team moving to group roles	
• 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)**	'Vision for Information drafted – date for approval to be confirmed Draft team structure developed: • Director of Improvement and Performance role paused (linked to ICB developments) • Director of Digital in post	
• move to aligned telecoms	31 March 2025 **(Single telephony team)** 30 May 2025 **(Secured single contract for Telephony Services)**	Underway – on track: • Single team as planned but funding for additional required posts may take longer • Procurement of service to support ULTH and LCHS nearing completion	
• data hosting	31 March 2025 **(Server Migration Completion)** **30 April 2025 (new date proposed by AGEM)**	Underway – on track: • As at the end of March, all but 6 of the 101 servers have been migrated. The digital team are working with AGEM to understand options and solutions. There is no risk to the project and group as this work relates to consolidation of the infrastructure	

Work Stream 8: Estates & Facilities

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Estates Strategy, Service Developments & Transformation			
Develop the Estates Strategy in support of delivery of the agreed group strategic aims & objectives, planned service developments & transformation projects and in support of reducing health inequalities:	31 March 2025 **(commencement of work to develop the strategy)** 2 September 2025 **(board approval)**	Underway although likely to be impacted by the decision on the future model for the provision of EFM services – *see next action*	
• consider & evaluate the different models for the provision of EFM services across the group to include the option of a wholly owned subsidiary model and present the findings and recommendations for approval to the Group Leadership Team and Trust Board	31 March 2025	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	30 June 2025	External support to undertake the review being sourced at an estimated cost of £22.5k. Procurement process commenced. Work to be progressed in the 2025/26 financial year	
• continue the programme of ward refurbishments, as funding is available	Ongoing	No funding currently available – programme to be reviewed in new financial year	
• undertake a review of all leases and licences across the group	30 June 2025	Underway – although some difficulties have been experienced in obtaining information on leases and licences under the previous shared service arrangements. Dialogue now underway with relevant landlords	
• produce a visual 'map' of all services and where they sit within the group and ensure this is aligned with each trust's CQC registration / Statement of Purpose'	31 December 2024	**Complete:** 'Map' of services produced and shared with ELT	
• deliver the agreed 2024/25 EFM transformation projects and EFM improvement plans	31 March 2025	**Complete:** Plan and projects delivered for 2024/25. Plan in development for 2025/26	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Restructure of EFM			
Complete the restructure of the EFM senior management team and underpinning workforce plans and associated work plans to ensure the two trusts are able to meet and, where necessary, improve compliance with statutory requirements to include the bringing together of the emergency planning and health & safety teams	30 June 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:	Ongoing	Ongoing	
• develop a single approach to the movement of EFM staff across the group	31 March 2025	Underway but impacted by gaps and capacity issues in the team. Also linked to future EFM model	
• commission a cultural review of estates services and continue to deliver the improvement actions identified in the facilities services cultural review	30 June 2025	Not yet started due to gaps & capacity issues in the team. Also linked to future EFM model	
• align and improve the processes for staff development, on boarding etc. across EFM	30 June 2025	Not yet started due to gaps & capacity issues in the team. Also linked to future EFM model	
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	
• align the process for the completion and submission of the annual Premises Assurance Model (PAM) assessment and for delivery of the agreed improvement actions	31 July 2025	Commenced – on track although latest NHSE guidance and assessment tool awaited	
• undertake a review of Approved Persons (APs) for the relevant HTMs and as a key element of the EFM governance & assurance processes	30 September 2025	Not yet due – deadline may be impacted if gaps & capacity issues in the team remain unresolved	
• review, update and align the EFM policies and procedures across the group	31 December 2025	Review of EFM policies & procedures is underway: Fire Policy & Health & Safety Policy currently going through ratification process	

Work Stream 9: Strategy & Planning

Key Tasks / Milestones	Timescales	Current Position including agree remedial actions where progress is 'off track'	RAG
Harmonise the strategy & planning process across the two trusts including the development of a single strategy management policy and strategy group	31 December 2024	**Complete**	
Develop a combined strategy and set of strategic aims & objectives for the group: to include the development of an integrated delivery plan* setting out the programmes and projects to be delivered in Year 1 of the Strategy against the strategic aims, and the associated measures and outcomes [**Note:** The joint Trust Board has agreed to move from 5 to 3 strategic aims – board workshop planed for early 2025 to agree the underpinning strategic aims and linked to the review and alignment of the BAF and agreement of the 'risk appetite' for the group]	31 March 2025	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 to be approved by the Group Board in May 2025 – slippage due to urgent planning work	
Harmonise the underpinning strategies e.g. clinical, quality, people, digital etc.	30 June 2025	Once the group strategy has been approved the underpinning enabling strategies and plans will be developed	
Develop a single operational & financial plan for the group including the responsibilities of divisions / directorates for the delivery of the strategic aims & objectives and priorities for the group (linked to the development of the Accountability & Performance Management Framework)	31 March 2025	**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	Underway although progress impacted by delayed planning guidance. New Productivity & Transformation Framework developed and approved by GLT on Friday, 4 April 2024. Productivity, Improvement & Transformation Group being set up 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 is underway 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	Underway although progress impacted by delayed planning guidance. The improvement and finance teams are working closely to develop a finance improvement tracker	

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 and plan developed and due for approval at GLT on 2 May 2025 (initially due for approval on 27 March 2025 but deferred to priority work on the operational & financial plan) QMS not yet started	
Develop a proposal for primary, community and acute care collaboration (Alliance Model) and a spectrum of integration	31 March 2025	Operating model socialised through the re-launched Group Leadership Team (GLT) and implementation plan developed Final operating model to be approved by the board in May 2025 – slippage due to urgent planning work	
Develop a Partnership Strategy for the group	30 May 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	
Support development of the Group Sustainability & Green Plan - Phase 1	31 March 2025 (Phase 1) 1 July 2025 (board approval)	Phase 1 - Existing ULTH and LCHS green plans reviewed. Improvement workshops completed and areas of opportunity and risk identified. A network of 'Green Champions' has been formed and initial LCHG Green Group meetings have been scheduled. Refreshed Green Plan being drafted using the national template and are scheduled for board approval on 1 July 2025. Work remains ongoing with the ICB to support the system sustainability agenda. The sustainability agenda is being embedded in the new LCHG strategy and the SRO for the programme is the Group Director of Estates & Facilities	
Develop a clinical services and practitioners strategy for the group	31 August 2025	Underway – on track	
Build and shape a new group strategy and planning team with OD support to fully align with required functions	31 August 2025	Underway – on track	

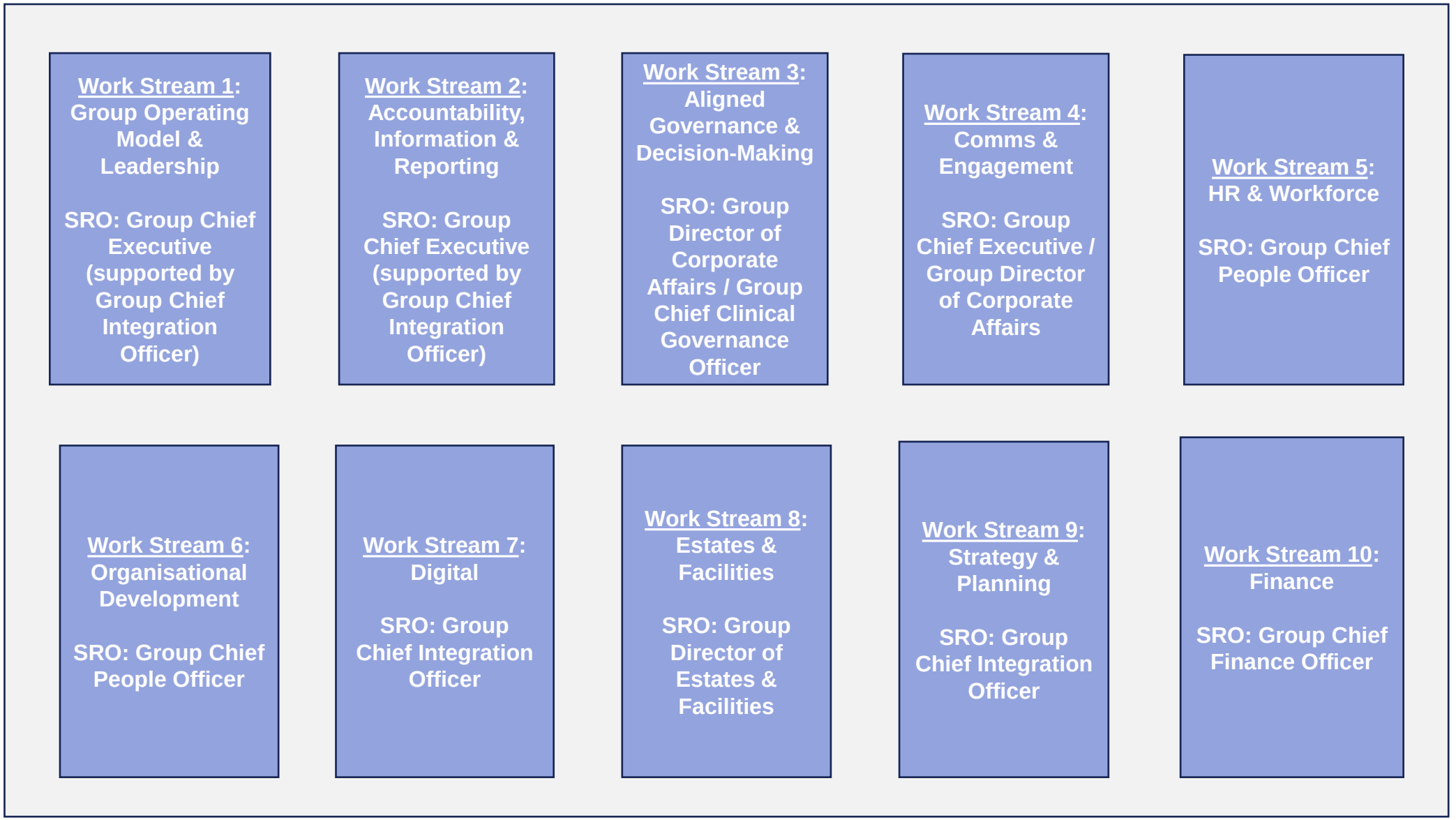
Work Stream 10: Finance

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Develop the Finance Strategy for the group in support of delivery of the agreed group strategic aims & objectives	30 June 2025 (strategy drafted) 1 July 2025 (board approval)	Currently on track	
Harmonise the financial planning & budget setting processes across the group	31 January 2025	Planning assumptions and budget setting processes aligned but need embedding. Budget setting complete for 2025/26	
• produce and roll-out a revised budget holder manual	28 February 2025	Single budget holder manual developed and published	
Develop a single operational & financial plan for the group including the responsibilities of divisions / directorates for the delivery of the strategic aims & objectives and priorities for the group (linked to the development of the Accountability Framework)	31 March 2025 **(see also work stream 9: strategy)**	Operational & financial plan developed, approved and submitted	
Align and strengthen financial reporting ensuring reporting from a group, individual trust and service level perspective and including the development of financial information dashboards reflecting user feedback	31 March 2025	Financial reporting is now consistent across the group. Work to further strengthen information dashboard is ongoing Bottom up review of budgets complete	
Harmonise the business case development, review and approval process ensuring a consistent approach and methodology	31 July 2025	Underway. Capital, Revenue & Investment Group (CRIG) being reviewed and strengthened	
As part of the development of the Accountability & Performance Management Framework for the group, align and strengthen the mechanisms for holding divisions / directorates to account for budgetary control, the delivery of financial plans and cost improvements	31 March 2025	Performance Management & Accountability Framework drafted (including a clear process and ratings for escalation / intervention) and approved by GLT on Friday, 4 April 2025 and is due to be approved by the board on Tuesday, 6 May 2025. Aligned IPR and final KPIs / metrics for 2025 / 26 currently being worked up Consistent approach adopted to PRMs from January 2025. Oversight of delivery of agreed financial priorities and improvements will be undertaken through the new Productivity, Improvement & Transformation Group	

Work Stream 10: Finance

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Complete the review, harmonisation and approval of key documents & governing instruments to reflect the move to group and changes to the operating model to include but not limited to: • Standing Financial Instructions • Scheme of Delegation & Powers Reserved for the Boards	31 March 2025	Underway with corporate governance team: this action cannot be completed until other work stream actions are complete – **suggested revised timescale for completion: 25 July 2025 (Audit Committee) and 2 September 2025 (Group Board approval)**	
Harmonise the financial policies and processes across the group	December 2025	Underway – on track. Current financial policies all up to date. Mapping exercise to be undertake to identify those still be aligned and to agree timescales. Oversees Visitors & Private Patients policy aligned and approved	
Align the Internal Audit arrangements	August 2025	Underway – on track. Internal audit arrangements have been aligned. A joint Audit Committee is in place with auditors working to develop a single report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability	
Review, harmonise and strengthen the financial training offer and culture	June 2025	Underway – on track. First finance roadshow training event held in February 2025. Budget holder refresher training held during February & March 2025	

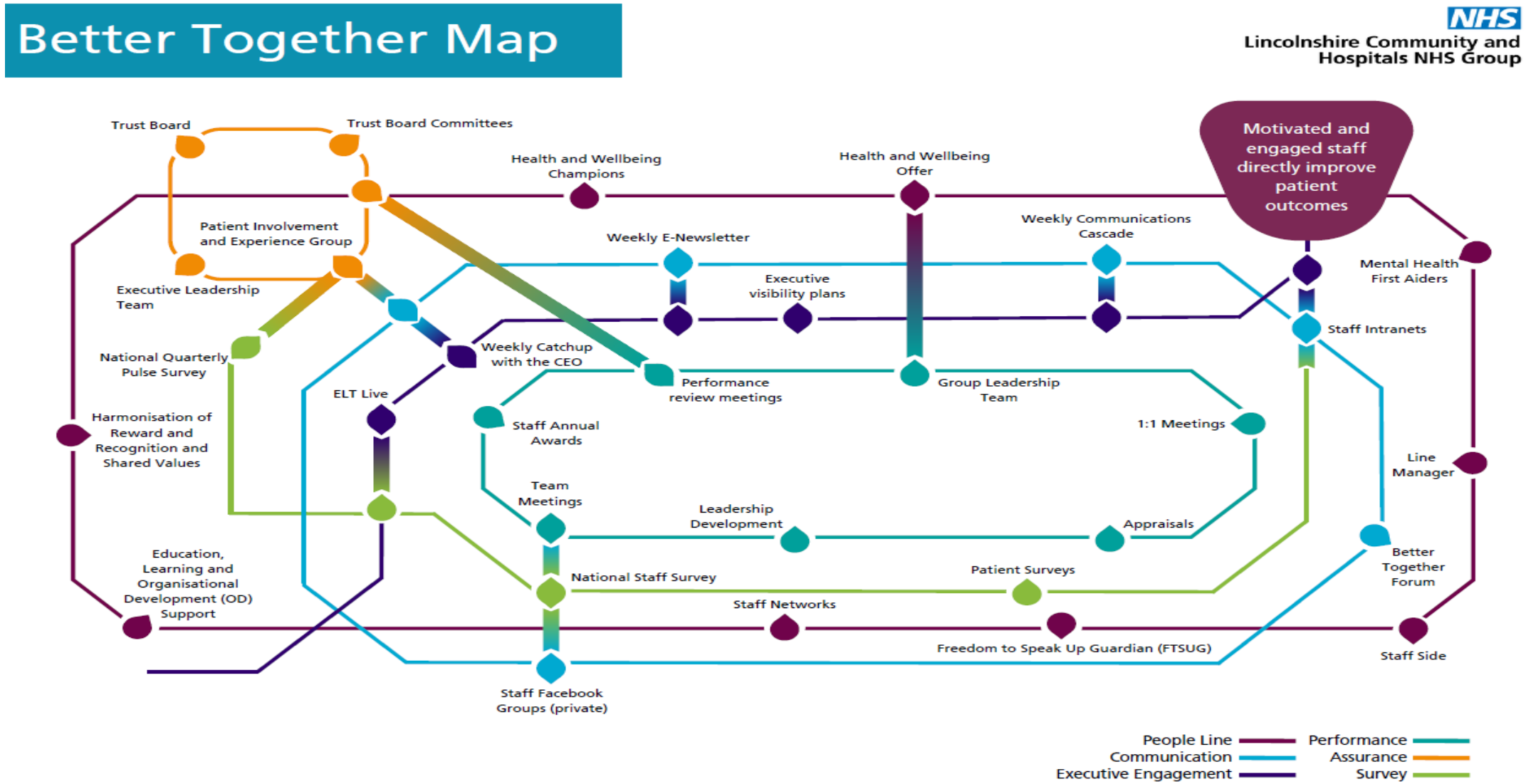
Appendix A: Group Development Programme: Work Streams & SROs



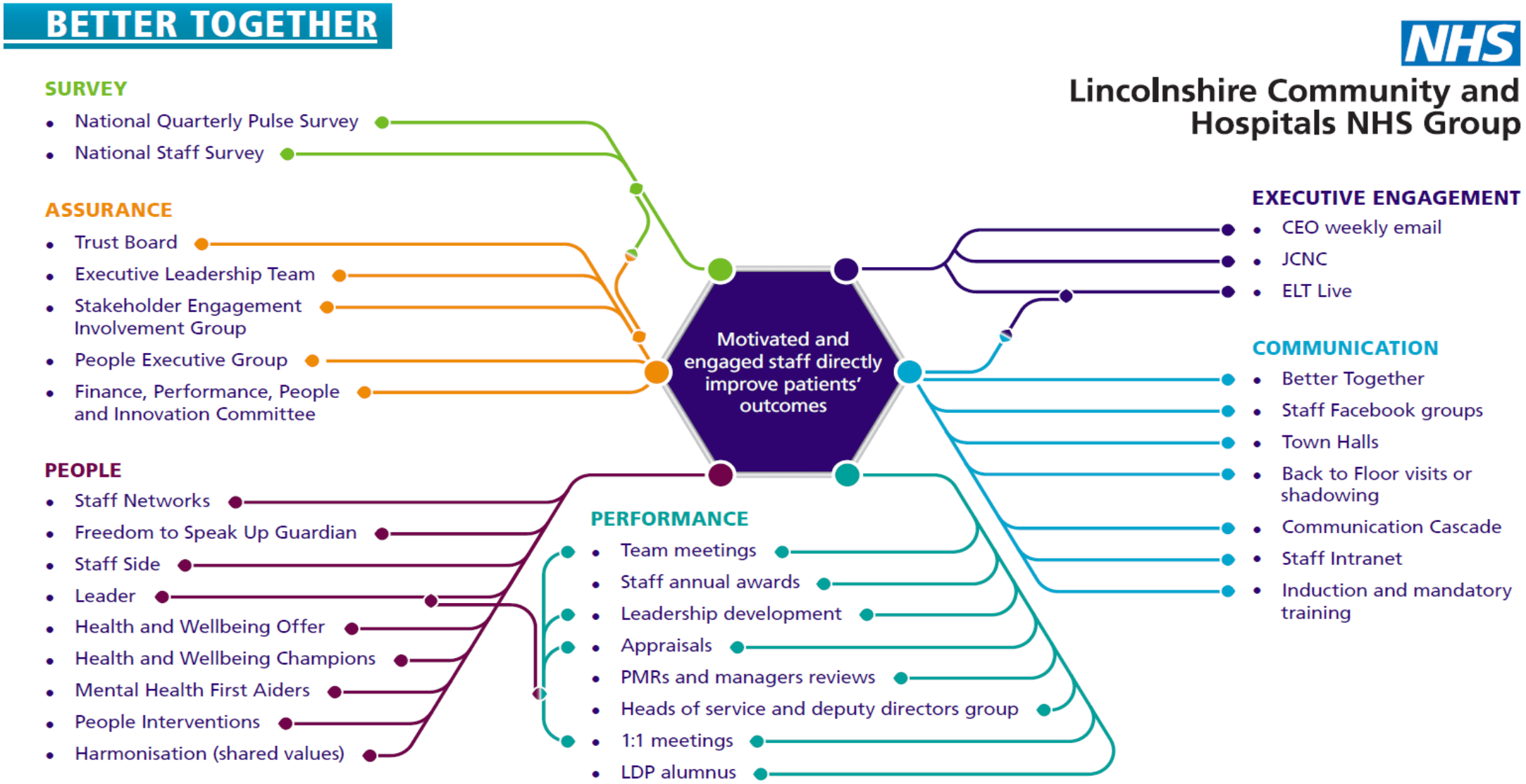
Appendix B: Group Development Programme Delivery RAG Rating

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

Appendix C: Staff Engagement 'Tube Map'



Appendix C: Staff Engagement 'Tube Map'



NHS
Lincolnshire Community and Hospitals NHS Group

Board & Board Committee Governance:

- ‘Board & Board Committee Joint Working Principles Framework’
- ‘Board Committee Oversight & Assurance Map’
- Board Committee Terms of Reference and Work Plans (Updated)

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6 May 2025*
Item Number	*6.3*

Board & Board Committee Governance

Accountable Director	*Jayne Warner, Group Director of Corporate Affairs*
Presented by	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Jayne Warner, Group Director of Corporate Affairs* *Wendy Booth, Interim Governance Advisor*
Recommendations/ Decision Required	*The Group Board is asked to:* • *review and approve or agree any required changes to the board committee Terms of Reference & Work Plans to reflect the new group strategic aims & objectives;* • *review and approve or agree any required changes to the 'Board Committee Oversight & Assurance Map';* • *review and approve or agree any required changes to the 'Board & Board Committees Joint Working Principles Framework';* • *agree the need for any additional action or assurance at this stage*

How the report supports the delivery of the LCHG strategic aims & objectives	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings	*X*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	*X*
2b: Empower our people to continuously improve and innovate	*X*
2c: Nurture compassionate and diverse leadership	*X*
2d: Recognising our people through thanks and celebration	*X*
Population: Better Health – Improve population health:	

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

Executive Summary

Background & Introduction

As part of the formation of the Lincolnshire Community & Hospitals NHS Group (LCHG), a joint Group Board and joint board committees were established. Initial Terms of Reference and Work Plans for the first board committees to work jointly – specifically the Quality, People, Finance & Performance and Integration Committees were approved by the Group Board. However, it was agreed that Terms of Reference & Work Plans would be updated once the group strategic aims & objectives had been agreed.

In respect of the Integration Committee, it was also anticipated that the work plan would require some refinement to reflect both changes within the LCHG and as this new committee became fully operational.

Since the introduction of the first board committees to work jointly, the Remuneration Committees and Audit & Risk Committees within each trust have also now moved to working jointly.

Summary of the Report

This report provides the updated Terms of Reference and Work Plans for the Quality, People, Finance & Performance and Integration Committees. It should be noted, however, that whilst work plans have been updated to ensure alignment with the new group strategic aims & objectives, some further refinement is required to the detailed content of some work plans. This is particularly the case in relation to the Integration Committee.

The report also provides:

- a draft 'Board Committees Oversight & Assurance Map', which is intended to provide a simple, visual overview of the oversight & assurance role of each of the board committees. Detailed reporting requirements and frequencies will be captured within individual committee work plans and will continue to be refined as outlined above;

- a draft 'Board & Board Committees Joint Working Principles Framework'. This document outlines the joint working principles for the board and board committees, as referred to in the Group Partnership Agreement, to ensure:

    - there is collective understanding of joint working principles in this context;

    - that both trusts can continue to make decisions and operate in accordance with the statutory & regulatory requirements that apply to them through the group board and joint board committees;

    - there is continued robust corporate reporting.

Revised committee reporting templates have also been drafted (including a new board committee upward report template and a board & board committee report template). However, it has been suggested that these are finalised and approved by the Group Board

after the next board development session, to be facilitated by NHS Providers, on the topic of 'board and committee reporting' and 'reporting for assurance'.

The report also provides the draft Terms of Reference and Work Plan for the joint Audit & Risk Committee. (Updated Terms of Reference for the joint Remuneration Committee will be provided for Group Board approval at a later date.)

Group Board Action Required

The Group Board is asked to:

- review and approve or agree any required changes to the board committee Terms of Reference & Work Plans for the Quality, People, Finance & Performance and Integration Committees which have been updated to reflect the new group strategic aims & objectives – whilst recognising the ongoing work to refine some work plans;

- review and approve or agree any required changes to the *'Board Committee Oversight & Assurance Map';*

- review and approve or agree any required changes to the *'Board & Board Committees Joint Working Principles Framework';*

- approve the Terms of Reference and Work Plan for the joint Audit & Risk Committee;

- agree the need for any additional action or assurance at this stage

BOARD & COMMITTEE JOINT WORKING PRINCIPLES FRAMEWORK

1.0 Purpose

1.1 As part of the formation of the Lincolnshire Community & Hospitals NHS Group (LCHG), a Group Chair, Group (as well as trust-specific) NEDs, Group Chief Executive and Group Executive Leadership Team have been appointed. A joint group board and joint board committees have also been established.

1.2 Under the group model arrangement, individual boards will be retained in statute, however decision making will take place via this joint working approach.

1.3 This framework document outlines the joint working principles which have been agreed for the board and board committees, as referred to in the Group Partnership Agreement, to ensure:

- there is collective understanding of joint working principles in this context;
- 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.

1.4 In support of the move to aligned governance and decision-making and the adoption of joint working principles, the format and structure of board and committee document templates have also be harmonised across the two trusts and common guidance developed.

2 Area

2.1 This document applies to the LCHG group board and board committees.

3 Duties

3.1 The **Group Chair** will be responsible for ensuring the development of the board and board committees joint working principles framework.

3.2 The **Group Chair** and **Group Chief Executive** will be responsible for ensuring the implementation of and adherence to the board and board committees joint working principles framework.

3.3 The **Group Director of Corporate Affairs** will be responsible for the development, regular review and updating of the board and board committees joint working principles framework on behalf of the **Group Chair** and **Group Chief Executive** and for providing advice and support, as required, on its application. The **Group Director of Corporate Affairs** will also be responsible for ensuring the development, regular review and updating of board and board committee document templates which reflect the joint working principles and for the development of supporting common guidance ***(see also 1.5)***.

3.4 The **Group Executive Leads and Non-Executive Chairs** of the board committees will be responsible for ensuring the agendas, minutes and upward

reports etc. are developed in accordance with the board and board committees joint working principles framework using the approved group templates.

3.5 **Group Executive Directors / Chief Officers** (and others producing board and board committee reports on their behalf) will be responsible for ensuring adherence to the board and board committees joint working principles framework and the common guidance for producing board and board committee reports.

4 Key Principles

4.1 The following key principles will apply:

Boards

4.1.1 Boards will remain separately constituted in accordance with the respective trust's Standing Orders but will exercise their functions jointly (but see also 4.1.7 & 4.1.8)

4.1.2 Joint board meetings will be referred to as Group Board meetings.

4.1.3 Group Board meetings will continue to be required to be quorate in accordance with Standing Orders.

4.1.4 Board members will be required to declare any new and / or relevant conflicts of interest at the beginning of each meeting.

4.1.5 A single group board reporting framework (forward work plan) will be developed to reflect joint agenda items but to also reflect those which are trust specific; the latter recognising the different risks and challenges within each trust. A single group Board Assurance Framework (BAF) will also be developed adhering to the same principles.

4.1.6 The Group Board will have a new common format for agendas, minutes, action logs, reports / report cover sheets, upward reports and annual review of effectiveness self-assessment pro-formas ***(see also 1.4 above)***.

4.1.7 The Group Board will have a single agenda but, where required to meet statutory requirements, will also clearly indicate any items which are trust specific.

4.1.8 A single set of minutes of the Group Board will be produced but will be tailored to clearly reflect the discussions, conclusions and decisions reached on both joint and trust specific agenda items.

Committees

4.1.9 A single set of Terms of Reference will be produced for each of the LCHG joint board committees (Quality, Finance & Performance, People, Integration, Audit & Risk and Remuneration).

4.1.10 Committees of the board meeting jointly will be referred to as joint board committees reflecting the joint exercise of delegated functions.

4.1.11 Joint board committees will have a single non-executive director chair.

4.1.12 Joint board committees will continue to be required to be quorate in accordance with the agreed joint Terms of Reference.

4.1.13 The matters delegated to each of the joint board committees – and those matters reserved to the Group Board – will be set out in the respective trust's Standing Orders & Scheme of Delegation.

4.1.14 Joint board committee work plans will be developed for each joint committee reflecting both joint agenda items and those which are trust specific; the latter recognising the different risks and challenges within each trust.

4.1.15 Joint board committees will have common formats for agendas, minutes, actions logs, reports / report cover sheets, upward reports and annual review of effectiveness self-assessment pro-formas ***(see also 1.4 above)***.

4.1.16 Joint board committees will have a single agenda but, where required to meet statutory requirements, will also clearly indicate any items which are trust specific.

4.1.17 A single set of minutes of the joint board committees will be produced but will be tailored to clearly reflect the discussions, conclusions and decisions reached on both joint and trust specific agenda items.

5 Monitoring Compliance and Effectiveness

5.1 Monitoring compliance with and effectiveness of the board and board committee joint working principles framework will be undertaken as part of the annual review of effectiveness of the board and board committees. Monitoring of effectiveness of the aligned governance and decision-making arrangements for the group will also be tested as part of a range of internal and external assurances e.g. internal audit, external governance / well-led reviews, CQC inspections.

6 Associated Documents

6.1 Common guidance and templates for the production of board and board committee reports

7 Definitions

7.1 Joint committees: a committee or committees of the board exercising its delegated functions jointly.

8 Consultation

8.1 The board and board committees joint working principles framework has been shared with and developed in conjunction with the Group Board.

9 Dissemination

9.1 The board and board committees joint working principles framework will be shared with the Group Board and with senior managers and others responsible for producing board and committee reports.

10 Implementation

10.1 The implementation of the board and board committees joint working principles framework will be supported be advice and guidance on the production of board and committee papers.

11 Reference Documents

11.1 LCHG Group Partnership Agreement

April 2025

Lincolnshire Community & Hospitals NHS Group:

United Lincolnshire Teaching Hospitals NHS Trust (ULTH)
Lincolnshire Community Health Services NHS Trust (LCHS)

Joint Committees: Oversight & Assurance 'Map'

Integration	Audit	Finance & Performance	Quality	People	Remuneration
Integration: LCHS Strategy	Internal & External Audit	Financial Strategy	Quality Strategy, Quality Account & Quality Priorities	People Strategy & Delivery Plans	Leadership Structure & Succession Planning
Productivity, Transformation & Improvement	Counter Fraud	Financial Planning	**Patient Safety** including:	Education, Training & Development	Nominations
Alliance Model	Governance, Risk	Operational Planning	Infection Prevention & Control	Equality, Diversity & Inclusion	Pay Framework
Left Shift (Acute to OOH transformation)	Management & Internal Control Systems	Winter Planning	Maternity & Neonatal Safety (including CNST & Ockenden)	Guardian of Safe Working	CEO & Executive Appraisal
Estates Strategy	Financial Reporting & Control	EPRR / Business Continuity	Medicines Management & Pharmacy	Freedom to Speak Up	Remuneration (including benchmarking)
Estates Rationalisation & Space Management	Standing Orders, Standing Financial Instructions & Scheme of Delegation	Financial & Operational Performance	Pressure Ulcers	Occupational Health / Health & Wellbeing	Cost of Living
Sustainability & the Green Plan (including Net Zero)	Waiving of Standing Orders	Cost Efficiency, Improvement & Productivity (Cost Outputs)	Deteriorating Patients	Recruitment & Retention	Terms & Conditions
Digital Planning & Delivery	Losses & Compensation	Estates & Facilities Compliance (including the Premises Assurance Model)	Falls	Workforce Planning	Severance Agreements & Payments
EPR Assurance	Salary Over / Under Payments	Procurement (Strategy & Improvement Plan / KPIs)	Diabetes / DKA	Workforce Metrics	Pension Payments
EDMD Assurance	Standards of Business Conduct	Capital Planning & Delivery	Clinical Harm	Employee Relations (including MHPS / other capability & conduct issues and exclusions)	Redundancy
'Vision for Information'	Debt Management	Capital Investment & Business Cases / Revenue Business Cases / Post Investment Evaluations	PSIRF including learning from incidents / DoC	Staff Engagement, Communication & Recognition	Top Earners
Research & Innovation	Going Concern Reviews	Budgetary Management	Human Factors	Staff Survey	Executive & VSM Temporary & Interim Appointments (including IR35 / Off Payroll Arrangements)
ICB Target Operating Model	Information Governance / Data Security & Protection Toolkit (DSPT Compliance) / Cyber Security	Contract Management	Claims	Culture, Vision & Values	Fit & Proper Persons Test (FPPT) – Policy & Compliance with the FPPT Framework
Partnership Operating Model	Document Control	Security Management	High Profile Cases	Organisational Development	
Collaborative Models of Care	Data Quality	Health & Safety	Ward Accreditation	Leadership, Talent Management & Succession Planning	
Integrated Neighbourhood Team	FTSU (Annual Review of Arrangements)	Fire Safety	**Clinical Effectiveness** including:	Gender Pay Gap	
Community Primary Partnerships	Annual Report and Accounts & Annual Governance Statement	**Risks to financial delivery**	Clinical Audit	Sexual Safety Charter	
Regeneration Plans with Partners	Engagement of External Audit for Non-Audit Work	**Risks to capital and major projects delivery**	NICE	Nursing & Midwifery Staffing Report	
Health Inequalities	Oversight of Work of Other Board Committees	**Risks to operational performance**	GIRFT	Apprenticeships	
Risks to delivery of the integration & transformation agendas		**Risks arising from the ageing estates**	Mortality & Learning from Deaths	WRES / WDES	
Risks to delivery of the digital agenda			**Patient Experience & Involvement** including:	Modern Slavery	
			Palliative Care / End of Life	Staff Vaccination	
			Complaints	Occupational Health	
			Safeguarding & Vulnerabilities / Children in Care	Job Planning	
			PLACE	Medical Revalidation	
			CQC / Regulatory Compliance	Clinical Education	
			Quality Impact Assessment (QIA)	Workforce Finance (including temporary staffing / agency spend)	
			External Visits	**Risks to / impact on workforce**	
			Deep Dives (Various Topics)		
			Risks to / impact on Quality & Safety		

Audit and Risk Committee
Terms of Reference

1. Authority

The Audit and Risk Committee is established as a joint committee by the Trust Boards of both Lincolnshire Community Health Services NHS Trust and United Lincolnshire Teaching Hospitals NHS Trust in line with the Group Partnership Working Agreement and the powers set out in both trusts' Standing Orders and Standing Financial Instructions.

The Standing Orders and Standing Financial Instructions of both trusts, as far as they are applicable, shall apply to the committee and any of its established groups.

The Audit and Risk Committee holds only those powers as delegated in these terms of reference and, in accordance with the Group Partnership Working Agreement, will report to the Group Board.

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by both governing bodies to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose of the Committee

The Audit and Risk Committee exists to scrutinise the robustness of and provide assurance to the Group Board that there is an effective system of governance and control for risk, the accounting policies and the accounts of each organisation, the planned activity and results of both internal and external audit and assurances relating to the corporate governance requirements for each organisation.

3. Membership

The members of the Committee are:

- Non-Executive Director (Chair)
- Non-Executive Director (Quality Committee Chair)
- Non-Executive Director (Finance and Performance Committee Chair)
- Non-Executive Director (People Committee Chair)
- Non-Executive Director (Integration Committee Chair)

The following roles will be routine attendees at the Committee:

- Group Chief Finance Officer
- Group Director of Corporate Affairs (Company Secretary)
- Representative from Internal Audit
- Representative from External Audit
- Counter Fraud Representative (at least twice annually)

- Group Deputy Chief Finance Officer
- Chief Clinical Governance Officer
- Associate Non-Executive Director

The Accountable Officer should discuss at least annually with the committee the process for assurance that supports the Annual Governance Statements and should attend the committee when it considers the draft Annual Governance Statements and the Annual Reports and Accounts.

Executive Directors / Senior Managers may be invited to attend when the committee is discussing areas of risk or operation that are the responsibility of that director / manager.

Members will be expected to conduct business in line with the Trust values and objectives. Members of, and those attending, the committee shall behave in accordance with the Trust Standing Orders and Standards of Business Conduct Policy.

Members must demonstrate the equality and diversity implications of decisions they make.

4. Attendance and Quorum

The committee will be quorate when three of the five Non-Executive Director members are present.

5. Frequency

The committee will not meet less than five times per year. At least once a year the committee will meet privately with the internal and external auditors.

6. Specific Duties

The Audit and Risk Committee will:

Integrated governance, risk management and internal control:

- Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisations activities (clinical and non-clinical), that supports the achievement of the organisations objectives
- Review the adequacy and effectiveness of all risk related disclosure statements (in particular the annual governance statements) together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Group Board.
- Review the adequacy and effectiveness of the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- Review the adequacy and effectiveness of the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting

and self-certifications including the NHS Code of Governance and NHS Provider Licence
- Review the adequacy and effectiveness of the policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA

Internal Audit:

- Consider the provision of the internal audit service and the costs involved.
- Review and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Consider the major findings of internal audit work (and management response) and ensuring coordination between the internal and external auditors to optimise the use of audit resources.
- Ensure that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitor the effectiveness of internal audit and carry out an annual review.

External Audit:

- The committee shall review and monitor the external auditors independence and objectivity and the effectiveness of the audit process. In particular the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work
- Consider the appointment and performance of external auditors, as far as the rules governing the appointment permit (and make recommendations to the Group Board when appropriate).
- Discuss and agree with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discuss with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Review all external audit reports, including the report to those charged with governance (before its submission to the Group Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions:

- The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. Including but not limited to any reviews by DHSC arm's length bodies or regulators/inspectors for example, the CQC, NHS Resolution, Royal Colleges, accreditation bodies etc.
- The committee will review the work of other committees within the organisation whose work can provide relevant assurance to the audit committee's own areas of responsibility.
- The committee will satisfy itself on the assurance that can be gained from the clinical audit function through its review of the work of the Quality Committee.

Counter Fraud:

- The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

- The committee will refer any suspicions of fraud, bribery and corruption to the NHSCFA.

Management:

- The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- The committee may request specific reports from individual functions within the organisation

Financial Reporting:

- The committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.
- The committee will ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.
- The committee shall review the annual report and financial statements before submission to the Group Board focussing particularly on:
    - The wording in the Annual Governance Statements and other disclosures relevant to the terms of reference of the committee and to each trust.
    - Changes in and compliance with, accounting policies, practices and estimation techniques
    - Unadjusted misstatements in the financial statements
    - Significant judgements in preparation of the financial statements
    - Significant adjustments resulting from the audit
    - Letters of representation
    - Explanations for significant variances

Raising Concerns:

- The committee shall review the effectiveness of the arrangements in place for allowing staff and contractors to raise (in confidence) concerns about possible improprieties in financial, clinical safety or workforce matters and ensure that any concerns are investigated proportionately and independently and in line with relevant policies.

Governance Regulatory Compliance

- The committee shall review the organisation's reporting on compliance with the NHS provider licence, NHS Code of Governance and the Fit and Proper Persons Test Framework.
- The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

7. Administrative support

The committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the chair prior to the meeting.

Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working

days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The chair of the committee shall report to the Group Board after each meeting and provide a report on how it has discharged its responsibilities, escalating any concerns where necessary.

The committee shall report at least annually to the Group Board on its work in support of the Annual Governance Statements, specifically commenting on:

- The fitness for purpose of the Group Board Assurance Framework
- The completeness and embeddedness of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts

The annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee has considered in relation to the financial statements and how they were addressed.

9. Monitoring effectiveness and Compliance with Terms of Reference

The committee will complete an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Group Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The terms of reference for the committee will be reviewed annually by the committee and submitted to the Group Board for approval.

The committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:
Approved by:
Next Review Date:

United Lincolnshire Teaching Hospitals NHS Trust/ Lincolnshire Community Healthcare Services NHS Group Audit Committee Forward Reporting Schedule 2025/2026

Agenda Item	Lead	Apr	May	July	Oct	Jan
Governance						
Review the board assurance framework	Dir of CA	x		x	x	x
Review the risk management system	CCGO	x		x	x	x
Note business of other committees and review inter-relationships	Non Exec Chairs	x		x	x	x
Review draft Annual Governance Statement	Dir of CA	x	x			
Receive other sources of assurance	Dir of CA	x		x	x	x
Review Fit and Proper Person Test	Dir of CA	x				
Review Draft Provider Licence Self Certification	Dir of CA	x				
Review the draft Annual Report	Dir of CA	x	x			
Review the Quality Account	CCGO	Delegated to Quality Committee for assurance				
Review whistle blowing arrangements	Dir of CA	Delegated to People Committee and Board for assurance				
Review arrangements for cyber security	CIO	Delegated to Finance and Performance Committee				
Review other reports and policies as appropriate	Dir of CA	x		x	x	x
Review clinical audit	CCGO	Delegated to Quality Governance Committee for assurance				
Financial Focus						
Agree annual accounts and annual report timetable and plans	CFO/ Dir of CA					x
Review of annual report and accounts progress	CFO/ Dir of CA	x				
Review of Audited Annual Accounts and Financial Statements (including external audit opinion)	CFO		x			
Review risks and controls around financial management	CFO			x		x
Review changes to standing orders, standing financial instructions/ prime financial policies and changes to accounting policies	CFO/ Dir of CA	x		x		x
Review losses and special payments	CFO	x		x	x	x
Review waiving of standing orders	CFO	x		x	x	x
Internal/ Exernal Audit						
Review and approve the annual internal audit plan	CFO	x				
Review and approve internal audit terms of reference	CFO	x				
Review the effectiveness of internal audit	CFO				x	
Receive internal audit progress reports	Internal Audit	x		x	x	x
Receive Head of Internal Audit Opinion	Internal Audit		x			
Agreement of external audit plans and fee	CFO	x				
Review the effectiveness of external audit	CFO				x	
Review external audit progress reports	External Audit	x		x	x	x
Receive External Audit annual governance report	External Audit			x		
Receive external auditors Annual Audit letter	External Audit			x		
Counter Fraud and Security						
Review annual reports on counter fraud activity	LCFS			x		

Review Annual Counter fraud work programmes	LCFS	x				
Receive Counter fraud progress reports	LCFS	X		X	X	x
Review organisations self review against NHSCFA standards	LCFS			x		
Review effectiveness of those carrying out Counter fraud activity	CFO				x	
General						
Review the terms of reference	Dir of CA	X		X	X	x
Review the Committee effectiveness	Dir of CA					x
Develop improvement plan based on review of effectiveness	Dir of CA	x				
Produce Annual Report for Trust Board	Dir of CA			x		
Private meeting with Internal /External Auditors	Chair	x				
Other activites						
Policies	Dir of CA					

Finance and Performance Committee
Terms of Reference

1. Authority

The Finance and Performance Committee is established as a joint committee by the Trust Boards of both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) in line with the Group Partnership Working Agreement and the powers set out in both trusts' Standing Orders and Standing Financial Instructions.

The Standing Orders and Standing Financial Instructions of the Trust Boards and the Group Partnership Working Agreement, as far as they are applicable, shall apply to the committee and any of its established groups, either jointly or individually.

The Finance and Performance Committee holds only those powers as delegated in these terms of reference and, in accordance with the Group Partnership Working Agreement, will report to the Group Board.

The Finance and Performance Committee is authorised to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within its terms of reference. This includes referral of matters for consideration to another board committee or other relevant group.

2. Purpose of the Committee

The Finance and Performance Committee exists to scrutinise the robustness of and provide assurance to the Group Board that there is an effective system of governance and internal control across the across the areas of finance, operational performance, estates compliance and information governance / data security compliance within the two trusts and wider group to deliver the agreed group strategic aims & objectives and provide high quality care.

The relevant group strategic aim & objectives aligned to the Finance and Performance Committee for 2025 / 26 are:

Patients: Better Care – Timely, affordable, high quality care in the right place:

- Objective 1b: Reduce waiting times for our patients
- Objective 1c: Improve productivity and deliver financial sustainability
- Objective 1d: Provide modern, clean and fit for purpose care settings

3. Membership

The members of the committee are:

- Non-Executive Director (Chair)
- Associate Non-Executive Director
- Associate Non-Executive Director
- Group Chief Finance Officer
- Group Chief Operating Officer
- Group Chief Integration Officer
- Group Chief Estates & Facilities Officer

The following roles will be routine attendees at the committee:

- Deputy Trust Secretary
- Group Director of Corporate Affairs
- Deputy Director of Finance

4. Attendance and Quorum

The committee will be quorate when four of the membership are present. This must include two Non-Executive / Associate Non-Executive Directors and one Executive Director.

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf. A deputy in attendance for a committee member will contribute to the quoracy but does not negate the need for the attendance of the Non-Executive Directors and Executive Directors referred to above.

Members should attend at least 75% of meetings each financial year but should aim to attend all.

The Group Chief Finance Officer is the Executive Lead for the committee.

Other attendees may be invited to attend the meetings as appropriate.

Observers will be permitted as agreed by the chair.

5. Frequency

The committee will meet monthly.

6. Specific Duties

The Finance Committee will:

- Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly
- Approve the business planning timetable
- Seek assurance that the trusts and wider group have in place robust and effective operational and financial planning arrangements and delivery plans

- Review, challenge and monitor in-year financial and operational performance
- Consider the control and mitigation of finance & operational performance and related risks and provide assurance to the Group Board that such risks are being effectively controlled and managed
- Provide oversight of and receive assurance on delivery of agreed Cost Improvement Plans and associated efficiency and productivity programmes
- Provide oversight of and receive assurance on procurement processes and performance
- Review estates & facilities compliance including health & safety requirements and compliance with the Premises Assurance Model (PAM)
- Provide oversight of and receive assurance in respect of compliance with the Data Security Protection Toolkit
- Provide assurance to the Board that all legal and regulatory requirements relating to finance, operational, estates compliance and data security are met, including directives, regulations, national standards (including constitutional standards), policies, reports, reviews and best practice
- Review and provide assurance to the Group Board on those strategic objectives within the Group Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance and actions where necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions

7. Administrative support

The committee will be supported administratively by the corporate administrative team.

The committee will operate using a work plan to inform its core agenda. Topical / emerging issues will be added to the agenda as required. The agenda will be agreed with the chair and the Group Chief Financial Officer prior to the meeting.

Agendas and supporting papers will be circulated no later than 5 working days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 working days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The chair of the committee shall report to the Group Board after each meeting and provide an upward report on assurances received, escalating any concerns where necessary.

The committee will advise the Audit & Risk Committee on the adequacy of assurances available and contribute to the Annual Governance Statements.

The committee will refer any necessary issues outside its terms of reference, as appropriate, to the relevant board committee or other relevant group.

9. Monitoring effectiveness and Compliance with Terms of Reference

The committee will complete an annual review of its effectiveness and provide an annual report to the Group Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Group Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The terms of reference for the committee will be reviewed annually by the committee and submitted to the Group Board for approval and, together with the work plan, will be reviewed at each meeting of the committee to ensure they remain fit for purpose.

The committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:

Approved by:

Next Review Date:

Lincolnshire Community & Hospitals NHS Group:
Finance & Performance Committee Work Plan 2025/26 (DRAFT)

Agenda Item	Oversight Group*	Method of Reporting	Executive / Non-Executive Lead	Report Lead	Frequency	Quarter 1 Apr	Quarter 1 May	Quarter 1 Jun	Quarter 2 Jul	Quarter 2 Aug	Quarter 2 Sep	Quarter 3 Oct	Quarter 3 Nov	Quarter 3 Dec	Quarter 4 Jan	Quarter 4 Feb	Quarter 4 Mar	Action
Business Items (all committees)**																		
Minutes of the Previous Meetings		Written	Committee Chair	Deputy Trust Secretary	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Approval
Matters Arising & Action Log (management & monitoring of committee actions)		Written	Committee Chair	Deputy Trust Secretary	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Noting
Topical, Legal & Regulatory Update		Verbal / Written, as required	Group Director of Corporate Affairs	Deputy Trust Secretary	Quarterly			X			X			X			X	Discussion & Assurance
Review of Committee Effectiveness - Self Assessment		Written	Committee Chair	Group Director of Corporate Affairs	Annually										X			Discussion
Annual Report - Review of Committee Effectiveness		Written	Committee Chair	Group Director of Corporate Affairs	Annually											X (Draft)	X (Final)	Discussion & Assurance
Review of Committee Terms of Reference & Work Plans		Written	Committee Chair	Group Director of Corporate Affairs	Annually	X (Final)											X (Annual Review)	Approval
Review of Reporting Group Terms of Reference & Work Plans		Written	Committee Chair	Group Director of Corporate Affairs	Annually	X (Final)											X (Annual Review)	Approval
Matters Referred (all committees)**																		
Matters referred by the Trust Boards or other Board Committees		Written	Committee Chair	Group Director of Corporate Affairs	As required	**To be added to the agenda as required**												Discussion
Matters to be referred to other Board Committees		Written	Committee Chair	Group Director of Corporate Affairs	As required	**To be added to the agenda / agreed at the relevant meeting as required (and recorded in the minutes & action log)**												Discussion
Risk and Assurance (all committees)**																		
Board Assurance Framework		Written	Group Director of Corporate Affairs	Deputy Trust Secretary	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Risk Register Report		Written	Group Executive Lead(s)	Group Chief Clinical Governance Officer	Quarterly		X (Q4)			X (Q1)			X (Q2)			X (Q3)		Discussion & Assurance
Review of relevant internal & external audit reports & recommendations (as required)		Written	Group Director of Corporate Affairs	Deputy Trust Secretary	As required	**To be added to the agenda as required**												Discussion
Review of relevant external reports, recommendations & assurances including CQC, as appropriate		Written	Group Executive Lead(s)	Group Director of Corporate Affairs / Group Chief Clinical Governance Officer	As required	**To be added to the agenda as required**												Discussion & Assurance
CQC Action Plan		Written	Group Executive Lead(s)	Head of Compliance	As required	X			X			X			X			Discussion & Assurance
Committee Specific Business Items**																		
Objective 1b: Reduce waiting times for our patients																		
ULHT:																		
Finance & Performance Committee Performance / KPI Dashboard / Scorecard (including operational performance / access targets)		Written	Group Executive Lead(s)	Associate Director of Performance & Information	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Deep Dives & Improvement Plans		Written	Group Executive Lead(s)	Group Executive Lead(s)	As required	**To be added to the agenda as required**												Discussion & Assurance
LCHS:																		
Finance & Performance Committee Performance / KPI Dashboard / Scorecard (including operational performance / access targets)		Written	Group Executive Lead(s)	Associate Director of Performance & Information	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Deep Dives & Improvement Plans		Written	Group Executive Lead(s)	Group Executive Lead(s)	As required	**To be added to the agenda as required**												Discussion & Assurance
Objective 1c: Improve productivity and deliver financial sustainability																		
Financial Strategy		Written	Group Chief Finance Officer	TBC	Three Yearly			X										Review & Endorse for Group Board Approval
Procurement Strategy		Written	Group Chief Finance Officer	TBC	Three Yearly													Review & Endorse for Group Board Approval
Business Planning Timetable		Written	Group Chief Finance Officer	TBC	Annually							X						Approval
Annual Plan (Operational & Financial) including Cost Improvement Programme (CIP)		Written	Group Chief Finance Officer / Group Chief Operating Officer	TBC	Annually										X	X	X	Review & Endorse for Trust Board Approval
Winter Plan		Written	Group Chief Operating Officer	TBC	Annually				X									Approval
Finance Report		Written	Group Chief Finance Officer	TBC	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
CIP Report		Written	Group Chief Finance Officer	TBC	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Productivity Plans		Written	Group Chief Finance Officer / Group Chief Operating Officer	TBC	Quarterly	X			X			X			X			Discussion & Assurance
Capital Plan		Written	Group Chief Financial Officer	TBC	Annually											X		Endorse for Group Board Approval
Capital Finance Report: Plan Delivery & Expenditure Against Plan		Written	Group Chief Finance Officer	TBC	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Review & Evaluation of Business Cases / Approval of Investment & Disinvestment Decisions & Business Cases within Delegated Limits and / or Endorsement for Group Board Approval		Written	Group Chief Financial Officer	TBC	As required	**To be added to the agenda as required**												Approval & Assurance
Costing & Benchmarking Report		Written	Group Chief Finance Officer	TBC	Quarterly				X (Annual submission)		X (Q1)			X (Q2)			X (Q3)	Discussion & Assurance
Procurement Report		Written	Group Chief Finance Officer	Deputy Director of Procurement	Quarterly			X			X			X			X	Discussion & Assurance
Contract Awards within Delegated Limits and / or Endorsement for Group Board Approval		Written	Group Chief Finance Officer	Deputy Director of Procurement	As required	**To be added to the agenda as required**												Approval & / or Escalation
Deep Dives & Improvement Plans		Written	Group Chief Finance Officer	TBC	As required	**To be added to the agenda as required**												Assurance
Objective 1d: Provide modern, clear and fit for purpose care settings																		
Estates & Facilities Update including EFM compliance & key risks, health & safety, fire safety, & security management		Written	Group Director of Estates & Facilities	TBC	Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Assurance
Premises Assurance Model (PAM) Annual Self Assessment		Written	Group Director of Estates & Facilities	TBC	Annually				X									Assurance
Upward Highlight / Exception Reports from Groups reporting to the Committee																		
Emergency Planning Group including EPRR core standards submission and assurance and business continuity assurance	EPRR Group	Written	Group Chief Estates and Facilities Officer	Group Director of Estates & Facilities	Annually (EPRR core standards) / Monthly (assurance)	X	X (EPRR core standards)	X	X	X	X	X	X	X	X	X	X	Endorse for Group Board Approval (EPRR core standards) &
Information Governance Group including DPST compliance submission	Information Governance Group	Written	Group Director of Corporate Affairs	Group Director of Corporate Affairs	Deputy Trust Secretary	X	X	X (DPST submission)	X	X	X	X	X	X	X	X	X	Approval (DPST) & Assurance

Notes

*In some instances reporting and assurance to the Finance & Performance Committee will happen via the oversight / reporting sub-group upward reports. Where appropriate, reports submitted directly to the Finance & Performance Committee will however have been considered and be supported by the upward report from the relevant oversight sub-group; specifically key highlights and any required escalations. This will help to avoid duplication of discussions and actions. Where relevant, the upward reports from reporting sub-groups will be aligned on the agenda to the relevant strategic objectives for which the committee has the oversight role. This will support both the flow of the meeting and the process of triangulation and assurance

**This work plan reflects the core business of the Finance & Performance Committee. Topical / emerging issues will be added to the committees' agenda as required.

Integration Committee
Terms of Reference

1. Authority

The Integration Committee is established as a joint committee by the Trust Boards of both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) in line with the Group Partnership Working Agreement and the powers set out in both trusts' Standing Orders and Standing Financial Instructions.

The Standing Orders and Standing Financial Instructions of the Trust Boards and the Group Partnership Working Agreement, as far as they are applicable, shall apply to the committee and any of its established groups, either jointly or individually.

The Integration Committee holds only those powers as delegated in these terms of reference and, in accordance with the Group Partnership Working Agreement, will report to the Group Board.

The Integration Committee is authorised to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within its terms of reference. This includes referral of matters for consideration to another board committee or other relevant group.

2. Purpose of the Committee

The Integration Committee exists to scrutinise the robustness of and provide assurance to the Group Board on delivery of the group's transformation & integration agenda and strategic aims and objectives – both internally within ULTH & LCHS and through the ongoing development of relationships with external partners including Community Primary Partnerships – for the benefit of our population.

The Integration Committee will oversee the development of the Out Of Hospital Model and the direct delivery work with other system partners not limited too Mental Health, Primary Care, Third and Voluntary Sector organisations.

The Integration Committee with be the lead committee for oversight of the group's digital delivery and transformation agenda including the development of the "Vision for Information" and for oversight of the estates strategy, estates rationalisation & space management and sustainability & the Green Plan (including Net Zero).

The relevant group strategic aim & objectives aligned to the Integration Committee for 2025 / 26 are:

Population: Better Health – Improve Population Health:

- Objective 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services

- Objective 3b: Move from prescription to prevention, through a population health management & health inequalities approach

- Objective 3c: Enhance our digital, research and innovation capability

- Objective 3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan

The Integration Committee will have oversight of and seek assurance in relation to the following areas:

- Socioeconomic development
- Sustainability and the Green Strategic Plan
- Widening participation e.g. third sector organisations
- Regeneration plans with partners
- Anchor institution

The committee will work with the other board committees to ensure that full oversight of the areas of responsibility are covered.

3. Membership

The members of the committee are:

- Non-Executive Director (Chair)
- Non-Executive Director (LCHS)
- Associate Non-Executive Director
- Group Chief Integration Officer / Deputy Group Chief Executive
- Group Chief Operating Officer
- Group Chief Finance Officer
- Group Chief Medical Officer or Group Chief Nurse (as required)
- Group Director of Estates & Facilities

The following roles will be routine attendees at the Committee:

- Deputy Trust Secretary
- Group Director of Corporate Affairs
- PCNA Representative
- Trust Wide Lead for Integration and Planning, ULTH

4. Attendance and Quorum

The committee will be quorate when four of the membership are present. This must include two Non-Executive / Associate Non-Executive Directors, and two group Executive Directors (or formally appointed deputies).

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf. A deputy in attendance for a committee member will contribute to the quoracy but does not negate the need for the attendance of the Non-Executive Directors and Executive Directors referred to above.

Members should attend at least 75% of meetings each financial year but should aim to attend all.

The Group Chief Integration Officer in the Executive Lead for the committee.

Other attendees may be invited to attend the meetings as appropriate.

Observers will be permitted as agreed by the committee chair.

5. Frequency

The committee will meet monthly.

6. Specific Duties

The Integration Committee will:

- Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly with exception reporting as the norm.
- Through the receipt of upward reports from relevant reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the Integration Committee.
- Consider progress with and risks to delivery of the group's integration agenda & objectives and provide assurance to the Group Board that such risks are being effectively controlled and managed and / or escalate such risks to ensure timely and appropriate mitigating actions are put in place. Where appropriate, the committee may seek to request deep dives are undertaken to identify the required improvement and actions.
- Receive assurance that all appropriate actions are being taken to ensure full participation in population partnership initiatives and programmes of change and, in turn provide assurance to the Board on the robustness of delivery plans. This will include the receipt of plans for the continued development of Community Primary Partnership(s) over time supporting both Place and group strategies and seeking assurance on the robustness of plans to increase the range and scope of the Community primary partnership(s), anchor partners work and the group's role within them.
- Seek assurance on the adequacy of plans to realise the group's ambition of addressing the wider determinants of health and health inequalities.
- Seek assurance for the operational performance and delivery of Out of Hospital Services delivering on Integrated Care.
- Ensure that proposed changes to services are being made on the basis of strong clinical evidence and best practice.

- Seek assurance in respect of delivery of the group's digital agenda and objectives including development of the 'Vision for Information'.
- Review and seek assurance on delivery of the estates strategy, estates rationalisation & space management and sustainability & the Green Plan (including Net Zero) programmes of work.
- Ensure that key enablers to the delivery of the integration agenda are properly considered as part of the agreement of the group integration plan and programmes of work and that these plans and programmes of work are appropriately aligned to the longer term strategy, vision and values for the group.
- Review and provide assurance to the Group Board on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance and actions where necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions.

7. Administrative support

The committee will be supported administratively by the corporate administrative team.

The committee will operate using a work plan to inform its core agenda. Topical / emerging issues will be added to the agenda as required. The agenda will be agreed with the committee chair and the Group Chief Integration Officer prior to the meeting.

Agendas and supporting papers will be circulated no later than 5 working days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 5 working days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The chair of the committee shall report to the Group Board after each meeting and provide an upward report on assurances received, escalating any concerns where necessary.

The committee will advise the Audit & Risk Committee of the adequacy of assurances available and contribute to the Annual Governance Statements.

The committee will refer any necessary issues outside its terms of reference, as appropriate, to the relevant board committee or other relevant group.

9. Monitoring effectiveness and Compliance with Terms of Reference

The committee will complete an annual review of its effectiveness and provide an annual report to the Group Board on its work in discharging its responsibilities, delivering its objectives and complying with

its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The Terms of Reference for the committee will be reviewed annually by the committee and submitted to the Group Board for approval and, together with the work plan, will be reviewed at each meeting of the committee to ensure they remain fit for purpose.

The committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:

Approved by:

Next Review Date:

Lincolnshire Community & Hospitals NHS Group

Integration Committee Work Plan 2025/26 (Draft)

						Quarter 1			Quarter 2			Quarter 3			Quarter 4			
Agenda Item	**Oversight Group***	**Method of Reporting**	**Executive / Non-Executive Lead**	**Report Lead**	**Frequency**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Action**
Business Items (all committees)**																		
Minutes of the Previous Meetings		Written	Committee Chair		Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Approval
Matters Arising & Action Log (management & monitoring of committee actions)		Written	Committee Chair		Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Noting
Integration Committee Performance / KPI Dashboard		Written	Group Executive Lead(s)		Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion
Topical, Legal & Regulatory Update		Verbal / Written, as required	Group Director of Corporate Affairs		Quarterly			X			X			X			X	Discussion & Assurance
Review of Committee Effectiveness - Self Assessment		Written	Committee Chair	Group Director of Corporate Affairs	Annually										X			Discussion
Annual Report - Review of Committee Effectiveness		Written	Committee Chair	Group Director of Corporate Affairs	Annually											X (Draft)	X (Final)	Discussion & Assurance
Review of Committee Terms of Reference & Work Plans		Written	Committee Chair	Group Director of Corporate Affairs	Annually	X (Final)							X (Initial Draft November 2024 - New Committee)				X (Annual Review)	Approval
Review of Reporting Group Terms of Reference & Work Plans		Written	Committee Chair	Group Director of Corporate Affairs	Annually	X (Final)											X (Annual Review)	Approval
Matters Referred (all committees)**																		
Matters referred by the Trust Boards or other Board Committees		Written		Committee Chair	As required	**To be added to the agenda as required**												Discussion
Matters to be referred to other Board Committees		Written		Committee Chair	As required	**To be added to the agenda / agreed at the relevant meeting as required (and recorded in the minutes & action log)**												Discussion
Risk and Assurance (all committees)**																		
Board Assurance Framework		Written	Group Director of Corporate Affairs		Monthly	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Risk Register Report		Written	Group Executive Lead(s)		Quarterly		X (Q4)			X (Q1)			X (Q2)			X (Q3)		Discussion & Assurance
Review of relevant internal & external audit reports & recommendations (as required)		Written	Group Director of Corporate Affairs		As required	**To be added to the agenda as required**												Discussion
Review of relevant external reports, recommendations & assurances including CQC, as appropriate		Written	Group Executive Lead(s)		As required	**To be added to the agenda as required**												Discussion & Assurance
CQC Action Plan		Written	Group Executive Lead(s)	Head of Compliance	As required	X	X	X	X	X	X	X	X	X	X	X	X	Discussion & Assurance
Committee Specific Business Items**																		
Objective 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services																		
Stroke Implementation																		
Grantham ASR Implementation																		
Specialty Reviews Update																		
Integration Update including Alliance Model			Group Chief Integration Officer	TBC	TBC													Assurance
Left Shift (Acute to OOH Transformation)			Group Chief Integration Officer	TBC	TBC													Assurance
EMAP Leadership & Delivery Programme		Written	TBC	TBC	TBC													Assurance
System Anchor Plan		Written	TBC	TBC	TBC													Assurance
ICB Target Operating Model		Written	TBC	TBC	TBC													Assurance
Partnership Operating Model		Written	TBC	TBC	TBC													Assurance
Collaborative Models of Care		Written	TBC	TBC	TBC													Assurance
Integrated Neightbourhood Team Update		Written	TBC	TBC	TBC													Assurance
Community Primary Partnerships Update		Written	TBC	TBC	TBC													Assurance
Regeneration Plans with Partners		Written	TBC	TBC	TBC													Assurance
Estates Strategy		Written	Group Director of Estates & Facilities	TBC	Three-Yearly					X								Review & Endorse for Group Board Approval
Estates Rationalisation & Space Management Report		Written	Group Director of Estates & Facilities	TBC	TBC													Discussion & Assurance
Objective 3b: Move from prescription to prevention, through a population health management & health inequalities approach																		
Health Inequalities Update		Written	Group Chief Integration Officer	TBC	TBC													
Objective 3c: Enhance our digital, research and innovation capability																		
Digital Planning & Delivery Update including EDMD and EPR		Written	Group Chief Integration	Director of Digital	Bi-monthly	X		X		X		X		X		X		Assurance
Digital Strategy		Written	Group Chief Integration Officer	Director of Digital	Three-Yearly			X										Review & Endorse for Trust Board Approval
Vision for Information		Written	Group Chief Integration Officer	TBC	TBC													Approval
Objective 3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan																		
Productivity, Transformation & Improvement Report		Written	Group Chief Integration	TBC	TBC													Assurance
Sustainability & Green Strategic Plan (including Net Zero)		Written	Group Director of Estates & Facilities	TBC	TBC													Assurance
Upward Reports from Sub-Groups, as appropriate																		
Currently being finalised																		Assurance
Notes																		

*In some instances reporting and assurance to the Integration Committee will happen via the oversight / reporting sub-group upward reports. Where appropriate, reports submitted directly to the Integration Committee will however have been considered and be supported by the upward report from the relevant oversight sub-group; specifically key highlights and any required escalations. This will help to avoid duplication of discussions and actions. Where relevant, the upward reports from reporting sub-groups will be aligned on the agenda to the relevant strategic objectives for which the committee has the oversight role. This will support both the flow of the meeting and the process of triangulation and assurance

**This work plan reflects the core business of the Integration Committee. Topical / emerging issues will be added to the committees' agenda as required.

Lincolnshire Community & Hospitals NHS Group:
People Committee Work Plan 2025/26 (Draft)

				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Agenda Item	**Oversight Group****	**Executive Lead**	**Lead for Reports**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Business Items															
Committee Self Assessment		Director of Corporate Affairs	Deputy Trust Secretary										X		
Annual Report - Committee Effectiveness		Director of Corporate Affairs	Deputy Trust Secretary										X (Draft)	X	
Review of Committee Terms of Reference		Director of Corporate Affairs	Deputy Trust Secretary												X
Review of Forward Reporting Schedule		Director of Corporate Affairs	Deputy Trust Secretary												X
Reporting Group Terms of Reference and Forward Reporting Schedules		Chief People Officer	Director of People and Organisational Development	X											
Committee (People) Performance Dashboard to inc. Executive Scorecard		Chief People Officer	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Topical, legal and regulatory update		Director of Corporate Affairs	Deputy Trust Secretary			X			X			X			X
Staff Experience Story		Chief People Officer												X	
Matters Referred															
Matter referred by Trust Board or other Board Committees		Director of Corporate Affairs	Deputy Trust Secretary	**To be added to the agenda as required**											
Risk and Assurance															
Board Assurance Framework		Director of Corporate Affairs	Deputy Trust Secretary	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register Report		Chief People Officer	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Review of relevant external reports/inquiries including CQC (As Required)		Executive Lead	Executive Lead							X			X		
Progress against CQC improvement actions relevant to the Committee		Chief People Officer	Head of Compliance	X	X	X	X	X	X	X	X		X		
Review of relevant internal & external audit reports		Director of Corporate Affairs	Deputy Trust Secretary	**To be added to the agenda as required**											
Audit Recommendations		Director of Corporate Affairs	Deputy Trust Secretary			X			X			X			X
Strategy															
People Strategy		Chief People Officer	Director of People and Organisational Development												
Other Strategies TBC by Committee/Board		Chief People Officer	Director of People and Organisational Development												
Objective 2a - Enable our people to fulfil their potential through training, development and education															
Medical Education update		Chief Medical Officer	Assistant Director of Education			X			X			X			X
Non Clinical Education Update		Chief People Officer	Assistant Director of Education			X			X			X			X
Medical Revalidation		Chief Medical Officer	Medical Director				X								
Safer Staffing Nursing		Chief Nurse	Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Safer Staffing Medical		Chief Medical Officer	Business Manager to the GCMO	X	X	X	X	X	X	X	X	X	X	X	X
Objective 2b - Empower our people to continuously improve and innovate															
Vacancy Rates		Chief People Officer	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Turnover Rates		Chief People Officer	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Rates of appraisal/mandatory training compliance		Chief People Officer	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Job Planning - % complete		Chief People Officer	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Learning days per staff member		Chief People Officer	Head of Organisational Development	**Data not yet available - reporting to commence 2022/23**											
Sickness/absence data		Chief People Officer	Director of People and Organisational Development	X	X	X	X	X	X	X	X	X	X	X	X
Staff Survey feedback		Chief People Officer	Head of Organisational Development						X				X		X
National Staff Survey Feedback		Chief People Officer	Head of Organisational Development						X				X		X
Pulse Survey feedback		Chief People Officer	Head of Organisational Development	X				X					X	X	
Guardians of Safe Working		Chief Medical Officer	Guardian of Safe Working		X	X Annual Report		X		X	X			X	
Freedom to Speak Up		Chief Executive	Freedom to Speak Up Guardian	X (Annual Report)			X						X		
Objective 2c - Nurture compassionate and diverse leadership															
WRES Annual Report	EDIG	Chief People Officer	Equality, Diversity and Inclusion Lead				X								
WRES Action Plan **	EDIG	Chief People Officer	Equality, Diversity and Inclusion Lead					X							
WDES Annual Report	EDIG	Chief People Officer	Equality, Diversity and Inclusion Lead				X								
WDES Action Plan **	EDIG	Chief People Officer	Equality, Diversity and Inclusion Lead					X							
EDI Annual Report	EDIG	Chief People Officer	Equality, Diversity and Inclusion Lead			X									
EDI Objectives **	EDIG	Chief People Officer	Equality, Diversity and Inclusion Lead		X (Draft)	X (Final)									
Gender Pay Gap		Chief People Officer	Equality, Diversity and Inclusion Lead										X		
Modern Slavery Statement		Group People Officer	TBC												
Sexual Safety Charter		Group People Officer	TBC												
Employee Relations Activity		Chief People Officer	Head of HR Operations			X			X			X			X
Employee Exclusions		Chief People Officer	Deputy Director of People and Organisational Development	X		X		X		X		X		X	
NHS and System People Plan update		Chief People Officer	Director of People and Organisational Development			X			X			X			X
Objective 2d - Recognising our people through thanks and celebration															
TBC															
Upward Highlight / Exception Reports from Groups reporting to the Committee															
Workforce Strategy Group				X	X	X	X	X	X	X	X	X	X	X	X
Education Oversight Group				X	X	X	X	X	X	X	X	X	X	X	X
Equality, Diversity and Inclusion Group				X		X		X		X		X		X	
Culture and Leadership Group				X	X	X	X	X	X	X	X	X	X	X	X
Reporting from Divisions/Deep Dives															
Notes:															
Green highlights are items which will sit within the Committee Scorecard															

People Committee
Terms of Reference

1. Authority

The People Committee is established as a joint committee by the Trust Boards of both United Lincolnshire Teaching Hospitals NHS Trust (ULTH) and Lincolnshire Community Health Services NHS Trust (LCHS) in line with the Group Partnership Agreement and the powers set out in both trusts' Standing Orders and Standing Financial Instructions.

The Standing Orders and Standing Financial Instructions and the Group Partnership Working Agreement, as far as they are applicable, shall apply to the committee and any of its established groups, either jointly or individually.

The People Committee holds only those powers as delegated in these terms of reference and, in accordance with the Partnership Working agreement, will report to the Group Board.

The People Committee is authorised to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within its terms of reference. This includes referral of matters for consideration to another board committee or other relevant group.

2. Purpose of the Committee

The People Committee exists to scrutinise the robustness of and provide assurance to the Group Board that there is an effective system of governance and internal control across workforce and organisational development that supports the two organisations and the wider group to deliver thee group strategic aims & objectives and provide safe, high quality care.

The relevant group strategic aim and objectives assigned to the People Committee for 2025 / 26 are:

People: Better Opportunities – Develop, empower and retain great people:

- Objective 2a: Enable our people to fulfil their potential through training, development and education
- Objective 2b: Empower our people to continuously improve and innovate
- Objective 2c: Nurture compassionate and diverse leadership
- Objective 2d: Recognising our people through thanks and celebration

3. Membership

The members of the committee are:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Group Chief People Officer
- Group Chief Nursing Officer
- Group Chief Medical Officer

The following roles will be routine attendees at the Committee:

- Director of People and Organisational Development
- Deputy Trust Secretary
- Director of Corporate Affairs

An invitation to attend will be offered by the committee chair to:

- Chief Integration Officer (as required)
- Chief Operating Officer (as required)
- Chair of reporting groups (as required)
- Divisional Representatives (as required)
- Freedom to Speak Up Guardians (as required)
- Guardian of Safe Working (as required)

4. Attendance and Quorum

The committee will be quorate when four members are present. This must include at least one Non-Executive Director and two Group Executive Directors.

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf. A deputy in attendance for a committee member will contribute to the quoracy but does not negate the need for the attendance of the Non-Executive and Executive Directors referred to above.

Members should attend at least 75% of meetings each financial year but should aim to attend all.

The Chief People Officer is the Executive Lead for the Committee.

Other attendees may be invited to attend the meetings as appropriate.

Observers will be permitted as agreed by the Chair.

5. Frequency

The committee will meet monthly.

6. Specific Duties

The People Committee will:

- Ensure that there are robust processes in place for the effective management of people and organisational development.
- Ensure that there are effective structures in place to support people and OD and that these structures operate effectively and that action is taken to address areas of concern.
- Through the receipt of upward reports from the reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the People Committee.
- Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly
- Consider the control and mitigation of workforce related risks and provide assurance to the Board that such risks are being effectively controlled and managed
- Provide assurance to the Board that all legal and regulatory requirements relating to the workforce are met, including directives, regulations, national standards, policies, reports, reviews and best practice
- Review and provide assurance through the Integrated Improvement Plan and Performance Review Meeting reporting, on those strategic objectives within the Group Board Assurance Framework, identified as the responsibility of the committee seeking, where necessary, further action.

7. Administrative support

The committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the Chair prior to the meeting.

Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 10 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The chair of the committee shall report to the Group Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

Key issues arising from the committee will be provided to the Group Board to demonstrate effective internal control and to enable the Group Board to have confidence in the control systems in place.

The committee will advise the Audit & Risk Committee of the adequacy of assurances available and contribute to the Annual Governance Statements.

The committee will refer any necessary issues outside its terms of reference, as appropriate, to the relevant board committee or other relevant group.

9. Monitoring effectiveness and Compliance with Terms of Reference

The committee will complete an annual review of its effectiveness and provide an annual report to the Group Board on its work in discharging its responsibilities, delivering its specific duties and complying with its terms of reference, specifically commenting on relevant aspects of the Group Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The terms of reference for the committee will be reviewed annually by the committee and submitted to the Group Board for approval.

The committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:

Approved by:

Next Review Date:

Quality Committee
Terms of Reference

1. Authority

The Quality Committee is established as a joint committee by the Trust Boards of both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) in line with the Group Partnership Working Agreement and the powers set out in both trusts' Standing Orders and Standing Financial Instructions.

The Standing Orders and Standing Financial Instructions and the Group Partnership Working Agreement, as far as they are applicable, shall apply to the committee and any of its established groups, either jointly or individually.

The Quality Committee is a non-executive committee and holds only those powers as delegated in these terms of reference and, in accordance with the Group Partnership Working Agreement, will report to the Group Board.

The Quality Committee is authorised to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within its terms of reference. This includes referral of matters for consideration to another board committee of other relevant group.

2. Purpose of the Committee

The Quality Committee exists to scrutinise the robustness of and provide assurance to the Group Board that there are effective systems of quality governance and internal control across the clinical activities of the two organisations and wider group to deliver the group strategic aims and objectives and provide safe, high quality care.

The relevant strategic aim & objectives assigned to the Quality Committee for 2025 / 26 are:

Patients: Better Care – Timely, affordable, high quality care in the right place:

- Objective 1a – Improve patient safety, patient experience and deliver clinically effective care

3. Membership

The members of the committee are:

- Non-Executive Director (LCHS) – Chair

- Non-Executive Director (ULHT) – Deputy Chair
- Associate Non-Executive Director (ULTH)
- Group Chief Nursing Officer (CQC Nominated Individual, Lead Director for Safeguarding)
- Group Chief Medical Officer (Accountable Officer for Controlled Drugs, DIPC)
- Group Chief Operating Officer
- Group Chief Integration Officer
- Group Chief Clinical Governance Officer

The committee will routinely be attended by:

- Deputy Trust Secretary
- Director of Corporate Affairs

An invitation to attend will be offered by the committee chair to:

- ICB Representative
- Patient Safety Partners
- Divisional representatives (rolling programme)

4. Attendance and Quorum

The committee will be quorate when four members are present. This must include at least one Non-Executive Director and one Group Executive Director.

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf. A deputy in attendance for a committee member will contribute to the quoracy but does not negate the need for the attendance of one Non-Executive and one Group Executive Officer as described above.

Members should attend at least 75% of meetings each financial year but should aim to attend all.

The Group Chief Nurse is the Executive Lead for the committee.

Other attendees may be invited to attend the meetings as appropriate.

Observers will be permitted as agreed by the chair.

5. Frequency

The committee will meet monthly.

6. Specific Duties

The Quality Committee will:

- Ensure that there are robust processes in place for the effective management of clinical governance, quality and risk.
- Ensure that there are effective structures in place to support clinical governance and that these structures operate effectively and that action is taken to address areas of concern.
- Through the receipt of upward reports from the reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the Quality Committee.
- Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboards monthly with exception reporting as the norm.
- Use outcome measures to demonstrate continuous improvement.
- Consider the control and mitigation of quality related risks and provide assurance to the Group Board that such risks are being effectively controlled and managed in line with the risk appetite statement. Whilst the committee's remit covers all of the Group's services, the committee has a specific oversight role in relation to the quality & safety of United Lincolnshire Teaching Hospitals Trust's maternity services (reference: Ockenden).
- Review and provide assurance on those strategic objectives within the Group Board Assurance Frameworks, identified as the responsibility of the committee seeking where necessary further action.
- Provide assurance to the Board that all legal and regulatory requirements relating to quality are met, including directives, regulations, national standards, policies, reports, reviews and best practice.
- Review & challenge the annual Quality Accounts ensuring they are a balanced and accurate reflection of both Trusts position.
- Approve and monitor the annual clinical audit plans.
- Monitor the implementation of agreed action plans in relation to all major internal reviews and all external reviews within the remit of the Quality Committee.
- Ensure that there is sufficient time on the agenda to allow for strategic discussion items on areas of responsibility of the committee and to include horizon scanning on the current and future environment.

7. Administrative support

The committee will be supported administratively by the corporate administrative team.

The committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the chair and the Group Chief Nurse (the Executive Director lead for the committee) prior to the meeting.

Agendas and supporting papers will be circulated no later than 5 working days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 5 working days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The chair of the committee shall report to the Group Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

Key issues arising from the committee will be provided to the Group Board to demonstrate effective internal control and to enable the Group Board to have confidence in the control systems in place.

The committee will advise the Audit & Risk Committee of the adequacy of assurances available and contribute to the Annual Governance Statements.

The committee will refer any necessary issues outside its terms of reference, as appropriate, to the relevant board committee or other relevant group.

9. Monitoring effectiveness and Compliance with Terms of Reference

The committee will complete an annual review of its effectiveness and provide an annual report to the Group Board on its work in discharging its responsibilities, delivering its specific duties and complying with its terms of reference, specifically commenting on relevant aspects of the Group Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The terms of reference for the committee will be reviewed annually by the committee and submitted to the Group Board for approval.

The committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:

Approved by:

Next Review Date:

Lincolnshire Community and Hospitals NHS Group
Quality Committee Work Plan 2025/26 (Draft)

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Agenda Item	**Lead**	**Sub-Group/ Person Responsible**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Business Items														
Declarations of Interest			X	X	X	X	X	X	X	X	X	X	X	X
Approve the minutes of the previous meeting			X	X	X	X	X	X	X	X	X	X	X	X
Actions Directed from the Quality Committee or other Groups			X	X	X	X	X	X	X	X	X	X	X	X
Patient / Staff Experience Story			X	X	X	X	X	X	X	X	X	X	X	X
Board Assurance Framework 2023/24			X	X	X	X	X	X	X	X	X	X	X	X
Objective 1a - Improve patient safety, patient experience and deliver clinically effective care														
Patient Safety Group Upward Report			X	X	X	X	X	X	X	X	X	X	X	X
High Profile Cases Report			X	X	X	X	X	X	X	X	X	X	X	X
Claims Annual Report														
Infection Control Annual Report														
Medicines Management Annual Report														
Safeguarding Annual Report														
Maternity and Neonatal Oversight Group Upward Report									X		X		X	
Patient Experience and Involvement Group Upward Report			X	X	X	X	X	X	X	X	X	X	X	X
Safeguarding and Vulnerabilities Oversight Group Upward Report (to include Children in Care Update)										X		X		X
Children in Care Update											X		X	
Patient Experience Annual Report														
Complaints Annual Report														
PLACE Annual Report														
Clinical Effectiveness Group Upward Report			X	X	X	X	X	X	X	X	X	X	X	X
Clinical Audit Annual Report														
Clinical Audit Forward Programme														
Approval of Quality Account														
Focused Discussion Topics:														
Pressure Ulcers					X									
Infection Control Annual Reports						X								
Human Factors Update							X							
Pharmacy/Medicines Management								X						
Deteriorating Patients														
Falls														
Diabetes / DKA														
Clinical Harm														X
End of Life Care														X
Ward Accreditation														
Complaints Annual Report					X									
Children in Care						X								
Safeguarding Annual Reports							X							
Clinical Audit Annual Reports					X									
NICE Update							X							
National Audit Programme								X						
Palliative Care / End of Life														
Risk and Assurance														
Quality Committee Risk Register Report			X	X	X	X	X	X	X	X	X	X	X	X
Policy Position Update										X	X	X	X	X
Internal Audit Reports			**To be added to the agenda as required**											
Update on Internal Audit Recommendations			X	X	X	X	X	X	X	X	X	X	X	X
Relevant External Reviews and Enquiries			**To be added to the agenda as required**											
CQC Assurance Report			X	X	X	X	X	X	X			X		
Topical, Legal and Regulatory Update			X			X				X			X	
Quality Committee Performance Dashboard			X	X	X	X	X	X	X	X	X	X	X	X
Integrated Improvement Plan			X	X	X	X	X	X	X	X	X			
Quality Impact Assessment Assurance Report				X			X	X		X			X	
ICB Update			X	X	X	X	X	X	X	X	X	X	X	X
End of Meeting Review														
Terms of Reference and Work Programme			X	X	X	X	X	X	X	X	X	X	X	X
Matters Arising from the Minutes / Action Log			X	X	X	X	X	X	X	X	X	X	X	X
Any Other Business			X	X	X	X	X	X	X	X	X	X	X	X
Agree the Committee Assurance Report to the Board			X	X	X	X	X	X	X	X	X	X	X	X
Agree issues to refer to other Board Committees			X	X	X	X	X	X	X	X	X	X	X	X
Reflection on Outcomes and Decisions			X	X	X	X	X	X	X	X	X	X	X	X
Notes:														

NHS
Lincolnshire Community and Hospitals NHS Group

Performance Management and Accountability Framework

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

Meeting	*Trust Board*
Date of Meeting	*6 May 2025*
Item Number	*6.3*

Performance Management and Accountability Framework

Accountable Director	*Daren Fradgley, Group Chief Integration Officer/Deputy Group CEO*
Presented by	*Daren Fradgley, Group Chief Integration Officer/Deputy Group CEO*
Author(s)	*Kathryn Helley, Group Chief Clinical Governance Officer* *Shaun Caig, Associate Director of Performance and Information*
Recommendations/ Decision Required	*The Board is asked to:- approve the new framework*

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

Executive Summary

This document provides the LCHG Performance & Accountability Framework which outlines the processes in place and defined responsibilities ('board to ward / service / patient') that enable the Group Board and other key personnel to understand and monitor achievement of national & local targets and indicators (as set out in the group's 6 performance / improvement pillars: strategy, quality, finance, workforce, operational performance and risk & governance), and ensure appropriate action is taken when performance against these targets and indicators deteriorates.

This framework describes how performance & improvement will be measured, managed, monitored and reported including how the group will utilise improved information management (as part of the group's Vision for Information') to understand trends and drive better performance and introduce a tiered performance assurance and rating process to ensure a rigorous, supportive and consistent approach to performance management and accountability is achieved at all levels of the organisation.

The primary purpose of the LCHG Performance Management & Accountability Framework is to provide a consistent, integrated approach to support the group to make systematic, continuous improvements to performance enabling achievement of its strategic aims & objectives. Its secondary purpose is to enable the group to be publicly accountable for its performance and to allow any other person or organisation with an interest in its services, through relevant internal and external assurance mechanisms, to see and understand how we will work to improve. The Performance Management & Accountability Framework is part of the Trust's wider governance framework which aims to protect the interests of all stakeholders.

Need to include group logo and not just ULTH

LCHG PERFORMANCE MANAGEMENT & ACCOUNTABILITY FRAMEWORK

Executive Lead	Group Chief Integration Officer
Author(s)	Associate Director of Performance & Information Group Chief Clinical Governance Officer
Version	v3.8 Draft
Date	March 2025
Review Date	February 2026 (annually)

Statement of Intent

United Lincolnshire Teaching Hospitals Trust (ULTH) and Lincolnshire Community Health Services Trust (LCHS), known as the Lincolnshire Community & Hospitals Group (LCHG), are committed to ensuring the provision of timely, affordable, high quality care in the right place, developing, empowering & retaining great people and improving population health. The group acknowledges that timely access to treatment and the delivery of other key performance measures and agreed improvement plans and, in turn, a robust Performance Management & Accountability Framework, are critical to the achievement of those aims.

This document provides the LCHG Performance & Accountability Framework which outlines the processes in place and defined responsibilities ('board to ward / service / patient') that enable the Group Board and other key personnel to understand and monitor achievement of national & local targets and indicators (as set out in the group's 6 performance / improvement pillars: strategy, quality, finance, workforce, operational performance and risk & governance), and ensure appropriate action is taken when performance against these targets and indicators deteriorates.

Effective performance management and accountability will support decision making, organisational planning and service delivery and will remain a key group focus.

Group Chief Executive Officer **Group Chief Integration Officer**

Contents

1.0 Introduction

It is LCHG's intention to implement a clear Performance Management & Accountability Framework which sets out the overarching principles and approach to delivering a high performing organisation and aims to ensure that the group successfully delivers national standards for performance and contractual targets as well as locally agreed improvement plans and other priorities including those set out within the Annual Planning Guidance.

This framework describes how performance & improvement will be measured, managed, monitored and reported including how the group will utilise improved information management (as part of the group's Vision for Information') to understand trends and drive better performance and introduce a tiered performance assurance and rating process to ensure a rigorous, supportive and consistent approach to performance management and accountability is achieved at all levels of the organisation.

1.1 Definition

Performance management is about establishing a formal, regular and rigorous system of data collection and usage to indicate trends and measure the performance of services. Performance management should be used to help identify areas of best practice, to focus on continuous improvement and delivering improved outcomes, to take action to improve patient care and to ensure that the activities of services are in line with the overall organisational strategy and priorities.

1.2 Purpose

The primary purpose of the LCHG Performance Management & Accountability Framework is to provide a consistent, integrated approach to support the group to make systematic, continuous improvements to performance enabling achievement of its strategic aims & objectives. Its secondary purpose is to enable the group to be publicly accountable for its performance and to allow any other person or organisation with an interest in its services, through relevant internal and external assurance mechanisms, to see and understand how we will work to improve. The Performance Management & Accountability Framework is part of the Trust's wider governance framework which aims to protect the interests of all stakeholders.

2. The Performance Management & Accountability Framework

2.1 Key Principles & Components

The LCHG Performance Management & Accountability Framework and associated arrangements have been developed to ensure it reflects the following key principles:

- is aligned to the strategic aims & objectives of the group and strategic partners;
- reflects the relevant statutory and regulatory standards, requirements and contracts relevant to the trusts and wider group;
- reflects the NHS Oversight Framework;
- takes account of relevant external best practice guidance e.g. *'The Insightful Provider Board';*
- flows from ward / service / patient to board and from board to ward / service / patient;
- ensures consistency of approach and alignment of care groups / directorates across the group to ensure that all are working together to achieve the group's aims & objectives;
- 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 & service / care group perspective;
- is balanced across the group's 6 performance / improvement pillars of: strategy, quality & safety, performance: operational delivery, workforce, finance, governance & risk;

- is underpinned by a harmonised and supportive accountability & performance review process;
- is action focussed in support of delivery and risk mitigation.

The LCHG Performance Management & Accountability Framework also encompass the following components:

- Quality of care, access and outcomes
- Finance and use of resources
- Governance, risk and compliance
- Workforce and staff experience
- Estates & Facilities compliance
- Transformation, innovation and improvement

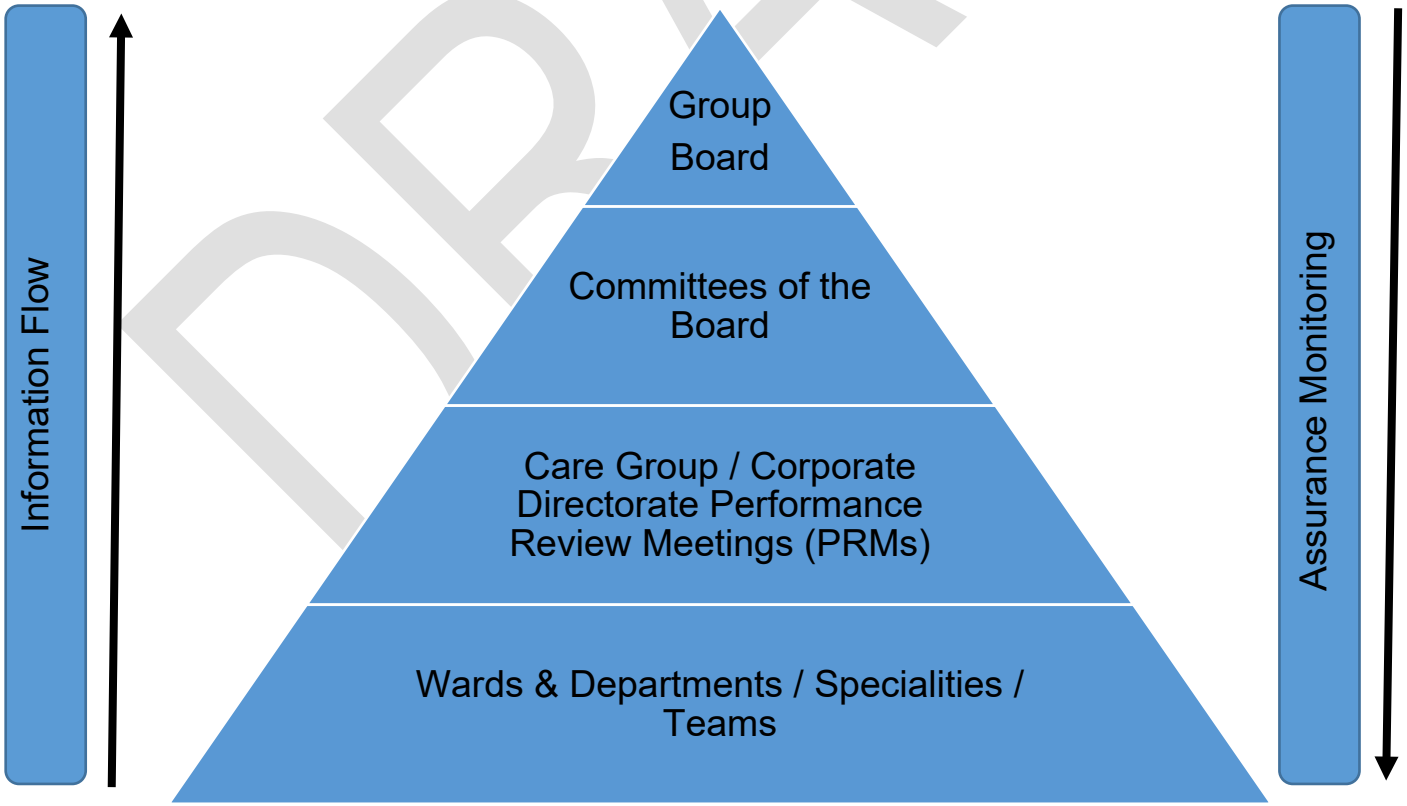
2.2 Reporting levels

The main strands of performance reporting within LCHG are:

- Board performance reporting
- Operational performance reporting
- Planning priorities and improvement plans
- National and local performance reporting

Reporting structures have been designed to support the differing needs of the board, board committees and the operational teams (as described in 2.3 – 2.6 below) and information flows mirror the group's management and governance structure. This is illustrated in Figure 1 below.

Figure 1



A key aspect of this approach is that operational performance measures are identified at as low a common denominator as possible. Measures agreed at ward / department level are summarised to create a specialty / service level that can then be further summated, if appropriate, to a care group

level. Care group level performance measures are then summated to give a trust / group-wide picture of performance.

2.3 Board Reporting

The group's IPR, using a balanced scorecard approach, provides a summary of the business-critical targets and indicators for LCHG. It is produced monthly, with formal submission to the Group Board bi-monthly, and highlights key areas of success or concern and actions being taken to address the issues. Performance is also visually displayed in the form of tables and SPC charts which show historic performance and trends.

The relevant board committees (finance & performance, workforce, quality and integration) have delegated authority from the Group Board for oversight of delivery – from an assurance perspective – of agreed performance metrics and improvement plans and each receive the relevant sections of the IPR monthly.

2.4 Operational Reporting

Care group performance reporting follows a similar format to the board report and contains the targets and indicators disaggregated to care group level. Its purpose is to provide an insight into the contribution of individual care groups to performance of the business-critical targets and indicators, as well as furnishing the care groups with performance data more specific to their area of activity.

2.5 Planning Priorities

Each year through the Annual Planning round, the board agree a set of planning priorities, these inform the objectives and priorities of Care Groups & Corporate Directorates. Progress against these priorities is monitored through Care Group / Corporate Directorate PRMs; with quarterly updates provided to the board and / or board committees, as appropriate.

2.6 Key Performance Indicators

The set of Key Performance Indicators (KPIs) which inform the group's Performance & Accountability Framework and the 6 performance / improvement pillars and which are reported in the IPR are reviewed and set each year to take account of changes in local, contractual, and regulatory requirements. KPIs are drawn from a variety of sources and cover a wide range of themes, including agreed group improvement plans.

Where national guidance exists the metric are constructed according to such guidance to allow for benchmarking. Where guidance is not available, the metrics are defined locally in discussion with senior managers and clinicians as required.

3. Roles and Responsibilities

3.1 Group Board

The Group Board is responsible for setting strategy and seeking assurance that risks to delivery of its strategic aims & objectives (including the delivery of agreed performance targets & indicators) are being mitigated.

The Group Board has overall responsibility for the ensuring the approval and implementation of the Performance Management & Accountability Framework.

The Board is also responsible for ensuring that the individual trusts within the group remain at all times compliant with the NHS Provider License and NHS Constitution. Effective implementation and

embedding of the Performance Management & Accountability Framework will support the Group Board in meeting these requirements and receiving and providing the necessary assurances.

The Group Board will receive regular reports assuring them of the quality and performance of services and in respect of the achievement of the group's strategic objectives including information provided within the IPR, the Board Assurance Framework (BAF) and other routine reports.

3.2 Board Committees (Quality, Finance & Performance, People , and Integration)

Board committees are chaired by a non-executive director and have delegated authority from the Group Board for oversight of delivery – from an assurance perspective – of agreed performance metrics and improvement plans.

3.3 Chief Executive Officer

The Group Chief Executive Officer is responsible for the management of the organisation including for the delivery of performance. The Group Chief Executive Officer is also responsible for ensuring that the Performance Management & Accountability Framework and associated arrangements are appropriate and meet the needs of the group in support of delivery of its strategic aims & objectives.

3.4 Group Chief Integration Officer / Deputy Chief Executive

The Group Chief Integration Officer, supported by executive colleagues, is responsible for operationalising and managing the Performance & Accountability Framework and associated arrangements on behalf of the Group Chief Executive. This will including chairing PRMs. The exception being where a Care Group or Corporate Directorate is rated 'Inadequate' and the Group Chief Executive will chair fortnightly PRMs.

The Performance & Information Services team, under the management of the Group Chief Integration Officer, are responsible for providing the data and management information both within the group and to appropriate external parties in support of the operation of the Performance Management & Accountability Framework.

3.5 Group Executive Leadership Team

The Group Executive Leadership Team will review the performance of the Care Groups at the Care Group PRMs, providing appropriate challenge and support as required.

The Group Executive Leadership Team will review the performance of the Corporate Directorates at the Directorate PRMs, providing appropriate challenge and support as required.

3.6 Group Leadership Team

The Group Leadership Team is the main management decision-making forum for the group and brings together the executive leadership and senior operational and clinical leadership, ensuring clinical input remains central to decision-making across the group. The Group Leadership Team is responsible collectively for the oversight and delivery of group performance including the agreement of the required risk mitigations and improvements.

3.7 Care Group Triumvirates / Quadrumvirates

Care Group Triumvirates / Quadrumvirates, comprising the following roles, are accountable for delivering performance targets and indicators within their respective Care Groups:

- Care Group Managing Director
- Care Group Clinical Director
- Care Group Lead Nurse / AHP / CYP & Director of Midwifery

The Care Group Triumvirates / Quadrumvirates, in turn, will be responsible for holding their teams to account for the delivery of the agreed performance and improvements and for providing the supporting resources to deliver objectives and activity at each level.

Care Group Triumvirates / Quadrumvirates and their teams are also responsible for working together with other care groups and corporate directorates to achieve the overall group aims & objectives and for ensuring issues and risks to delivery are escalated within their individual PRMs and / or to the Executive Leadership Team / Group Leadership Team.

The Finance, People & Activity Meeting (FPAM) is a key tool to support the Care Group PRMs. These meetings will be used to discuss items in greater detail than the high level expected at PRMs. To ensure the efficient operation of the Performance Management & Accountability Framework, Care Groups will need to ensure suitable time is available for the review of performance information and the preparation for PRMs.

3.8 Corporate Directors and Senior Management Teams

Executive Directors and Senior Management Teams within Corporate Directorates are accountable for delivering performance targets, objectives and other priorities agreed with them and for holding to account and providing the supporting resources to their teams to deliver objectives and activity at each level in support of the care groups and overall delivery of the group's strategic aims & objectives.

3.9 Staff

All staff have a role in managing and improving performance and identifying and contributing to delivery of the required improvement actions within their area of work. The underlying principle that performance is everyone's responsibility relies heavily on effective appraisals enabling every employee to be the best they can be, understanding what performance means for them and their role. Objective setting, not just at individual level, is required and those objectives will provide the context for how performance will be measured, whether a KPI or local measure or how an individual contributes to team/ward objectives. Competency frameworks provide an assessment process to ensure all staff have the skills, knowledge, experience and behaviours to deliver performance aligned with group values.

3.10 External Oversight

External oversight of delivery of agreed performance metrics and planning priorities will be undertaken by the Integrated Care Board in accordance with the NHS Oversight Framework. Where required, this will include the co-ordination of any required support interventions, where appropriate, in conjunction with NHS England (NHSE).

The IPR will be shared and discussed with the ICB at the formal monthly performance and contract meetings.

3.10 Service Users

Members of the public are welcome to attend the public Group Board meetings every other month. The IPR is discussed at these meetings and is available via the Trust's website thereby providing openness and transparency in respect of group performance.

4. The Performance Review Process

The Performance Review Process is detailed below:

- On a monthly basis, data will be received by the Performance & Information Team who will validate and publish performance against plan via the IPR.

- The report will be shared monthly / bi-monthly with Care Groups, Corporate Directorates and the Group Board & board committees.

- The contractual KPIs are reported by exception to the Executive Leadership Team and also with commissioners in line with their reporting timetable.

- Each Care Group holds a monthly performance and data quality meeting at which any areas for concern are discussed and data validated as appropriate.

- Any issues identified are escalated to the relevant support group, such as PAS Management Group for Data Quality, or Patient Safety Group or Clinical Effectiveness Group for Quality or Safety concerns, or the Patient Experience and Involvement Group for issues relating to poor patient experience.

- Where performance is showing significant deterioration from plan the Senior Performance Manager will liaise with the Group Chief Integration Officer and the relevant Care Group Clinical Director or Managing Director to instigate an immediate action plan which will be monitored through the monthly Care Group Performance Review Meetings.

- The Associate Director of Performance & Information will escalate to Finance & Performance, Quality, People & Organisational Development or Integration Committee, or Group Leadership Team, via the relevant executive director lead, critical areas of performance deemed to be in or have the potential to be in significant failure against plan with no appropriate plan for recovery.

- The Executive Team and / or Group Leadership Team will decide what further action is required. Further action could span from the instigation of an audit to further understand the contributory factors, the agreement of enhanced monitoring (including the instigation of fortnightly PRMs) and / or the provision of additional support to the Care Group or Corporate Directorate *(see also section 5.2 below)*.

- Should it be agreed that an audit needs to take place, the Associate Director of Performance & Information will liaise with the appropriate individuals to instigate the audit depending on the subject matter.

- Regular progress will be fed back to the Executive Leadership Team and / or Group Leadership Team on each area escalated until the Executive Leadership Team and / or Group Leadership Team is assured that performance is being achieved on a sustained basis.

- In parallel with the everyday management of performance and the escalation to the Executive Leadership Team and / or Group Leadership Team of any critical areas of concern, regular performance review meetings, led by the Group Chief Integration Officer, will be held with each Care Group (monthly) and Corporate Directorates (quarterly) *(see also sections 5.1 & 5.2 below)*.

5. Care Group / Corporate Directorate Performance Review Meetings (PRMs)

5.1 Overview

The objective of the Care Group / Corporate Directorate PRMs is to review the performance of each Care Group / Corporate Directorate in relation to an agreed suite of KPIs under the group's 6 pillars of performance / improvement: strategy, operational performance, quality, workforce, finance, risk & governance and other agreed priorities (as appropriate to each Care Group & Corporate Directorate), in order to ensure compliance and continual improvement.

The PRM process will ensure the Executive Leadership Team has a clear overall view of performance across the group to gain clarity on the priority areas of concern, and associated actions, including operational and recovery plans.

The PRMs will also provide a forum for Care Groups / Corporate Directorates to discuss issues and challenges facing services with executive directors and agree solutions in partnership and also to share, recognise and celebrate success and good practice. The PRMs will also provide the opportunity to agree the level of targeted and tailored support which may be required.

There will be a clear and consistent schedule of Care Group / Corporate Directorate PRMs agreed at the start of each new financial year. The PA to the Group Chief Integration Officer will liaise with the Performance Team and is responsible for organising the review meetings on behalf of the Group Chief Integration Officer. Essential attendance for the PRMs is set out in detail in the Terms of Reference which are included at **Appendix 1.**

Whilst the (default) frequency for PRMs will be monthly (Care Groups) and quarterly (Corporate Directorates), this frequency may be increased where performance is 'off track' or decreased where good levels of performance are being achieved *(see also section 5.2 below)*.

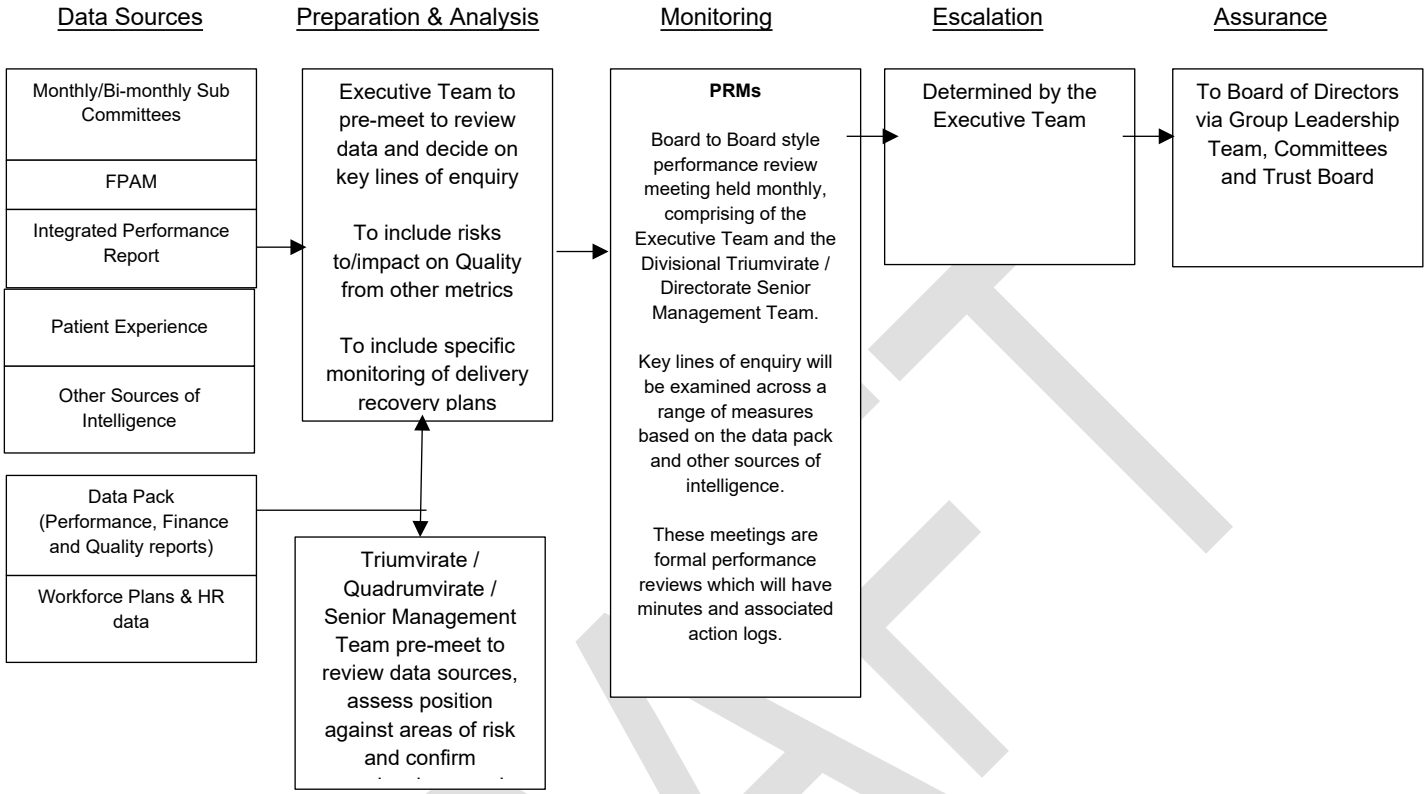
The meetings will be a 'Board to Board' style session, with the Executive Team raising relevant items with the Care Triumvirate / Quadrumvirates and in respect of Corporate Directorates with the Senior Management Team. There will also be the opportunity for escalations to be raised by the Care Group / Corporate Directorate, where specific support or intervention is required from the Executive Leadership Team. Whilst the PRMs are the mechanism for ensuring the Care Groups / Corporate Directorates are held to account for their performance, discussions will be collaborative and supportive.

As above, set prioritised indicators, specific to the core business of each Care Group / Corporate Directorate, will be agreed and Care Groups / Corporate Directorates will be held accountable for delivery of these key metrics.

Consistent data sources will be used for the meeting, adopting a CQC style Statistical Process Control (SPC) chart approach, so that the focus of the meeting will be on performance issues and agreeing appropriate remedial actions. The data pack will be used to identify key lines of enquiry and key areas of risk.

Figure 2 below illustrates the Care Group / Directorate PRM process.

Figure 2: Scope, function, and output of the Care Group / Corporate Directorate Performance Review Meetings



Standardised agendas and performance data packs, reflecting the group's 6 performance / improvement pillars, will be used to inform the PRMs. The Performance Manager & Divisional Information Analyst will be responsible for collating all information into the data pack for the meeting using an agreed template. The Performance Manager will analyse the information provided and work with the Care Group / Corporate Directorate to identify key risks and areas of concern that will be discussed in the meetings. Data packs will be provided to the Care Group / Corporate Directorate no later than one week before the PRM and will be circulated to all invitees no later than 2 days before the PRM.

The Performance Manager will attend all Care Group / Corporate Directorate PRMs and will be responsible for maintaining the action logs from the PRM meetings. Actions will be linked back to the Care Group / Corporate Directorate priorities as laid out in specialty business plans and will link to the delivery of the group's strategic aims & objectives.

5.2 Accountability and Autonomy

Each Care Group / Corporate Directorate will be rated based on their performance within the month against an agreed set of key KPIs across the group's 6 pillars of performance / improvement (as appropriate) and other agreed priorities. Progress will be updated on a monthly basis and will inform the IPR. A highlight report will be incorporated at the start of the IPR to provide an 'at a glance' view of where performance is not being achieved.

Each Care Group / Corporate Directorate will be assessed and rated on their performance at the end of each PRM. The starting point for the rating will be the percentage of KPIs which are within accepted range which will be mapped to the CQC ratings shown below:

Level	%
Inadequate	0 – 38
Requires Improvement	39 – 62
Good	63 – 87
Outstanding	88 – 100

As this approach does not take account of the qualitative information discussed and those areas not covered by a KPI, a discussion will then take place between the Executive Leadership Team and the Care Group or Corporate Directorate to agree whether there are any other factors which may affect the rating. Therefore if a modified rating is applied this will be clearly documented in the highlight report.

The final rating will then determine the frequency of future PRMs as follows:

Rating	Frequency
Inadequate	Fortnightly with the Chair becoming the Group Chief Executive
Requires Improvement	Monthly
Good	Every 2 months
Outstanding	Every 3 months

The Group Chief Integration Officer will chair PRMs with any rating other than 'Inadequate'.

For those Care Groups / Corporate Directorates deemed to be not achieving the required performance (i.e. are rated 'Requires Improvement'), monthly performance meetings will take place until performance against plan is achieved for a sustainable period of time. Where performance is deemed to be 'Inadequate', PRMs will be held fortnightly and will be chaired by the Group Chief Executive and the level of enhanced monitoring and / or targeted support required will be agreed with the Care Group / Corporate Directorate through that process.

It is also worth noting that there may be instances where a Care Group or Corporate Directorate is performing well overall, does not fall into the category of 'Inadequate' and does not warrant fortnightly PRMs but may require enhanced monitoring and / or targeted support. In such instances the level of enhanced monitoring and / or targeted support will be agreed with the Care Group or Directorate concerned.

Once a Care Group / Corporate Directorate is achieving against the required objectives and are rated 'Good' or 'Outstanding', PRMs will become less frequent as shown above. Further opportunities for earned autonomy will be explored, as appropriate.

6. Escalation & Assurance

After each round of PRMs the Performance Manager and the Senior Performance Manager will write a summary report for the Group Leadership Team (GLT). Where required, escalations will be brought to the attention of the relevant board committee and the board through the IPR. The Group Chief Integration Officer will then feedback responses and de-escalate these issues through the Performance Manager who will be the key point of liaison for the Care Groups and Corporate Directorates and will keep an action log of issues and escalation items that will be updated ahead of each PRM.

7. Planning Process

The Annual Planning Process enables KPIs and metrics to be developed and agreed relevant to the group's priorities during the planned period. The group's integrated performance dashboards will be produced to give a balanced view of performance across all areas of the group and, if KPIs are appropriate, interdependencies between indicators which may be causing performance to fail or achieve success will be easier to identify. This approach will be embedded during 2024/25 and a review of Key Performance Indicators will be completed during the planning process for 2025/26. Our KPIs and local indicators should contribute to delivering the outcomes set out in the group's objectives to ensure alignment with NHS strategic objectives.

8. Benchmarking

The group will use all available and appropriate benchmarking (e.g. GIFRT, Dr Foster, Model Health System) to understand and evaluate its position in relation to best practice and to identify areas and means of performance improvement. Using a systematic and continuous approach, benchmarking can help us to measure ourselves against others that are performing well. We will use benchmarking to identify best practice performance levels, determine the drivers of high performance, quantify gaps and build foundations for performance improvement.

NHS Benchmarking is completed annually by the group for a variety of areas such as Emergency Care, Theatres and Outpatients. Data is submitted by the group and collated into a report by NHS Benchmarking that compares the group against all other Trust's in the country. A summary report will be produced by the Analysis Team and presented at Finance Committee. Opportunities for improved productivity and efficiency will be shared with the Divisions and should feed into CIP programmes and clinical project teams.

9. Review of Performance & Accountability Framework

This framework will be reviewed annually or sooner where required to adapt to changes in the local, contractual and regulatory position regarding performance management.

Appendix 1

Care Group / Corporate Directorate Performance Review Meetings (PRMs)

Membership & Terms of Reference

1. Purpose

The purpose of the Care Group / Corporate Directorate PRMs is to review the performance of each Care Group / Corporate Directorate in relation to an agreed suite of KPIs under the group's 6 pillars of performance / improvement: strategy, operational performance, quality, workforce finance, risk & governance and other agreed priorities, in order to ensure compliance and continual improvement in the quality of services provided across the Lincolnshire Community & Hospitals Group (LCHG).
.
The PRMs will also provide a forum for Care Groups / Corporate Directorates to discuss issues and challenges facing services with executive directors and agree solutions in partnership.

2. Specific Duties

- To review current and anticipated future performance / improvement.
- To consider risks and issues to the delivery of agreed performance / improvement targets and priorities and to support resolution.
- To agree the need for additional monitoring and / or support.
- To celebrate success and share good practice and learning.

3. Membership

PRMs will have the following core membership:

Executive

- Group Deputy CEO/ Group Chief Integration Officer (Chair)*
- Group Chief Finance Officer
- Group Chief Operating Officer
- Group Chief Nurse
- Group Chief Medical Officer
- Group Chief Clinical Governance Officer
- Group Chief Estates and Facilities Officer

**The Group Chief Integration Officer will routinely chair PRMs. In the absence of the Group Chief Integration Officer, another executive director will be asked to chair the routine PRM meetings. Where a Care Group / Corporate Directorate is rated 'Inadequate', the Group Chief Executive will chair the fortnightly PRMs*

Care Group

- Divisional Managing Director
- Divisional Clinical Lead

- Divisional Nurse / AHP / CYP & Head of Midwifery

Corporate Directorates

- Relevant Group Chief / Executive Director
- Relevant members of the Directorate Senior Management Team

Support Teams

- Associate Director of Performance & Information
- Senior Performance Manager/Performance Manager

The membership will be limited to only those listed above.

4. Attendance & Quorum

The committee will be deemed to be quorate when two executive and two care group / corporate directorate members are present.

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf.

Attendance will be recorded and consistent non-attendance or failure to ensure a suitable deputy is in attendance will be escalated within the PRM summary report.

To ensure accurate recording of attendance and apologies it is essential that all invitees accept or decline meeting invitations.

5. Frequency

The meeting will take place monthly (Care Groups) / quarterly (Corporate Directorates) unless a decision is taken to increase or decrease the frequency of meetings based on robust performance delivery or lack thereof *(please also see section 5.2 above)*.

6. Cancellations of Meetings

The Chair has overall responsibility for decisions on the cancellation or re-arrangement of PRMs.

The meeting will only be cancelled or re-arranged if any of the following circumstances occur:

- LCHG has declared Level 4 and staff pertinent to the meeting are needed to support the frontline
- The Group Executive Leadership Team are attending an urgent, short notice meeting with a regulator
- If LCHG has declared a Major Incident

7. Admin Support

Administrative support to the meeting will be provided by the Performance & Information team. Data Packs will be drafted and tabled with the help of the Care Group / Corporate Directorate, together with other supporting teams (such as Workforce, Finance & Quality Governance). It is

aimed to provide packs one week prior to the meeting and a draft action log will be circulated within one week after the meeting has been held.

8. Governance Accountability, Reporting and Membership

After each round of PRMS a summary report will be prepared and submitted to the Group Leadership Team (GLT) highlighting any areas of escalation. Where required, escalations will be brought to the attention of the Group Board and relevant board committees through the IPR.

9. Review of Terms of Reference

The Terms of Reference for PRMs will be reviewed every three years or sooner should the need arise.

United Lincolnshire Teaching Hospitals NHS Trust

What AlignRT means to our staff and patients

About Us

- We have 3 treatment machines all with AlignRT with Postural Video and one CT with SimRT
- We treat around 2000 patients per year.
- Over 90% of them now use AlignRT

Breast Treatments

- Given us confidence to offer Complex treatments
- All breast patients tattoo free for nearly 5 years
- Saved us time and resources by detecting swelling

Thorax Treatments

- All treated without tattoos
- Postural video has helped minimise use of vacuum bags

Pelvis Treatments

- Reduced set up times
- Helping identify rotations
- Clinical trial approval
- Fully tattoo free

Head and Neck Treatments

- All patients now treated with an open face mask
- Patient comfort increased massively, and claustrophobia reduced
- We offer simple treatments completely mask free

Benefits for Staff

Standardisation

Techniques are easy to learn, and skills are transferable.

Progression

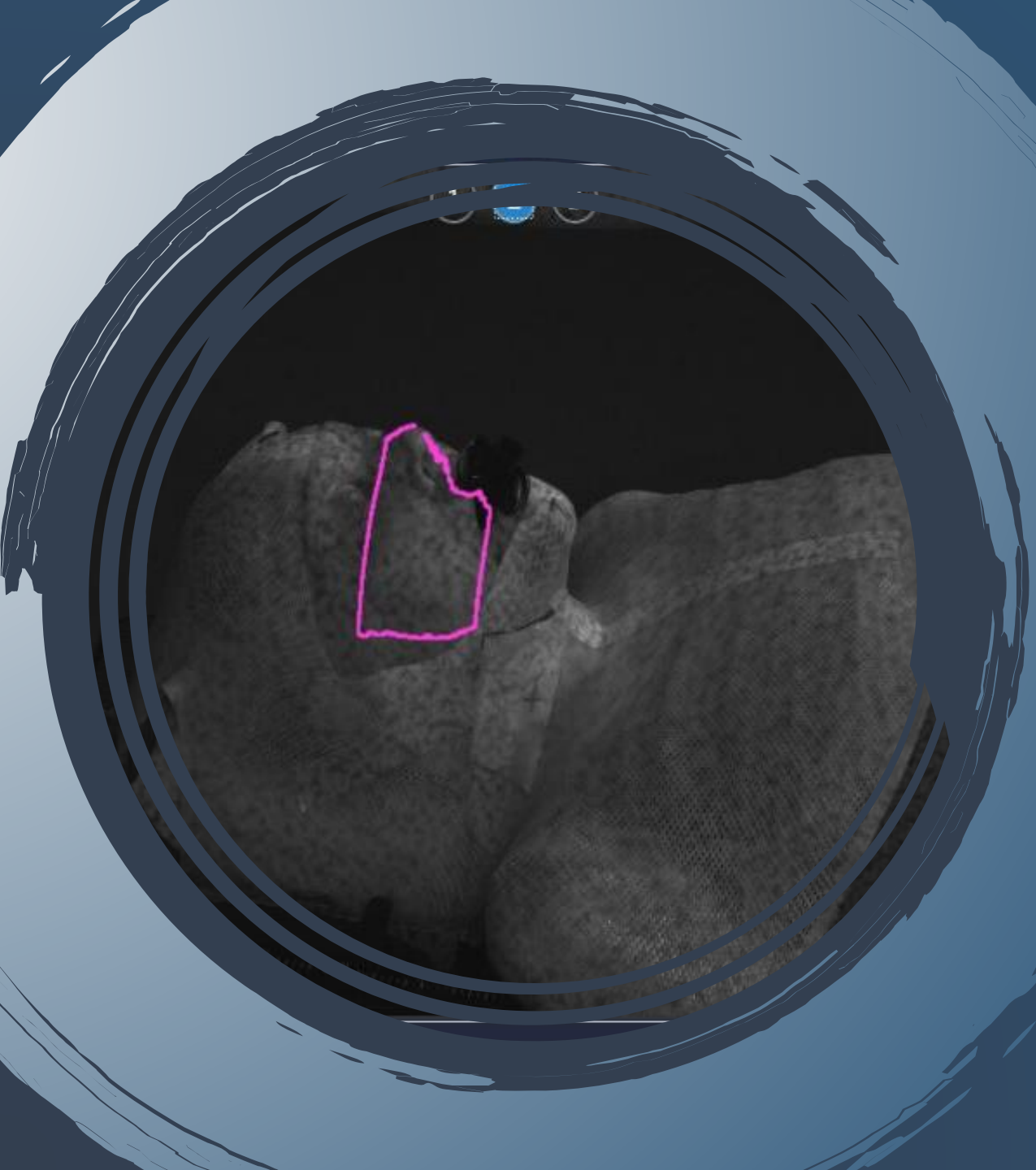
New skills to learn and more opportunities for job progression.

Peace of mind

Confidence that patients are safe during treatment.

Our Students

- 3 Students with SGRT related dissertations
- Able to prepare them for the future
- Our students are more employable

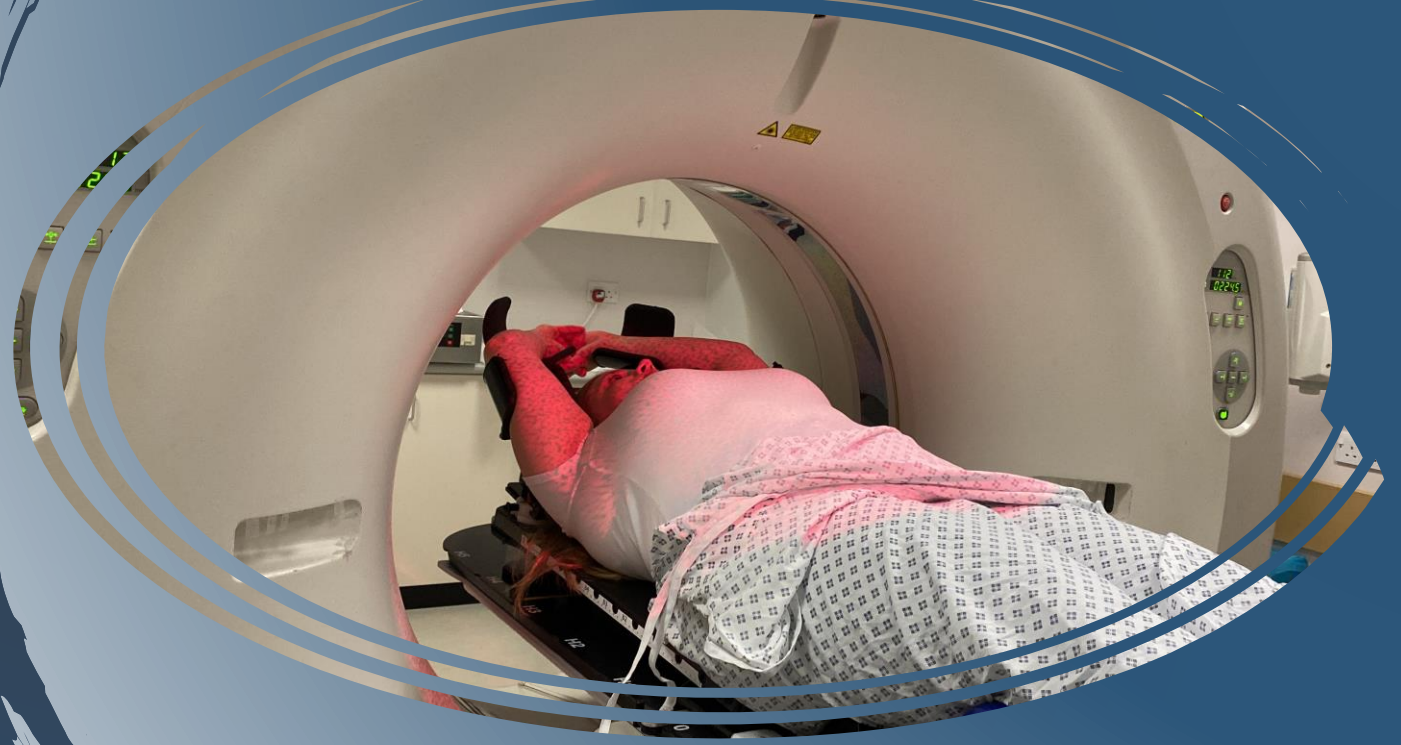


Case Study

- Patient with a tumour right next to their eye
- AlignRT used to position the patient and the bolus
- Full response, sight preserved

More examples

- Patients in too much pain for a conventional setup
- Avoiding unnecessary rescans
- Reducing margins



Recent awards

Thank you for listening

NHS
Lincolnshire Community and Hospitals NHS Group

Quality Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6 May 2025*
Item Number	*8.1*

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

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

Purpose

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

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

Due to the annual planning commitments across the Group the meeting worked to a reduce time and agenda receiving escalation reports only.

Upward Report

Escalation reports including:

- **Objective 1a – Deliver high quality care, which is safe, responsive and able to meet the needs of the population**
- **Objective 1b – Improve patient experience**
- **Objective 1c – Improve clinical outcomes**

The Committee received the following reports noting there were **no escalations** from the Committee to the Board:

- High Profile Cases Report
- Patient Experience and Involvement Group Exception Report

- Clinical Effectiveness Group Exception Report
- Patient Safety Group Exception Report

The Committee heard through the Patient Experience and Involvement Group report of the significant increase in referrals from patient and staff to the Chaplaincy service since Covid-19. It was noted that the primary reasons for referral were well-being, stress, anxiety and bereavement. Work was taking place to recruit volunteer chaplains and to streamline services to support patients and staff.

The Committee noted the position of clinical audits and recognised the improvements that had been made in respect of the National Paediatric Diabetes Audit (NPDA) with the service now being fully staffed.

A request was made by the Committee for a written report to be received in respect of paediatric cardiology to provide assurance following the reassurance offered through verbal updates in respect of the progress being made within the service.

The C-Difficile position was noted by the Committee with 95 cases to the end of February, reported against trajectory of 95 for the year. It was anticipated that the trajectory would be exceeded by the end of the year due to the national increase in cases.

The Committee noted that SHMI and HSMR remained as expected.

Assurance in respect of other areas

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

- Group Board Assurance Framework 2024/25 – for information
- Risk Report – for information

The Committee considered the risk report noting the position of this and recognising the recent discussions surrounding risk appetite.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

No matters to refer.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Quality Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6 May 2025*
Item Number	*8.1*

Quality Committee Upward Report of the meeting held on 15 April 2025

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

Purpose

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

This assurance Committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2025/26 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULTH and LCHS colleagues.

Upward Report

Assurance in respect of Objective 1a – Improve patient safety, patient experience and deliver clinically effective care

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

- Patient Safety Group (PSG) Upward Report
- High Profile Cases Report
- Maternity and Neonatal Oversight Group Upward Report
- Focussed Discussion – Clinical Harm
- Patient Experience and Involvement Group Upward Report
- Children in Care Update
- Clinical Effectiveness Upward Report

The Committee was pleased to note that PSG had received the first iteration of the Patient Safety Incident Investigation (PSII) report which would further develop in the coming months to detail learning improvements. It was noted that there were 24 PSIIs declared since this was launched in October 2023 with 13 investigations completed and 5 due to be received by the oversight committee.

The Committee received and recommended to the Board for approval the LCHG Patient Safety Incident Response Plan **(appended)** noting the Group approach that had been taken to the patient safety profile.

A reduction in falls were noted for both ULTH and LCHS with a reduction also noted in respect of pressure ulcers for ULTH. There was however a slight increase in pressure ulcers across LCHS with a deep dive report due to be presented to a future meeting.

There was recognition of the continued requirement for improvement in respect of Infection Prevention and Control for ULTH following recent visits by NHS England and the Integrated Care Board (ICB) with actions in place to strengthen processes and seek peer review.

The C-Difficile position at the end of March was reported as 98 cases, against a trajectory of 95. A number of MRSA cases were noted within maternity services with appropriate investigations and actions being undertaken, with ribotyping being completed to determine if the cases were linked.

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 Committee was pleased to note the achievement of CNST for year 6, following submission of non-compliance with an evidence review. Standards had now been released for year 7 of CNST with work commencing to deliver compliance. 100% compliance with duty of candour was noted.

The focussed discussion on clinical harm highlighted the processes in place for the management of clinical harm and the developments of utilising Datix reporting with the Committee endorsing the recommendations within the report to review clinical harm triggers for LCHS and to strengthen reporting and enable validation of data.

The Friends and Family Test (FFT) was being procured jointly across the Group to support gathering of patient feedback. There was also recognition of the benefit in automating quality metrics within patient experience to support monitoring of progress and support triangulation.

The Children in Care update identified the improvements seen in the previous quarter and the ongoing efforts to move to a single employed clinician to support consistency for the patient group.

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

Verbal updates were received, offering reassurance, in respect of paediatric cardiology and paediatric epilepsy with the Committee requesting written reports to future meetings to provide assurance.

Assurance in respect of other areas

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

- Group Board Assurance Framework 2025/26
- Risk Report
- Focussed Discussion – High Risks
- Quarterly Group CQC Progress Update
- Topical, Legal and Regulatory Update
- Committee Self-Assessment output and Committee Effectiveness Annual Report
- Internal Audit Report – Medical Device Management
- Policy Position Update
- Committee Performance Dashboard
- Draft Terms of Reference and Work Programme

The Committee noted the development of the 2025/26 Board Assurance Framework with the revised format and alignment to the Group strategic aims and objectives, raising concerns on the ability to effectively provide assurance ratings for the relevant areas contained within the objective.

Further work would be completed outside of the Committee to develop the format of the document to ensure appropriate review and assurance ratings could be provided by the Committee.

The Committee received and noted the risk register and considered the focussed discussion in respect of risks across the Group which demonstrated the oversight arrangements for risk and noted the need for a review of risk following the Board session on risk appetite.

The CQC progress update offered the position in respect of closure of actions and the proactive work of the Group with the Committee.

The policy position update highlighted the engagement of the divisions in providing updates as to the position of overdue policy documents with a number of documents realigned across the divisions which would provide appropriate oversight.

The Committee received the 2025/26 Terms of Reference and Work Programme (appended) which were offered to the Board for approval.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

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

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

Patient Safety Incident Response Plan (PSIRP)

Effective date: 1st April, 2025

Estimated refresh date: March 2026

Version:	V2.0
New or Replacement:	Replace – LCHS PSIRP 2024 and ULTH PSIRP 2023
Policy Number:	
Division & Specialty	Clinical Governance
Document author(s):	Lorna Adlington, Head of Patient Safety and Quality
Contributor(s):	Helen Shelton, Group Deputy Chief Clinical Governance Officer Bridy Rendall, Head of Patient Safety
Executive Sponsor (If Required)	Group Chief Clinical Governance Officer
Title of person responsible for review of document (e.g. Deputy Chief Nurse or Trust Lead (If Required))	Group Deputy Chief Clinical Governance Officer
Approved By:	Patient Safety Group, Quality Committee and Group Board
Date Approved:	TBC
Review Date:	April 2026
Policy is:	Group wide – incorporating United Lincolnshire Teaching Hospitals and Lincolnshire Community Health Services.

Contents

Corporate Policy Statement

The Lincolnshire Community and Hospitals Group is committed to promoting equality and diversity in all its activities to promote inclusive services, processes, practices and culture.

This plan reflects the Lincolnshire Community and Hospitals Group vision, values and behaviours and supports employees in working for the benefit of patient care. It takes account of the provisions outlined in the Equality Act 2010 to ensure no individual receives less favourable treatment on the grounds of age, disability, sex, race, gender reassignment, sexual orientation, religion and belief, marriage/civil partnership and pregnancy/maternity.

Alongside being committed to a proactive delivery of the Equality Act 2010, the Lincolnshire Community and Hospitals Group proudly seeks to embody the duties of the Public Sector Equality Duty (2011) in all its activity by:

1) Eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
2) Advancing equality of opportunity between people who share a protected characteristic and those who do not.
3) Fostering good relations between people who share a protected characteristic and those who do not.

We recognise high quality NHS patient care benefits by having a diverse community of staff who value one another.

Forward

‘The introduction of the PSIRF framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them.’

Aidan Fowler, National Director of Patient Safety, NHS England.

PSIRF is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves doing the same thing and calling it something different but a cultural and system shift in our thinking and response to patient safety incidents and how an incident is prevented from happening again. The challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident responses that support learning and improvement to prevent recurrence.

The NHS Patient Safety Strategy was published in July 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework (SIF). This document is the Patient Safety Incident Response Plan (PSIRP) which outlines how the Lincolnshire Community and Hospitals Group will look at patient safety incidents, what tools will be used to investigate and how it will share and embed learning into everyday work. This document is the first ‘ LCH Group’ PSIRP and details joint and individual priorities across both ULTH and LCHS Trusts – aligning focus and process to identify and embed the best learning and improvement opportunities for our patients.

This PSRIP will replace the previous United Lincolnshire Hospitals Trust and Lincolnshire Community Health Services PSIRP (2023/2024).

The Serious Incident Framework set the expectations for when and how organisations should investigate Serious Incidents. However, evidence from national reviews, patients, families, carers and staff and an engagement programme in 2018 revealed that organisations struggle to deliver these. The introduction of PSIRF supports a more autonomous flexible approach to management of patient safety events, underpinned by behaviours, decisions and actions that assist learning and improvement. PSIRF facilitates a move to examine incidents openly without fear of inappropriate sanction, support those affected and improve services. Unlike SIF, PSIRF is not an investigation framework that prescribes what to investigate. Instead, it:

- Advocates a coordinated and data driven approach to patients’ safety incident response that prioritises compassionate engagement with those affected by patient safety incidents.
- Embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Meaningful engagement with our patients, families and carers is a priority to ensure that their voice is the golden thread in any of our patient safety investigations. PSIRF sets out best principles for this engagement and our appointment to patient safety partners helps to ensure that the patient voice is involved at all stages of our patient safety processes.

Group work in moving towards a ‘just culture’ underpins how we will approach our incident responses; fostering a culture to allow people to feel psychologically safe, enabling them to speak up and highlight safety concerns without fear or repercussions. PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult that is, and we will continue work to how we can equip and support those affected to best hear the voice of those involved. The process of reviewing an incident can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure these are part of our PSIRF core objectives.

This continues to be a new way of managing our patient safety learning reviews. As a newly formed group we are still learning and accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. In this we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Importantly PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and carers whilst also protecting the well-being of our staff.

As a revised way of working we need to embrace a different cultural approach. PSIRF is a process of learning across the LCHG and continues to require ongoing review, revision and evaluation of impact and effectiveness to enable the refining of our PSIRF application.

Introduction

The NHS is changing the way it embraces patient safety, moving from a focus on individual incidents and issues to a more comprehensive look at system improvement with a holistic review of safety across the organisation.

This Patient Safety Incident Response Plan (PSIRP) sets out how Lincolnshire Community and Hospitals Group (incorporating United Lincolnshire Teaching Hospitals Trust (ULTH) and Lincolnshire Community Health Services NHS Trust (LCHS) intends to respond to patient safety incidents reported by staff, patients, their families, and carers. This PSIRP outlines a plan over a period of 12 months (April 2025 – March 2026) and is central to ongoing work to continually improve the quality and safety of the care we provide. The plan will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The plan is underpinned by our existing Lincolnshire Community and Hospitals Group policies on incident reporting, management, review and learning and the Group Patient Safety Incident Response Policy.

Our services

Lincolnshire Community and Hospitals Group cares for patients across the whole of Lincolnshire as both a community (LCHS) and acute (ULTH) provider. Both Trusts are statutory organisations working in partnership under a group collaboration to govern a provider collaborative. This Group model provides a central leadership body responsible for the strategic direction, and governance, of the two trusts.

Lincolnshire Community Health Services NHS Trust

LCHS cares for patients across the whole of Lincolnshire

Lincolnshire Community Health Services NHS Trust provides a wide range of community care across the county to meet the physical health needs of our community as close to their homes as possible.

Services are delivered through over 2554 substantive and bank staff, a range of trained healthcare professionals including nurses, allied health professionals, public health professionals, medics and GPs enabling great care across our communities. In 2023 / 2024 there were 773,595 contacts in community services and 2100 admissions to community hospitals.

Our staff provide high quality clinical care and expertise, coordinate, connect and advocate for our patients and carers in addition to driving digital innovation to improve access to services.

The Trust has a wide portfolio of healthcare services, in 47 buildings across 37 locations that includes:

- community nursing to support patients to get better care closer to home
- children and young people's services, including children in care and children's therapy services
- electronic assistive technology service (EATS)

- general and specialist integrated community nursing, immunisation, and vaccination services
- inpatient beds and outpatient clinics
- 4 community hospitals
- urgent care services including urgent treatment centres at Boston, Gainsborough, Louth, Lincoln, Skegness, and Spalding
- musculoskeletal (MSK) physiotherapy services
- occupational therapy, physiotherapy and speech and language therapy
- podiatry service
- safeguarding services for both children and adults
- integrated sexual health and contraceptive health.

United Lincolnshire Teaching Hospitals Trust

United Lincolnshire Teaching Hospitals NHS Trust (ULTH), situated in Lincolnshire, is one of the biggest acute hospital trusts in England serving a population of over 736,700 people. The trust provides acute care and specialist services to people in Lincolnshire and neighbouring counties.

Services are delivered through over 12,013 substantive and bank staff, variety of trained healthcare professionals including nurses, allied health professionals, public health professionals and medics enabling great care across all services.

ULTH is registered with the Care Quality Commission (CQC) to provide services at the following locations:

- Lincoln County Hospital (Acute Inpatient Beds, Maternity Unit, Emergency Department)
- Pilgrim Hospital Boston (Acute Inpatient Beds Maternity Unit, Emergency Department)
- Grantham District Hospital (Acute Inpatient Beds, Urgent Treatment Centre)

The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by NHS property services. These include:

- County Hospital Louth
- John Coupland Hospital, Gainsborough
- Johnson Community Hospital, Spalding
- Skegness and District General Hospital.

In the average year, we treat more than 140,000 Emergency Department patients, over 600,000 outpatients and over 140,000 inpatients, and deliver around 4000 babies.

The Trust provides a broad range of clinical services including community services, population-screening services, and a comprehensive range of planned and unscheduled secondary services.

Scope

Other types of incident responses exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners' inquests, or criminal investigations. The principle aims of each of these incident responses differ from the aims of a patient safety response and are outside the scope of this PSIRP.

Maternity services are considered as part of and inclusive of this patient safety incident response plan to ensure integration across the organisation and to promote shared learning in the widest sense. This ensures that all areas are included in the insight and improvement work associated with shared issues/challenges. Divisions and specialists' areas are all encouraged to work together to support a collaborative and integrated approach.

Patient safety incident response planning - defining our profile

PSIRF sets no rules or thresholds to determine what needs to be learned to inform improvement apart from the National requirements (see Table 2). A full review of all types of patient safety incidents across the Lincolnshire Community and Hospitals Group has been completed to understand what opportunities to learn and improve and develop a truly representative PSIRP.

Lincolnshire Community and Hospitals Group has a continuous commitment to learning from patient safety incidents and has an embedded understanding and insight into patient safety themes. This is supported through the Patient Safety Group that reports into the Quality Committee monthly. The role of the Patient Safety Group is to receive, review, scrutinise, challenge and respond to or escalate data and information across the clinical activities of the organisation that supports the LCHG to deliver its strategic objectives.

A weekly Patient Safety Response Planning Meeting, as a subgroup of Patient Safety Group, provides scrutiny and assurance that all aspects of patient safety incidents are being appropriately governed. This includes evidence that appropriate keys lines of enquiry are drafted and that lead investigators and family liaison officers are appointed to support and represent the patient/family/carer

As part of the review and planning around PSIRF there has been engagement with key stakeholders, both internal and external, and a review of data from a wide variety of sources to revise the safety profile. Using this approach has provided the opportunity to maximise learning and improvement and has facilitated the development of a Lincolnshire Community Hospitals Group Patient Safety Incident Response plan outlining local trust, group and national priorities. These priorities are detailed on page 18.

Stakeholder engagement

Development of the very first PSIRP across group was led by representatives from the original PSIRF implementation team supported by system and ICB partners. A wide variety of internal and external stakeholders were consulted including Maternity Voice Partners and the LMNS.

A review of the first year of PSIRF was undertaken and local learning informed the planning for the updated Group PSIRP engagement events. This early review provided insight into progress and learning to date and an opportunity to explore continued implementation of this approach. Learning from this review informed the engagement event, data review and supported the change of focus and responsibilities in the day-to-day management and learning from patient safety events.

A number of presentations have been delivered across the Group with a wide group of stakeholders to lead focused work around data and existing and emerging themes / priorities.

Data sources and how they were used to define our safety profile is detailed below. Once the data was collated, a series of workshops with our key internal and external stakeholders were undertaken to review this together to finalise the priorities for review by PSII. Engagement workshops included presentations, group work and use of a question-and-answer platforms to enable co-working on the development of our safety profile and response planning.

Data Sources

A thematic analysis approach was used to determine which areas of patient safety activity it should focus its local patient safety priorities. Our analysis used several data sources and safety insights from key stakeholders both internal and external.

A review of services across the group was undertaken based on the service codes set up in the Datix Risk Management system. Wider data sources were triangulated to look at themes / trends and areas of focus and improvement already underway. This was then shared with Corporate and Operational divisions across the group to ensure that all services had been captured. This approach sought to ensure that the shape and structure of the plan reflects the likely incidents that are experienced across Lincolnshire community and Hospitals group.

Patient safety data from April 2023 – March 2024 was reviewed which included (but not limited to) the following data sources:

- Themed analysis of Datix Incident data
- Patient Safety investigations (PSIIs)
- After Action reviews / Multi-disciplinary review
- Maternity investigations - including Maternity Incentive Scheme (NHS Resolution), Maternity and Newborn Safety Investigations programme (MNSI), Perinatal Mortality Review Tool, MBRRACE
- Risks held on the risk register
- Key themes from clinical audit and case note reviews
- Key themes from claims
- Key themes from incidents raised with the Trust from the ICB (known as HPFs)

- Issues identified from CQC inspections and other quality surveillance processes / visits
- Issues identified through safeguarding reviews
- Complaints / PALs data
- Themes arising from mortality/ learning from deaths and medical examiner reviews
- Patient experience data
- Nursing metric data
- Themes from safety climate surveys
- Themes from the Freedom to Speak Up Guardian feedback.
- Staff survey data
- Infection prevention and control data
- Learning from national inquiries (e.g. Ockenden) and the Core20PLUS5 programme (maternal health inequalities a top priority) to complement local safety intelligence.

Incident types, recurrence and severity were explored, together with careful consideration of safety improvement opportunities and knowledge, together with plans and interventions already in place. A range of staff, including leads for each of the above data collection systems, were consulted and the review also highlighted areas which required the collation of further intelligence to inform subsequent plans.

Cross-referencing the data from these various sources over the past year assisted with theming incidents and identification of an extensive list of incident types. Further stakeholder engagement and analysis enabled identification of the Trust's local priorities for focus as part of our PSIRP. It is recognised that there may be occasion to respond to an event that holds significant learning and that this is not within the priority list. The plan is a proactive mechanism to allocate resources to prioritise safety improvement, which aligns to the Group's Patient Safety Incident Response policy. The approach outlines the process for reviewing all patient safety incidents including maternity specific events. For this reason, capacity has been identified for ad-hoc PSIIs and use of a variety of PSIRF tools to support the greatest learning and improvement opportunity.

Patient Safety Data

From all the initial data collated, information was grouped into a number of broad themes which formed the Group's patient safety incident profile. The themes were reflective of the range of services provided across both Trusts and under the Group portfolio and the types of incidents reported. These are shown in the **Table 1** below:

Table 1:

Themes
Palliative and End of Life / Respect
Management of the Deteriorating patient
Management of Sepsis
Transfer of care across the interface (internal and external)
Communication
Fluid Management
Medication Issues
Diabetic pathways
Clinical Ownership
Discharge Processes
Documentation
Referral Pathways / Communication Between Specialties

Care of Vulnerable Patients
Frailty – identification of and management
Diagnostics
EPMA
Best Interest Decisions
Administrative Processes
Culture
Leadership development
Falls
Pressure Ulcers
Nutritional Needs
Children / Paediatric pathways
Speech and Language therapy
Delays in Appointments / Waiting Lists
Behaviour

Workshop were convened to discuss the outputs of the data. This scrutiny was led initially with wider stakeholders and a second to triangulate themes with existing improvement workstreams and identify priority areas that would generate the most learning as local Patient Safety Incident investigations (PSII).

Whilst the final list has been agreed it is recognised that this list is not fixed thereafter. Within our resource analysis, we have also established capacity for additional ad-hoc PSII, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

Defining our patient safety improvement profile

Lincolnshire Community and Hospitals Group has existing governance processes to ensure it gains insight from patient safety incidents and that this intelligence directly feeds into quality improvement activity. Consideration is also given to guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define any wider quality improvement work.

The Quality Committee (QC) will provide assurance that patient safety improvements, as part of PSIRF, continue to be of the highest standard. Its sub-group, the Patient Safety Group (PSG), will be responsible for the oversight of this patient safety improvement work including the robust use of quality improvement methodology.

Clinical and Corporate Care Groups across both arms of the Group are required to report to the PSG in order to monitor and measure patient safety activity across the organisations. The Patient Safety Group also provides assurance during the development of new safety improvement plans, following reviews undertaken within PSIRF, to ensure robust processes have been followed and requirements are met and are sufficient to improve patient safety in future.

Focus will be given to the development of safety improvement plans across the most significant incident types either those within national priorities, or those identified locally. We will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

Our patient safety incident response plan: national requirements

Certain events within healthcare require a specific type of response as set out in National policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event.

Specific patient safety incidents, incidents meeting the Never Events criteria (2018) and Deaths thought more likely than not due to problems in care i.e., incidents meeting the Learning from Deaths criteria will require a locally led Patient Safety Incident Investigation (PSII) to support learning and improvement. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but this approach is endorsed within Lincolnshire Community and Hospitals group as it fits with our intention to learn and improve within a 'just culture'. As well as PSII, some incident types require specific reporting and/or review processes to be followed.

For clarity, all types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the suggested methods and are detailed in the table below. From our incident and resource analysis we estimate, due to the services we provide across the LCHG, we will complete approximately 32 PSII reviews where both local and national requirements have been met per annum.

Table 2 below sets out the local and national mandated responses. As LCHS and ULTH do not directly provide mental health or custodial services it is more likely that these incident types (8,9,10 and 11) will be led by a secondary participant rather than being led from within LCHG.

Table 2:

	National Priority	Required response	Anticipated improvement route
1	Incidents meeting the Never Events criteria 2018	Locally led PSII	Create local organisational recommendations and actions and feed these into the quality improvement strategy
2	Deaths thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	Locally led PSII	Create local organisational recommendations and actions and feed these into the quality improvement strategy
3	Patient safety incidents meeting the 'Each Baby Counts' and maternal deaths criteria for MNSI investigation: • Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life. • Early neonatal death: the baby died, from any cause, within	Referred to Maternity and Newborn Safety Investigations Programme (MNSI) for independent patient safety incident investigation Referral to MBRRACE where applicable	Respond to recommendations as required and feed learning into safety profile planning and improvement priorities

	the first week of life (0 to 6 days). • Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic–ischaemic encephalopathy; or was therapeutically cooled (active cooling only); or – had decreased central tone, was comatose and had seizures of any kind. • Maternal deaths: death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).	Perinatal Mortality Review Tool (PMRT) **See Appendix 1**	
4	Child Deaths	Refer for Child Death Overview Panel review Locally led PSII (or other response) may be required alongside the panel review	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led PSII may be required alongside the LeDeR review.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
6	Safeguarding incidents in which: Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. Adults over 18 years old are in receipt of care and support needs from their local authority.	Refer to local authority safeguarding lead via named safeguarding lead Internal stakeholders will contribute to domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy

	The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and the local safeguarding adults boards	
7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy. See: Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)
8	Deaths of patients in custody (e.g., police custody, in prison etc.) where health provision is delivered by the NHS	Refer to the Prison and Probation Ombudsman or the Independent Office for Police Conduct to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
9	Deaths of patients detained under the Mental Health Act (1983), or where the mental Capacity Act (2005) applies, where there is a reason to think that the death may be linked to problems in care (incidents meeting the Learning from Death criteria)	Locally led PSII by the provider in which the event occurred with participation if required	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required with mental	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy

		health provider as lead and local participation if required	
11	Domestic homicide	Identified by the police usually in partnership with the local Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing review of the case.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy

Perinatal mortality review tool (PMRT) – patient safety incidents aligned to this programme of work will continue to be reviewed in line with the PMRT process. If learning is indicated by the PMRT review the local PSIRF decision making process will be followed to determine, on a case by case basis, the most proportionate response to maximise learning for improvement. This will involve input from all those affected.

Our patient safety incident response plan: local focus

PSIRF allows organisations to focus learning response resources on areas where improvement will have the greatest impact, based on their local incident profile and existing improvement work. Through analysis of our patient safety insights, based on the review of patient safety data and engagement meetings and workshops, it has been estimated that Lincolnshire Community and Hospitals Group will undertake no more than 32 patient safety incident investigations (PSII) over the next 12 months, 5 of which being locally defined projects (**See Table 3 below)**. Of the 5 locally defined priorities, 3 PSIIs will be focused across 'Group', 1 PSII focused in the community and 1 PSII focused in acute services. These selections reflect the breadth of services and patient pathways across the LCH Group and recognise the areas of focus required across both community and acute pathways of care.

All other incidents will continue to be reviewed using alternative review methods which will be outlined later within this plan. It is not the case that only the incidents identified for a PSII will get a review of care. This includes ensuring that reviews of maternity / obstetric incidents are undertaken in line with CNST / Saving Babies Lives requirements.

The breakdown of PSIIs is identified below in **Table 3**:

Criteria	Number of PSIIs
Deaths meeting the level 3 learning from deaths criteria	Estimating 18
Incidents meeting the Never Event Criteria	Estimating 5
Locally defined projects	5
Allocation for issues identified in year	Estimating 4
Total	**32**

The above calculation allows for decisions to be made in year to undertake a PSII outside of the locally defined projects if determined that the learning from the incident warrants this. The detail of this process, how the incidents for the locally defined projects will be identified and the other review methods to be used will be outlined in the Group Patient Safety Incident Response Policy. The outcomes and learning from PSIIs will be used to inform patient safety improvement planning and work.

Locally defined responses:

Table 4 demonstrates the criteria for selecting priorities for a PSII response:

Criteria	Considerations
Potential for learning and improvement	• Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding. • Likelihood of influencing: healthcare systems, professional practice, safety culture. • Value: extent of overlap with other improvement work; adequacy of past actions.
Systemic risk	• Complexity of interactions between different parts of the healthcare system.

Based on the analysis and selection criteria described above, local priorities for PSII have been set for the period 1st April 2025 to March 2026. The patient safety priorities were agreed through a wider representation of stakeholders across the Lincolnshire Community and Hospitals Group, Patient Safety Group, Group Leadership Team and Quality Committee in March 2025.

The agreed priorities are outlined in **Table 5** below:

Theme	Key Theme		Key Risks from Activity
1	Transfers of Care (between wards / departments / across both acute and community settings)	Group priority	Patient transfer internally and externally between departments and across the interface between acute and community settings has been identified as a theme. The underlying reasons for this are not fully understood.
2	Deteriorating Patient – focus on sepsis management and pathways.	Group priority	Identification of deterioration and signs of sepsis and immediate management continues to be on the top five incident categories. The underlying factors for this and improvement actions required are not fully understood.
3	Speech and Language Therapy (SaLT)	Group priority	SaLT has been identified as a theme leading to potential patient harm/actual harm across the group. The full pathway around the delivery of SaLT needs to be understood further to support patient care needs.
4	Deteriorating Patient – focus on fluid management	Acute priority	Work has been undertaken to improve care in relation to fluid management however, themesare still being reported in relation to this area. Underlying reasons for this are not yet understood and there are further opportunities

			for learning and improvement to improve patient safety.
5	Medication – transfer of medication	Community priority	Review of the data has identified a theme regarding transfer of medication and medicines management between care providers resulting in omitted, duplicated or wrong dose medicines administration leading to harm for patients. The systemic reasons and the opportunity for improvement actions are not fully understood.

Additionally, Infection Prevention and Control (IPC) incidents that compromise patient safety for example amputation consequential to sepsis, death due to C.Difficile, MRSA/MSSA bacteraemia, and Legionnaires disease outbreak will be subjected to a PSII for a learning response as per the devised IPC PSIRF matrix document.

Alongside the mandated PSII response (for Never Events, deaths assessed due to problems in care) will be undertaken where there is the potential for greatest learning and improvement, where it is perceived, there is opportunity for increased knowledge or insight of systems influence.

All incidents not meeting the PSII criteria will be managed at a local level via the use of the Learning from Patient Safety Events (LfPSE) within the Datix reporting system with ongoing thematic analysis via our existing Group assurance processes which may lead to new or supplement existing improvement work. Further information on this and the Duty of Candour principles can be found in the Group Incident Management Policy and the Group Duty of Candour Policy.

Timescales for PSIIs

Where a PSII is required (as defined in this plan for both local and national priorities), the investigation will start as soon as possible after the patient safety event is identified. PSII's will normally be completed within one to three months of their start date however, in exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe will be agreed between ULHT and the patient/family/carer.

No PSII should take longer than six months. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. Where the processes of external bodies delay access to information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigation.

Patient Safety Reviews

Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resource investigations into employment concerns, professional standards investigations, coroner inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

For any incident not meeting the PSII criteria, or any other incident, different review techniques can be adopted, depending on the intended aim and required outcome as reflected below:

Patient Safety Review type	Methods	Objective
Incident recovery	Initial safety review (ISR)	To take urgent measures to address serious and imminent: a. Discomfort, injury, or threat to life b. Damage to equipment or the environment.
	Risk Assessment	To assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised and control measures apply.
Team Review	Debrief	To conduct a post incident review as a team by discussing and answering a series of questions.
	Safety Huddle – Proactive and reactive	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data to: • Improve situational awareness • Focus on the patients most at risk • Share understanding of the day's focus and priorities • Agree actions • Enhance teamwork through communication and collaborative problem-solving • Celebrate successes in reducing harm.
	After Action Review (AAR)	A structured, facilitated discussion of an incident or event to identify: • What was expected to happen? • What happened? • Why was there a difference between what was expected and what happened? • What are the lessons that can be learnt?
	Multi-disciplinary team (MDT)	A structured discussion to identify learning from multiple patient safety incidents (including incidents were multiple patients were harmed or where there are similar types of incidents). Examples include: • delayed recognition of deteriorating patients • medication errors • admission or discharge-related safety events

Systematic Reviews To determine: • The circumstances and care leading up to and surrounding the incident. • Whether there were any problems with the care provided to the patient	Perinatal Mortality Review Tool (PMRT)	Systematic, multidisciplinary, high-quality audit and review to determine the circumstances and care leading up to and surrounding each still birth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
	Atain Review Tool	Joint review by maternity and neonatal services to identify learning points to care provision and improve understanding of potential areas of suboptimal care.
	Structured Judgement Review (SJR)	To determine whether there were any problems with the care provided to a patient by a service.
	Specialised Reviews	For example, falls, pressure ulcers, IPC reviews.
	Thematic Review	A themed review may be useful in understanding common links, themes, or issues within a cluster of investigations or incidents for example, pressure ulcers, deteriorating patient, post-partum haemorrhage, 3rd and 4th degree tears.
Monitoring	Audit	Regular review to improve the quality of care by evaluating delivered care against standards. Can be observational or include documentation review (or both).

PSIRF is changing the way the NHS embraces patient safety, moving away from a focus on individual incident investigations conducted under the Serious Incident Framework (SIF) (2015). Under SIF the NHS has extensively investigated themes such as Pressure Ulcers with minimal quality improvement or reduction in numbers reported, the transition to PSIRF will facilitate thematic AAR and cross-reference the themes/trends to provide a more comprehensive look at system improvement with a holistic review of safety across the organisation for increased learning opportunities and review areas of Patient Safety not previously explored.

A Human Factors systems-based approach to learn from incidents, ensure a positive 'Just Culture' is applied for staff involvement alongside capturing patient and family engagement within the review process. The outcomes are used to inform patient safety improvement planning and work going forward.

The intelligence collated from the AAR, MDTs and PSII will be discussed at a local level with ongoing thematic analysis via existing assurance processes. The thematic action outcomes will contribute to the development of an overarching improvement plan for said 'theme' for example pressure ulcers; the improvement plan will incorporate the SMART criteria. The use of the SMART criteria will guide objective/goal setting by being specific, measurable, achievable, relevant and time related.

The learning outcomes will be shared across the Group via the following but not limited to these methods: Safety Bulletin, Lessons Learned Library, 7-minute briefing, weekly comm's bulletin, Group Intranet, local Divisional Governance Groups and best practice forums.

Duty Of Candour

Priorities for ‘being open’ conversations and Duty of Candour include:

- All patient safety incidents leading to moderate harm or above.
- All incidents for which an investigation is undertaken.

Reference is made to the Group Policy around Duty of Candour.

Reviewing our PSIRP and policy

The patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated to respond to patient safety incidents. The plan will be reviewed every 12 months to ensure the focus remains up to date; as such it is expected that the PSIRP will continue to evolve over time. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

Updated plans will be published on individual Trust websites, replacing the previous version.

An annual review will be undertaken and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement feedback.

Glossary:

PSII - Patient Safety Incident Investigation

PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to address those system factors and help deliver safer care for our patients effectively and sustainably.

PSIRP - Patient Safety Incident Response Plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

PSIRF - Patient Safety Incident Response Framework

Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

AAR – After Action Review

A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

PSA – Patient Safety Audit

A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guideline).

PMRT - Perinatal Mortality Review Tool

Developed through a collaboration led by MBRRACE-UK with user and parent involvement, the PMRT ensures systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.

Perinatal Mortality Review Tool | PMRT | NPEU (ox.ac.uk)

MNSI – Maternity and Newborn Safety Investigations

The Maternity and Newborn Safety Investigations (MNSI) programme investigates certain cases of early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour in England, maternal deaths in England.

https://www.mnsi.org.uk/our-investigations

SJR - Structured Judgement Review

Developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths; the SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.

nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

Never Event

Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

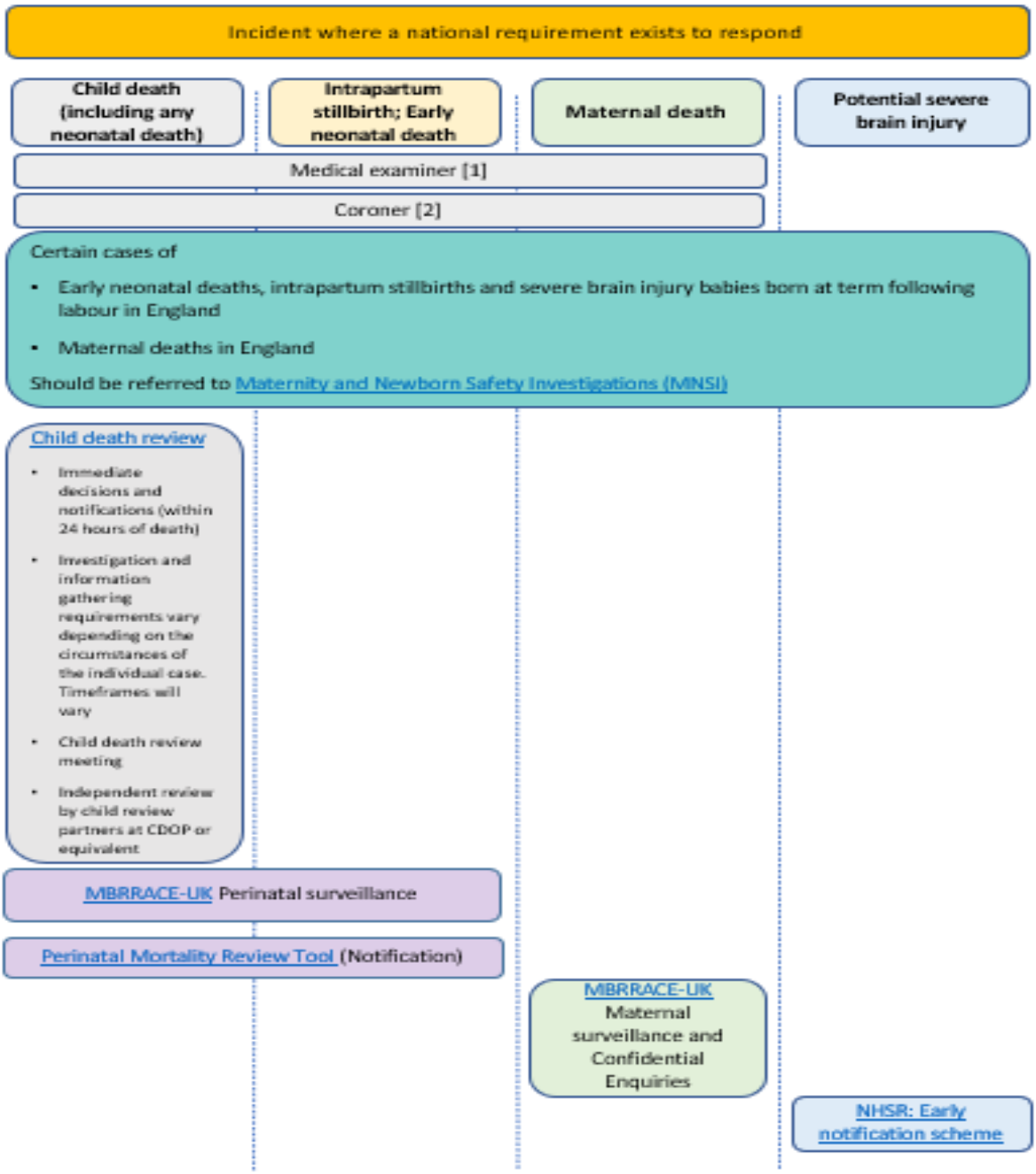
https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

Deaths thought more likely than not due to problems in care.

Incidents that meet the 'Learning from Deaths' (LfD) criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Appendix 1: National requirements for patient safety incident response in maternity



1. Medical Examiners offer Independent scrutiny of the causes of death; ensure appropriate direction of deaths to the coroner; provide a better service for the bereaved and opportunity to raise any concerns; improve quality of death certification; improve quality of mortality data
2. Coroner inquest when the cause of death is unknown or there is reason to think the death may not be due to natural causes. Inquest is to establish the medical cause of death, and how, when and where the death occurred

Appendix 2: Equality and Health Inequality Impact Assessment Tool

This tool has been developed by the Equality, Diversity and Inclusion Leads for use in the NHS Provider organisations in Lincolnshire. The tool is designed to ensure due regard is demonstrated to the Equality Act 2010, the Public Sector Equality Duty and potential health inequalities are also identified and addressed (as outlined in the Health and Social Care Act). Please complete all sections below. Instructions are in **bold** Email for all correspondence: email to lhnt.edifirst@nhs.net

Patient Safety Incident Response Plan

Description of activity	Patient Safety Incident response plan. The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy. The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims: Compassionate engagement and involvement of those affected by patient safety incidents. Application of a range of system-based approached to learning from patient safety incidents. Considered and proportionate responses to patient safety incidents Supportive oversight focused on strengthening response system functioning and improvement
Type of change	Updated PSIRP New PSIRP across Lincolnshire Community and Hospitals Group
Form completed by	Lorna Adlington
Date decision discussed & agreed	
Who is this likely to affect?	Service users X Staff X Wider Community □ If you have ticked one or more of the above, please detail in section B1, in what manner you believe they will be affected.

Equality Impact Assessment

Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Further, please consider other population groups which are at risk of health inequality and can include, but not be limited to, people who are; living in poverty / deprivation, geographically isolated (e.g., rural), carers, armed forces, migrants, homeless, asylum seekers/refugees, surviving abuse, in stigmatised occupations (e.g., sex workers), use substances etc.

Please ensure you consider the connections (intersectionality) between the protected characteristics and population groups at risk of health inequality (e.g., it is recognised that older men from a BAME background, with one or more comorbidities and living in deprivation are more at risk of a poorer outcome if they contract CV-19).

(Below must be table paragraph)

How does this activity / decision impact on protected or vulnerable groups? (e. g. their ability to access services / employment and understand any changes?) Please ensure you capture expected positive and negative impacts.	It will provide our people and our patients with a greater opportunity to be involved in patient safety learning events and contribute to learning and improvement. Greater focus on a just culture with emphasis on learning and improvement, quality driven care and services. The framework will support staff and ensure awareness of expectations. The patient voice is clear in all aspects of patient safety learning.
What data has been/ do you need to consider as part of this assessment? What is this showing/ telling you?	Duty of Candour, patient feedback, staff feedback. Greater emphasis on the role of all stakeholders as part of feedback and learning.

Risks and Mitigations

What actions can be taken to reduce / mitigate any negative impacts? (If none, please state.)	None
What data / information do you have to monitor the	To include but not exhaustive: • Incidents and incident trends

impact of the decision?	• Complaints data • Available clinical outcomes • Patient stories • Patient survey feedback (including Friends and Family Test) • Soft intelligence via available clinical or patient forums • Adherence to available NICE guidance • External inspection outcomes and ratings

Decision/Accountable Persons

Endorsement to proceed?	Yes / No Delete as appropriate and add detail or rationale
Any further actions required?	e.g., risk to be added to the risk register or capturing in local action log etc.
Name & job title accountable decision makers	
Date of decision	
Date for review	Please note: the equality impact assessment is a 'live' document and must be reviewed regularly / when any significant change occurs.

United Lincolnshire Hospitals NHS Trust

Annual Report to the Trust Board from the Quality Governance 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, amended. Under the agreed terms of reference, the Quality Committee was tasked as follows:

The Quality Committee will:

- Ensure that there are robust processes in place for the effective management of clinical governance, quality and risk.
- Ensure that there are effective structures in place to support clinical governance and that these structures operate effectively and that action is taken to address areas of concern.
- Through the receipt of upward reports from the reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the Quality Committee.
- Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboards monthly with exception reporting as the norm.
- Use outcome measures to demonstrate continuous improvement.
- Consider the control and mitigation of quality related risks and provide assurance to the Boards that such risks are being effectively controlled and managed in line with the Trusts' risk appetite statements. Whilst the committee's remit covers all of the Trusts services, the committee has a specific oversight role in relation to the quality & safety of United Lincolnshire Hospitals Trust's maternity services (reference: Ockenden).
- Review and provide assurance on those strategic objectives within the respective Board Assurance Frameworks, identified as the responsibility of the committee seeking where necessary further action.
- Provide assurance to the Boards that all legal and regulatory requirements relating to quality are met, including directives, regulations, national standards, policies, reports, reviews and best practice.
- Review & challenge the annual Quality Accounts ensuring they are a balanced and accurate reflection of both Trusts position.
- Approve and monitor the annual clinical audit plans.
- Monitor the implementation of agreed action plans in relation to all major internal reviews and all external reviews within the remit of the Quality Committee.

- Ensure that there is sufficient time on the agenda to allow for strategic discussion items on areas of responsibility of the committee and to include horizon scanning on the current and future environment.

MEETINGS

The Committee met monthly during the year and after each meeting provided an assurance report to the Trust Board.

During the year, to enable the Committee to support the development of the Quality Committee in Common, meeting durations were shortened to 1 hour. The Committee continued to deliver a full agenda through the submission of questions, by Committee members, ahead of the meeting which were responded to during the meeting.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2024/25 the Committee was chaired by Mr Jim Connolly.

Details of the Committee's membership and attendance during 2024/25 is set out below:
The members of the Committee are:

- Non-Executive Director – Chair
- Non-Executive Director – Deputy Chair (Maternity and Neonatal Safety Champion)
- Non-Executive Director (LCHS)
- Non-Executive Director (ULHT)
- Associate Non-Executive Director (ULHT)
- Group Chief Nursing Officer (CQC Nominated Individual, Lead Director for Safeguarding)
- Group Chief Medical Officer (Accountable Officer for Controlled Drugs, DIPC)
- Group Chief Operating Officer
- Group Chief Integration Officer
- Group Chief Clinical Governance Officer

Changes to the membership during the course of the year are detailed in the below table.

Voting Members	24 Apr 2024	21 May 2024	18 Jun 2024	23 Jul 2024	20 Aug 2024	17 Sept 2024	22 Oct 2024	19 Nov 2024	17 Dec 2024	21 Jan 2025	18 Feb 2025	18 Mar 2025
Non-Executive Director (Mr Connolly, Chair)	X	X	X	X	A	X	X	X	X	X	X	X

Non-Executive Director (Mrs Brown)	X	X	X	X	X	X	X	A	X	X	X	X
Non-Executive Director (Dr Gibson)	X	A	X	X								
Non-Executive Director, LCHS (Miss Shadlock)	X	X	X	X	X	X	A					
Associate Non-Executive Director (Mrs Wells)	A	X	X	X	X	A	X	X	X	X	X	X
Executive Director of Nursing/Group Chief Nurse	A	X	X	X	X	X	D	X	X	X	D	X
Group Chief Medical Officer	X	X	X	X	X	X	X	D	A	A	X	D
Chief Operating Officer/Group Chief Operating Officer	A	X	A	A	X	A	X	X	A	X	X	X
Group Chief Integration Officer					X	D	X	D	A	X	X	D
Director of Clinical Governance/Group Chief Clinical Governance Officer	X	X	D	X	D	X	X	X	D	X	D	A

A denotes Apologies given
D denotes Deputy in attendance
X denotes attendance

External members including representation from the Integrated Care Board also attend the Committee to provide external challenge and review and Patient Safety Partners are routine attendees of the Committee to provide additional challenge and review.

Colleagues are co-opted onto the Committee to offer expert opinion and assurance when required, such as the Deputy Director of Safeguarding, Head of Patient Experience and Director of Midwifery.

REVIEW OF BUSINESS

The Quality Committee followed a programme of work for the 2024/25 year.

The Quality Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2024/25:

- Objective 1a – Deliver high quality care which is safe, responsive and able to meet the needs of the population
- Objective 1b – Improve patient experience
- Objective 1c – Improve clinical outcomes
- Objective 1d – Deliver clinically led integrated services
- Objective 5b – Co-create a personalised care approach to integrate services for our population that are accessible and responsive
- Objective 5d – Transform key clinical pathways across the group resulting in improved clinical outcomes

During 2024/25 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF. The strategic objectives at the beginning of the year were rated as follows:

LCHS
Objective 1a – **GREEN**
Objective 1b – **GREEN**
Objective 1c – **GREEN**
Objective 1d – **UNRATED**
Objective 5b – **UNRATED**
Objective 5d – **UNRATED**

ULTH
Objective 1a – **GREEN**
Objective 1b – **GREEN**
Objective 1c – **GREEN**
Objective 1d – **UNRATED**
Objective 5b – **UNRATED**
Objective 5d – **UNRATED**

Through the year the Committee continued to receive reports offering assurance against the strategic objectives resulting in the objectives continuing to be rated as follows at the end of the year:

LCHS
Objective 1a – **GREEN**
Objective 1b – **AMBER**
Objective 1c – **GREEN**
Objective 1d – **UNRATED**
Objective 5b – **UNRATED**
Objective 5d – **UNRATED**

ULTH
Objective 1a – **GREEN**

Objective 1b – **AMBER**
Objective 1c – **GREEN**
Objective 1d – **UNRATED**
Objective 5b – **UNRATED**
Objective 5d – **UNRATED**

Whilst objectives 1d, 5b and 5d remained unrated during the year this was due to the Committee care taking the objectives whilst the Integration Committee was established. The Integration Committee was established in December 2024, at which point the objectives were moved to the Committee.

OVERVIEW

The Quality Committee has continued to, over the last twelve months, improve the assurance it can give to the Board that there is an effective system of quality governance and internal control across the clinical activities of the Trust. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan, as defined by the terms of reference through this annual report.

The Committee continues to receive monthly assurance/exception reports from the reporting groups offering assurance on effective quality governance across the Group.

The reporting groups are:

- Patient Safety Group
- Patient Experience and Involvement Group
- Clinical Effectiveness Group
- Maternity and Neonatal Oversight Group

Patient stories continued to be received by the Committee demonstrating the commitment of the Group to deliver the best patient care and on occasions when we did not get it right and there was evidence of learning and service improvements made.

The Committee has been well attended by members during the year with members coopted to the Committee as required to provide further insight into areas for consideration. On a bi-monthly basis the Director of Midwifery attended the Committee to present updates in respect of Maternity and Neonatal services to support the Clinical Negligence Scheme for Trusts (CNST) submissions and achievement.

The Chair and Executive Leads meet monthly to agree the forthcoming committee agenda in line with the work programme.

Key areas of focus of the Committee have included:

- CQC Inspection reports and outcomes
- Mortality
- Harm Reviews
- Never Events
- Patient Safety Incident Framework
- Infection, Prevention and Control
- CNST Maternity Scheme
- Maternity and Neonatal
- Medicines management
- Safeguarding arrangements including looked after children
- Palliative and End of Life Care
- Patient Experience

The Committee continued to have a focus on Maternity and Neonatal services with the Maternity and Neonatal Oversight Group continuing to be attended by the Non-Executive Director Maternity Safety Champion which offers greater assurance to the Committee and Board. There had also been national recognition, during the year, of the improvements and achievements of the service.

Detailed upward reports and supporting documents continued to be received by the Committee in line with reporting from the Group with reports offered to the Board, alongside supporting documents where necessary to provide evidence to the CNST submissions.

During the course of the year assurances continued to be received in respect of Infection Prevention and Control with the Committee recognising the increases in communicable diseases during the year. There was reflection of the Clostridium Difficile position that, whilst this reported slightly above trajectory, there had been significant increases in the national position, which were believed to be as a result of increased antibiotic usage.

The Committee continued to receive a lack of assurance in respect to Medicines Management and received a number of focussed discussions in this area in order to gain further assurances. A number of actions were in place to address ongoing concerns.

Significant progress on internal audit recommendations was seen with the closure of all outstanding audit recommendations achieved in year and the Committee had received regular reporting in respect of the Group Policy documents due to the need to address the position of overdue policy documents in place.

During the course of the year the Clinical Effectiveness Group continued to make progress with both local and national audit achievement alongside improved assurances being offered to the Committee.

Risks

The BAF and Corporate risk register have been updated and reviewed at the Committee on a monthly basis identifying where updates have been required based on assurances received at the Committee.

Performance Review

The Committee reviews performance against the agreed quality Key Performance Indicators and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover harm free care, improving patient experience and effective use of resource.

The Committee have actively ensured that the KPIs requiring monitoring by the Committee were reported. At each of the meetings during 2024/25 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified. The Committee noted the positive position during the year in respect of Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) performance.

During 2024/25 the Committee was pleased to note the introduction of the Patient Safety Incident Response Framework to LCHS, following the implementation at ULTH during the 2023/24 year.

Due to the progress in respect of the CQC Action plan, during the year reporting developed to a CQC Assurance report received on a quarterly basis with a focus on proactive evidence gathering.

Due to concerns noted in respect of Looked After Children the Committee requested regular reports to ensure that oversight was maintained on the position with reassurance being received. During the year it was noted that additional appointments were made to the workforce in order to address areas of concern. Recruitment to these roles was achieved in the later part of the year with an expectation of improvements being seen during the first quarter of the 2025/26 year.

Where the Committee identified areas further assurance was required, focused discussions were held or scheduled to be received through the work programme. The focused discussion areas included:

- Pressure ulcers
- Human Factors
- Pharmacy/Medicines Management
- Deteriorating Patients
- Falls
- Diabetes/DKA
- Clinical Harm
- End of Life Care
- Treatment Escalation Spaces

During 2024/25 referrals between the Board Committees were made in order to ensure that where necessary additional assurances were sought from the relevant responsible Committee in areas where responsibility for assurance extended beyond the remit of a single committee. A number of referrals to the Committee and from the Committee were made during the year offering opportunities for the Quality Committee to seek further assurances.

The Quality Committee is an essential element of the Group's corporate governance structure. It works closely with the Audit Committee and the Chair of the Quality Committee is also a member of the Audit Committee. The Committee received all internal audits relevant to its remit for consideration of the actions and oversight of the completion of these.

NHS
Lincolnshire Community and Hospitals NHS Group

Finance and Performance Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*6 May 2025*
Item Number	*8.2*

Finance Committee Upward Report of the meeting held on 20 March 2025

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

Purpose

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

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

Due to the annual planning commitments across the Group the meeting worked to a reduce time and agenda receiving escalation reports only.

Upward Report

Escalation reports including:

- **Objective 3a Deliver financially sustainable healthcare, making best use of resources**
- **Objectives 3c A modern, clean and fit for purpose environment across the Group**
- **Objectives 3d, 3e and 3f Reduce waits for patients who require urgent care, cancer and diagnostics to constitutional standards**
- **Objective 3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards – LCHS**
- **Objective 4d Enhanced data and digital capabilities**

The Committee received the escalation reports with **assurance** noting the allocation of an additional £25m of surge funding, of which £21m had been applied to ULTH, and was cash backed, therefore improving the cash position, removing the needs for external cash support.

The Group deficit position was reported as £15.8m, adverse to plan, as a result of the additional funding.

Progress was noted in respect of Cost Improvement Programmes (CIP) and stabilisation of the pay position in whole time equivalents with oversight of this through the Performance Review Meetings.

There had been no additional capital monies available to the Group at the end of the year however the Group was in a position to progress at pace, a number of schemes, should funding become available.

There was recognition of the challenges in the 2025/26 year in respect of the required savings with the Group undertaking planning and identifying CIP for the year.

Assurance in respect of other areas

Board Assurance Framework 2024/25
The Committee received the Board Assurance Framework for information.

Risk Report
The Committee received the joint report for information.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

No items for referral.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Finance and Performance Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*6 May 2025*
Item Number	*8.2*

Finance Committee Upward Report of the meeting held on 22 April 2025

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

Purpose

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

This assurance Committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2025/26 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULTH and LCHS colleagues.

Upward Report

Assurance in respect of Objective 1d Reduce waiting times for our patients

Operational Performance Report – ULTH/LCHS and Committee Performance Dashboard

The Committee received the reports with **assurance** noting from a ULTH perspective that there had been an increase in demand within the emergency departments, despite this strong performance was achieved with significant improvements in patients waiting 12-hours in the departments and ambulance handovers.

Zero 52-week waits had been achieved, and 65-weeks had been achieved against trajectory with those remaining due to patient choice. There had been a reduction in performance in respect of cancer services for faster diagnosis

standard and 62-day performance, driven by the backlog from the Christmas period however early indications were that this would recover in March.

Diagnostic performance continued to be challenging particularly for DEXA, audiology and non-obstetric ultrasound. Community Diagnostic Centre performance was delivering in a number of modalities however patient choice was impacting on activity levels.

The Committee noted the LCHS operational performance with a rise in patient incidents however this remained low with the Quality Committee considering the position. It was recognised that care hours per patient day would become a new productivity measure and work was ongoing in respect of discharge summaries and readmission rates with no discharge summary, which would begin to resolve with the introductions of the new electronic patient records.

The length of stay in community beds was inconsistent due to mixed occupancy, this resulted in an average length of stay of 21 days with a trajectory to reduce to 14 days.

Community Waiting Lists (CWL) were now being reported, and it was noted that there were a number of pathways which required review to ensure these were appropriate as there were a number of disconnected pathways.

Urgent Treatment Centre (UTC) activity was increasing due to the life and limb project with work also required to support access to services for patients through non-collocated UTCs.

A deep dive was requested by the Committee into a number of LCHS performance areas where gold standard targets had been set, to better understand performance against an appropriate trajectory.

The Committee noted the ongoing development of the integrated performance report for the Group which would present the top risks and offer an interactive dashboard as well as a pictorial view of the areas of focus.

Assurance in respect of Objective 1c Improve productivity and deliver financial sustainability

Finance Report inc CIP, Capital, PLICS Q3 and CRIG
The Committee received the report with **assurance** noting the year end position of an £18.2m deficit across the Group with an £18.3m deficit in ULTH and a £0.1m surplus in LCHS. The Committee noted that the position was £11.3m adverse to plan but within the revised control total agreed with NHS England.

The Cost Improvement Programme (CIP) was noted to have fully delivered at £47.1m and there had been full delivery of the capital programme at £93.3m with significant spend seen in month 12. The Cash position at month 12 was reported at £46.3m and was a combination of capital and revenue cash.

There was recognition of the discretionary spend controls introduced in March 2025 in line with recovery actions and it was noted that the new process had been challenging. In response to the national requirement to reduce corporate growth, a formal return is required to be submitted at the end of May.

Better Payment Practice Code was noted as challenging due to the cash position however this had improved in month 12.

The Committee received the Patient Level Information Costing Submission (PLCIS) report for quarter 3, noting the position and the data that demonstrated where issues were and provided the ability to focus on productivity plans and enabled triangulation to the efficiency programme.

The Committee recognised the overall positive position, despite the reported deficit, and noted the ongoing efforts to address the financial position in the coming year. It was noted that the phasing of the CIP would be key to delivering our plan with additional resource support for delivery.

2024/25 National Cost Collection Pre-submissions report
The Committee received the report noting the timeline for the submission with a request to the Board to approve delegated authority to the Committee for approval of the final submission for both LCHS and ULTH.

It was noted that the guidance had been received at the beginning of March with the submission winder opening in early June and closing a month later. The intention was to submit on 27 June with work required in respect of validation.

Productivity Plans
The Committee received the report noting the development of the Productivity, Improvement and Transformation Oversight Forum (PITOF) that would provide oversight and hold colleagues to account for delivery.

Whilst it was recognised that the group and the work remained underdevelopment the Committee noted the clear direction of travel with high quality data within the dashboard.

There was recognition that, through the reporting function being developed, any programmes starting to move off plan, would quickly be identified.

2025/26 Update on Cost Improvement Productivity and Efficiency Plan
The Committee received the report noting the focus that had been given to planning in recent weeks with **assurance** provided on the progress that had been made in respect of the 2025/26 plan.

It was noted that the process for monitoring, measuring and supporting delivery was being worked through with the intention to create a dashboard that would offer real time reporting.

The Committee noted the target of £79.3m CIP, of which £71.5m had been identified to date. Further work was being undertaken to close the gap however the Committee recognised the positive position of the Group at the start of the year.

Concern was noted however in respect of appropriate levels of support to ensure delivery. There was recognition of the plans being phased to ensure support was in place.

Assurance in respect of Objective 1d Provide modern, clean and fit for purpose care settings

Estates and Facilities Assurance Report
The Committee received the report with **assurance** noting that NHS Property Services had a robust action plan in place in respect of ventilation issues at County Hospital Louth. This had the potential to impact the Joint Advisory Group (JAG) accreditation for the endoscopy service however the JAG Auditor had been satisfied with the actions in place. Further improvements were required.

Electrical testing across sites had been rolled out to test back up power supplies across the acute sites and had highlighted a number of areas requiring improvement.

The Committee was pleased to note the success at bringing together a single estates helpdesk for the Group, following the LCHS estates work being moved from NHS Property Services to ULTH.

The Committee noted the current impact of vacancies within the directorate however noted that key roles were in moving through the vacancy control process. The internal audit report was noted as an area of concern due to the limited assurance with the Committee requesting further information to a future meeting to provide wider context to this.

Health and Safety Committee Assurance Report – Committee Upward Report
The Committee received the report noting that this was from the LCHS meeting held in January with the Health and Safety Committees moving to a Group approach from May, bringing together assurance across the organisations.

The Committee noted the ongoing fire safety issues in respect of Johnson Hospital, Spalding and County Hospital Louth, and was pleased to note that assurance was being gained from NHS Property Services, who had received the fire enforcement notice, however LCHS was a tenant at the sites.

Information Governance Group Assurance Report – Committee Upward Report
The Committee received the report noting the update offered and recognised the ongoing concerns associated with compliance with subject access requests and freedom of information requests.

Assurance in respect of other areas

Board Assurance Framework 2024/25
The Committee noted the development of the 2025/26 Board Assurance Framework with the revised format and alignment to the Group strategic aims and objectives noting the need to ensure clarity on the sources of assurance.

It was also noted that Internal Audit Reports should be recorded within the BAF as a source of assurance as these were received by the Committee.

Committee Terms of Reference and Work Programme
The Committee received the 2025/26 Terms of Reference and Work Programme (appended) which were offered to the Board for approval.

Review of Committee Effectiveness – Annual Report and Self-Assessment
The Committee received the reports and feedback was requested in respect of the annual report for this to be presented to the Board to support the completion of the annual reports and annual governance statements of the organisations.

Integrated Improvement Plan (ULTH) / Operational Plan – Q4 (LCHS)
The Committee received the reports with **assurance** noting that these offered the year end position and close for the 2024/25 year.

Risk Report
The Committee received the report noting that discussions through the Committee had covered the risks presented. It was noted that a full review of risks was underway to ensure alignment of these to the appropriate Committee

Policy Position Update
The Committee received the update noting that the position remained static and recognised the engagement that was taking place with identified leads in order for risk ratings and position updates to be provided for those documents which were overdue review.

Internal Audit Reports
The Committee received the series of internal audit reports noting the levels of assurance offered and noted that the recommendations would be monitored by the Committee to ensure closure.

CQC Improvement Plan – Quarterly report by exception
The Committee received the report noting the position and sought to understand the position and expectation of the actions being closed.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

No items for referral.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

Lincolnshire Community and Hospitals NHS Group

Annual Report to the Trust Board from the Finance and Performance 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 Finance and Performance Committee was tasked as follows:

The Finance and Performance Committee will:

- Agree a set of Key Performance Indicators to be presented in the committee Performance Dashboard monthly
- Approve the business planning timetable
- Seek assurance that the trusts and wider group have in place robust and effective operational and financial planning arrangements and delivery plans
- Review, challenge and monitor in-year financial and operational performance
- Consider the control and mitigation of finance, operational performance and estates related risks and provide assurance to the Trust Boards that such risks are being effectively controlled and managed
- Provide oversight of and receive assurance on delivery of agreed Cost Improvement Plans and associated efficiency and productivity programmes
- Provide oversight of and receive assurance on procurement processes and performance
- Review delivery of the relevant aspects of the estates strategy, priorities and compliance including health & safety requirements and compliance with the Premises Assurance Model (PAM)
- Provide oversight of and receive assurance in respect of compliance with the Data Security Protection Toolkit
- Provide assurance to the Trust Boards that all legal and regulatory requirements relating to finance, operational, estates performance and data security are met, including directives, regulations, national standards (including constitutional standards), policies, reports, reviews and best practice
- Review and provide assurance to the Trust Boards on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance and actions where

necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions.

MEETINGS

During the 2024/25 year the Committee was established across the Group and met for the first time as the Finance and Performance Committee in November 2024. Prior to the establishment of the Finance and Performance Committee the Finance, Performance and Estates Committee, ULTH and Finance, Performance, People and Innovation Committee, LCHS met to provide assurance in respect of the relevant strategic objectives with meetings taking place on a monthly basis and quoracy met for each.

Following establishment in November 2024 the Finance and Performance Committee met monthly however worked to a reduced agenda during March 2024 to support operational colleagues to undertake annual planning.

The Committee, after each meeting held, provided an assurance report to the Board which meets on a bi-monthly basis.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2024/25 the Committee was chaired by Ms Cecchini.

Details of the Committee's membership and attendance during 2024/25 is set out below:

Non-Executive Director **(Chair)**
Two Joint Associate Non-Executive Directors
Group Chief Finance Officer
Group Chief Operating Officer
Group Chief Integration Officer
Group Chief Estates & Facilities Officer
Group Chief People Officer

Members	**Nov 2024**	**Dec 2024**	**Jan 2025**	**Feb 2025**	**Mar 2025**
Non-Executive Director (Mrs Cecchini, Chair)	X	X	X	X	X
Associate Non-Executive Director (Mrs Buik)	X	X	X	X	X
Associate Non-Executive Director (Mr Orrell)	X	X	A	X	X

Group Chief Finance Officer	X	X	X	X	X
Group Chief Operating Officer	D	X	D	X	X
Group Chief Integration Officer	D	X	X	X	X
Group Chief Estates and Facilities Officer	X	X	X	X	D
Group Chief People Officer		X	X	X	X

X denotes attendance
A denotes Apologies given
D denotes Deputy in attendance

REVIEW OF BUSINESS

The Finance and Performance Committee followed a programme of work for the 2024/25 year.

The Finance and Performance Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2024/25:

- 3a: Deliver financially sustainable healthcare making best use of resources
- 3b: Drive better decisions and impactful action through insight
- 3c: A modern, clean and fit for purpose environment across the group
- 3d: Reduce waits for patients who require urgent and emergency care and ensure we meet all constitutional standards
  ULTH
- 3e: Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards
- 3f: Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards
  LCHS
- 3g: Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards

- 4d - Enhanced data and digital capability

During 2024/25 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF.

The strategic objectives at the beginning of the year were rated as follows. The ratings at the beginning of the year were provided by the Finance, Performance, People and Innovation Committee (LCHS) and Finance, Performance and Estates Committee (ULTH) prior to the establishment of the Group Committee:

LCHS
Objective 3a – **AMBER**
Objective 3b – **GREEN**
Objective 3c – **RED**
Objective 3d – **AMBER**
Objective 3g – **RED**
Objective 4d – **UNRATED**

ULTH
Objective 3a – **AMBER**
Objective 3b – **UNRATED**
Objective 3c – **AMBER**
Objective 3d – **UNRATED**
Objective 3e – **UNRATED**
Objective 3f – **UNRATED**
Objective 4d – **UNRATED**

At the end of the year the strategic objectives were rated as follows by the Finance and Performance Committee:

LCHS
Objective 3a – **GREEN**
Objective 3b – **GREEN**
Objective 3c – **RED**
Objective 3d – **AMBER**
Objective 3g – **AMBER**
Objective 4d – **GREEN**

ULTH
Objective 3a – **RED**
Objective 3b – **UNRATED**
Objective 3c – **AMBER**
Objective 3d – **AMBER**
Objective 3e – **AMBER**
Objective 3f – **AMBER**
Objective 4d – **UNRATED**

During the course of, the year the Committee received assurance across a number of areas resulting in changes, in year, to the assurance ratings presented above.

The Committee maintained oversight of the relevant strategic objectives relevant to its remit and whilst there are a number of objectives which remain unrated it has been recognised that this was due to the transition year through the formation and development of the Group. The Committee was unable to provide ratings for all objectives due to the transition year and insufficient assurances being provided to enable these to be rated.

OVERVIEW

The Finance and Performance Committee has offered a level of assurance to the Board on finance, operational performance, estates and digital services. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan, as defined by the terms of reference through this annual report.

The Committee has been well attended by members and the Chair has been actively involved in the agenda setting alongside the Group Chief Finance Officer and report authors.

Other key areas of focus of the Committee have included:

- Estates
- Health and Safety
- Emergency planning
- Digital services
- Procurement
- Information Governance
- Constitutional standards
- Internal Audit
- Planning

The Committee receives monthly assurance/exception reports from the reporting groups offering assurance on areas relevant to the remit of the Committee. The Committee maintained clear focus in 2024/25 on reporting from the Information Governance Group due to the concerns noted in meeting statutory requirements in respect of subject access requests (SARs) and Freedom of Information Requests (FOI). Focused work was noted in respect of the Data Security Protection Toolkit (DSPT) with a requirement for full review of the evidence, prior to submission to ensure an accurate submission was made, due to the changes made to the toolkit nationally.

The Committee continued to monitor the requirements to achieve zero 78-week and 65-week waits in year and was pleased to note the achievements made at the end of the financial year. Focus was also provided to discharge processes in order to improve flow through ULTH.

The Committee continued to monitor the delivery of the Integrated Improvement Plan noting that the delivery of projects had progressed during the course of the year with oversight provided by the Improvement Steering Group and supporting delivery of Cost Improvement Programmes (CIP).

The Committee received reports associated with strategic projects including the delivery of additional Community Diagnostic Centres (CDCs) at Lincoln and Skegness, and the new build of the Pilgrim Emergency Department. with a visit undertaken to the Grantham CDC by the Chief Operating Officer for NHS England, to celebrate the work of the Trust.

Other strategic project considered by the Committee included the investment and commencement of the new Endoscopy suite at Lincoln County Hospital.

Changes were made to the Estates function with the ULTH estates team taking on responsibility for the LCHS estate as the Group came together. This had highlighted a number of concerns in respect of the estates utilised by LCHS however reviews were being undertaken to address concerns. The Committee noted the fire enforcement notice at County Hospital Louth, against NHS Property Services (NHSPS), with recognition that NHSPS were acting to resolve issues in order to ensure the safety of LCHG staff and patients.

Deep dives continued to be received by the Committee into a number of areas where further assurance was required, and the Committee has received reports from the Digital Directorate with a clear focus on developments within cyber security and the migration of ULTH to the NHS tenant with the Committee noting the exceptional work that was undertaken to achieve this.

The Electronic Patient Record was considered by the Committee during the year with the Committee delighted to note the final approval of the ULTH business case by Treasury to enable the completion of the procurement process and commencement of the introduction of the EPR. The Committee also noted the achievement of the re-tendering process for the LCHS EPR.

The Electronic Document Management System (EDMS) was also procured in year which would be an enabler to the EPR for ULTH, supporting the move from paper based to electronic records.

Significant progress on internal audit recommendations and the Committee had received regular reporting in respect of the Group Policy documents due to the need to address the position of overdue policy documents in place.

Risks

The BAF and Corporate Risk Register have been reviewed at the Committee on a monthly basis identifying where updates have been required based on assurances received at the Committee.

Performance Review

The Committee reviews performance against the agreed Key Performance Indicators (KPIs) and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover operational performance and efficient use of resources.

The Committee have actively engaged in the development of the performance dashboard, ensuring that the KPIs requiring monitoring by the Committee were reported. At each of the meetings held during 2024/25 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified.

Performance discussions focused on operational performance with positive progress noted in a number of areas including cancer performance and the eradication of 78-week waits for ULTH.

The community performance metrics were monitored by the Committee with recognition that the position, in respect of community performance, required review due to the levels of performance being set above national trajectories.

Concerns remained in respect of the continued deterioration in urgent and emergency care, due to increases in demand and continued flow and discharge issues. Proactive work was in place across the Group to undertake programmes of work to improve this position.

The Committee noted throughout the year the financial position of the Group, with a deficit position reported noting that the majority of this was within the ULTH position. The Group delivered a year end position of £18.2m deficit, £11.3m adverse to plan, however this was delivered within the revised control total agreed with NHS England. Due to the position in year ULTH had been required to access cash draw down in the later part of the year however following the provision of surge funding nationally, cash drawdowns had not been required in the final months of the year.

Changes to the procurement act were noted by the Committee with significant work undertaken by the team to ensure that the Group was able to effectively enact these changes.

During the year the Committee maintained oversight of the Capital Programme noting a capital spend of £93.3m with delivery of this position at year end across the Group.

During 2024/25 referrals between the Board Committees were made in order to ensure that where necessary additional assurances were sought from the relevant responsible Committee in areas where responsibility for assurance extended beyond the remit of a single committee. A number of referrals were made during the year offering opportunities for the Committee to seek further assurances.

The Finance and Performance Committee is an essential element of the Group's corporate governance structure. It works closely with the Audit Committee and the Chair of the Finance and Performance Committee is also a member of the Audit Committee, which helps provide additional assurance on the adequacy of the Trusts financial controls and systems. The Committee received all internal audits relevant to its remit for consideration of the actions and oversight of the completion of these.

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Finance Briefing

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

Meeting	*Lincolnshire Community and Hospitals Group Board meeting*
Date of Meeting	*6th May 2025*
Item Number	*8.3*

Finance Report

Accountable Director	*Paul Antunes Goncalves, Group Chief Finance Officer*
Presented by	*Paul Antunes Goncalves, Group Chief Finance Officer*
Author(s)	*Finance Team*
Recommendations/ Decision Required	The Board is asked to: • Note the contents of the Finance report in respect of Revenue, Capital, Cash and CIP positions. • Note the Group has delivered a deficit for 2024/25 of £18.2m, although this is adverse to plan, it is in line with agreed outturn position with the regulator. • Note the Group delivered its capital programme for 2024/25, utilising £93.3m of available funding. • Note that the Group did not achieve its' planned cash position for 2024/25 but did manage a very challenging cash position to minimise the impact of this upon supplier payments. • Note that the Group delivered its CIP target for 2024/25, however there was a significant reliance on non-recurrent CIP and in year mitigations to support this position.

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	
1b Improve patient experience	
1c Improve clinical outcomes	
1d Deliver clinically led integrated services	
2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	
2b To be the employer of choice	
3a Deliver financially sustainable healthcare, making the best use of resources	*X*
3b Drive better decision and impactful action through insight	
3c A modern, clean and fit for purpose environment across the Group	
3d Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards	

3e Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)	
3f Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)	
3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	
4b Successful delivery of the Acute Services Review	
4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	
5c Tackle system priorities and service transformation in partnership with our population and communities	
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	

Executive Summary

Trust Board is asked to note the following:

- **2024/25 Revenue position**
  The Group did not achieve its' planned £6.9m deficit for 2024/25; while an outturn deficit of £18.2m was £11.3m adverse to plan, it was within a revised control total of £18.5m agreed with NHSE.

- **2024/25 Capital position**
  The Group did achieve its' capital programme for 2024/25 with capital expenditure of £93.3m (99.7% of plan)

- **2024/25 CIP position**
  The Group did achieve its' CIP target of £47.1m for 2024/25; the Group exceeded the target by £0.7m (1.6%).

- **M12 Cash position**
  The Group did not achieve its' planned cash £55.3m cash position for 2024/25; however, the Group has managed a very challenging cash position to minimise the impact of this upon supplier payments.

Lincolnshire Community and Hospitals NHS Group
Board Meeting – 6 May 2025
Finance Briefing

Executive Summary

In 2024/25, the Group set a challenging plan as part of our System control total. The Group made significant progress on reducing our agency spend (£11.2m lower than previous year) whilst also implementing additional controls on vacancies and non-pay which supported our in year financial position. The Group delivered our efficiency target, although a large element was delivered through non-recurrent measures and mitigating actions. Overall, the Group missed our financial plan by £11.3m, which was in line with our revised position agreed with System.

In 2024/25 the Group have spent £93.3m on our capital programmes, which was a significant increase from last year (circa £65m). This has enabled key developments to be progressed/completed including Community Diagnostics Centre's in Skegness and Boston, improvements in our ED at Pilgrim Hospital, £7.5m of new medical equipment, over £10m of improvements in our digital infrastructure and nearly £19m of improvements in our general estate portfolio.

Our Better Payment Practice Code performance has been impacted by our cash position; however, we have ended the year at 93% based on volume at United Lincolnshire Teaching Hospitals and 86% at Lincolnshire Community Healthcare Services.

Summary Position

	Group performance			LCHS performance			ULTH performance		
Month 12 Position	Year To Date			Year To Date			Year To Date		
	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m
Surplus / (Deficit)	(6.9)	(18.2)	(11.3)	(0.0)	0.0	0.1	(6.9)	(18.3)	(11.4)
CIP Delivery	47.1	47.9	0.7	7.0	7.4	0.4	40.1	40.5	0.4
Capital Spend	93.5	93.3	0.2	5.4	5.2	0.2	88.1	88.1	0.0
Agency Spend	(17.6)	(24.0)	(6.4)	(2.7)	(1.4)	1.3	(14.9)	(22.6)	(7.7)
Cash Balance	55.3	46.3	(9.1)	30.0	27.1	(2.9)	25.3	19.2	(6.2)

Delivery of financial duties

- **Breakeven** – The Group did **not achieve** its' planned £6.9m deficit for 2024/25; while an outturn deficit of £18.2m was £11.3m adverse to plan, it was within a revised control total of £18.5m agreed with NHSE.

- **CIP** – The Group **did achieve** its' CIP target of £47.1m for 2024/25; the Group exceeded the target by £0.7m (1.6%).

- **Capital** – The Group **did achieve** its' capital programme for 2024/25 with capital expenditure of £93.3m (99.7% of plan).

- **Agency** – The Group did **not achieve** its' agency target for 2024/25; while expenditure of £24.0m was £6.4m higher than planned, it was £11.2m lower than expenditure of £35.2m in 2023/24.

- **Cash** – The Group did **not achieve** its' planned £55.3m cash position for 2024/25. However, the impact on supplier payments was minimised through collaboratively working with System partners and business cases securing additional NHSE cash support.

Revenue Position

The Group's financial position has been challenging in 2024/25 and has required mitigating actions to be taken to manage the financial position.

The Group has seen our pay position grow, as we have opened our Community Diagnostics Centres, continued our overseas nursing recruitment and reduced our vacancy rates. To manage our pay position the Group implemented enhanced vacancy controls during the year which stabilised our Whole Time Equivalent position and associated pay expenditure.

In year we have also seen the impact of resolving our Band 2 to Band 3 backdated pay settlement which increased our pay bill above Plan by £5.1m, mainly due to the multi-year back pay settlement. We are pleased that this issue has been resolved, and the ongoing impact has been built into our 2025/26 Plan.

As part of our mitigating actions, the Group have implemented enhanced non pay control on categories of spend that have been assessed as potentially discretionary. These controls served to reduce our spend on a temporary basis but are not a sustainable recovery action.

The Group has delivered our efficiency target with a significant reduction in our agency spend across all areas (medical, dental and back office). Our Procurement department have delivered reductions in our consumable costs that have contributed to our efficiency programme whilst our Estates and Facilities team delivered significant savings in our support costs. However, there has been a reliance on non-recurrent savings to support our efficiency programme, as we move into 2025/26 our focus has shifted to delivering recurrent and sustainable transformation savings.

Capital Position

The Group have delivered the largest capital plan in recent years, utilising the full £93.3m budget envelope for 2024/25.

This has allowed for significant improvements to be made across our estates, digital infrastructure, medical/clinical equipment, alongside supporting new developments.

In 2024/25 we have opened two new Community Diagnostic Centres that enable care to be delivered closer to the communities we serve in state-of-the-art facilities. These units have also been supported by our hospital charity that funded some additional items which will benefit both patients and staff in both sites. We are extremely thankful for the work our charity has done and all the donations' people have made.

The Group has a challenging estate given the geographical footprint of Lincolnshire and we are pleased to have made £18.9m of estates improvements during the year. We will continue to focus our capital spend on managing our infrastructure challenges in 2025/26 and beyond.

In 2024/25 we have also invested nearly £20m on our new Emergency Department at Pilgrim Hospital in Boston, we look forward to opening the Department in 2025/26.

People Committee Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6 May 2025*
Item Number	*9.1*

People Committee Upward Report of the meeting held on 21 March 2025

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

Purpose

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

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

Due to the annual planning commitments across the Group the meeting worked to a reduce time and agenda receiving escalation reports only.

Upward Report

Escalation reports including:

- **Objective 2a – Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise**
- **Objective 2b – to be the employer of choice**
- **Objective 4c – group our research and innovation through education, learning and training**

The Committee received the escalation reports with **assurance** noting the reduction in overall vacancy rates for both LCHS and ULTH with turnover continuing to decrease.

Improvements were also noted in relation to sickness rates and the continued focus on improving appraisal rates was noted with the introduction of the appraisal cycle at ULTH to reflect that of LCHS.

The Committee noted the reference within the Health Service Journal for Lincolnshire being in the top 5 most improved Trusts across the UK in respect of staff survey results, this related to ULTH. There was however recognition that the improvement journey for the Trust continued, with recognition of the impact of the cultural and financial challenges in the coming year.

Concern was noted by the Committee in respect of staff raising concerns about patient safety issues which would be referred to the Quality Committee for triangulation.

The Committee noted the business planning process with an overview of workforce having been presented to the Board through a development session, the plan was due to be submitted on the 24 March.

Once planning processes were completed the known position in respect of the required resource to support the Cost Improvement Programmes would be known and it would be possible to build in phasing to deliver these in line with resource.

Assurance in respect of other areas

Board Assurance Framework 2024/25
The Committee received the Board Assurance Framework for information.

Risk Report
The Committee received the joint report for information.

Issues where assurance remains outstanding for escalation to the Board

None

Items referred to other Committees for Assurance

The Committee wished to refer to the Quality Committee the national staff survey results and the safety concerns indicated in these to request triangulation with quality and safety data.

Attendance Summary for rolling 12-month period

Voting Members	A	M	J	J	A	S	O	N	D	J	F	M
Phil Baker, Non-Executive Director, ULTH (Chair)							X	X	X	X	X	X
Vicki Wells, Associate Non-Executive Director (Chair – from March 25)							X	X	X	X	X	X
Gail Shadlock, Non-Executive Director, LCHS							X	A	X	X	A	A
Claire Low, Group Chief People Officer							X	D	X	X	X	X
Colin Farquharson Group Chief Medical Officer							D	X	X	A	D	X
Nerea Odongo, Group Chief Nurse							X	X	X	X	D	X

X in attendance
A apologies given
D deputy attended

People Committee Upward Report

Lincolnshire Community Health Services NHS Trust
United Lincolnshire Hospitals NHS Trust

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6 May 2025*
Item Number	*9.1*

People Committee Upward Report of the meeting held on 11 April 2025

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

Purpose

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

This assurance Committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2025/26 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULTH and LCHS colleagues.

Upward Report

Assurance in respect of Objective 2a – Enable our people to fulfil their potential through training, development and education

Education Oversight Group Upward Report inc. Non-Clinical Education Update

The Committee received the report reflecting that this offered a positive position with significant improvement noted in respect of statutory and mandatory training.

The recent visit from the University of Lincoln and University of Nottingham was noted for ULTH with a positive outcome from this following concerns raised at previous visits.

Work was taking place to develop relevant key performance indicators (KPIs) for the group which would feed into the Committee dashboard to ensure key metrics had appropriate oversight.

It was noted that there was a plan in place for the Continuing Professional Development funding across the year however concern was noted in respect of the apprenticeship levy with the national position not yet known. Further information would be provided to the Committee once available.

Medical/Clinical Education Update
The Committee received the report with **assurance** noting the interim quality assurance visit that had been undertaken by the University of Nottingham the previous month which had provided assurance in respect of the governance associated with the funding position.

The Committee noted that the Group Chief Medical Officer would take on the role of Board Champion for medical education.

There was recognition of the achievement of ensuring support mechanisms were in place for locally employed doctors (LEDs) with all LEDs now having been allocated clinical supervisors as well as having the ability to exception report.

Safer Staffing Nursing and AHP
The Committee received the joint report with **assurance** noting that there had been an increase in sickness levels in nursing ward areas with support in place from HR to understand the increase.

Bank and agency use continued to reduce along with a reduction being noted in falls and pressure ulcers on wards for ULTH.

The Committee noted that the community nursing safer staffing tool had been implemented in LCHS which, following national benchmarking, had indicated a ‘junior skill mix’ in the community with work being undertaken to ensure appropriate skill mix.

It was noted that funding had not yet been agreed for the recommended increase in midwives following the Birth Rate Plus outputs however mitigations were being considered on the approach to be taken.

The Committee noted the transparency of the report and reflected on the position that was reported, noting that this was increasing the oversight of the Committee to the nursing and AHP staffing position which was welcomed.

Safer Staffing Medical
The Committee received the report with **assurance** noting the change in bank and agency shift rates which were as a result of the change to the registering of shift fill rates, rather than a reduction in activity.

There was recognition that the bank and agency rates remained high however this related to the ongoing negotiations of Extra Contractual Rates for ULTH.

The Committee noted the challenges in respect of identifying data for LCHS however a process was now in place to report this with future reports due to provide clarity in the position.

Overall, it was noted that there was stability within the staff group with bank and agency spend being reduced as well as there being low vacancy and sickness rates.

Assurance in respect of Objective 2b – Empower our people to continuously improve and innovate

Workforce Strategy Group Upward Report and Committee Performance Dashboard – LCHS and ULTH
The Committee received the upward report and performance dashboards noting that the data considered by the group related to February due to the timing of the meeting.

The group focused discussions on Healthcare Support Worker (HCSW) vacancy and retention rates and noted that Allied Health Professional (AHP) and dental vacancy rates had seen a reduction which was positive.

The group received the medical workforce update as a standing item and it was noted that this would now be offered as a written report to the group, rather than verbal updates. The Committee was pleased to note the delivery of £9.4m savings from the medical workforce programme however noted the final figure would be provided following validation.

The Committee noted the work taking place in respect of absence management and the intended deep dive for reasons of absence including anxiety, stress and depression in order to understand key themes. Return to work compliance was also being addressed through performance review meetings.

Employee relations activity was noted by the Committee with the development of this featuring as a KPI within the scorecard in addition to a deep dive being undertaken in respect of improving reporting and outputs.

Research, Development and Innovation Update
The Committee received the report which was taken as read noting that this would now be reported to the Integration Committee in line with the 2025/26 strategic aims and objectives.

Freedom to Speak Up Quarterly Report – LCHS/ULTH
The Committee received the report with **assurance** noting that this was the first Group report from the Freedom to Speak Up Guardians for both LCHS and ULTH which was well received.

Concern was noted in respect of the reduction in 'speak up' figures which were reducing compared to previous report however the Committee noted the actions being taken across the Group to ensure leadership visibility and emphasis speaking up when visiting teams.

Update on actions related to Guardian of Safe Working escalations
The Committee received the update in relation to the requested actions resulting from the Guardian of Safe Working escalations to the previous meeting noting that study leave, and exception reporting had been resolved.

Rest spaces continued to be an area of concern however the Committee noted that the estates team, through the Space Group, continued to seek suitable areas however a degree of investment would be required.

Assurance in respect of Objective 2c – Nurture compassionate and diverse leadership

Culture and Leadership Group Upward Report
The Committee received the report noting that a number of Group policies had now been approved and would support in ensuring equality across the Group, particularly the contractual policies agreed with both Staff Side groups.

Roadshows were due to commence at the end of April to promote the Group values to staff with Group Leadership Team members supporting the events. This would provide the opportunity to launch the values and behaviour framework as well as offering updates on recent local and national messaging.

Metrics were being developed for inclusion in future reports to offer the position across the Group and how culture is being impacted on. There was recognition that culture was being raised through a number of reporting routes and the inclusion of metrics would offer this in a single place.

Equality, Diversity and Inclusion (EDI) Group Upward Report
The Committee received the report and associated action plans noting the work being undertaken to hold a Board Development Session in respect of EDI.

There was recognition of the benefit of triangulating the staff survey results with EDI data which would be considered by the group at the following meeting.

The Committee received and approved the Group equality objectives for 2025/26 **(appended)**.

Estates and Facilities Update re staff survey, vacancies and absence – ULTH
The Committee received the report which offered an update in respect of the work being undertaken to support the estates and facilities teams. There was

recognition of year-on-year improvements in staff survey results as a result of the engagement that had taken place.

The Committee recognised the high turnover within the directorate due to the nature of the roles, such as housekeeping, which had a 14% turnover rate, and for the engineering-based roles due to an aging workforce.

It was noted that apprenticeships were being considered in respect of the engineering-based roles to support the future workforce and there was recognition of the pay levels within the NHS which could be considered a limiting factor, however there were noted benefits of working within the NHS.

The Committee noted the benefit of understanding the current position following the previous concerns however was pleased to note the ongoing engagement with the teams, recognising the challenges described.

Assurance in respect of Objective 2d – Recognising our people through thanks and celebration

No reports due

Assurance in respect of other areas

Group Board Assurance Framework 2025/26
The Committee received a verbal update noting the ongoing work to develop the 2025/26 Board Assurance Framework (BAF) which was due to be presented to the Board at the May meeting.

The Committee noted that the development of the content of the BAF in respect of the relevant controls, assurances and associated gaps and mitigations.

Committee Self-Assessment output and Committee Effectiveness Annual Report
The Committee received the report noting the output of the self-assessment and received the Committee Effectiveness Annual Report. Comments were sought on the annual report prior to submission to the Board with the Committee noting that this would support the completion of the annual reports and annual governance statements for LCHS and ULTH.

Topical, Legal and Regulatory Update
The Committee received the report for information noting the value of the contents.

Risk Report
The Committee received the joint report with **assurance** noting that the risks remained static and noted the deep dive that was scheduled to take place in the coming weeks to review all People risks.

Policy Position Update
The Committee received the report noting the position presented and the completion of the risk ratings for the overdue policy documents.

Movement was noted in respect of the progress to develop Group policy documents with a number going through final approval stages.

Internal Audit Reports
The Committee received the series of internal audit reports noting the levels of assurance offered and noted that the recommendations would be monitored by the Committee to ensure closure.

Internal Audit Recommendations
The Committee received the report noting the open actions resulting from internal audit recommendations with the Committee requesting that updates were provided to internal audit to appropriately close open recommendations ahead of the next meeting.

Progress against CQC Improvement Actions – Exception Report
The Committee received the report noting that this offered both the national position for the CQC and the Group position in respect of actions and the proactive approach being taken.

Any other business
The Committee considered the Cost Improvement Programme and, noting that this was not within the remit of the Committee to gain assurance on, requested a report that would demonstrate the impact of change programmes through the Culture and Leadership Group and Workforce Strategy Group Upward Reports.

Issues where assurance remains outstanding for escalation to the Board

None

Items referred to other Committees for Assurance

No items for referral.

Attendance Summary for rolling 12-month period

Voting Members	M	J	J	A	S	O	N	D	J	F	M	A
Phil Baker, Non-Executive Director, ULTH (Chair)						X	X	X	X	X	X	
Vicki Wells, Associate Non-Executive Director (Chair – from March 25)						X	X	X	X	X	X	X
Gail Shadlock, Non-Executive Director, LCHS						X	A	X	X	A	A	X
Claire Low, Group Chief People Officer						X	D	X	X	X	X	D

Colin Farquharson Group Chief Medical Officer						D	X	X	A	D	X	X
Nerea Odongo, Group Chief Nurse						X	X	X	X	D	X	X

X in attendance
A apologies given
D deputy attended

LCHG EQUALITY OBJECTIVES 2025 - 2026

EQUALITY OBJECTIVE 1: Person-centred care is experienced by all, with a well-informed, responsive approach to equality of patient experience and to the reduction of health inequalities.

- Enable all significant patient services and policy to have their work underpinned by an equality and health inequality impact assessment, including where there are proposed changes.
- Deliver compliance with the NHS EDS (Domain 1) to ensure patient services are reviewed in line with the NHS EDS framework.
- Support the Group to deliver compliance with the NHS Accessible Information Standard (AIS) to enable patients and service users with a sensory impairment to receive communication in appropriate formats (pending publication of AIS 2).
- Engage with the new LCHG Health Inequalities Forum to facilitate appropriate provision for health inequalities to be addressed for the population of Lincolnshire.
- Continue to promote access to the Group approach to Interpretation and Translation services to ensure patients and service users have a responsive service to their linguistic requirements.

EQUALITY OBJECTIVE 2: Promote LCHG as an employer of choice to attract high quality staff and ensure internationally recruited colleagues and all new staff experience a positive onboarding.

- Support the Recruitment Teams in the Group to embed fair and inclusive recruitment processes via appropriate training and inclusivity champions (NHS High Impact Action 2 – HIA2).
- Promote use of the Lincolnshire ICB Inclusive Recruitment Toolkit.
- Support the Talent Academy, the Apprenticeship Centre, and Organisational Development Team to embed a structured talent management approach (HIA 2).
- Support the MAPLE network in their ambitions to enable both organisations to work towards achieving Disability Confident Leader status. This includes key projects to promote employment for disabled people.
- The EDI Team to advise HR Teams in relation to areas of employment under-representation and to advise on strategies to address this.
- The EDI Team to support LCHG to implement a comprehensive induction, onboarding, and development programme for internationally recruited staff. (HIA 5).

EQUALITY OBJECTIVE 3: Promote LCHG as an employer of choice through actively enabling staff growth, development, and retention.

- Develop and implement an improvement plan to eliminate the gender pay gap (HIA 3).
- Develop and implement the new Ethnicity Pay Gap reporting and ensuing action plans (HIA 3).
- Prepare plans for the new Disability Pay Gap implementation once technical specification and ESR capability established in 2025-2026 (HIA 3).
- Support LCHG to create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur (HIA 6).

- Analyse both LCHS and ULTH NHS Staff Survey data by protected characteristics and engage with the Group Staff Networks, Staffside and Organisational Development to develop plans which actively support staff growth, development and retention.
- LCHG EDI Team to work towards harmonising WRES and WDES action planning in 2025-2026.
- Develop and implement a LCHG approach to Leading Inclusively with Cultural Intelligence.
- Develop and implement a LCHG approach to utilising the Lincolnshie ICB Allyship (Active Bystander) Toolkit.
- Develop and implement a LCHG approach to Reciprocal Mentoring.

EQUALITY OBJECTIVE 4: LCHG to develop and implement an improvement plan to address health inequalities within the workforce (HIA 4).

- Engage Occupational Health, Health and Wellbeing Teams and Staff Networks to identify which staff groups are at risk of health inequalities.
- Engage Occupational Health and Health and Wellbeing Teams to support the promotion and development of workstreams to improve staff groups at risk of health inequalities.

EQUALITY OBJECTIVE 5: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable (HIA1).

Engage with the Board to agree Board objectives aligned to the national EDI agenda, for example through:

- Allyship/Active Bystander,
- Board Staff Network Sponsors,
- Reciprocal Mentoring,
- Leading inclusively with Cultural Intelligence programme.

Lincolnshire Community and Hospitals NHS Group

Annual Report to the Board from the People 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 People Committee was tasked as follows:

The People Committee will:

- Ensure that there are robust processes in place for the effective management of people and organisational development.
- Ensure that there are effective structures in place to support people and OD and that these structures operate effectively and that action is taken to address areas of concern.
- Through the receipt of upward reports from the reporting groups, have oversight and scrutiny of the functions for which they have delegated responsibility from the People Committee.
- Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboard monthly
- Consider the control and mitigation of workforce related risks and provide assurance to the Board that such risks are being effectively controlled and managed
- Provide assurance to the Board that all legal and regulatory requirements relating to the workforce are met, including directives, regulations, national standards, policies, reports, reviews and best practice
- Review and provide assurance through the Integrated Improvement Plan and Performance Review Meeting reporting, on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee seeking where necessary further action

MEETINGS

During the 2024/25 year the Committee was established across the Group and met for the first time as the People Committee in October 2024. Prior to the establishment of the People Committee the People and Organisational Development Committee, ULTH and Finance, Performance, People and Innovation Committee,

LCHS met to provide assurance in respect of the relevant strategic objectives with meetings taking place on a monthly basis and quoracy met for each.

Following establishment in October 2024 the People Committee met monthly however worked to a reduced agenda during March 2024 to support operational colleagues to undertake annual planning.

The Committee, after each meeting held, provided an assurance report to the Board which meets on a bi-monthly basis.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2024/25 the Committee was chaired by Professor Philip Baker.

Details of the Committee's membership and attendance during 2024/25, from October 2024 is set out below:

Non-Executive Director, ULTH (Chair)
Non-Executive Director, LCHS (Deputy Chair)
Group Chief People Officer
Group Chief Medical Officer
Group Chief Nurse
Associate Non-Executive Director, ULTH

Members	15 Oct 2024	12 Nov 2024	20 Dec 2024	14 Jan 2025	14 Feb 2024	21 Mar 2025
Non-Exec Director, ULTH (Philip Baker) (Chair)	X	X	X	X	X	X
Non-Executive Director, LCHS (Ms Shadlock)	X	A	X	X	A	A
Group Chief People Officer	X	A	X	X	X	X
Group Chief Medical Officer	D	X	X	A	D	X
Group Chief Nurse	X	X	X	X	D	X
Associate Non-Executive Director (Vicki Wells)	X	X	X	X	X	X

A denotes Apologies given
D denotes Deputy in attendance

REVIEW OF BUSINESS

The People Committee followed a programme of work for the 2024/25 year.

The People Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2024/25:

- Objective 2a Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise
- Objective 2b To be the employer of choice
- Objective 4c Grow our research and innovation through education, learning and training

During 2024/25 the Committee has utilised the Board Assurance Framework (BAF) to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF. The strategic objectives at the beginning of the year were rated as follows:

LCHS
Objective 2a – **GREEN**
Objective 2b – **GREEN**
Objective 4c – **Unrated**

ULTH
Objective 2a – **AMBER**
Objective 2b – **GREEN**
Objective 4c – **RED**

Through the year the Committee continued to receive reports offering assurance against the strategic objectives. The Committee undertook significant reviews of the BAF and associated assurances resulting in the objectives being rated as follows at the end of the year:

LCHS
Objective 2a – **GREEN**
Objective 2b – **AMBER**
Objective 4c – **Unrated**

ULTH
Objective 2a – **GREEN**
Objective 2b – **AMBER**
Objective 4c – **RED**

OVERVIEW

The People Committee has offered a level of assurance to the Board on people and organisational development. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan as defined by the terms of reference, through this annual report.

The work programme for the Committee has focused on the workforce across the Group as well as developing the Group to be an employer of choice and research and innovation.

The Committee has been well attended by members throughout the year and the Chair has been actively involved in the agenda setting alongside the Director of People and Organisational Development.

Other key areas of focus of the Committee have included:

- Freedom to Speak Up
- Guardians of Safe Working
- Safer Staffing
- Culture and Leadership Programme
- Education
- Research and Innovation

During 2024/25 the Committee saw the development of the reporting groups which came together across the Group and, whilst these continue to embed, have started to provide streamlined reporting and further assurances to the Committee.

The Committee has received the Committee Performance Dashboard which continues to develop as a Group document to provide consistent reporting across the organisations and provided clear oversight of the reporting metrics.

The Committee has encouraged the development of the Education Oversight Group to ensure that there is appropriate scrutiny and assurance in place for the Group in respect of education for staff. This meeting will also take responsibility to consider education funding and ensure that this is utilised across the Group effectively.

Reporting continued to be received from both the Freedom to Speak Up Guardian and Guardian of Safe Working to the Committee which demonstrates the Groups' commitment to supporting staff to be able to raise concerns to be addressed.

Regular reports are received by the Committee with attendance at the Committee meetings by both Guardians to ensure that appropriate assurances are received and where necessary escalations made. Where escalations have been made by the Guardians, to the Committee, clear actions have been assigned and taken to support the Guardians in their work.

Through the reports the Committee was pleased to note the levels of reporting from staff within the organisation along with the closure of a number of concerns raised through there reporting routes.

Regular reporting continued to be received from the Equality, Diversity and Inclusion Group with the Committee noting the progress being made for the staff networks to come together across the Group as well as the joint working, enabling initiatives to be launched in ULTH that were already in place at LCHS.

The annual Gender Pay Gap reports were presented to the Committee showing improvement across both organisations and 3-year action plans in place to support parity moving forwards.

Updates were received in respect of recruitment and vacancy rates with the Committee receiving updates in respect of vacancy control processes to support management of the financial position of the Group.

The Committee, through the Committee Performance Dashboard noted the continued challenges with completion rates of appraisals. Towards the end of the 2024/25 year the Committee was pleased to note the introduction of an appraisal cycle for ULTH which would see all appraisals completed in quarter 1. This was in line with the LCHS approach, ensuring consistency across the organisations.

Updates were received in respect of the National Staff Survey with the Committee noting the work being undertaken with the divisions to ensure ownership of the outputs and development of actions plans at a local level.

During the course of 2024/25 the Committee remained concerned with the progress in respect of research and innovation noting that this would move to report through the Integration Committee in the 2025/26 year, however some progress was noted in respect of recruitment to clinical trials.

The Committee was pleased to note the achievement for ULTH of Teaching Hospital status in year which demonstrated the progress made and commitment to education of the Trust.

Risks

The BAF and Corporate Risk Register have been reviewed at the Committee on a monthly basis identifying where updates have been required based on assurances received at the Committee.

Performance Review

The Committee reviews performance against the agreed Key Performance Indicators (KPIs) and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover a vacancies, staffing levels, staff training and development, staff health and wellbeing, sickness absences and equality diversity and inclusion. The metrics presented within the report have been reviewed to ensure that the information presented offers a clear position on the performance of the Group.

At each of the meetings held during 2024/25 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified. Significant scrutiny of the KPIs was undertaken through the Workforce Strategy Group enabling the Committee to be directly sighted on areas of concern and to be assured on actions being taken to address those.

The Committee has continued to receive and discuss regular reports in respect of Safer Staffing with moderate levels of assurance continuing to be offered to the Committee. The inclusion of Allied Health Professional staffing data had further strengthened the report, and the Committee noted during the year the exceptional fill rates that had been achieved across the nursing workforce.

The Committee also requested a Safer Staffing report for medical staff, to replicated that of nursing. It was recognised that, whilst the report offered some level of assurance, continued development of the report would be required to enable the Committee to receive sufficient levels of assurance.

During 2024/25 referrals between the Board Committees were made in order to ensure that where necessary additional assurances were sought from the relevant responsible Committee, in areas where responsibility for assurance extended beyond the remit of a single committee. A number of referrals were made during the year offering opportunities for the Committee to seek further assurances.

The People Committee is an essential element of the Group's corporate governance structure. It works closely with the Audit Committee and the Chair of the People Committee is a member of the Audit Committee, which helps provide additional assurance on the adequacy of the Groups workforce. The Committee received all internal audits relevant to its remit for consideration of the actions and oversight of the completion of these.

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG National Staff Survey Results 2024-25

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6th May 2025*
Item Number	*9.2*

2024/25 National Staff Survey

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Claire Low, Group Chief People Officer*
Author(s)	*Kerry Swift, Deputy Director of People*
Recommendations/ Decision Required	*The Board is asked to note the contents of this report for information.*

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

Executive Summary

This report provides Board with an overview of the national staff survey results (NSS) for 2024-25 across both Lincolnshire Community Health Services (LCHS) and United Lincolnshire Hospitals Trust (ULTH).

Across LCHG a total of 12,293 colleagues were invited to complete the 2024 NSS, resulting in return rates of 55% (1,231 colleagues) for Lincolnshire Community Health Services (LCHS) and 36% (3,570 colleagues) for United Lincolnshire Teaching Hospitals NHS Trust (ULTH).

Both response rates have reduced from that of last year with LCHS seeing a 1% reduction and ULTH an 8% reduction.

The tables in appendix 1 show the top 5, bottom 5, most improved and most declined scores both organisations. This data represents key areas of further focus alongside areas of celebration. This data will be used to support key messaging through to divisions alongside the divisional data to support overarching NSS action plans.

Net promoter scores are also included in this paper within appendix 2 and align to how LCHG links to being an **employer of choice** and a place where **care of patients** is considered by our colleagues to be at a standard, they would be happy with. This also shows whether the **care of patients** is a **top priority**.

A point to note within ULTH bottom 5 scores as measured against the average are two net promoter question scores, 25c – would recommend this organisation as a place to work and 25d if a friend needed treatment, would be happy with the standard of care. Both of which have improved from last year's survey output but sit below the Picker average.

Additionally, LCHS have seen the net promoter question, 25c – would recommend this organisation as a place to work, in the most declined category as well. The Net Promoter Scores are contained within Appendix 2.

The 7 people promise elements are also detailed within this paper to show areas of improvement and decline across both organisations and these will inform the divisionally owned action plans. Full details at both an organisational and directorate/divisional level are contained within appendices 3 and 4.

For LCHS out of the 7 people promise elements, 5 areas decreased, with 2 areas remaining the same and for ULTH, 5 areas increased, with 2 areas remaining the same.

It should also be noted that ULTH have received a "Certificate of Recognition" from NHS England, in acknowledgement of the improvements achieved in the People Promise scores and morale and engagement scores.

The staff survey results have been shared with various committees and leaders across directorates/divisions. Leaders are developing their local action plans, supported by the Organisational Development teams. These will be completed by the end of May and shared at a future Group Leadership Team meeting in June 2025.

Purpose

The purpose of this report is to provide the Board with a high-level overview on the 2024 National Staff Survey (NSS) results across Lincolnshire Community Health Services (LCHS) and United Lincolnshire Teaching Hospitals (ULTH). In addition, it will cover progress to date and actions being taken.

These reports are based on the respective Trust average against organisations that have completed their survey with Picker. Currently each organisation sits within separate benchmarking groups with LCHS compared to a group for Community Trusts and ULTH compared to a group for Acute and Community Trusts. For the 2024 survey Picker were commissioned by 8 Community Trusts and 58 Acute and Community Trusts.

The questions in the NHS Staff Survey are aligned to the 7 People Promise areas, plus staff engagement and morale themes. The People Promise sets out, in the words of the NHS staff, the things that would most improve their working experience.

This report will further outline the variations and improvement / decline in scores across the 7 People Promise areas and other key areas, compared to last year's survey data and in comparison with the Picker average comparator group.

It also presents a heat map showing results that cover the three main net promotor score questions (NPS) which are:

- **Q25c** would recommend our organisation as a place to work.
- **Q25d** be happy with standard of care provided if a friend or relative needed treatment.
- **Q25a** consider that the care of patients / service users is our top priority.

Key messages

The overall response rate for LCHS was 55% (1,231 people out of 2,244 eligible staff), this is a decrease of 1% on last year's response rate of 56% and 6% below the Picker average for Community Trusts of 61%.

The overall response rate for ULTH was 36% (3,574 voices out of 9,951 eligible staff), this is a decrease of 8% on last year's response rate of 44%. The picker average for acute and acute community trusts this year stood at 48%.

Overview of results

The information contained within appendix 1, provided by Picker represents the upper and lower end of organisational results against the Picker average for the equivalent comparator group.

These tables show the top 5, bottom 5, most improved and most declined scores for each organisation, which detail where the biggest improvements have been seen, but conversely, also where the areas of development are.

This data represents key areas of further focus alongside areas of celebration and will be used to support key messaging through to divisions/directorates alongside their divisional data to support overarching NSS action planning.

Commonality of improvements seen across both organisations includes:

- Q11b – in the last 12 months, not experienced any musculo-skeletal problems as a result of work.
- Q12a – never / rarely find work emotionally exhausting.

Both these areas could be attributed to the much-improved well-being / EAP offer available across LCHG as free text responses have indicated this.

A point to note within ULTH bottom 5 scores as measured against the average are two net promoter question scores, 25c – would recommend this organisation as a place to work and 25d if a friend needed treatment, would be happy with the standard of care. Both of which have improved from last year's survey output, but still remain below the Picker average.

Additionally, LCHS have seen the net promoter question, 25c – would recommend this organisation as a place to work, in the most declined category as well.

Net Promoter Score Questions (NPS)

In order to provide a clear focus in terms of areas of the organisation where colleagues rate the Trusts across the three NPS questions, this can be linked specifically to LCHG being an **employer of choice** and a place where **care of patients** is considered by colleagues to be at a standard, they would be happy with and whether the **care of patients** is a **top priority**.

LCHS NPS Questions

Q25a – 'Care of patients/service users is organisation's top priority' is 79%, which is a 1% *decrease* from 80% last year.

Q25c – 'Would recommend organisation as a place to work' is 64%, which is a 4% *decrease* from 68% from last year.

Q25d – 'If friend/relative needed treatment, would be happy with the standard of care provided by the organisation' is 76%, which is the *same* score as last year.

ULTH NPS Questions

Q25a – 'Care of patients/service users is organisation's top priority' is 67.5% which is an *increase* of 1.8% from 65.7% last year.

Q25c – 'Would recommend organisation as a place to work' is 51.9% which is an *increase* of 5.3% from 46.6% last year.

Q25d – 'If friend/relative needed treatment would be happy with the standard of care provided by the organisation is 49.4% an *increase* of 4.9% from 44.5% last year.

Heat maps in full for all divisions/directorates are available in appendix 2 and are being used to help focus on areas where the Trusts continue to receive lower ratings.

People Promise Overview

There is a real contrast to be seen as regards the People Promise scores - ULTH have shown *improvement* against 5 of the 7 key indicators, particularly in relation to, we are safe and healthy, we are always learning and we are flexible. It must be noted however that the overall response rate for ULTH has decreased by 8% which may be a contributing factor.

In contrast, LCHS have seen a *decline* in scores across 5 of the 7 elements with 2 elements reaming the same as the 2023 results. This decline from 2023 only represents a marginal reduction of 0.1%, however. The overall response rate has also decreased slightly by 1%.

Table 1 below highlights some of the key messages from each element.

People Promise Elements	***Comments / Themes***
We are compassionate and Inclusive	*Compassionate culture and leadership have shown through as areas of improvement and development across LCHG. This fits in alongside our current work streams.*
We are recognised and rewarded	*The value of work undertaken recognised by line managers was seen as a decline across LCHG as was colleagues showing appreciation to one another in the line of work. For LCHS within significance testing there was seen to be a significant decline in this element.*
We each have a voice that counts	*Scores around raising concerns have risen across ULTH, but remain static within LCHS. Autonomy and control were seen as areas reporting lower than the average across LCHG, particularly around the ability to make improvements in areas of work.*
We are safe and healthy	*Bullying and harassment score negatively decreased featured for LCHS and for ULTH in terms of colleague related bullying, this is indicative of the HWB survey findings and action plan.*
We are always learning	*Scores as regards appraisals were higher in the LCHS scores and lower in the ULTH scores, this links to an LCHG appraisal cycle approach being introduced in April as an action. Access to learning opportunities within LCHS is to be a focus also.*

 *We work flexibly*	*Focus here in the main links to the ability to address line managers as regards the opportunities for flexible working.*
 *We are a team*	*Team working elements have declined across LCHS, but risen in ULTH, areas to consider here include more effective use of team meetings and clearly setting objectives.*

The People Promise graphics are contained within appendices 3 and 4 and show the relative improvements and declines in terms of the people promise elements and provides the contrasting view from last year's results for context, both as an overall Trust and by division/directorate.

Importantly, at the bottom of the respective organisational People Promise NSS scores, attention should be paid to the comparison section at the bottom of each graphic. This shows how each organisation is performing against the worst, average and best indicators within their respective bench marking group.

It should also be noted that a communication of personal thanks has been received by ULTH from the Director for Staff Experience and Leadership Development for NHS England. This has awarded ULTH a "Certificate of Recognition" with thanks and acknowledgement of the achievement in improving the experience and engagement of colleagues in the organisation. This notes the improvements in the People Promise scores and in morale and engagement scores. It particularly recognises the hard work of colleagues and the significant achievement given the challenging environment the NHS is operating in currently.

Next Steps

The overall response rate for ULTH has significantly decreased this year and work will be undertaken locally with leaders to increase awareness of and promote buy in to the National Staff Survey process with their teams.

Other actions include:

- A move to divisionally owned action plans for ULTH leaders and increased accountability as regards ensuring actions are completed. This is anticipated to increase engagement.
- Whilst there appears to be a number of declines and improvements across respective organisations within LCHG, it should be emphasised that any decline is marginal.
- This information has been cascaded across LCHG using a hybrid of both ULTH and LCHS previous approaches.
- Organisational Development teams will offer support in terms of interpreting data and guidance as regards how to use this, specifically around building directorate/divisional level action plans.
- Directorate/divisional level action plans to be built and presented to Group Leadership Team (GLT) by respective leaders in June 2025.

Conclusion/Recommendations

The Board is asked to note the content of this report.

The national staff survey results have now been shared with the Executive Leadership Team, Group Leadership Team, Culture and Leadership Group, and the People Committee, together with the wider leadership in directorates/divisions. The Organisational Development teams are working with leaders to support them in developing the service areas' action plans.

The divisions/care group action plans will completed by the end of May and then shared by leaders at a future Group Leadership Team in June. The actions from these will be owned by the respective leaders and will be critical in driving forward improvements in their areas.

Appendices

Appendix 1

Key NSS Data ULTH

Top 5 scores vs Organisation Average	Org	Picker Avg
q4c. Satisfied with level of pay	35%	32%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	78%	75%
q11c. In last 12 months, have not felt unwell due to work related stress	62%	59%
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	73%	70%
q12a. Never/rarely find work emotionally exhausting	26%	23%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	49%	61%
q19c. Organisation ensure errors/near misses/incidents do not repeat	59%	67%
q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	48%	55%
q25c. Would recommend organisation as place to work	52%	59%
q19a. Staff involved in an error/near miss/incident treated fairly	52%	59%

Most improved scores	Org 2024	Org 2023
q23a. Received appraisal in the past 12 months	84%	77%
q25c. Would recommend organisation as place to work	52%	47%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	49%	45%
q12g. Never/rarely lack energy for family and friends	38%	33%
q3i. Enough staff at organisation to do my job properly	34%	29%

Most declined scores	Org 2024	Org 2023
q13d. Last experience of physical violence reported	67%	70%
q3a. Always know what work responsibilities are	83%	84%
q3e. Involved in deciding changes that affect work	46%	47%
q3f. Able to make improvements happen in my area of work	51%	52%
q2c. Time often/always passes quickly when I am working	71%	72%

Key NSS Data LCHS

Top 5 scores vs Organisation Average	Org	Picker Avg
q23a. Received appraisal in the past 12 months	94%	91%
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	78%	75%
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	51%	48%
q24b. There are opportunities for me to develop my career in this organisation	54%	52%
q12a. Never/rarely find work emotionally exhausting	27%	25%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q5c. Relationships at work are unstrained	48%	57%
q18. Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	70%	77%
q7d. Team members understand each other's roles	69%	75%
q3a. Always know what work responsibilities are	79%	85%
q9d. Immediate manager takes a positive interest in my health & well-being	73%	79%

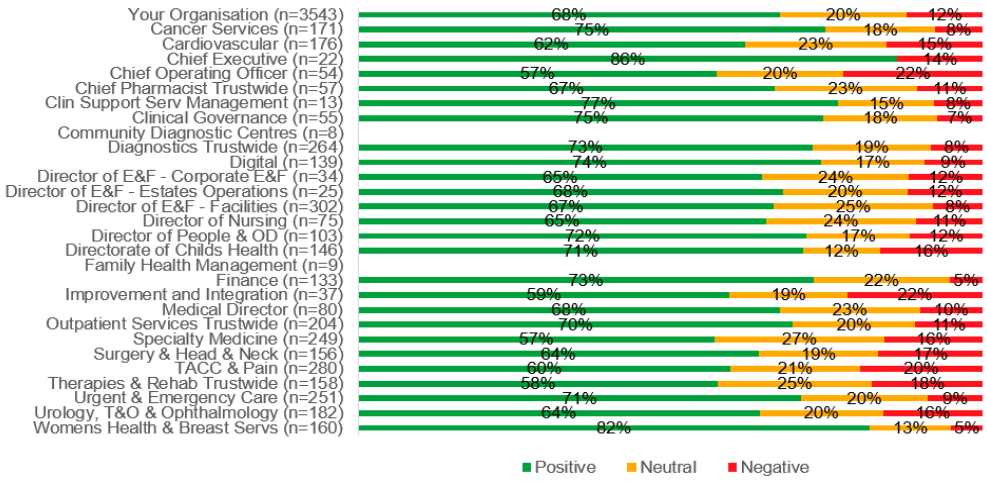
Most improved scores	Org 2024	Org 2023
q13d. Last experience of physical violence reported	81%	76%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	76%	71%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	44%	40%
q6c. Achieve a good balance between work and home life	61%	59%
q19d. Feedback given on changes made following errors/near misses/incidents	62%	60%

Most declined scores	Org 2024	Org 2023
q3f. Able to make improvements happen in my area of work	55%	59%
q15. Organisation acts fairly: career progression	63%	68%
q25c. Would recommend organisation as place to work	64%	68%
q7f. Team has enough freedom in how to do its work	61%	65%
q4c. Satisfied with level of pay	36%	40%

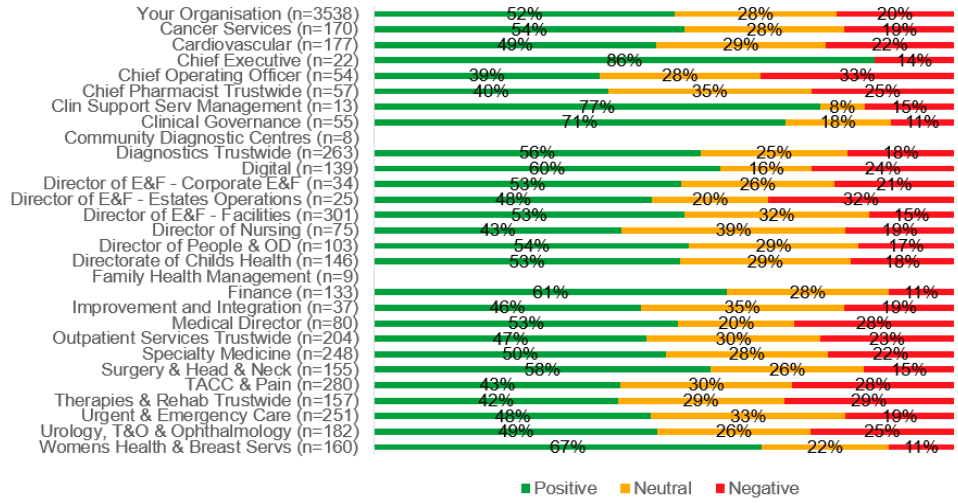
Appendix 2

ULTH Net Promoter Score Heat maps

ULTH – q25a care of patient/service users is organisations top priority

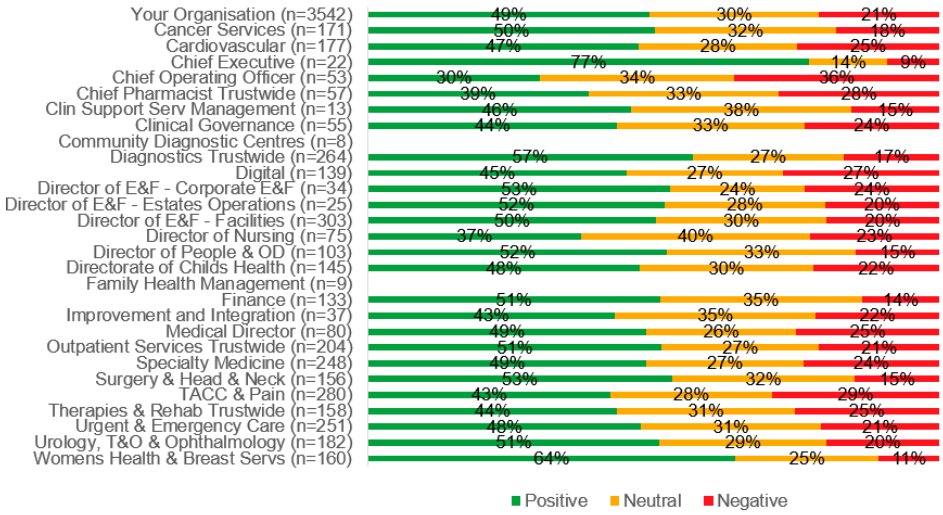


ULTH - q25c Would recommend organisation as place to work



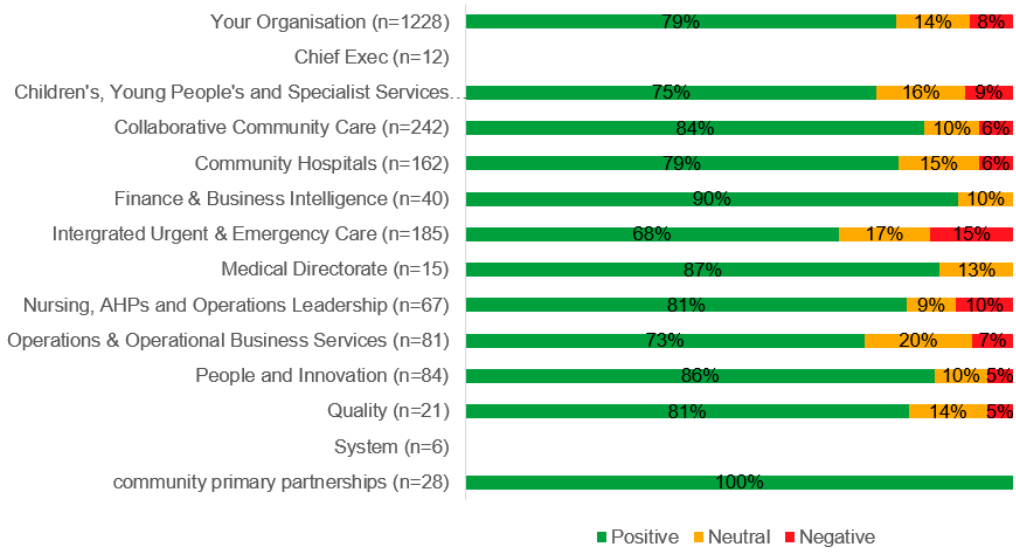
ULHT –

q25d If friend/relative needed treatment would be happy with standard of care provided by organisation

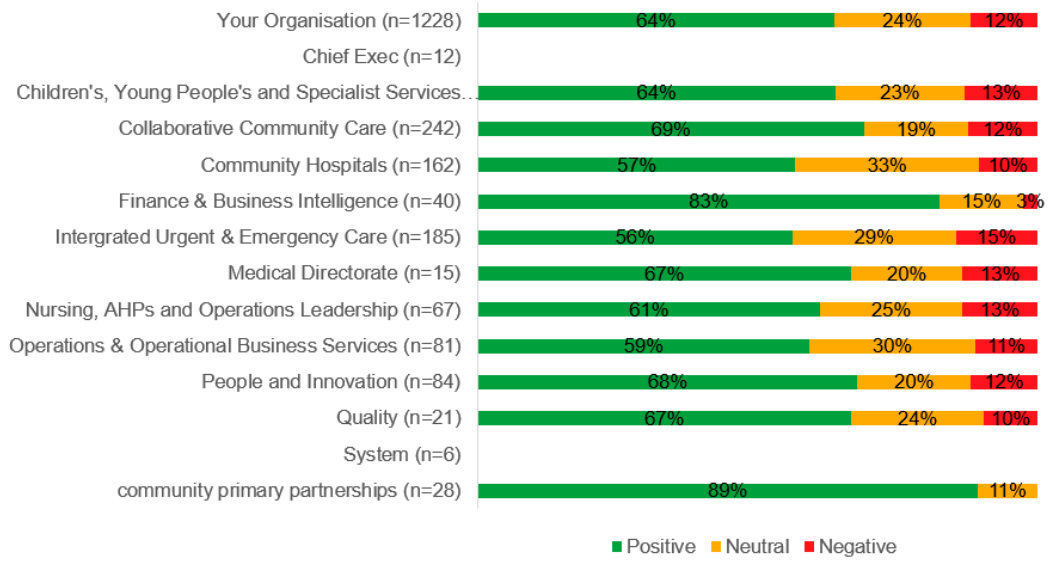


LCHS Net Promoter Heat Maps

LCHS - q25a Care of patients/service users is organisation's top priority

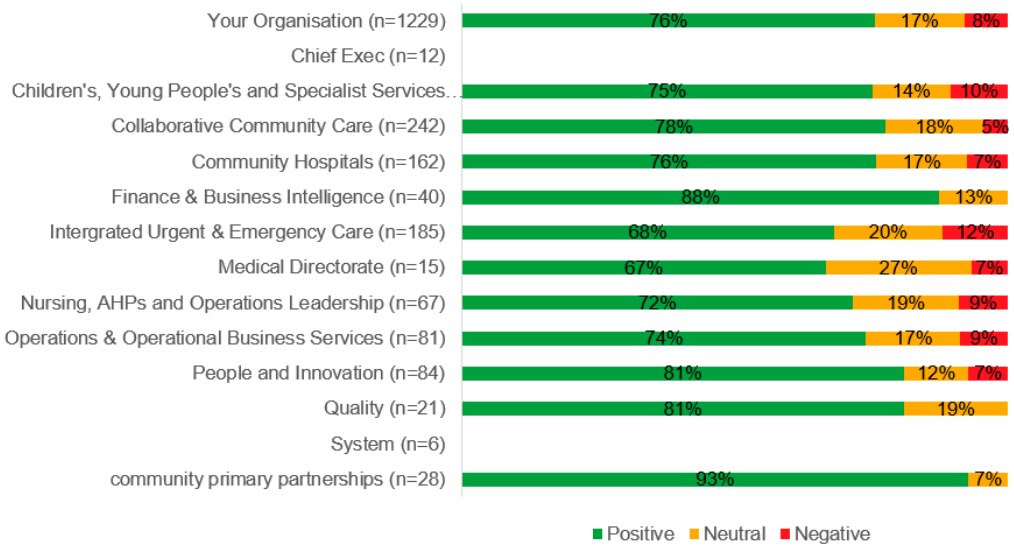


LCHS - q25c Would recommend organisation as place to work



LCHS –

q25d If friend/relative needed treatment would be happy with standard of care provided by organisation



Our NHS

Staff Survey Results

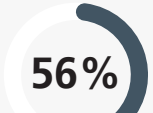
Lincolnshire Community and Hospitals NHS Group

LCHS Overview 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

2024 Final response rate

1231 of our People completed their survey in 2024



2023 Final response rate

Our score is **LOWER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0
Our score is **LOWER** than last year	Our score is **LOWER** than last year	Our score is **LOWER** than last year	Our score is the **SAME** as last year	Our score is the **SAME** as last year	Our score is **LOWER** than last year	Our score is **LOWER** than last year	Our score is **LOWER** than last year	Our score is the **SAME** as last year
2023 Results 7.6	6.4	7.0	6.4	6.0	6.8	7.0	7.1	6.0

How do we compare to the other 16 Community Trusts in 2024

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	70%	8.0	6.8	7.3	6.6	6.2	7.3	7.4	7.5	6.4
Average	61%	7.8	6.4	7.1	6.5	6.0	6.9	7.2	7.2	6.2
Worst	52%	7.3	6.0	6.8	6.1	5.6	6.5	6.8	6.9	5.8

Our NHS

Staff Survey Results

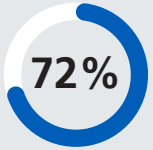
Lincolnshire Community and Hospitals NHS Group

LCHS | Chief Exec 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

2024 Final response rate

12 of your People completed their survey in 2024



2023 Final response rate

Your score is **HIGHER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.0	6.0	6.6	6.6	5.4	7.8	6.3	6.9	5.4
Your score is **HIGHER** than last year	Your score is the **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is the SAME as last year	Your score is **HIGHER** than last year	Your score is **LOWER** than last year
2023 Results: 6.8	5.5	6.1	5.9	5.3	6.1	6.3	6.4	5.7

How do you compare to the LCHS score for 2024

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

Our NHS

Staff Survey Results

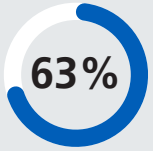
Lincolnshire Community and Hospitals NHS Group

LCHS | Children's, Young People's and Specialist Services | 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

2024 Final response rate

286 of your People completed their survey in 2024



2023 Final response rate

Your score is **LOWER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.6	6.3	6.9	6.3	6.1	6.7	7.1	7.0	6.0
Your score is **LOWER** than last year	Your score is the **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year
2023 Results: 7.9	6.7	7.3	6.5	6.4	7.0	7.4	7.4	6.3

How do you compare to the LCHS score for 2024

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

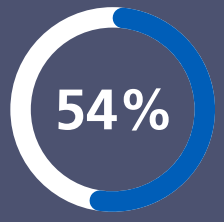
Our NHS

Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

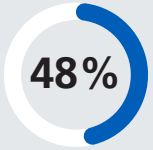
LCHS | Collaborative Community Care **2024**

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



2024 Final response rate

243 of your People completed their survey in 2024



2023 Final response rate

Your score is **HIGHER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.8	6.3	7.1	6.3	6.3	6.5	7.1	7.3	6.2
Your score is **HIGHER** than last year	Your score is the **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year
2023 Results: 7.7	6.2	7.0	6.0	6.1	6.2	7.0	7.2	5.9

How do you compare to the LCHS score for 2024

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

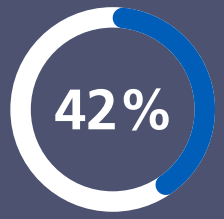
Our NHS

Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

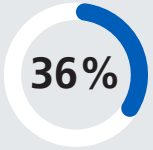
LCHS | Community Hospitals 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



2024 Final response rate

162 of your People completed their survey in 2024



2023 Final response rate

Your score is **HIGHER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.1	5.9	6.7	6.3	5.7	6.4	6.4	6.9	6.0
Your score is **LOWER** than last year	Your score is the **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **HIGHER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year
2023 Results: 7.3	6.0	6.8	6.4	6.0	6.1	6.6	7.1	6.1

How do you compare to the LCHS score for 2024

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

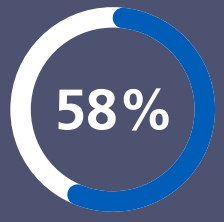
Our NHS

Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

LCHS | Community Primary Partnership | 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



2024 Final response rate

29 of your People completed their survey in 2024

2023 Final response rate

NEW directorate for 2024

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
8.3	7.0	7.9	7.4	6.5	8.2	7.8	8.0	7.2
NEW directorate for 2024	NEW directorate for 2024	NEW directorate for 2024	NEW directorate for 2024	NEW directorate for 2024	NEW directorate for 2024	NEW directorate for 2024	NEW directorate for 2024	NEW directorate for 2024
2023 Results: N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

How do you compare to the LCHS score for 2024

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

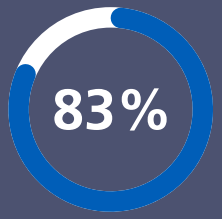
Our NHS

Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

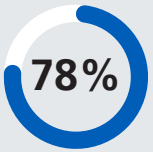
LCHS | Finance and Business Intelligence | 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



2024 Final response rate

40 of your People completed their survey in 2024



2023 Final response rate

Your score is **HIGHER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
8.0	7.3	7.5	7.1	6.6	8.1	7.4	7.9	6.5
Your score is **LOWER** than last year	Your score is the **HIGHER** than last year	Your score is **LOWER** than last year	Your score is **HIGHER** than last year	Your score is **LOWER** than last year	Your score is **HIGHER** than last year	Your score is **LOWER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year
2023 Results: 8.1	7.0	8.0	7.0	6.9	7.9	7.5	7.7	6.3

How do you compare to the LCHS score for 2024

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

Our NHS
Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

LCHS | Innovation 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

2024 Final response rate

32 of your People completed their survey in 2024

2023 Final response rate

Your score is **HIGHER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.8	6.7	7.0	7.2	6.0	7.8	7.3	7.1	6.3
Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is the **SAME** as last year	Your score is **LOWER** than last year
2023 Results: 7.9	7.0	7.3	7.3	6.2	7.9	7.5	7.1	6.6

How do you compare to the LCHS score for 2024

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

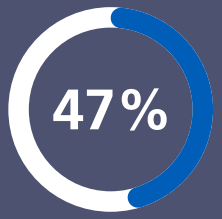
Our NHS

Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

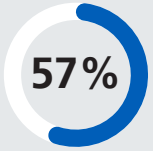
LCHS | Integrated Urgent & Emergency Care | 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



2024 Final response rate

185 of your People completed their survey in 2024



2023 Final response rate

Your score is **HIGHER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.1	5.9	6.4	6.1	5.5	6.3	6.3	6.5	5.6
Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year
2023 Results: 7.2	6.1	6.5	6.3	5.7	6.6	6.4	6.8	6.0

How do you compare to the LCHS score for 2024

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

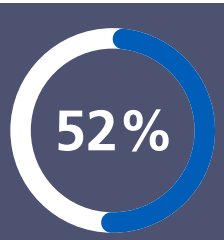
Our NHS

Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

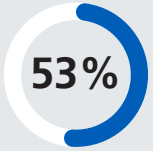
LCHS | Medical 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



2024 Final response rate

15 of your People completed their survey in 2024



2023 Final response rate

Your score is **HIGHER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.8	6.8	7.1	6.9	6.3	7.4	7.3	7.2	6.3
Your score is **HIGHER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **HIGHER** than last year	Your score is **LOWER** than last year	Your score is the **SAME** as last year	Your score is **HIGHER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year
2023 Results: 7.7	7.1	7.3	6.8	6.9	7.4	7.2	7.6	6.6

How do you compare to the LCHS score for 2024

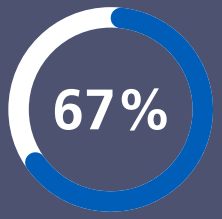
We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

Our NHS
Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

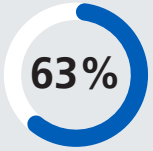
LCHS | Nursing, AHPs and Operations Leadership | 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



2024 Final response rate

67 of your People completed their survey in 2024



2023 Final response rate

Your score is **HIGHER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.6	6.5	7.1	6.3	6.1	6.9	7.0	7.3	6.0
Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **HIGHER** than last year	Your score is the **SAME** as last year	Your score is **HIGHER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **HIGHER** than last year
2023 Results: 7.8	6.7	7.4	6.1	6.1	6.7	7.2	7.5	5.8

How do you compare to the LCHS score for 2024

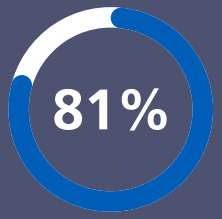
We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

Our NHS
Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

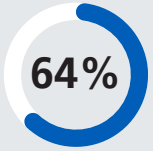
LCHS | Operations & Operational Business Services | 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



2024 Final response rate

81 of your People completed their survey in 2024



2023 Final response rate

Your score is **HIGHER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.2	6.0	6.3	6.6	5.3	6.5	6.5	6.5	6.0
Your score is **HIGHER** than last year	Your score is **LOWER** than last year	Your score is the **SAME** as last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year
2023 Results: 7.1	2023 Results: 6.1	2023 Results: 6.3	2023 Results: 6.5	2023 Results: 5.0	2023 Results: 6.3	2023 Results: 6.3	2023 Results: 6.4	2023 Results: 5.8

How do you compare to the LCHS score for 2024

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

Our NHS

Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

LCHS | People 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

2024 Final response rate

52 of your People completed their survey in 2024

2023 Final response rate

Your score is **LOWER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.9	6.9	7.4	7.4	6.3	8.3	7.3	7.3	6.4
Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **HIGHER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year	Your score is **LOWER** than last year
2023 Results: 8.1	7.0	7.6	7.1	6.7	8.6	7.7	7.6	6.5

How do you compare to the LCHS score for 2024

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

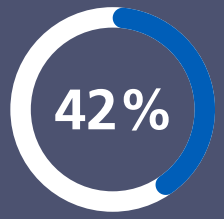
Our NHS

Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

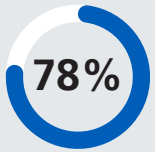
LCHS | Quality 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



2024 Final response rate

162 of your People completed their survey in 2024



2023 Final response rate

Your score is **HIGHER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.8	6.6	7.0	6.3	6.8	6.7	7.1	7.0	5.9
Your score is **HIGHER** than last year	Your score is the **SAME** as last year	Your score is **HIGHER** than last year	Your score is **LOWER** than last year	Your score is **HIGHER** than last year	Your score is **LOWER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is the **SAME** as last year
2023 Results: 7.4	2023 Results: 6.6	2023 Results: 6.7	2023 Results: 6.7	2023 Results: 5.9	2023 Results: 6.8	2023 Results: 7.0	2023 Results: 6.6	2023 Results: 5.9

How do you compare to the LCHS score for 2024

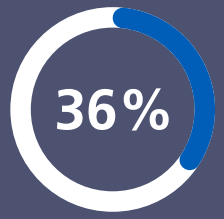
We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.5	6.2	6.9	6.4	6.0	6.7	6.9	7.0	6.0

Our NHS
Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

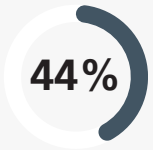
ULTH Overview 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



2024 Final response rate

3,574 of our People completed their survey in 2024



2023 Final response rate

Our score is **LOWER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.0	5.9	6.4	6.1	5.5	6.3	6.6	6.6	5.9
Our score is the **SAME** as last year	Our score is **HIGHER** than last year	Our score is the **SAME** as last year	Our score is **HIGHER** than last year	Our score is **HIGHER** than last year	Our score is **HIGHER** than last year	Our score is **HIGHER** than last year	Our score is **HIGHER** than last year	Our score is **HIGHER** than last year
2023 Results: 7.0	5.8	6.4	6.0	5.3	6.1	6.5	6.5	5.7

How do we compare to the other 122 Acute and Community Trusts in 2024

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	71%	7.7	6.3	7.1	6.5	6.1	6.9	7.1	7.4	6.4
Average	49%	7.2	5.9	6.7	6.1	5.6	6.2	6.7	6.8	5.9
Worst	30%	6.6	5.2	6.0	5.5	4.8	5.6	6.3	6.0	5.1

Our NHS

Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

ULTH | Surgery 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

Your 2024 Final response rate 2024

623 of your People completed their survey in 2024

Your 2023 Final response rate

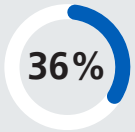
Your score is **LOWER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your 2024 score	6.8	5.5	6.1	5.9	5.3	6.1	6.3	6.4	5.7
Compared to last year	Your score is **HIGHER** than last year	Your score is the **SAME** as last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is the **SAME** as last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year
2023 Results	6.7	5.5	6.0	5.7	5.2	5.7	6.3	6.2	5.4

How do you compare to the ULTH score for 2024



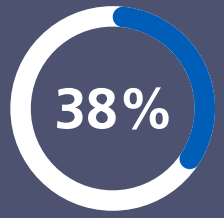
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
ULTH 2024 score	7.0	5.9	6.4	6.1	5.5	6.3	6.6	6.6	5.9

Our NHS
Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

ULTH | CSS 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

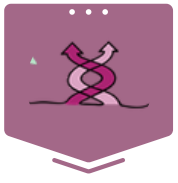


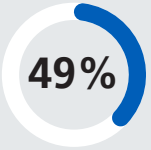
Your 2024 Final response rate 2024

876 of your People completed their survey in 2024

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

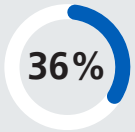
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
									
									
	7.1	5.9	6.5	6.2	5.4	6.2	6.5	6.6	5.9
	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is the **SAME** as last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year
2023 Results	7.0	5.8	6.4	6.0	5.3	6.1	6.5	6.4	5.7



Your 2023 Final response rate

Your score is **LOWER** than last year

How do you compare to the ULTH score for 2024



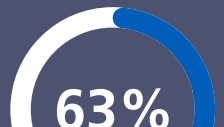
									
	7.0	5.9	6.4	6.1	5.5	6.3	6.6	6.6	5.9

Our NHS
Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

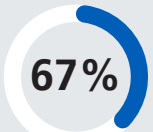
ULTH | Corporate 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



Your 2024 Final response rate 2024

701 of your People completed their survey in 2024



Your 2023 Final response rate

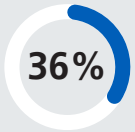
Your score is **LOWER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your score	7.3	6.5	6.6	6.7	5.9	7.0	7.1	6.8	6.2
Compared to last year	Your score is **LOWER** than last year	Your score is the **SAME** as last year	Your score is **LOWER** than last year	Your score is **HIGHER** than last year	Your score is the **SAME** as last year	Your score is the **SAME** as last year	Your score is the **SAME** as last year	Your score is **LOWER** than last year	Your score is the **SAME** as last year
2023 Results	7.4	6.5	6.8	6.6	5.9	7.0	7.1	6.9	6.2

How do you compare to the ULTH score for 2024



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
ULTH 2024	7.0	5.9	6.4	6.1	5.5	6.3	6.6	6.6	5.9

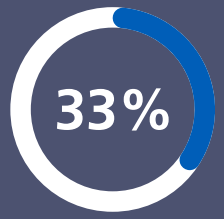
Our NHS

Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

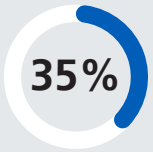
ULTH | Estates & Facilities 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



Your 2024 Final response rate 2024

375 of your People completed their survey in 2024



Your 2023 Final response rate

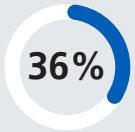
Your score is **LOWER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
								
								
Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year
2023 Results	6.6	5.5	6.1	6.2	4.3	6.0	5.9	6.3	5.7

How do you compare to the ULTH score for 2024



7.0	5.9	6.4	6.1	5.5	6.3	6.6	6.6	5.9

Our NHS

Staff Survey Results

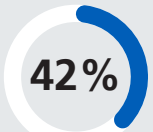
Lincolnshire Community and Hospitals NHS Group

ULTH | Family Health 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

Your 2024 Final response rate 2024

316 of your People completed their survey in 2024



Your 2023 Final response rate

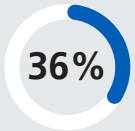
Your score is **LOWER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.4	6.1	6.8	6.2	5.6	6.3	6.9	7.0	6.0
Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year
2023 Results: 7.3	5.9	6.6	5.9	5.3	6.0	6.7	6.8	5.8

How do you compare to the ULTH score for 2024



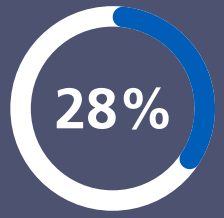
We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
7.0	5.9	6.4	6.1	5.5	6.3	6.6	6.6	5.9

Our NHS
Staff Survey Results

Lincolnshire Community and Hospitals NHS Group

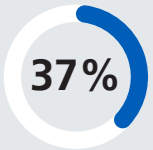
ULTH | Medicine 2024

The questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.



Your 2024 Final response rate 2024

683 of your People completed their survey in 2024



Your 2023 Final response rate

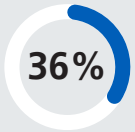
Your score is **LOWER** than last year

People Promise Elements and Themes

The People Promise elements and themes are scored on a 0 - 10 scale, **where a higher score is more positive than a lower score.**

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
								
								
Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year	Your score is **HIGHER** than last year
2023 Results: 6.7	5.5	6.2	5.4	5.4	5.9	6.2	6.4	5.4

How do you compare to the ULTH score for 2024



7.0	5.9	6.4	6.1	5.5	6.3	6.6	6.6	5.9

NHS
Lincolnshire Community and Hospitals NHS Group

New Board Member Appraisal Framework

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6th May 2025*
Item Number	*9.4*

New Board Member Appraisal Framework

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Claire Low, Group Chief People Officer*
Author(s)	*Claire Low, Group Chief People Officer*
Recommendations/ Decision Required	*The Board is asked to:-* • Confirm receipt of the recommendations outlined in this paper and the outline plan.

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

Executive Summary

Purpose

In April 2025 NHS England published a new Board Member appraisal Framework all chairs, chief executives, executive directors and non-executive directors. The introduction is as described below:

The framework has been produced in response to Messenger Review recommendations and stakeholder feedback, including that regarding the existing chair appraisal framework, which it replaces.

It is important for all colleagues across the NHS to take part in the appraisal process. And as leaders, for you to model behaviours and set the standard that everyone has a regular apprai

Key messages

The framework incorporates the 6 domains of the leadership competency framework into a single approach for all executive and non-executive roles and aligns with the fit and proper person test (FPPT) framework.

It will establish clear expectations and enhance consistency in standards for board-level appraisals across the NHS, with the flexibility to adapt the process depending on whether the appraisee is an executive or non-executive director and enabling integration into local policies.

Organisations can either incorporate the framework principles into their own local processes or use the processes and editable forms we provide.
Those which have already started their appraisals are not expected to redo them but should use the framework for future appraisals.

Submission of appraisals

- Appraisals for chairs of NHS trusts and integrated care boards must be shared with NHS England by Monday 30 June 2025 via england.chairsappraisal@nhs.net to facilitate regional director sign-off.
- Appraisals for non-executive directors of NHS trusts must be shared with NHS England by Tuesday 30 September 2025 via england.chairsappraisal@nhs.net.
- Chairs of NHS foundation trusts are encouraged to share the outcomes of their appraisals to provide NHS England with an understanding of the wider support and development needed.
- Appraisals for chief executives, executive directors and non-executive directors of integrated care boards and foundation trusts, and those for chief executives and executive directors of NHS trusts should be retained in line with organisational policies and do not need to be shared with NHS England.
- Appraisal forms a key part of the fit and proper persons annual process. As per the prior year, integrated care boards, NHS trusts and foundation trusts should submit

the FPPT submission reporting template to regional directors by Monday 30 June 2025.

On receipt of integrated care board and NHS trust chair appraisals, the Senior Appointments and Assessment team will forward these to the relevant regional director for review and endorsement. Appraisals reviewed by your regional director will then be endorsed by an NHS England executive director

Conclusion/Recommendations

It is recommended that the new Frameworks are accepted by the Board and agreement to for these to be reviewed in line with the current appraisal process cycles and objectives to ensure compliance and future fit with the new guidelines. A detailed report confirming the outcome of this review to be provided at a future Board session. In addition acknowledgement of the submission timescales that must be adhered to and agreement to the submission deadlines.

It is also recommended that a yearly review of Group Executive Directors is presented by the Group Chief Executive to Renumeration Committee on a yearly basis.

Board are asked to agree to the above recommendations and required submission requirements.

NHS
Lincolnshire Community and Hospitals NHS Group

Integration Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*6 May 2025*
Item Number	*10.1*

Integration Committee Upward Report of the meeting held on 27 March 2025

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

Purpose

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

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

Due to the annual planning commitments across the Group the meeting worked to a reduce time and agenda receiving escalation reports only.

Upward Report

Escalation reports including:

- **Objective 1d – Deliver clinically led integrated services**
- **Objective 3c – A modern, clean and fit for purpose environment across the group**
- **Objective 4a – Established collaborative models of care with our partners including Primary Care Network Alliance (PCNA)**
- **Objective 4b – Successful delivery of the Acute Services Review**
- **Objective 4d – Enhanced data and digital capabilities**
- **Objective 5a – Develop a Population Health Management and Health Inequalities approach for our Core20PLUS5 with our ICS**

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

The Committee received the escalation reports with **assurance** noting the need for further development of the reports from the community senior leadership team meeting (SLT) to ensure this provided the correct assurance to the Committee without duplication.

It was noted that there were no areas of concern in respect of the community part of the Group, which was progressing through reorganisation from three care groups into two however, until the infrastructure was in place the flow would not be seen through reporting with work taking place to ensure appropriate governance was in place.

Current programmes of work were noted as being approximately 2-months behind schedule due to the recent focus on planning however due to the significant work that had already been undertaken, this delay should be resolved by the end of quarter 2.

The Committee received the Trust Wide Improvement Steering Group upward report, offering the exit position of the 2024/25 programme with dual reporting reducing in the 25/26 year.

The Committee received a verbal update in respect of estates noting the recent focus on planning and the main schemes that would be in place to support the financial position in the 25/26 year. The main schemes included, central production units, space utilisation and car parking.

There were a number of leases across the Group that required review to determine an appropriate approach, in line with space utilisation and to ensure cost effectiveness.

A verbal update was offered in respect of digital with the Committee noting the recent core activity of the digital team being the migration. The Committee commended the team for the work that had been undertaken, delivering the best possible outcome. It was also noted that work was ongoing to bring the ICB and GP Digital teams into the group as part of the system plan and further detail would follow in the coming months.

Treasury approval had been received for the ULTH Electronic Patient Record (EPR) which would now be progressed to the Cabinet Office for sign off and the LCHS EPR was progressing as planned. The Electronic Document Management System (EDMS) for ULTH was in the final stages of award with the intention to complete the programme in 18-months to support benefits realisation. The Committee noted the system digital novation that would be worked through by the Group.

The Intermediate Care Programme update was noted with the recognition of the issues impacting discharge with support required to ensure transformation of this could be achieved.

Assurance in respect of other areas

Board Assurance Framework 2024/25
The Committee received the Board Assurance Framework for information.

Risk Report
The Committee received the joint report for information.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

None.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

Integration Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*6 May 2025*
Item Number	*10.1*

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

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

Purpose

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

This assurance Committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2025/26 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG) and was attended by both ULTH and LCHS colleagues.

Upward Report

Assurance in respect of Objective 3a – Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services / Objective 3b – Move from prescription to prevention, through a population health management & health inequalities approach

Estates and Facilities Update

The Committee received the report with **assurance** noting the creation of the space group for transformational elements across the Groups' 55 properties which would support services in the left-shift.

All sites, following the LCHS estate coming across to ULTH management, had been visited to undertake the required safety checks to ensure that assurance could be provided to the Finance and Performance Committee.

Changes had been made to the approach for space requests ensuring that these were managed through an agreed process and to support the wider space utilisation and transformation agenda.

The Committee noted the map of properties that had been provided and reflected that this demonstrated the known disparity across the county and would support ensuring the right care in the right buildings in the right place.

Booking Centre Update
The Committee received the verbal update noting the ongoing work to review and rationalise booking across ULTH. It was noted that a detailed plan would come to committee once the procurement for a delivery partner was closed.

EMAP Executive Group Revised Plan for 25/26
The Committee received the report noting the impact of the national position on the approach of EMAP whereby the intent to scale up had now been revised.

It was recognised that there was a financial impact on organisations to support EMAP with ULTH hosting this. The revised annual plan was noted with the Committee recognising that the financial contribution from the Group for the 25/26 year would reduce, with support provided by the Committee for this to be £32k, from £50k in the 24/25 year. This level of investment would provide a common dashboard across the East Midlands for oncology services.

The Committee recognised the benefits of the EMAP and noted that, whilst this had not been as successful as hoped, there was significant benefits in being linked across the region to other hospitals.

Alliance Steering Group Upward Report
The Committee received the report noting the progress in respect of the Alliance Care Group and the establishment of the Alliance Steering Group. The Committee offers the Alliance Update report (appendix 1) and the steering group terms of reference (appendix 2) to the Board for information to demonstrate the sizeable change being managed moving forward.

The Committee noted the four workstreams of the Alliance Steering Group, these being the LCHG Planned and Unplanned Care Group, left-shift redesign, Integrated Neighbourhood Teams and Health Inequalities. Updates on the workstreams would be offered to the Committee, through the upward report.

Pre-Op Assessment move to Spalding – for information
The Committee received the report for information noting the work in respect of space utilisation as well as providing positive patient experience which would see a dedicated clinical suite for pre-op assessments.

It was recognised that there was a need to undertake appropriate staff engagement however the assessment of the patient journey had been undertaken with the determination that this would improve the patient experience with no detriment.

Assurance in respect of Objective 3c – Enhance our digital, research and innovation capability

Digital Oversight Group Upward Report inc Digital Plan Delivery Update
The Committee received the report with **assurance** recognising the big four projects including NHS net migration, 2 Electronic Patient Records (EPRs) and the Electronic Document Management System (EDMS).

The Committee was pleased to note the success of the NHS net migration with the success and learning from this being a test case for the ULTH EPR implementation especially with the success of team visibility and engagement.

The speed of delivery of the EDMS continued to be considered with the ambition of halving the delivery period to 18-months to support benefits such as the release of space and capital. The EPRs for both LCHS and ULTH were progressing with the ULHT case.

The Committee received the first draft of the Group Digital Strategy, this had been required as part of the ULTH EPR case however it was now appropriate for this to be reworked to a Group strategy. The digital delivery plan was offered to the Committee and detailed the programmes of work being undertaken by the digital team, alongside the big four and the timelines being worked to.

ICB AGEM Digital novation
The Committee received the report noting the progress being made in respect of the novation of digital services from the ICB AGEM to the Group.

It was noted that appropriate due diligence was being undertaken with the Committee supportive of the direction of travel within the report and noted that future reports and recommendations would be put forward to the Committee in the coming months.

Intermediate Care Support Proposal
The Committee received the repot noting that activity was underway to identify external support to the Group to support delivery of change. A formal paper would be presented would the procurement was closed.

Research and Innovation Report
The Committee received the report noting the changes to the budget setting of the Research Delivery Network (RDN), moving from a focus on the number of recruits to trials but also the complexity and performance of these as well as the pace of recruiting to a trial from commencement. There was

an expectation that ULTH would benefit from the change due to the focus on commercial trials which, whilst lower recruit numbers were more complex.

The Committee was pleased to note improved engagement across the organisation however time allocation continued to be a concern for clinicians to be able to deliver research activities.

Innovation was noted as an area requiring further consideration for reporting due to the system level approach, there was however due to be a Lincolnshire wide expo held for researchers and stakeholders so that projects could be showcased and learning taken form others.

The Committee noted the University Teaching Hospital update and the ability for Teaching Hospital to be utilised in the Group branding, it was however noted that further work was required in order to achieve University Teaching status in respect of having joint academics in post.

Assurance in respect of Objective 3d – Drive forward our improvement and efficiency agenda including sustainability and Green Plan

Green Group Terms of Reference
The Committee received the Terms of Reference for the Group noting that this was the final set of terms of reference for the reporting groups of the Committee and noted that the Green Plan would require sign off by the Board.

The Committee noted that the Green Plan was due to be presented in either June or July in order to seek approval of the Board.

ICB Target Operating Model Update
The Committee received the report noting the update that was offered and reflected on the national position that was driving the change being described with the recognition that this would impact multiple Committees across the Group.

There was a need to ensure that all appropriate due diligence was undertaken, in addition to ensuring that there was appropriate resource within the Group to support the expected changes. The Committee agreed with ELT support to set up a short term subgroup to look at the detail of this work and see greater details on the plans moving forward

Productivity, Improvement and Transformation Oversight Forum (PITOF) Upward Report
The Committee received the reports from the Trust Wider Improvement Steering Group (ULTH) and Pillar Programme Board (LCHS) upward report noting the development of the PITOF which would be in place from May.

The Committee noted the £56.3m Cost Improvement Programme (CIP) required across the Group for the 25/26 year with a £23m contribution to the system gap. It was anticipated that there would be assurance on the plan by the end of April

and that this would also include the close of the current £7.8m gap against the total CIP.

There was clarity on the resource required to support CIP delivery and moving forward it would be possible to provide overview of the assurance on the programmes, gaps and next steps.

The Committee commended the work that had been undertaken to identify the plans for the year and noted that the level of CIP delivery that was required was significant.

Operational Plan Report – Q4 Close down – LCHS
The Committee received the report with **assurance** noting the close down position that was presented.

Assurance in respect of other areas

Committee Performance Dashboard
The Committee received the report with **assurance** noting the development of the dashboard and Group metrics.

There was recognition of the development opportunities becoming visible through the performance reporting with the Committee noting that getting services connected offered the greatest opportunity to drive both attendance and admission avoidance.

The Committee was pleased to note the development of the report recognising the level of details that this presented and would enable clarity of oversight.

The dashboard would continue to be developed over the coming months with further metrics, with each Committee receiving relevant elements of reporting and the Integration Committee utilising the data to identify and support transformation and to determine if innovation and changes are impacting on performance.

Risk Report
The Committee received the report noting that there had been no changes from the previous report and recognised the ongoing work, following the recent Board discussion in respect of risk appetite, to appropriately align risks to the Committees.

Board Assurance Framework 2025/26
The Committee received an update on the work being undertaken to develop the 2025/26 Board Assurance Framework (BAF) which was due to be presented to the Board at the May meeting.

The Committee noted that the development of the content of the BAF in respect of the relevant controls, assurances and associated gaps and mitigations which were due to be completed ahead of the Board meeting.

Reporting Group Map
The Committee noted the report group map which would be utilised by the Committee for the coming months to ensure oversight of the strategic objective and provide line of sight on the assurances being offered to the Committee through the reporting groups.

Issues where assurance remains outstanding for escalation to the Board

No escalations required.

Items referred to other Committees for Assurance

None.

Attendance Summary for rolling 12-month period

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

X in attendance
A apologies given
D deputy attended

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Strategy 2025-2030

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

Meeting	*Trust Board*
Date of Meeting	3rd May 2025
Item Number	Item 10.2

LCHG 2025-2030 Strategy

Accountable Director	*Daren Fradgley, Chief Integration Officer & Deputy Chief Executive*
Presented by	*Daren Fradgley, Chief Integration Officer & Deputy Chief Executive*
Author(s)	*Dr. Sameedha Rich-Mahadkar, Director of Improvement and Integration* *Sally Robinson, Head of Strategy and Best Practise* *Vicky Holden, Associate Director of Partnerships* *Steve Knight, Communication officer*
Recommendations/ Decision Required	Following previous discussions at GLT, ELT and Board we have now co-produced the final draft LCHG Strategy for 2025-2030. Trust Boad are asked to: 1. Agree and approve the new LCHG Strategy which includes previously the previously approved new LCHG Vision, strategic aims and objectives. *A separate summary version is also being developed and will be published on the Trust's website.* *Appendix 1 contains, personas that describe what will be different for our staff and patients/citizens through the implementation of the strategy* *Appendix 2- contains our comms plan*

How the report supports the delivery of the priorities within the LCHG Board Assurance Framework	
1a Deliver high quality care which is safe, responsive and able to meet the needs of the population	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
1d Deliver clinically led integrated services	*X*

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

NHS
Lincolnshire Community and Hospitals NHS Group

Better care
Better opportunities
Better health

Group Strategy 2025-30

Caring and building a healthier future for all

Contents

INTRODUCTION

We are delighted to publish the Lincolnshire Community and Hospitals NHS Group strategy for the next five years.

This comes at an incredibly exciting time, one year into Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) forming a Group arrangement, providing a wealth of opportunities for greater integrated working that will positively benefit the people of Lincolnshire. Our renewed vision for LCHG is "**caring and building a healthier future for all**". Our 12,700 staff provide a wide range of health and care services to more than 775,000 people living across Lincolnshire. The Group model is the key enabler to the delivery of our strategy and will be the key to ensure we provide value, high quality services and improved clinical outcomes to the people of Lincolnshire.

This document sets out the next stage in the evolution of the delivery of healthcare in Lincolnshire and our ambitions for the future. The strategy provides a framework for how the Group will continue to transform our clinical services in the medium to long term, whilst simultaneously taking urgent action in priority areas to address some of the more immediate challenges faced.

HOW WE DEVELOPED THIS STRATEGY?

We have developed our strategy with energy and passion, in collaboration with our clinical and corporate colleagues, Integrated Care Board (ICB) and other system partners including primary care, as well as alongside our patients.

We have held three workshops attended by over 120 people from a range of teams and areas during the strategy development over the last year. Crucially, we have also engaged with over 125 patients, so their views are a core tenet within our strategic thinking.

This strategy sets out the plan for LCHG over the next five years as we collectively work towards improving how we deliver services for our patients; improving the population health of the communities we serve and making it easier for our wonderful staff to deliver the high quality care they want to provide.

NATIONAL PICTURE

The NHS England Planning Guidance for 2025/26 outlines the strategic priorities and actions to address ongoing challenges within the NHS, with a strong focus on elective recovery. This includes the government's efforts to reduce the significant elective care backlog that resulted from the COVID-19 pandemic. Specific targets are set for reducing waiting times for elective care, optimising hospital capacity and expanding the use of innovative approaches such as digital consultations and community-based care to increase efficiency. The guidance supports the broader ambitions of the NHS Long Term Plan, which emphasises prevention, mental health services, and more personalised care, alongside continued reforms in workforce development and integration across care systems.

The NHSE Planning Guidance also resonates with the Department of Health and Social Care's 'Road to Recovery' initiative which focuses on three strategic shifts:

Moving care from

- Hospital to community,
- Sickness to prevention, and
- Analogue to digital.

This vision aligns with the guidance's focus on restoring the NHS post-pandemic, particularly in terms of addressing health inequalities and ensuring long-term sustainability. Additionally, Lord Darzi's contributions underscore the need for a more integrated, patient-centred approach to care. Together, these efforts aim to reshape the NHS, ensuring it is equipped to meet both present and future challenges while continuing to provide high-quality care for all patients.

Health inequalities and poorer outcomes for vulnerable groups worsened during the COVID-19 pandemic and have not recovered since. Systems are expected to analyse their waiting list data according to health inequality outcomes and relevant characteristics, including deprivation and ethnicity.

Nationally against the backdrop of an extremely tight financial settlement, the focus in 25/26 for the NHS is on performance recovery – bringing down the hospital waiting list, cutting long A&E wait times, and enabling more people to access GPs. Budgets are more stretched than ever. NHS service providers are being asked to increase productivity by 4%, with a 1% reduction in cost base, which inevitably means cuts to spending as there is little money to invest. We need to have tough trade offs to reduce or stop spending on some services and functions and achieve unprecedented productivity growth in others. The national target is achieving a 10% and 30% reduction for bank and agency. Open and ongoing conversations will be needed with staff, the public and stakeholders at organisation, place and system level about what it's going to take to improve productivity, reduce waste and tackle unwarranted variation. A balanced financial plan requires reduced employment costs, which includes a headcount reduction in the system.

NHS England has also published the report from the stocktake of primary care and integrated care systems led by Dr Claire Fuller. It makes a series of recommendations for local and national leaders and articulates important ideas about the future shape of urgent care and about the further development of neighbourhood teams.

It focuses on:

- Developing neighbourhood level 'teams of teams'
- Establishing a system-level model of same day urgent care access
- Delivering continuity of care by improving personalised care services
- More preventative care, using primary care to create healthier communities
- Three key enablers of change: workforce, estates, and data

NATIONAL STRATEGIC DRIVERS

3 Big shifts in 10 Year Health Plan*

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

*10 Year Health Plan due for publish in Spring 2025

5 Mandate Objectives Road to Recovery

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

4 Objectives Elective Care Reform

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

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

3 Essential Offers – Fuller Report (2022)

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

OUR POPULATION

Lincolnshire is one of the largest counties by area in England. It has a population of 775,000 however seasonal variation means this increases significantly at certain times of the year (there are 812,00 patients registered with a GP).

The county is made up of large towns, small dispersed rural areas and coastal communities, with population density around a third of the average for England. While deprivation in Lincolnshire is in line with the national average, and some urban areas e.g., Lincoln are relatively affluent, coastal resort towns such as Skegness and Mablethorpe are among the 10% most deprived districts in England.

A range of geographical and structural factors impact on access to and delivery of healthcare to our population. These include access to transport, lower levels of educational attainment that affect health literacy, and economic factors that affect health and quality of life. For example, in West Lindsey, only a third of residents can get to a GP within 15 minutes on foot or by public transport, and in East Lindsey some of our residents have to undertake an 80 mile round trip to access our PET-CT service.

Key facts about our population:

- Lincolnshire is ethnically less diverse than the rest of England (95.8% report their ethnicity as 'White' compared to 81.7% nationally).
- In Boston, 5.7% of residents report Polish is their main language.
- Our population is older (23% are aged over 65, compared to 18% nationally) and over half are classed as frail.
- Our population is in poorer health (over 50% are identified as high need or having long-term conditions that need intensive support).
- More adults smoke (15.4% compared to 11.9% nationally), are overweight or obese (67.6% compared to 64% nationally), and less physically active (58% meet the UK's physical activity guidelines compared with 63% nationally).
- The top five health conditions are: hypertension/high blood pressure, depression, obesity, diabetes, and asthma.

Lincolnshire has a transient population, due to people migrating for study, work and tourism. Individuals may experience issues with continuity of care due to transitory living arrangements, being unfamiliar with local services, and medical records not being easily transferable between different healthcare trusts and this can put unpredictable pressure on some of our key services.

A core component within our strategy includes tackling health inequalities, delivering care closer to people's homes, and exploring innovative digital solutions.

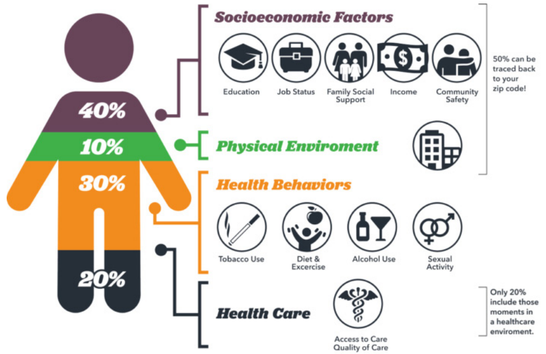
What are Social Determinants of Health (SDOH) and why do they matter?

Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

There is growing awareness that social risks negatively impact health outcomes and that addressing social risks improves health outcomes. For example:

- Food insecurity correlates with higher levels of diabetes, hypertension, and heart failure
- Housing stability (measured by the number of moves in the last 12 months) co-relates to non-attendance of healthcare appointments
- Transportation barriers result in missed appointments, delayed care, and lower medication compliance

Addressing SDOH is a very important approach in achieving health equity, and therefore a core concept in the development of our LCHG strategy, as we recognise the importance of delivering healthcare outside traditional hospital environments. How we treat our patients only impacts 20% of their overall health outcomes, hence working differently with health and social care partners, voluntary and third sector; putting prevention and moving care closer to home is a fundamental shift in how we are approaching our strategy.



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Understanding the population that we serve

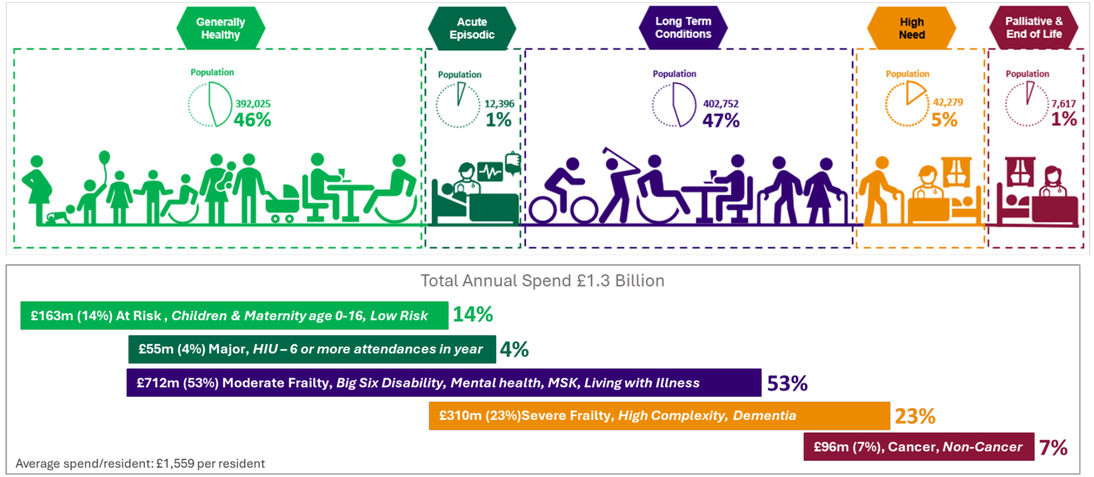
In Lincolnshire, we have the first national population health management tool which triangulates all of the business intelligence from all providers. This gives us a huge amount of knowledge, when it comes to planning futures services, investment and their locations based on population needs Population Health Management (PHM) provides insight on where and how we spend our population budget as a health system. PHM focusses on improving our patients' outcomes by addressing the needs of local populations and shifting care from being reactive to proactive. We know that 47% of our population have one or more long term conditions and our system spends circa 53% of its £1.3 billion annual budget on looking after them. Figure on the next page depicts our spend against various population health segments

- We spend 4% of our Lincolnshire system budget on acute episodic care. This equates to £4,600 per person each year who has one or more emergency hospital admissions in that year
- £2,800 per person per year for those deemed 'high intensity users'. High Intensity Users are individuals aged 18 and over who attend an Emergency Department more than expected – typically more than five times a month, or more than 20 times a year.

We spend:

- £13,500 each year per person on citizens with high need and severe frailty
- £7,300 each year per person with high complexity, plus
- £15,700 per person every year for those on end of life/palliative care pathways

This knowledge provides us with an opportunity to look at where and how we deliver care. Keeping SDOH principles in mind, we recognise that this spend as a health system, only accounts for 20% of a persons' overall health outcomes- so moving care closer to home is going to help us focus on prevention, reducing the reliance on acute care and delivering more activity through community and neighbourhood teams. This will ensure that we are making the best use of our resources for our patients and our citizens of Lincolnshire.

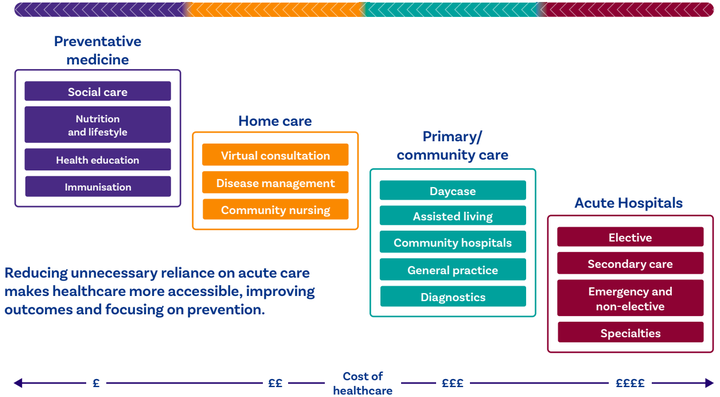


Source: population health management data (Lincolnshire ICB, 2024)

HOW WILL WE DELIVER CARE DIFFERENTLY?

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 unnecessary hospital admissions.



Reducing unnecessary reliance on acute care makes healthcare more accessible, improving outcomes and focusing on prevention.

This approach will also help ensure financial resources are spent in a way to better support community, primary care and preventative approaches to healthcare service delivery. We will look to extend work already commenced with a number of our Primary Care Networks and other health, social care and 3rd sector partners to deliver pathways of care differently for our patients with long term conditions such as diabetes, cardiovascular disease and respiratory disease.

This work will involve the use of population health data and other key metrics to identify how we can transform the way we provide care to patients on these pathways to reduce any identified health inequalities, support patients to self-manage their conditions, embed preventative measures to reduce long term demand and contribute to improvements related to the wider social determinants of health.

WORKING TOGETHER WITH OUR SYSTEM PARTNERS

There is a long history of joint working in Lincolnshire between the NHS, Local Authority and wider partners – together known as the Lincolnshire Integrated Care System (ICS).

To drive the delivery of the Lincolnshire Integrated Care System ambition and aims, three strategies have been developed. The first two of these, the Health and Wellbeing Strategy and the Integrated Care Partnership Strategy, set out the priorities and key enablers for the partners in the Lincolnshire Integrated Care System to meet the health and wellbeing needs of the Lincolnshire population in the widest sense.

The third of these, the NHS Lincolnshire Joint Forward Plan, describes the priorities that the Lincolnshire NHS and its partners will jointly focus on to meet the physical and mental health needs of the Lincolnshire population, in the context of the overall ICS ambition and aims.

These priorities are:

- A better relationship with the people of Lincolnshire
- Living well, staying well
- Improving access
- Delivering integrated community care
- A happy and valued workforce

Our strategy has been developed to ensure alignment with system strategies and plans to strengthen focus on key areas and build the opportunity for collaboration across teams and organisations.

Anchor Institution

ULHT and LCHS recognise our responsibilities as Anchor Institutions; where large non-profit, public sector organisations acknowledge that our long-term sustainability is tied to the wellbeing of the populations we serve.

We recognise our role in influencing the wider health and wellbeing of our populations, and along with our system partners have committed to focusing on building healthier, safe and more resilient communities, promoting local skills and employment, decarbonising and safeguarding our world and supporting growth of responsible local/regional business.

Our new Green Plans for 2025 will be key enablers to the delivery of some of our priority Anchor responsibilities and ambitions and we will work with our local communities and partners to deliver even greater local benefits (e.g. through procurement, supply chains, partnership working, community outreach). We will strengthen our relationship with the University of Lincoln to enhance local employment opportunities through the development of a joint strategy with a focus on educating and developing the workforce for the future.

Working collaboratively as a Lincolnshire Anchor System will allow us to maximise the impact of our activities and directly supports the aims of both LCHG and the ICS.

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

VISION, STRATEGIC AIMS AND OBJECTIVES

We have come together as a Group to work differently with our system partners, remove duplication and barriers to working seamlessly to deliver best health outcomes for patients and our citizens, our vision is “caring and building a healthier future for all.” To help deliver our strategic intentions we have set ourselves the following strategic aims and objectives.

Our strategic aims capture the three things we must do to deliver our vision. They are our long-term goals and create the bridge between our vision and the annual goals needed to achieve it.

The strategic objectives are the things we must do to deliver each of the strategic aims. They act as a roadmap, aligning efforts across teams to ensure that every action contributes to our overarching aims. Assurance ratings are assigned to each strategic objective in the Board Assurance Framework. Progress updates against each aim are monitored at relevant board committees.

STRATEGIC AIM 1 - PATIENTS

We want to ensure that every interaction our staff have with our patients has a positive impact on their patients' health and wellbeing and that every LCHG contact adds value to their experience of the NHS.

Every care journey begins with a need—whether sudden, ongoing, or expected. In those moments, what matters most to individuals is being seen, supported, and treated in a way that feels timely, compassionate, and in the right place. This strategy is built around those experiences, focusing on providing care that is responsive, well-connected, and centred on the needs of patients and communities. It recognises the importance of making best use of resources and ensuring care is delivered from safe environments that support long-term sustainability and value.

Where ill-health does occur, we want our patients to receive high quality, safe and compassionate care that achieves the best possible clinical outcomes. We are committed to continuously improving our services, treatments, and care to enhance the experience of all our patients to achieve this, it is key that every member of our teams is empowered to lead and make improvements in their everyday work and that all performance and outcomes are measured and monitored in a systematic manner.

Objective 1a – improve patient safety, patient experience and deliver clinically effective care

Safe patient care is the foundation of high-quality healthcare. Our strategy aligns with requirements of the National Patient Safety Strategy and the national Patient Safety Incident Response Framework (PSIRF), promoting a culture of openness, learning, and continuous improvement.

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety (NHSE, 2025). This new approach to patient safety is underpinned by the 'Just Culture' that is being embedded across the Group, which will enable a culture of psychological safety and an approach to learning when things do go wrong.

At LCHG, we have looked at trends in our incident reporting over time and are working collaboratively to identify solutions, while promoting a strong organisational safety culture. We are driven to deliver the best possible care and health outcomes. We want to ensure our services remain safe and embed strong processes to learn from practise.

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

Our commitment to providing personalised care means that we will not make decisions about your care without you being fully informed allowing you to be in control and make informed choices.

We will develop a culture that enables patient involvement and choices regarding their own health. Patient panels and a co-production approach bring together the lived experience and voice of our patients to feedback and input into ongoing pieces of work and will be an important part of this process, but we will also consult wider when needed.

A patient's perspective!

Our patients will see changes to how they book their outpatient appointments and how they are reminded of future appointments ensuring we promote patient choice.

We have trialled and implemented a digital appointment service in some areas and are looking at apps to allow patients to book appointments which are convenient for them.

Group outpatient appointments may also be offered to help patients get seen quicker and to also provide additional support and insight from others with lived experience of conditions and injuries.

While a traditional outpatient review could last 10-15 minutes per patient, a group consultation can run for up to 90 mins with around 12 participants which allows more time to be spent with a healthcare professional or team and others for peer to peer support. Group sessions can be run face to face or virtually and can help create a deeper sense of community between patients and staff, allowing people to learn from each other, and share lived experience.

Patients may be invited to appointments virtually – over the phone, or via video – or they may be asked to see a colleague face to face in a community based venue allowing our patients to experience quicker care, closer to home.

Objective 1b – Reduce waiting times for our patients

Whilst we continue to operate under significant operational pressures, we will continue our focus on key areas of improvement such as reducing ambulance handover delays at hospitals and in the community, and on the timely and safe discharge of patients who no longer require hospital care.

We are recovering and improving the efficiency of our elective services in order of clinical priority to ensure our patients are not waiting longer than they should to be seen. We will transform the way we provide elective care whilst reducing long waits and reducing the risk of harm to our patients.

Objective 1c – Improve productivity and deliver financial sustainability

We know that effective financial management flows from focusing on service quality.

We are committed to using public money responsibly and investing in innovation and research to improve patient, carer, family and staff experience. We want to increase productivity which means working more effectively and not necessarily harder and reducing waste whilst not sacrificing quality.

We are operating in an extremely challenging financial environment. Our vision is that we will have eradicated our underlying deficit and are in a position where each year we spend no more than what we are allocated. This will involve making some difficult decisions at times and our focus will be to ensure we fully understand the potential impact of these for our staff, partners and population. This will be a significant challenge but will be greatly supported by our strong internal quality improvement and waste reduction ethos, our cost improvement programme, our Lincolnshire joint system working on financial recovery and the opportunities brought about by our Group arrangements.

Objective 1d – Provide modern, clean and fit for purpose care settings

Managing our estate effectively across LCHS and ULTH will support the delivery of high-quality care which is, both financially and environmentally viable. We also recognise that modern fit-for-purpose premises can have a significant positive impact on patient recovery and staff wellbeing.

We will continue to develop, invest in and maintain our estate across our acute and community sites, seeking to make our buildings and facilities more accessible, ensuring we are utilising all spaces efficiently. By 2030 we expect to have invested £122.5 million in redevelopment, refurbishment and transformation projects making all our sites fit for 21st century healthcare.

An example – Community Diagnostic Centres

Thanks to significant financial investment, we now have three Community Diagnostic Centres (CDCs) open across the county – in Grantham, Skegness and Lincoln.

These state-of-the-art facilities include MRI scanners, CT scanners, ultrasound rooms, X-Ray rooms and much more to enable diagnostic testing to take place away from our acute hospital sites.

The CDCs have helped us to provide extra capacity across the county, through additional equipment, late opening hours (until 8pm), and accessible spaces in convenient locations with free parking – making it easier for our patients to access efficient care, closer to home offering an alternative venue to access care quickly and easily away from busy hospital sites.

Over the next five years we will look to expand the number of CDCs, their opening times and also the range of testing, training and facilities available – making diagnostics more accessible than ever!

STRATEGIC AIM 2- PEOPLE

Our people are extremely important to us, and we will continue to have a clear focus on sustaining a happy, productive and engaged workforce. We want to ensure our people fulfil their maximum potential and that they are recognised for doing so, as we also recognise the impact this has on the quality of care we provide for our patients and population.

Objective 2a – Enable our people to fulfil their potential through training, development, research and education

The Lincolnshire Talent Academy is an umbrella body made up of health and care organisations within the county. The academy delivers proactive services to aid recruitment and skills development of our current and future workforce, whilst also ensuring the portability and integration of skills across the health and care system. With a common shared goal across all stakeholders – to adopt a 'grow our own' culture within the county- the Lincolnshire Talent Academy provides the foundation for our collaborative approach.

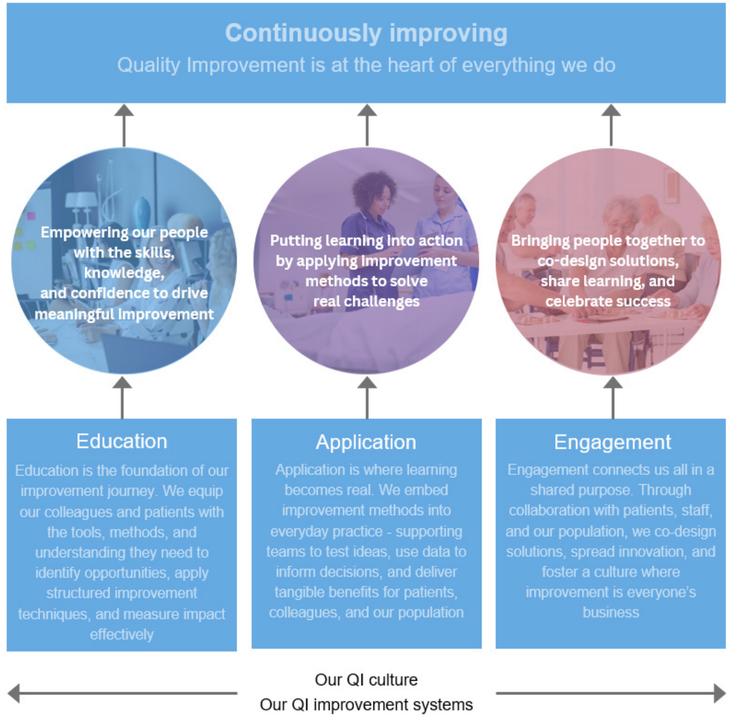
Formed in 2015 the Talent Academy has helped to inspire thousands of young people and the general community to consider careers within the NHS and wider health and care sector. The first of its kind to be created, its model of partnership delivery has been recognised nationally many times over as best practice and has since been replicated across the country.

In numbers, the Talent Academy has facilitated over 6500 careers events, engaged with over 130,000 people, processed 11,000 work experience requests and directly hosted over 5,700 placements. Helping our workforce develop, the academy has recruited and supported more than 1,450 apprentices through its programmes and currently works with 37 active providers to help our workforce develop and grow further.

A new LCHG Research Plan will be developed which will clearly outline the steps required to build our capacity and capability to deliver our research ambitions including establishing a Clinical Research Facility, complementing our vision to provide world-leading experimental research for the population of Lincolnshire and working in partnership with the University of Lincoln and other key educational institutions to ensure we continue to develop and retain a highly skilled workforce for the future.

Objective 2b – Empower our people to continuously improve and innovate

We are launching our Quality Improvement Enabling Plan 2025-2030 which outlines our unwavering commitment to excellence and innovation. By fostering a culture of continuous improvement, we aim to inspire every member of our organisation to strive for the highest standards. This plan is not just about processes and metrics; it's about touching hearts and minds, ensuring that every improvement we make resonates deeply with our core values. Our approach to Quality Improvement (QI) is underpinned by three key enablers: education, application, and engagement. Together, these elements ensure a consistent, structured, and sustainable approach to improvement across our organisation.



The Institute for Healthcare Improvement model for improvement is a widely used framework for accelerating QI in healthcare. It consists of three fundamental questions and the Plan-Do-Study-Act (PDSA) cycle.

1. What are we trying to accomplish? This helps set clear, measurable aims.
2. How will we know that a change is an improvement? This involves establishing measures to track progress.
3. What changes can we make that will result in improvement? This focuses on identifying and testing potential changes.

The PDSA cycle allows teams to test changes on a small scale, study the results, and refine the changes before broader implementation.

Using this model ensures a structured approach to QI, promoting continuous learning and adaptation. Its benefits include improved patient outcomes, enhanced efficiency, and the ability to close equity gaps by applying an equity lens throughout the process.

SPOTLIGHT – Cath Lab Improvements

The QI team at ULTH worked with the Cardiac Catheterization Laboratory to address the significant waits for a post cardiac device implantation check that was standing at approximately 41.3 hours against a target time of four hours. This was having an impact on patient experience and flow as well as contributing to a 12 month wait to be seen for the procedure.

Using QI tools to analyse and measure the current process, several factors were identified and then addressed through PDSA improvement cycles until it was felt by all that all improvement had been achieved. The QI team then built a final new process in conjunction with the cath labs team. The final outcome was an average wait time down from 41.3 hours to 10.9 hours, enabling a timelier service for patients with a greatly improved experience with less time in the hospital and few overnight stays.

The implementation and adherence to the new process freed up the equivalent of 988 patient bed days saving in the region of £340k per annum whilst reducing demands on inpatient wards and staff.

Objective 2c – Nurture compassionate and diverse leadership

For a QI culture to be effectively embedded, QI activities must occur throughout all level of the organisation. Leaders have a responsibility to role model the expected behaviours of their staff. The LCHG QI team will therefore run LCHG 100 QI events for leaders throughout the Group, supporting these staff to develop their own QI projects and learn the skills expected of their staff regarding QI so that they can effectively support future QI activities within their remit.

The new Learning Improvement Networks (LINs) have been established nationally to enable an opportunity for NHS trusts to work collaboratively together to make a real difference to the NHS. LCHG is part of the East Midlands LIN and plans are already underway to explore opportunities for shared improvement learning across our urgent and emergency care and planned care pathways.

We will also continue to work closely with Health Innovation East Midlands (HIEM) who support NHS providers to find, test and implement new solutions to make care better for our patients. They also help to connect the NHS with industry partners who can accelerate our ambitions, sharing innovations from across England to allow us to benefit from the experiences of others.

We want to redouble our efforts to reduce discrimination, violence, bullying and harassment and continue to embed equality and diversity in all that we do. The connection between a highly engaged workforce and improved patient outcomes is well documented and it's no surprise that a more satisfied workforce leads to better patient experience. Our culture isn't static and is nurtured by our values and behaviours, the role-modelling by our leaders and through the many activities that together create our organisations workforce.

We need to create excellent employee experiences and fundamentally change 'how we do things around here'. We must build a modern culture where staff feel supported, valued and respected – and want to stay and develop in our organisation. Offering better support to our staff, adopting flexible and smarter ways of working, optimising technology, planning and delivery of capability and capacity, workforce redesign, and working across organisational boundaries are the critical changes that will move us on from traditional approaches to workforce.

We are also committed to doing this work in partnership with our staff organisations and will continue to invest in our Staff Networks which available to help support staff and make valuable improvements to the ways in which we work.

An example – Staff Menopause Clinic

Our trailblazing staff-menopause service, driven and established by the Women's Staff Network in partnership with Occupational Health is the first of its kind in England, offering NHS staff members access to a nurse specialist and doctor-led clinic for help, diagnosis and treatment support. In 2025 we supported our 500th staff member and we will continue to develop this service to ensure we help and support our workforce to remain healthy and well at work.

Objective 2d – Recognise our people through thanks and celebration

It is so important that we recognise and appreciate our colleagues and volunteers, and we have created a range of channels and ways to do this – from daily recognition and simply saying thank you, through to our annual staff awards.

The LCHG staff awards are an opportunity for the people of Lincolnshire to recognise the hard work, dedication and care shown by community and hospital staff working across the county, and where they have demonstrated exceptional professionalism and care. Every year we hold an awards ceremony to celebrate those nominated and to crown our winners.

In 2024 we held our first joint LCHG Staff Awards. Staff members from across the group came together to celebrate over 1000 nominations.

The DAISY (Diseases Attacking the Immune System) Award is an international recognition program that honours and celebrates the skilful, compassionate care nurses and midwives provide every day. LCHG are really proud to have had a number of our compassionate nurses and midwives be recognised as DAISY Award Honourees.

STRATEGIC AIM 3 - POPULATION

We will adopt a more system-focused approach to the design and delivery of services through 'left shift' of activity, with services designed around our rural communities and their unique needs and circumstances. We will ensure that decisions about any provision of services work within the system as a whole, and that services are delivered in the context of the right patient pathway, location or provider.

We want to be an effective system partner, recognising that the outcomes and impact we can achieve together for our population are greater than any individual organisation can deliver alone. This will also enable us to address Social Determinants of Health, which is fundamental in achieving health equity and will support us in delivering healthcare outside traditional hospital environments.

Objective 3a – Transform clinical pathways and rationalise our estates, investing more in community care and reducing reliance on acute services

- We will use population health data and other key information to co-design our services with patients and system partners, as left shift and pathway redesign are key transformation programmes of work for LCHG. We will ensure that we consider all possible opportunities related to the location, the staff groups we use and ways that we can introduce innovation in our delivery models to improve outcomes for our population and reduce reliance on acute services.

Examples of how we can use left shift to invest in community care and deliver services differently:

- Left shift could include a change of delivery location such as moving clinics from an acute hospital site to a community hospital, GP practice, or even a community venue such as a library or community centre.
- Left shift could also include changing the way we deliver services by using new roles such as allied health professionals, therapy support workers, health coaches or advanced clinical practitioners to deliver care that might have traditionally been provided by other healthcare professionals.
- The biggest and most transformational change combines both location and the way the service is designed and delivered, resulting in new models of care focussed on improving population health outcomes rather than organisational silos.

Examples of how left shift has worked in other areas

- A community based ophthalmology service in Manchester offers eye services and treatment from high street locations. The network of community based locations offer easier access with better parking facilities and no need to walk around a large hospital site, with a lengthy waiting time in clinic. Clinics being on the high street also allow patients the chance to get on with daily life in an area of the city they are familiar with. The introduction of the clinics has also had a positive impact on performance, with the service moving from 70% to 95% of patients being seen within 7 days of their intended review date. Friends and Family Test data evidences that patients are supportive of the new clinics - 95% say they are either likely or extremely likely to recommend the high street community clinics to friends and family.
- The Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) Project addressed the need to develop personalised, person-centred palliative and end of life care. The project delivered enhanced care through an integrated approach between primary care/GPs, community services, acute hospitals and specialist teams in the area. The aim was to reduce the amount of unplanned time people spent in hospital during their last year of life. Collaboration between the providers allowed for rapid intervention and assessments to allow patients to go home quicker, with enhanced hands-on care provided at home with specialist level oversight to reduce the need for further hospital visits. Taking a personalised approach, the project provided wrap around support both practical and emotional for both the patient and the family and included follow up support for bereaved families. The project, backed by £9million of social investment has supported over 1500 people, and those cared for have spent on average 9 fewer days in hospital which is better for the patient, and

Objective 3b – Move from prescription to prevention, through a population health management and health inequalities approach

Increasing our focus on prevention and public health, we have an important role to play in supporting the wider health and wellbeing of the populations we serve and to keep people well in the community. The NHS prevention agenda will be a key driver as we use evidence-based programs such as our tobacco dependency services to support our population to adopt healthier behaviours to improve overall health and reduce demand for treatment. We know that by tackling and treating disease and illness earlier we reduce the burden on our health care services and encourage better health outcomes for our patients. Prevention is better than cure.

Objective 3c – Enhance our digital and research and innovation capability

Healthcare research is vital for the deployment of safe and effective healthcare strategies and interventions. We play an important role in developing the treatments of tomorrow through research, but our ambition is to do more. We achieved 'Teaching Hospital' status for United Lincolnshire Hospitals NHS Trust in 2024. We continue to build on this, striving to growing our clinical academics and aspiring to achieve teaching status across the Group.

We hold an ambition to grow and develop our culture of research, building on the amazing work that colleagues are already doing to bring cutting-edge research to the population of Lincolnshire. By 2030 we will offer many more patients the opportunity to take part in high quality research, and be leading significantly more research in Lincolnshire, contributing to changes in care that will directly impact upon and improve the health and wellbeing of the diverse populations that we serve. Our relationship with the University of Lincoln will also be key to deliver our research ambitions and we look forward to continuing to build on the positive progress we have already made.

Clinical Research Facility

This dedicated research space will offer the facilities for outpatient and specialist research clinics, with the opportunity to bring together multi-disciplinary teams of clinicians and research support to deliver all phases of research in a modern, state of the art premises.

The facility will not only allow dedicated space for research delivery, but also accommodation for research development activities, with space for academic staff to work alongside clinical services and NHS research support to progress research grant applications and formulate future research strategies.

Objective 3d – Drive forward our improvement, efficiency and sustainability agenda including our Green Plan

Harnessing the power of digital technology to transform services and to open up new opportunities is a core enabler for this strategy. Digital technology has great potential to improve how the NHS delivers its services. The Group will invest around £130 million over a 10-year period to deliver over £55 million of recurrent annual benefits (both cash and non-cash releasing), by upgrading Electronic Patient Record (EPR) systems across Lincolnshire. This will provide a holistic view of patients care, easily accessible in one place.

By working in collaboration with the other trusts in the region, we can maximise the impact and opportunities with our electronic patient records, supporting deployment, ensuring that information is fully accessible to support patients who may need to receive care in other settings across the East Midlands.

Our digital technology infrastructure and real time data will enable our staff to fully understand their services and identify, deploy and monitor service transformations both within LCHG and across the wider health and social care system. For patients this will mean that they engage in and receive care in digitally enabled, innovative ways that help them to have more control, understanding and insights into the care they receive.

SPOTLIGHT – Digital Infrastructure

We are in the third year of a three year £20 million investment (as part of the EPR investment) upgrading and enhancing our digital infrastructure to ensure that it is resilient, robust and efficient and also supports the green agenda. We will continue to roll out "Single Sign On" so that our clinicians don't have to log into so many different systems. We have replaced over 2,000 wireless access points (to provide improved coverage and increased bandwidth to support increased use) and so our hospital sites now have a significantly improved wifi as the newer technology provides for better coverage and stability.

Patient Perspective – Patient Entertainment

We have delivered a brand new Patient Entertainment Portal so our patients can benefit from free entertainment during their stay on their own devices or on one of the 150 devices that are available to borrow across our sites. We know time spent in hospital can feel long, so by providing access to a patient entertainment system and free wifi we are enabling patients to stay in touch with loved ones.

Delivering large scale transformation requires us to work differently with our system partners.

We have established a multi year productivity, improvement and transformation programmes alongside an Alliance Steering Group to ensure our strategic priorities and left shift transformation and Cost Improvement Plans are effectively delivered.

CLINICAL OPERATING FRAMEWORK TO UNDERPIN DELIVERY OF OUR STRATEGY

Key to the success of any strategy, is in its delivery. Our clinical operating framework sets out how our services will be delivered in the most appropriate way for our communities, combining aspects of acute and community care to work differently with wider partners within our health system.

A fundamental ethos of being in a vertical integrated group model is giving community its primacy and driving a left shift of activity (closer to home) whilst maintaining the highest quality of care.

Our patients and staff told us that making services more accessible, reducing waiting times and improving the quality of services is key, and we will ensure that within all three core areas of our clinical operating framework (figure right) we work with our system partners to support 'left shift'.

We have two Emergency Departments within our acute hospitals. Lincoln County Hospital has a modern Emergency Department and a state of the art resuscitation centre. A new Emergency Department opens at Pilgrim Hospital at Boston in May 2025, with the latest technology and excellent patient facilities and equipment. Both the Emergency Departments have Urgent Treatment Centres (UTCs) attached to them which has been central to clinical pathways being developed and joint working between the consultants and health professionals. Work is ongoing to develop integrated streaming and direct access to specialties.

Both of our Emergency Departments are consultant-led and we have an emergency care consultant in charge on every shift. There are developments within urgent and emergency community services to support admission avoidance pathways through clinical assessment services and a Care Coordination Hub. Bringing together Urgent Community Response (UCR) Services and home visiting services will see people being supported in their home and preventing attendance at the front door of our urgent and emergency care services. There is an opportunity to develop digital access and AI technology to enhance patient pathways in this area.

We want to become the provider of choice in Lincolnshire for surgical services and grow our market share, maximising the utilisation of our Grantham Elective Hub to ensure that patients receive care locally and are offered the highest standards of care when compared to our peers. Alongside this, we want to continue to deliver outstanding family health services delivering continuity of care both in and out of hospital settings. We want to deliver efficient clinical support services and infrastructure to all the clinical services at LCHG and our partners, including continuing to mobilise and deliver services from the new Community Diagnostic Centres (CDCs) and working with partners to deliver care in alternative locations such as the Campus for future living – a pioneering health and education facility in Mablethorpe home to consultation rooms, seminar and teaching rooms, laboratory and event spaces. The campus aims to connect public, private and voluntary services to support residents through health innovation, technology and research. . We will ensure we are utilising all our spaces and assets across the community and acute hospital settings. We will develop strategic business cases for our theatres refurbishment, maternity services. These will be detailed within our estate's strategy.

Many of our community services are led by allied health professionals who use a holistic approach to assess, treat, diagnose and manage a range of conditions in adults and children across community settings. The focus is on prevention and improvement of health and wellbeing to maximise the potential for individuals to live full and active lives.

Community hospitals and transitional care provide a critical role across services and system providers to ensure that home first principles are proactively viewed as the starting position and not the end point. The service provides an essential function in supporting the Neighbourhood Teams to achieve admission avoidance and reduce acute delayed transfer of care. Bridging the gap between hospital and home maximises recovery and promotes independence with an emphasis on 'home first' through time limited rehabilitation and support for older people and adults with long term conditions.

We will continue to provide specialised acute services where it is appropriate for us to do so with the facilities, we have available. These include adult and children's cancer services (including radiotherapy and chemotherapy), specialist rehabilitation, cardiology services, vascular services, neonatal services and critical care. We aspire to develop a Lincolnshire Centre of Excellence for Cancer Care.

We will actively engage with the regional clinical networks linked to our specialised services to support equity of access and patient outcomes. Being an active member of the East Midlands Acute Provider (EMAP) Collaborative will enable us to design, develop and deliver specialised services in partnership across the region, supporting equity of access and outcomes for patients in Lincolnshire.

Utilising population health insights, alongside benchmarking information from Model Hospital, GIRFT and our internal PLICS financial data, we have identified key services that we want to redesign utilising our QI principles to deliver them closer to home and drive 'left shift'. By looking at areas for 'left shift' such as OPAT/IV therapies, rheumatology, stroke, dermatology, ENT surgery, gynaecology/women's hubs, haematology and respiratory as an integrated system with LCHG/ICB/primary care/GPs and wider partners like social care, policing, and third sector providers – will help embed end-to-end integrated pathways to increase the number of patients receiving care in a timely manner, and, in a way that is most accessible.

We have set up an Alliance Care Group to create a common, organisational-agnostic space that identifies and takes forward opportunities to collaborate at scale across a range of partners. All our clinical support services form a core part of the alliance. We have developed an out of hospital collaborative operating model to help us work effectively with primary care/PCNs and GPs. Integrated Neighbourhood Teams will be working through identifying and implementing opportunities to collaborate at scale with PCNs, PCNA, GPs, ICB, Voluntary Community Faith and Social Enterprise (VCFSE) and independent sectors. Key workstreams include primary and secondary care interface, developing and approving a joint plan for neighbourhood health and integrated neighbourhood working e.g. aligning nursing in the community around PCNs, palliative and end of life services, and targeted health inequalities work The alliance arrangement will help to create a robust partnerships through which we can respond to future demand and changing levels of need and ensure we are targeting whole system service redesign. A proposed road map of our alliance programme is depicted below.

2025/2026 Roadmap

Phase 1

By April 2025 **1**

Reposition
- 2 wards from acute to community
- 1 additional ward for community patients, via productivity modelling

Reposition to the NEW Alliance Care Directorate
- Clinical Support (excluding Cancer services)
- Dermatology
- Rheumatology

Redesign & Relaunch
- Tier 3 Weight management
- OPAT

Establish Alliance Care Directorate Structure

Delivery of priorities within the **Secondary, Primary care Interface programme**

Implement Repositioning Transformation Programme

Phase 2

By September 2025 **2**

Embed
- Dermatology, Diabetes and Rheumatology into **6** PCNs

Reposition to the Alliance Care Directorate
- Heart failure
- CPP
- Care Navigation
- Neighbourhood Teams

Redesign & Relaunch
- Community nursing via K2 PCN pilot

Improve scores **Secondary, Primary care Interface programme**

Work with PCNs to establish Phase 4 Services

Phase 3

By March 2026 **3**

Embed
- Dermatology, Diabetes and Rheumatology into **ALL** PCNs

Reposition to the Alliance Care Directorate
- Therapies
- Rehabilitation
- Outpatients, Nursing and Appointment Booking
- Screening Services
- Paediatrics
- Women's Health (where appropriate)

Phase 4

April 2026 Onwards **4**

Reposition to the Alliance Care Directorate
- Services identified in phase 3
- Services based on long term conditions and PHM

Measure and Evaluate
- Programmes
- External Relationships

Phase 4 of transition of services into the Alliance

ROADMAP TO DELIVERY

This strategy, and the care group plans which underpin it, mark an important step forward for our Group. It identifies the key priorities for the Group, ensuring we are focused on the right things for both our patients and our staff. There is a strong focus on 'getting the basics right' first, whilst also planning for longer-term changes to our services. The board assurance framework will provide a clear and strong governance approach to monitor delivery of the strategy.

We have adopted the following approach to monitor delivery of 2025/26 LCHG Strategy:

- A deep dive on relevant objectives and actions at relevant Board Committees as described in the table below
- Ensuring, at the end of each quarter, that we have a summary report on each strategic aim at individual committees and a summary at Trust Board, which will focus on highlighting progress and key actions/mitigations for off track actions.

Strategic Aim	Committee
Aim 1- Patients	Quality Committee
	Finance and Performance Committee
Aim 2- People	People Committee
Aim 3- Population	Integration Committee

Enabling strategies

There are a wide range of key enabling strategies and plans for each strategic aim that will support the delivery of the LCHG strategy. All of the enabling strategies are either in development or being reviewed and published to reflect the vision outlined within this strategy and they will help us deliver our objectives. Enabling strategies/plans support us to achieve our aims include but are not limited to:

- Quality and Safety Strategy
- Estates Strategy
- Digital Strategy
- People Plan
- Research and Innovation Strategy
- Quality Improvement Plan

Care groups annual plan

Each care group will analyse their services in line with the national planning guidance and constitutional standards of delivery. They will produce a SWOT (Strengths, Weaknesses, Opportunities and Threats) to be able to consider key areas of developments and identify areas of improvement which will form part of their care group plan. An example of what the annual care group plans will include and what this looks like is shown below.

The delivery of care groups plans will be monitored via their Performance Review Meetings in line with the updated Performance Review Framework.

2025/2026 Care Group Plan

Patients	People	Population
Provide timely, high quality, affordable care in the right place	Develop, empower and retain great people	Improve population health
We will…	We will…	We will…

IN SUMMARY

In closing, this strategy reflects our collective commitment to improving the health and wellbeing of people across Lincolnshire. By working together – across services, communities and systems – we can create the environment for our population to not only live longer, but live healthier lives.

We would like to thank our dedicated staff, our patients and our system and partner organisations for their continued commitment, collaboration and care. It is through your efforts that this strategy will become a reality, delivering meaningful and lasting change for everyone in Lincolnshire.

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Lincolnshire Community and Hospitals NHS Group
Lincoln County Hospital
Greetwell Road
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LN2 5QY

SANDRA – COMMUNITY NURSE

Sandra is an experienced and dedicated community nurse who bring compassion, expertise, and a real enthusiasm for integrated care to her role. She is genuinely excited about the opportunities that the new Group arrangements will create – not only for her own professional development, but also for the wider benefits to patient care across Lincolnshire.

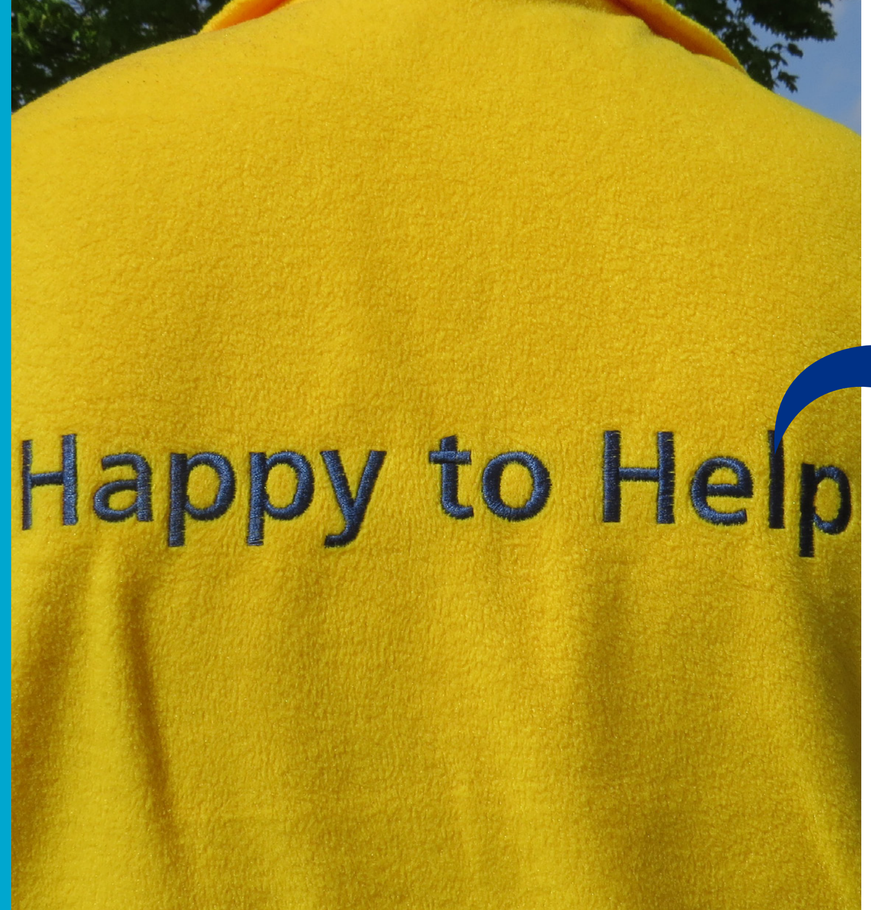
Sandra is particularly looking forward to working more closely with colleagues across different teams, services, and locations, building stronger partnerships and sharing knowledge and skills across organisational boundaries. She sees the opportunity to undertake joint roles as a key step in developing a richer understanding of both community and acute care, supporting more seamless, person-centred experiences for patients.

Sandra's enthusiasm, adaptability, and unwavering focus on patients make her a highly valued member of the team. She is proud to be part of this new chapter, helping to shape a future in which joined up, high quality care is the standard across Lincolnshire.

With a strong commitment to continuous learning, Sandra views the Group model as an exciting platform to broaden her skills, deepen her knowledge of integrated care, and progress her career within a more connected, ambitious healthcare system. She values being part of organisations that places collaboration, innovation, and patient centred care at the heart of everything they do.

BEN – VOLUNTEER

Ben has been a dedicated NHS volunteer for the past three years, generously giving his time to support patients, visitors, and staff at his local acute hospital during his retirement. Throughout his volunteering journey, Ben has loved every minute of his experience, finding deep fulfilment in helping others and contributing to the life of the hospital.



During his time on site, Ben has gained valuable insight into the day-to-day challenges faced by patients and visitors as they navigate the hospital estate. His observations have highlighted several opportunities for improving how people are directed around the site, enhancing both experience and efficiency.

Ben's enthusiasm, fresh perspective, and commitment to continuous improvement embody the true spirit of NHS volunteering.

Motivated to make a difference, Ben is now working with the hospital's Quality Improvement (QI) team to develop his ideas further. With their support, he will turn his feedback into a structured improvement project, with clear outcomes and measurable impacts. The QI team will guide Ben through the process, ensuring his experiences are translated into meaningful change that benefits everyone who comes through the hospital doors.

LINDSAY - ESTATES

Lindsay has been a valued member of the estates team at the community hospital for the past 12 years, working to ensure the buildings remain safe, functional, and welcoming for patients, visitors, and staff alike. Lindsay loves the variety that the role brings and enjoys working closely with colleagues across the hospital, building strong relationships and making a positive difference every day.

Alongside their technical expertise, Lindsay is passionate about sustainability and is a strong advocate for the hospital's green agenda. Always on the lookout for ways to make the hospital more environmentally friendly, Lindsay is committed to identifying and supporting practical improvements that reduce the sites carbon footprint.

Recently, Lindsay became a Green Champion, helping to drive forward the organisation's environmental ambitions. They are excited about the upcoming launch of the Group Green Plan and the journey towards achieving net zero. Through their work, Lindsay is playing an important role in supporting sustainable change and ensuring the community hospital continues to service its population in a greener, more responsible way for the future.

CALLUM – ALLIED HEALTH PROFESSIONAL (AHP)

Callum is a dedicated AHP who has recently benefited from the support and opportunities provided by the AHP Faculty, which committed to facilitating system-wide working across all parts of the care system where AHPs play a vital role.

Through the faculty, Callum has explored new approaches to career progression, work experience, and coordination across organisational boundaries. He is particularly excited about the Lincolnshire-wide approach to developing the AHP profession, including the introduction of degree apprenticeship opportunities, which are opening up new and flexible routes into advanced clinical roles. These developments are creating clear pathways for AHPs to grow, develop, and lead within the health and care system.

As the Group continues to integrate care across organisational boundaries, our AHPs will play an increasingly vital role in shaping and delivering future models of service. With the ongoing support of the AHP Faculty, Callum – and many others like him – will be well placed to drive innovation, improve patient outcomes, and lead the way in delivering high-quality, integrated care.

Keen to continue expanding his skills, Callum is preparing to undertake a clinical placement in a new area of practice. This experience will broaden his clinical knowledge and support his ambition to move into a clinical leadership role in the future.

BETTY – CATERING ASSISTANT

For Betty, a member of the catering and restaurant team at our acute hospital, food is about so much more than just nutrition – its about comfort, dignity and care. When the opportunity came to redesign the patient menu, Betty was determined to make sure it truly reflected the voices and needs of the people we care for.

She set out to work directly with patients, listening carefully to what mattered most: the types of food they loved, the importance of choice at different times of day, and the cultural and faith-based needs that must be respected. Betty paid particular attention to patients with specific dietary needs, such as those requiring texture-modified meals, striving to ensure that flavour, enjoyment, and presentation were never compromised.

Balancing taste and inclusivity with the need to manage costs carefully, Betty brought together ideas and expertise from across the hospital. She used QI methods to structure the project and worked closely with colleagues from the finance efficiency and the patient experience teams to make sure every detail was right.

Thanks to Betty's passion and collaborative spirit, the new menu reflects a deep understanding of the people we serve. It's designed to bring a little joy to every meal and make every patient's stay with us feel that bit more personal and caring.

Through her work, Betty has shown that when we truly listen, we can turn everyday experiences like mealtimes into something that supports recovery, wellbeing and dignity for all.

ARMAN – PROJECT MANAGER

Arman is a Project Manager at LCHG and joined the Group just over six months ago, bringing with him valuable experience from the private sector and a fresh perspective on delivering complex change. New to the NHS, Arman quickly recognised both the incredible opportunities and the scale of the challenges ahead and is excited to be playing a key role in transforming services for the benefit of patients across Lincolnshire.

In his role, Arman is responsible for ensuring that projects are delivered on time, within budget, and with clear, measurable outcomes. His work is wide-ranging and dynamic, from supporting the left shift of activity away from acute hospitals to community settings, to redesigning clinical pathways, implementing innovative remote monitoring solutions, and much more. Every day brings new opportunities to collaborate with colleagues from across a range of teams and services, making no two days the same.

Arman's passion lies in making a tangible difference. By helping LCHG deliver high-quality, sustainable care, he knows his work is contributing to better health outcomes for the Lincolnshire population. With his strong project management skills, enthusiasm, and commitment to improvement, Arman is proud to be part of shaping the future of healthcare delivery across the Group.

JACINTA – CONSULTANT

Jacinta, a consultant working across both the community and acute services within the Group, is playing a vital role in supporting the transition to digital-enabled care at LCHG.

With over 20 years of clinical expertise, Jacinta is collaborating closely with the Digital Transformation team to help deliver major innovations, including the move to electronic prescribing, digital patient records, and other essential digital solutions. Her work is key to ensuring that the Group moves confidently from analogue to digital, improving the quality, speed and accuracy of the care we provide.

Through her leadership and collaborative spirit, Jacinta exemplifies the commitment to transformation that will define the future of care across LCHG.

Jacinta's approach is centred around strong clinical advocacy. She uses her experience to represent the voice of both patients and colleagues, ensuring that the digital systems introduced are truly fit for purpose, support high quality care, and are aligned to the Group's wider vision and ambitions. By bridging the gap between clinical practice and digital innovation, Jacinta is helping to create a health system that is more responsive, more efficient, and better for everyone who relies on our services.

WHAT THE FUTURE LOOKS LIKE FOR LEO

Leo is eight years old. He is a quiet boy who struggles to hear what his teachers are saying sometimes when he is in his classroom and as a result, is falling behind in his learning. He keeps getting recurrent ear infections but his mum works full time and finds it difficult to get time out of work and to access a GP appointment. His grandfather collects him from school most days and tries to support him with his homework but finds it difficult to communicate easily with Leo because he also has difficulties with his hearing. Leo's mum is worried that he will continue to fall behind at school if he isn't see by someone soon.

Following a referral from the school nurse, Leo is seen in his local GP practice by a GP who specialises in ear problems. The GP suspects Leo has glue ear but wants to check that his initial diagnosis of Leo is correct, so he accesses an MDT digital tool that allows him to discuss Leo's case directly with an ENT specialist at the hospital. The specialist agrees with the GP and puts Leo on the waiting list for surgery.

Leo's mum receives a telephone call from the hospital to make an appointment for Leo's pre-operative assessment with a paediatric specialist nurse at a time that suits Leo's mum. The assessment is able to be offered virtually - meaning that Leo and his mum don't need to take time off from school or work or travel into the hospital on the bus, which takes over an hour from where they live.

Leo and his mum are sent a virtual tour of the hospital and ward area so that they both can see where they should attend on the day of the operation and what the ward area and nursing team look like. This helps to reassure Leo and his mum of what to expect on the day and makes it a little less scary. Leo attends for his procedure and is back at home safe and sound later the same day.

Leo is followed up at home by a children's community nurse who checks he is okay after his procedure and answers any questions he and his mum have. The community nurse updates Leo's records which both his GP and the hospital specialist have access to and Leo wont need to attend any more appointments until he is followed up by an audiologist in the community several months later.

Leo's hearing is much improved, he is more actively engaged with his teachers and fellow pupils at school and is learning well. He is looking forward to moving up into Year 5 and wants to become an engineer when he grows up.

WHAT THE FUTURE LOOKS LIKE FOR MARY

Mary is an 82 year old retired nurse who has three children and two grandchildren. Her family don't live locally but she has a good network of friends and likes to be as independent as she can be. Her husband passed away six months ago and after she started to get a little bit forgetful she visited her GP and was diagnosed with dementia. Recently she has started to struggle with her medications and she is at risk of becoming physically unwell to the point where she needs admitting to hospital. Mary and her family are worried about this as they have heard stories of people getting 'stuck' in hospital beds and she doesn't want to risk losing her independence and ending up in long term care.

Both Mary and her family want her to remain at home for as long as possible, so they work with her GP and the community team to develop a comprehensive package of care from social care alongside intervention fro the re-ablement team who can assess Mary's for any aids, adaptations or equipment she needs to keep her safe.

Using proactive care Mary is able to live at home longer with access to local, integrated teams of specialists and professionals across the health, social care and third sector. Mary's family feel confident and happy that she is safe at home with the support around her.

Mary's package includes regular appointments with a community consultant geriatrician or advanced care practitioner at her local community centre. The centre also hosts a health and wellbeing space where Mary can access advice and support from local volunteer groups, social care and charities and where she can meet her friends for a cup of tea and a chat. They also offer day centre facilities should Mary's needs increase in the future.

WHAT THE FUTURE LOOKS LIKE FOR PETER

Peter is a 58 year old postman who enjoys playing darts with his mates at the pub and spending time with his family. He has had type 2 diabetes for several years but doesn't enjoy exercise and finds it difficult to stick to a healthy diet. He doesn't like to bother the GP and doesn't really trust healthcare professionals so tends to avoid regular check ups or any screening appointments he receives.

Peter is able to access a local health and wellbeing centre to suit his shifts where he is encouraged to self monitor his diabetes and upload his results onto a digital system which his GP and diabetes team can access and review. This reduces the need for him to attend face to face appointments as his healthcare professionals can also message him directly via the app with any advice or recommendations based on his results.

Peter's diabetes team and GP are able to keep a close eye on Peter's diabetes without needing to invite him into the hospital or GP practice for an appointment. This means Peter doesn't need to take any time off work and other people with more urgent needs are able to be seen more quickly.

A wellbeing coach at the local community centre is able to offer Peter advice on his diet and a membership to a local gym, and shares a healthcare plan that Peter is also able to discuss with his employer. It turns out that Peter's employer also offers an employee assistance programme and Peter is able to access this for further support around his lifestyle as well as other financial advice and support.

Peter is now able to understand and control his diabetes through self monitoring, diet and exercise which has enabled him to stay well and out of hospital. He now understands the importance of regular checks and has returned his bowel screening test when he received it recently. He is feeling optimistic about the future and about being able to continue working in the job he loves for as long as he chooses to.

WHAT THE FUTURE LOOKS LIKE FOR JANE

Jane is a 34 year old cleaner who has mild learning difficulties and has been experiencing pain in her knee for several months. She had a nasty fall five years ago and her knee has become progressively worse since, her job involves standing on her feet all day and she is finding it difficult to get around. She doesn't drive and so has to catch the bus to her local town to do her shopping.

Jane is able to access a first contact physiotherapist through her GP surgery. The physio sees her within the local village community centre where a monthly MSK clinic and group exercise session take place. The MSK team take a personalised approach with Jane, understanding what's important to her, how her function is being affected by her current knee pain and what she would like to see change. The physio is able to prescribe Jane some mild pain killers to help manage her symptoms in the short term.

Jane receives a personalised treatment programme, with exercises provided that she can follow at home with no special equipment and also by attending the monthly exercise group in her local gym. Jane's knee pain settles as she strengthens her leg muscles, and she does not need to attend the hospital for any scans/x-rays or other diagnostics.

12 weeks later Jane's symptoms have improved significantly, she is able to work without pain, no longer needs to take the pain relief medication and hasn't had to take any time off work. She has made good friends at the monthly exercise group and they all meet up regularly for a cup of tea and a chat at the weekends.

WHAT THE FUTURE LOOKS LIKE FOR JOSEPHINE

Josephine is a 67 year old retired teacher. She is married with no children and her and her husband enjoy spending time in the garden and visiting the coast. Three years ago she was diagnosed with bowel cancer and was recently told that she is now on a palliative care pathway. Since finding this out Josephine has struggled to talk to her husband about het prognosis and she is feeling scared and isolated. She is also worried about how her husband will cope when she is no longer around.

Josephine and her husband are able to be seen by an integrated team which includes her GP, community nursing team and acute hospital specialist in her local GP surgery. They also have access to a 24/7 telephone number although they prefer to speak to someone face to face if they can.

Josephine's team are also able to refer to Macmillan services, allowing her a safe space to speak openly about her cancer. They also find a local reading group that Josephine and her husband are able to join and have made new friends together. Josephine feels relieved that her husband has a wider network than before who can support him when she is no longer around.

Josephine's records are shared amongst all the providers involved in her care and the ambulance service. Should their be an emergency, her EoL plan is followed and she remains at home where possible. If Josephine becomes unwell, her integrated team are able to care for her at home, avoiding the need for her to be admitted to hospital. If Josephine does need an admission for any reason as a last resort, her team are able to facilitate her discharge home as soon as possible by wrapping support around her and her husband in a personalised approach.

The palliative nurse works closely with Josephine and her husband to minimise the number of appointments and wherever possible sees her at home, providing as much time as possible for Josephine and her husband to be together for as long as possible, supporting Josephine's wishes to remain at home.

WHAT THE FUTURE LOOKS LIKE FOR ASIM

Asim is a 45year old teacher who has noticed that his vision has been a little blurry of late. He already wears glasses and is up to date with his eye tests, however he has started to struggle reading his students assignments and is getting behind in is marking. He teaches full time, his partner Glen also works full time and they are also busy at the weekend supporting Asim's elderly mother who lives alone. He finds it difficult to get through to his GP as he is always working when the telephone lines open.

Asim is able to make an appointment via a website on a Saturday to see his optometrist at the local high street opticians. They check his eye sight but notice he has some increased pressure within his eye which they think might be causing his blurry vision and Asim also mentions that his mother has glaucoma. The optometrist has close links with the hospital based consultant and is able to directly refer Asim's case for urgent review

Asim attends the appointment with the hospital consultant within his GP practice. The consultant is able to check Asim's eyes and advises that he will need to continue to use the eye drops and have regular check ups because of his family history. Asim is able to have these regular checks at his local high street optometrist, with annual virtual clinic review with his hospital consultant.

The hospital consultant is able to view the test results taken by the local high street optometrist and agrees that Asim's eye pressure needs further investigation. He makes an appointment to see Asim in his local GP practice and is able to recommend eye drops which the optometrist is able to prescribe immediately for Asim.

Asim feels much happier now that he understand the problems with his eyes, the eye drops have improved his vision, he is back on top of his marking and he hasn't had to take any time off work to attend his appointments. He can manage his appointment with the optometrist via their website which makes it easy to reschedule if anything urgent crops up with his mother.

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Strategy 2025-2030

Socialisation, Communications & Engagement Plan

Caring and building a healthier future for all

Author: Sally Robinson – Head of Strategy & Best Practice, ULTH

Introduction

- This communications plan outlines the strategic approach to supporting the successful socialisation of the LCHG new 5-year strategy. As the NHS continues to navigate a complex landscape of healthcare transformation, workforce challenges, and evolving patient needs, clear, consistent, and engaging communication is essential to building awareness, understanding, and ownership of our strategic priorities.

- Our aim is to ensure that the strategy is not only well-understood across all levels of the organisation and by external partners, but that it also inspires a shared sense of purpose and commitment. This plan provides a framework for how we will communicate the strategy's vision, aims and values while fostering two-way dialogue and meaningful engagement with staff, stakeholders and the communities we serve.

- Through this plan, we will embed the strategy into everyday practice, enabling our workforce to align their efforts and decision-making with our long-term objectives. It also ensures that our partners and the public and kept informed and involved, reinforcing trust and transparency in all that we do.

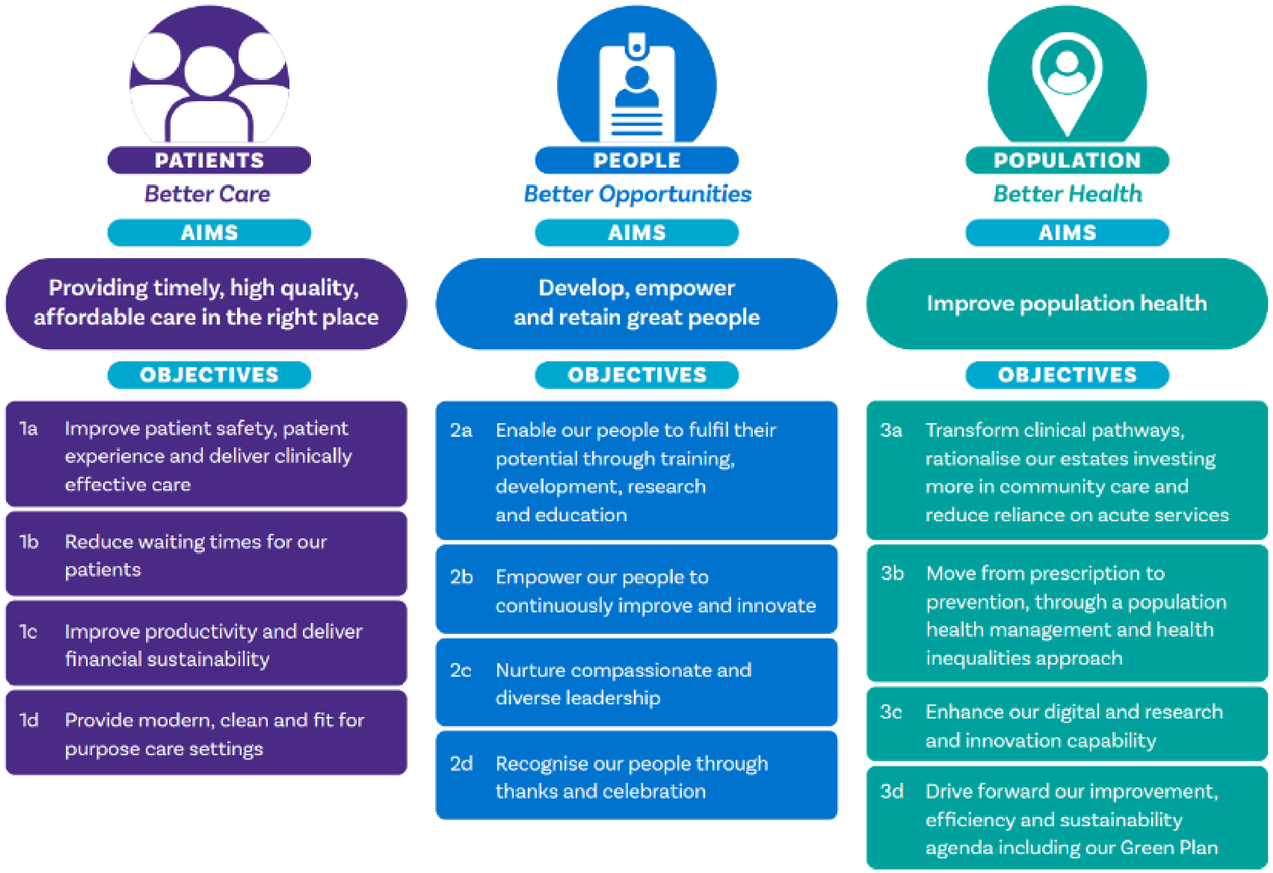
Content

Strategy Launch

- Staff Roadshows
- External Partners
- Patients/Public
- Internal Communications

Ongoing Engagement

- Staff
- Partners
- Patients/Public



Strategy Launch (May – July 2025)

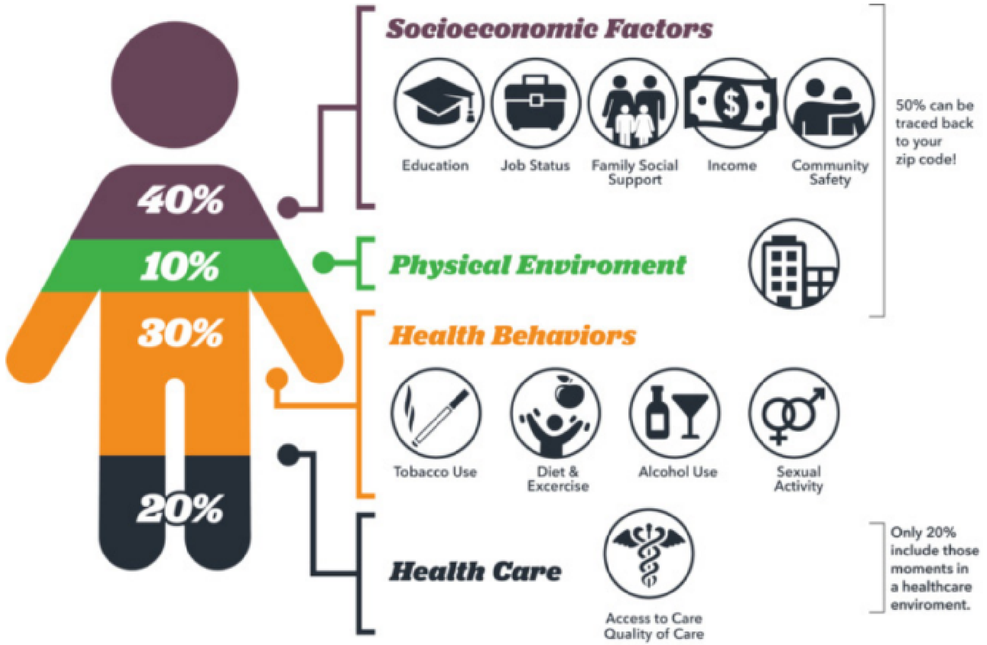
Staff Roadshows

- Strategy inclusion in staff roadshows May - July 2025
- Graphics showcasing key elements, plan on a page, staff and patient persona information to be displayed to generate conversation and understanding
- Strategy team direct support at majority of dates
- Information on strategic direction included in crib sheet for GLT members leading each roadshow session
- Insights collected into areas and elements of the strategy which may need more explanation, comms support re: clarity of message and understanding

External Partners

Copy of strategy document shared with the following external partners with supporting introduction:

Lincolnshire Integrated Care Board (ICB)	Voluntary & 3rd Sector Organisations
Lincolnshire Partnership Foundation Trust (LPFT)	General Practice, Primary Care – Lincolnshire Medical Council
University of Lincoln Institute for Rural & Coastal Health	Lincolnshire County Council – Health & Scrutiny Committee & Adult Social Care
University of Lincoln Medical School	East Midlands Acute Provider (EMAP)
East Midlands Ambulance Service (EMAS)	Local MP's & Councillors
Healthwatch	Regional & Surrounding NHS Trusts



Patients/Public

- A copy of the document will be placed on our public facing website
- Social media posts on LinkedIn, Facebook and Instagram to support launch of new strategy
- Strategy shared with patient panel for awareness

Internal Communications

- Strategy added to intranet
- Strategy intranet pages to be updated allowing additional information be added following insights from staff roadshows and other feedback
- Staff and patient personas to be used in comms to support story telling and engagement
- Strategy communications added to cascade and round up during May and June
- CEO Blog
- CEO/Dep CEO & CIO sound bite released discussing the launch of new Strategy and their hopes for the next 5 years

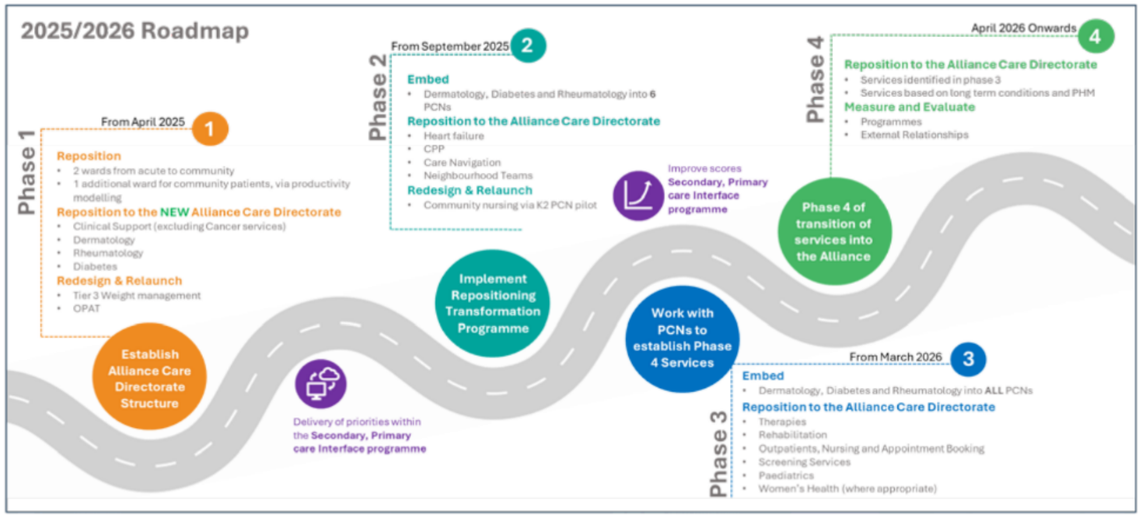
Ongoing Engagement (2025 – 2030)

Staff

- Regular updates on strategy achievements and success stories in internal comms
- Key elements explained further with examples linked to insights from staff roadshows
- KPI socialisation to ensure an understanding of how we are measuring the strategies impact
- Annual strategy impact statement detailing what has happened – good news, key measures etc
- Ongoing sharing of patient and staff personas – but move into real life case studies, sharing the stories of our staff and patients to raise awareness and trust
- Visible strategy, improvement and redesign team in areas of work aligned to Group strategy
- Development of enabling strategies to support delivery

External Partners

- Annual impact statement shared with external partners
- Visible strategy team aligned to areas of work where system collaboration is required
- Key updates shared when major milestones are hit
- Ongoing collaboration through Alliance Care Group support by strategic direction



Patients/Public

- Annual impact statement shared with patient panel and added to public facing website

- Use of social media to share good news stories and achievements

- Inclusion of more patient personas – move to real life case studies (anonymised where appropriate) to use in media stories to raise profile of work done

This plan outlines a coordinated, and inclusive approach to engaging patients, staff, partners and the wider public in the delivery of our LCHG 5-Year Strategy.

Through transparent messaging, consistent channels, and ongoing feedback loops, we will ensure that every stakeholder can understand, contribute to, and benefit from the strategic changes ahead.

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Board Alliance Update

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6th May 2025*
Item Number	*10.3*

Alliance Update

Accountable Director	*Daren Fradgley, Group CIO/Deputy CEO*
Presented by	*Daren Fradgley, Group CIO/Deputy CEO*
Author(s)	*Dr. Sameedha Rich-Mahadkar, Director of Improvement and Integration (ULTH)* *Nikki Pownall, Group Deputy CIO Ops* *Vicky Holden, Associate Director of Partnerships (ULTH)* *Angela Sharp, Deputy Director of Strategy and Partnerships (LCHS)*
Recommendations/ Decision Required	*This paper provides a brief update in relation to the Alliance Model, including the establishment of the Alliance Steering Group and an update on the agreed 'Left Shift' Programme. Board are asked to note the update and the plans to engage collaboratively with various system partners in order to support delivery.*

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

3g Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)	X
4a Establish collaborative models of care with all our partners including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector	X
4b Successful delivery of the Acute Services Review	
4c Grow our research and innovation through education, learning and training	
4d Enhanced data and digital capability	X
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	X
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	X
5c Tackle system priorities and service transformation in partnership with our population and communities	X
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	X

Alliance Update for Trust Board May 2024

1. Introduction

This paper provides a brief update on the Alliance Model, including the establishment of the Alliance Steering Group and an update on the agreed 'Left Shift' Transformation Programme. 'Left shift' is a term used to describe expanding and improving care in local communities so that patients and service users can be better cared for at home, minimising the amount of time patients spend in hospital and, where possible, avoiding hospital admission or attendance in the first place. This means treating more patients in primary care or the community and reducing referrals and treatment in secondary care. It also means having a clear focus on prevention and self-care, helping our population to take an active role in the management of their health and wellbeing to reduce the overall demand on health and social care services in the future.

2. Alliance Update

The Alliance model is a key enabler for LCHG to support delivery of the Department of Health 'Road to Recover' initiatives focussed on moving care from hospital to community, sickness to prevention and analogue to digital.

The Alliance will be a common, organisational-agnostic space that identifies and takes forward opportunities to collaborate at scale across a range of partners. This includes the design/redesign of clinical pathways of care, using population health management datasets, service models and delivery vehicles to enable care to be delivered closer to people's homes and communities, enabled by digital solutions.

The Alliance consists of three core areas (i) a partnership space, where we will look to work with key partners in an innovative way to drive 'left shift' (figure 1) (ii) left shift transformation programmes, key services that we want to deliver within community settings which do not need to delivered on an acute site (iii) as part of LCHG coming together, we have restructured our care groups (figure 2) and created an alliance care group which will host all of the clinical support services (expect outpatients and cancer services). These are described below.

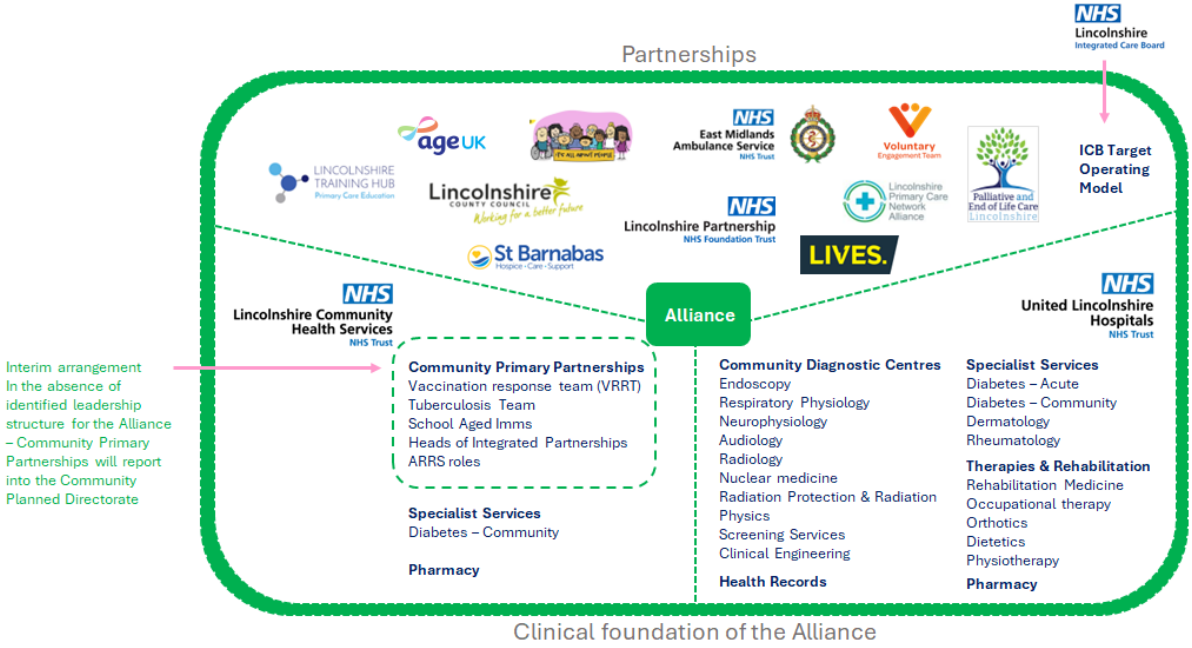


Figure 1- Foundations of the Alliance Care Group

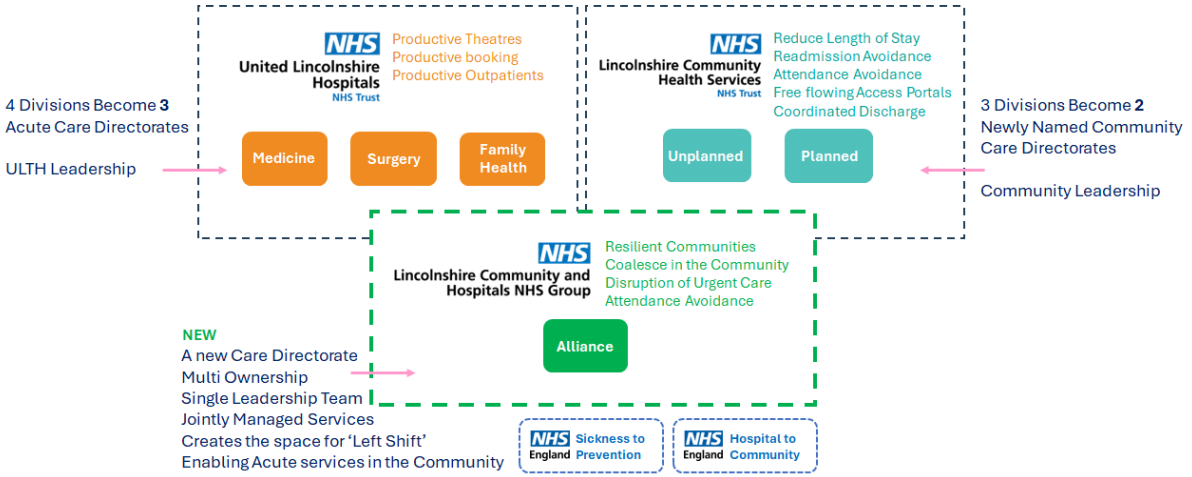


Figure 2- New LCHG Care Groups

A roadmap for delivery of the alliance plan alongside key milestones is described in figure 3 and figure 4.

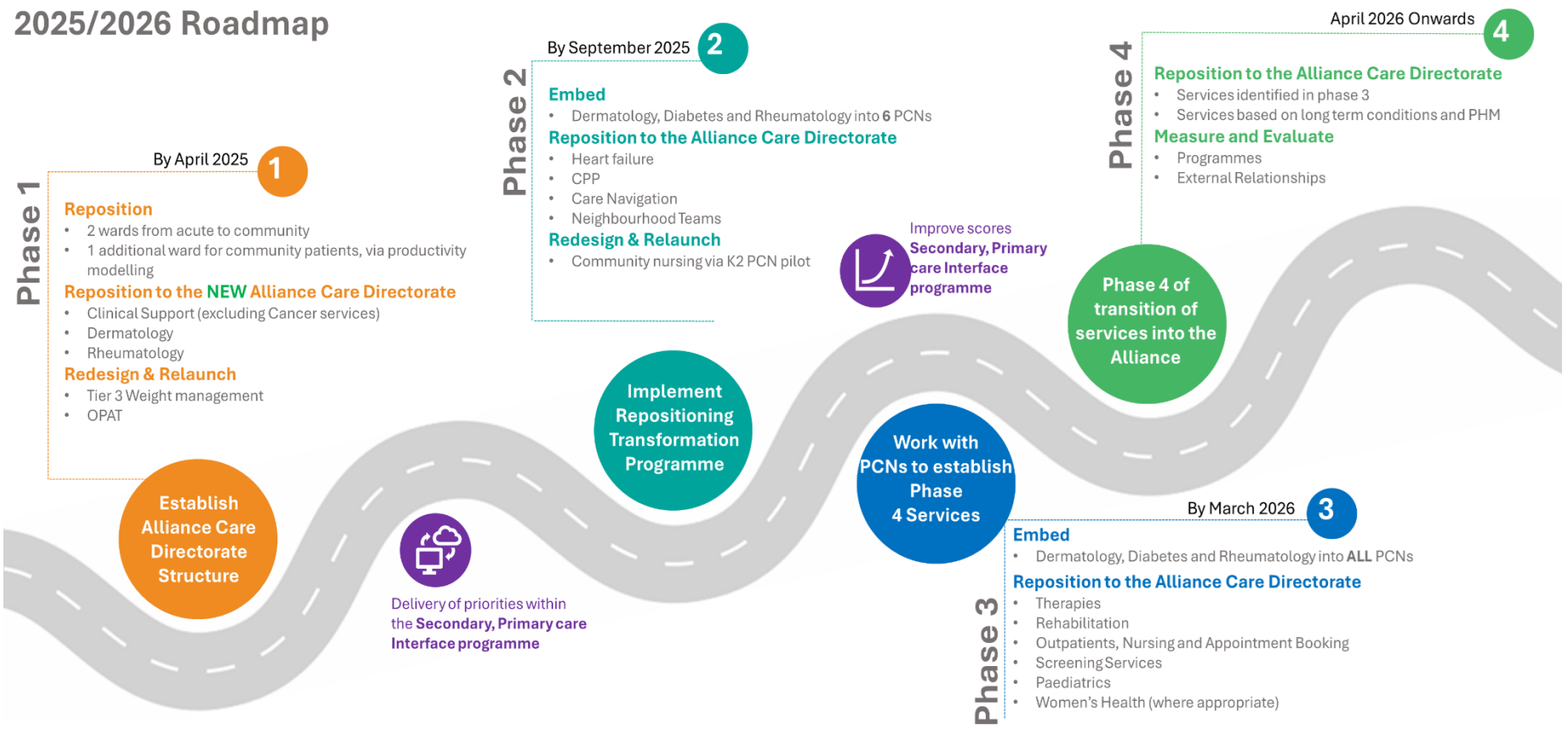


Figure 3- Alliance Roadmap 2025/2026

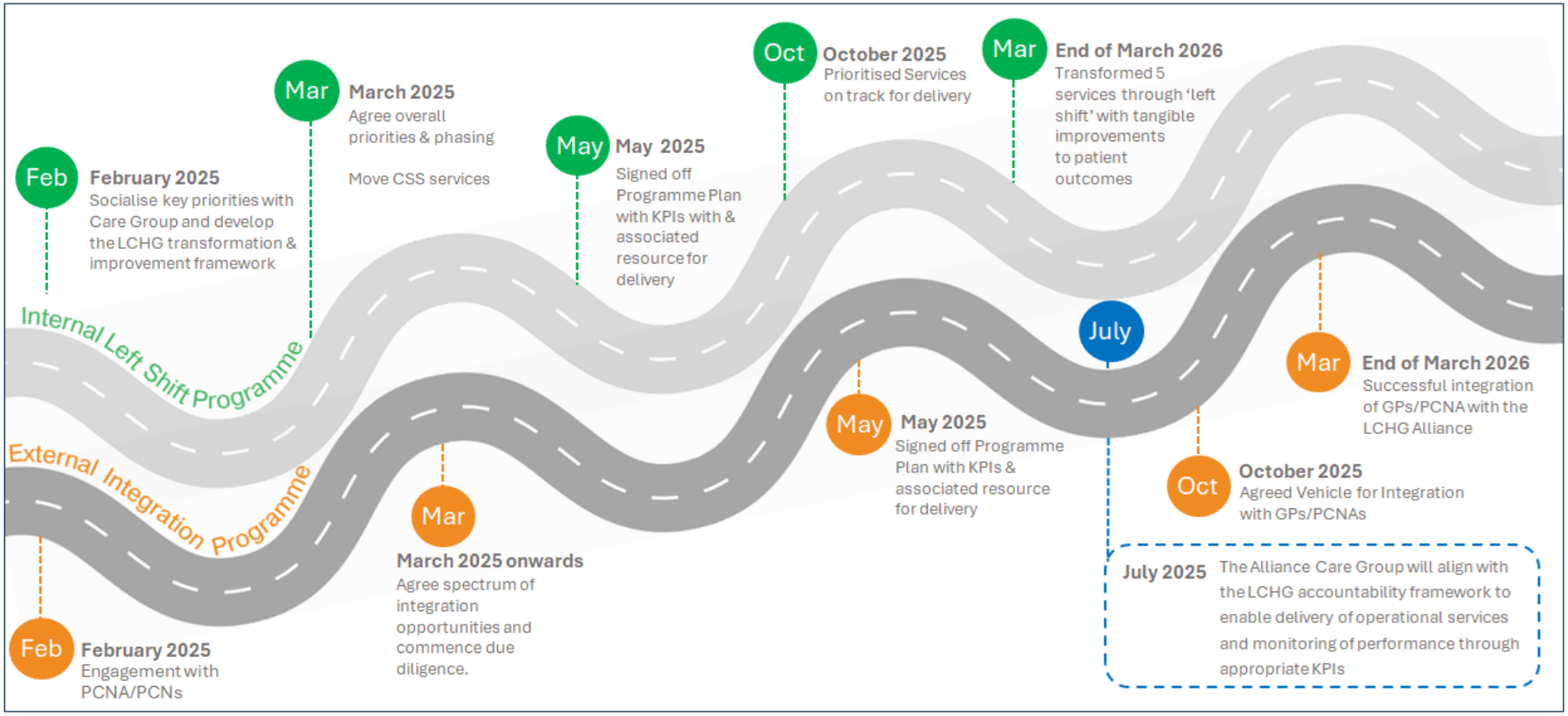
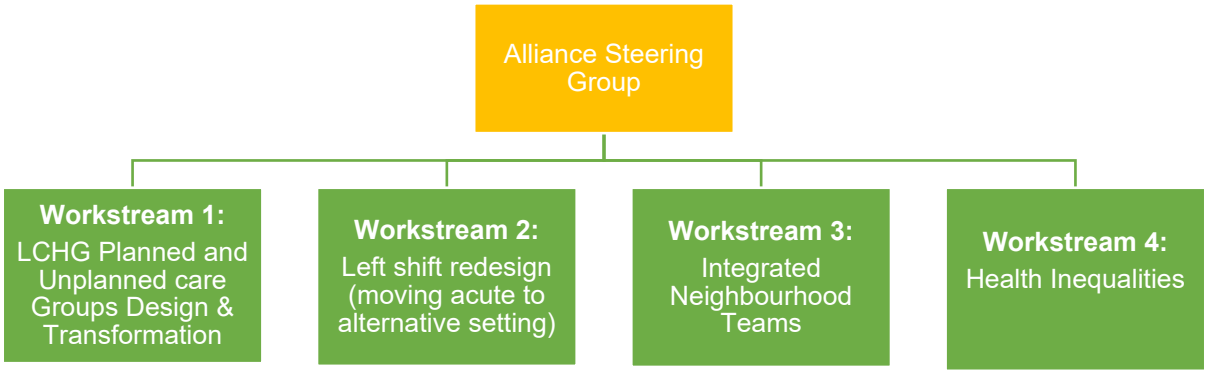


Figure 4- Key Milestones 2025/2026

3. Establishing the Governance

An Alliance Steering Group has been established, with the first meeting to be held in May 2025 in order to oversee delivery of the Alliance Programme through four key workstreams.



a) Workstream 1 LCHG Planned and Unplanned Care Groups – Design and Transformation:

Aim is to develop a plan to realise LCHG's ambition of addressing the wider determinants of health and health inequalities, and to realise the operational performance and delivery of out of hospital services. Workstream 1 has been finalised as part of the Planned and Unplanned Care Group Productivity and Efficiency processes. Resources are currently being allocated from corporate teams to support the delivery of these programmes during 2025/26. Key areas include:

- Intermediate Care Transformation
- Integration of IV Therapy, Virtual Ward, UCR, Home Visiting, CAS
- AIR and Virtual Wards – a Deep dive has started – part of commissioner review for 2025/2026
- End of Life – whole system
- Transforming Community Hospitals – reducing LOS by 3 days
- TB Service Remodel
- Respiratory Review
- Transforming Community Nursing

Progress will be reported via Productivity, Improvement and Transformation Oversight Framework (PITOF), following review through the Planned and Unplanned Care Group governance (currently in development), with an upward highlight report to Integration Committee.

b) Workstream 2 'Left Shift' Redesign Programme (moving from acute to alternatives):

Aim is pathway redesign and new service models in collaboration with stakeholders across the group and external partners to reduce reliance on acute care and deliver services closer to people's homes. Delivery plan priorities for 2025/26 include Dermatology, Neurology, Rheumatology and Respiratory. Several programmes have already commenced assigned leads are working with the care groups to clarify scope

and delivery of the projects before the end of April 2025. The left shift programme is grounded in Population Health Management (PHM) and best practice modelling, and the PHM support is being provided via the ICB Population Health Management Team and LCHG Business Analysts. All of the Workstream 2 projects will be reported within an overarching Alliance Workstream Programme that will also be reported into the new Productivity Improvement and Transformation Oversight Forum (PITOF). Digital and estates will be key enablers for this workstream, clear information on space availability and specifications will be required in order to support the identification of service location moves and a space allocation group will be required to assist in prioritisation.

c) Workstream 3 Integrated Neighbourhood Teams:

Aim is identifying and implementing opportunities to collaborate at scale with Primary Care, the ICB and Voluntary Community Faith and Social Enterprise (VCFSE) and independent sectors. Key workstreams include primary and secondary care interface, developing and approving a joint plan for neighbourhood health and integrated neighbourhood working e.g. aligning nursing in the community around PCNs, Palliative and End of life services, and targeted health inequalities work.

Primary and Secondary Care Interface – we have been raising awareness at Resident Doctor Forum in relation to FMed3 requests. Working on AHP onward referrals, the FMed3 and onward referral guidance to be included in Trust Clinician Inductions and a new Discharge letter template to be agreed and implemented to support clarity of Primary Care actions. Key highlights include a positive follow up meeting with NHSE on 24th March 2025 regarding the work completed within the Primary and Secondary Care Interface.

Neighbourhood health and integrated neighbourhood working (INW) has developed, with the Group Chief Integration Office being named as the SRO for INW for the system. A work plan will be developed in line with the planning guidance and Neighbourhood Health principles which are a pre-cursor to the 10-year plan and a new model for Palliative and End of Life Services (PEOL), which will see all PEOL delivery for the county moving into the Alliance, is currently being scoped and will be taken forward through the Alliance Steering Group.

We have been working collaboratively with Primary Care to discuss the approach to collaboration across a spectrum of models (Figure 5 below) and our left shift (redesign) programmes identified within Workstream 2 will allow for direct discussions with primary care in regard to end to end pathway redesign work to ensure that we meet the needs of the population and reduce health inequalities across our service delivery. We are working collaboratively with the Medical Director from the Lincolnshire PCNA, Holding a Board to Board session with PCNAs in Q1. We are also working on creating a ‘brochure’ which will outline our integration, and collaboration offers for our partners.

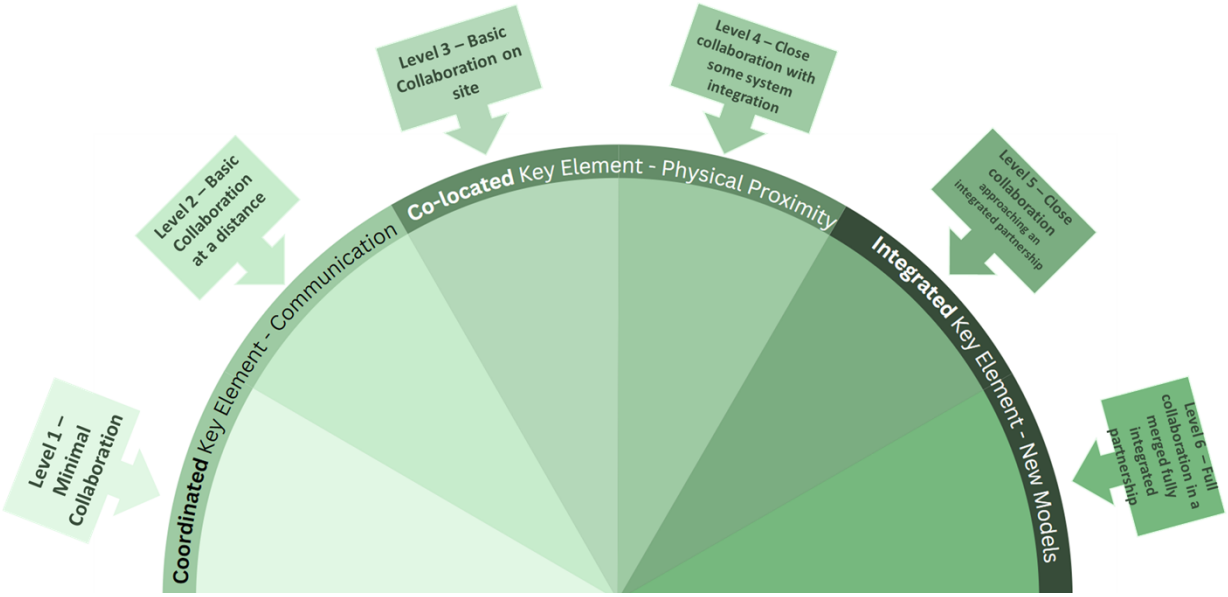


Figure 5- Spectrum of collaboration.

d) Workstream 4 Health Inequalities:

Aim is identifying and addressing health inequalities, focusing on the use of the Health Inequalities Maturity Matrix to drive areas of improvement and reduce health inequalities across our population. The LCHG Health Inequalities Working Group, which meets on a monthly basis, has continued to develop plans within 4 key workstreams aligned to the Health Inequalities maturity matrix. Action plans have been developed to address improvements in our maturity ratings and highlight reports will be produced for future Integration Committee Updates on a quarterly basis. In addition to this, a proposal will be developed in relation to a new LCHG Co-production strategy, learning from system partners who have been able to embed this within their standard service change process. Once approved this strategy will be piloted within one of our left shift programmes to ensure we involve people with lived experience in the redesign of their services.

4. Recommendations

- Trust Board are asked to note the update and the plans to engage collaboratively with various system partners in order to support delivery of the Alliance Programme, which is a key enabler to the delivery of our strategic ambitions and the Department of Health and Social Care's 'Road to Recovery' initiatives.

- First meeting of the Alliance Board is due to take place in May 2025 with sub-groups also to be established (excluding the existing Health Inequalities' Working Group) to oversee delivery of the four key workstreams.

- Workstreams to continue to progress as per work plans, with highlight reports to be received, overseen and assured at Integration Committee.

NHS
Lincolnshire Community and Hospitals NHS Group

Integrated Performance Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6th May 2025*
Item Number	*11*

Integrated Performance Report for March 2025 (ULTH)

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Daren Fradgley, Group Chief Integration Officer*
Author(s)	*Sharon Parker, Performance Manager*

Recommendations/ Decision Required

- *The Board is asked to note the current performance. The Board is asked to approve action to be taken where performance is below the expected target.*

Key to note:
Quality

- *Medication incidents reported as causing harm has increased in March to 10.5% against a trajectory of 10.70% compared to 8.3% in February.*

- *Duty of Candour for verbal compliance in February has improved to 100%, compared to 96% in January. Written compliance for February has also improved to 100%, compared to 74% in January.*

Performance

- *The year end target for 4 hour performance was established at 78%. The full UEC combined Type 1, Type 3 (both co-located and separate sites) achieved 78.21% in March signifying a 4.49% improvement compared to February 2025.*

- *7.3% of patients (T1 only) exceeded 12 hour wait in department in ED.*

- *Average response time for Cat2 ambulance conveyances in March was approximately 33.04 minutes reflecting a decrease of 1.56 minutes compared to February 2025 and remaining above the targeted 30 minutes.*

- *Long Waiters - at the end of February, the Trust reported 0 patients waiting longer than 104 weeks; 0 patients waiting over 78 weeks, 32 patients waiting over 65 weeks, which was better than forecast.*

- *Performance for DM01 in March showed a slight deterioration to 68.34% from 73.15% in February. MRI performance remained strong with the most pressured diagnostics now being Dexa, NOUS and Audiology with Nous being the main contributor to the reduction in performance.*

- *28-day Faster Diagnosis Standard (FDS) in February achieved 80.3% which is an improvement from January 75.2% and is still above the 75% target.*

- *62-day classic treatment performance for February was 59.8%, a slight deterioration from the January position of 62.0%.*

- *104+ day waiters increased slightly to 78 as of 9th April compared to 76 as of 12th March, The highest risk specialities are colorectal, head & Neck and prostate.*

Finance (is now reported for the Group)

The Group had planned a deficit for 2024/25 of £6.9m inclusive of a £47.1m cost improvement programme.

- *2024/25 Revenue position*
  The Group did not achieve its' planned £6.9m deficit for 2024/25; while an outturn deficit of £18.2m was £11.3m adverse to plan, it was within a revised control total of £18.5m agreed with NHSE.

- *2024/25 Capital position*
  The Group did achieve its' capital programme for 2024/25 with capital expenditure of £93.3m (99.7% of plan)

- *2024/25 CIP position*
  The Group did achieve its' CIP target of £47.1m for 2024/25; the Group exceeded the target by £0.7m (1.6%).

- *M11 Cash position*
  The Group did not achieve its' planned cash £55.3m cash position for 2024/25; however, the Group has managed a very challenging cash position to minimise the impact of this upon supplier payments.

Workforce

- *Mandatory training for March is 92.95% against a plan of 90%*
- *March sickness rate is 5.31% against Q4 target of 5.50%*
- *Staff AfC appraisals at 76.50% for March against Q4 target 90.00%*
- *Staff turnover at 9.40% for March against Q4 target of 9.00%*
- *Vacancies at 6.21% for March against Q4 target of 4.50%*

The Board is asked to approve action to be taken where performance is below the expected target.

How the report supports the delivery of the 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	*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

Quality

Falls

There has been 1 fall resulting in moderate harm and 1 fall resulting in severe harm, which is a decrease from the previous month. All incidents are under validation to ensure the correct level of review is undertaken. Falls Prevention Steering Group (FPSG) provides oversight and assurance of actions being taken to improve in areas reporting increased numbers of incidents. There are weekly/monthly divisional meetings to establish themes and shared learning from falls to improve practice.

Pressure Ulcers

There have been 40 category 2 and 7 category 3 pressure ulcers in March, an increase from the previous month. Skin Integrity Group (SIG) provides oversight and receives Divisional performance reports, which provide assurance of the improvement actions being taken in areas reporting increased number of incidents. Quality Matron and Tissue Viability team provide support to areas with increased number of incidents.

VTE

In March, compliance remained below the 95% target, reaching 92.6%. While this may indicate that assessments are not being completed in the 14-hour timeframe, a key issue is the discrepancy between the actual time of assessment completion and the time recorded in Careflow. Currently, the time recorded in Careflow reflects when ward clerks input the data rather than when the assessment was completed. Since ward clerks are unable to amend the recorded time, this results in an inaccurate representation of compliance. Additionally, the only system that accurately captures the assessment time is ePMA, where the timestamp reflects the actual time of completion. However, not all clinicians use ePMA for VTE risk assessment, leading to inconsistencies in data accuracy. To address this, reminders will be sent to clinical leads of each speciality to reinforce the importance of using ePMA for risk assessment documentation. There is work happening on identifying a viable solution to amend Careflow timestamps to reflect actual completion times.

Medications

Medication incidents reported as causing harm has increased slightly to 10.50% against a trajectory of 10.7%. The majority of incidents are at the point of prescribing and administration of medication and the main error is omitting medicines. Improving medication incidents

from omitted medicines is a work stream as part of the new Patient Safety Incident Response Framework (PSIRF) with action planning underway following the completion of the review.

Patient safety Alerts

There was 1 Safety Alert with a deadline for completion in March; however, this was not completed within the timeframe. Monthly Safety Alerts exception report is now discussed at Patient Safety Group. CAS/FSN Alerts Oversight Group has been implemented which convenes monthly to discuss issues which may arise and prevent the Trust meeting the deadlines and to put plans in place to mitigate. Use of Dashboards for monitoring compliance on Alerts Module on DatixIQ.

SHMI

The Trust SHMI has increased to 109.53 for March but remains within expected limits. Any diagnosis group alerting is subject to a case note review. HSMR is at 98.41 (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.

eDD Compliance

eDD Performance continues to be below the 95% target, currently at 88.6%. A dashboard is in place to highlight compliance at both ward and consultant level with each Division now reviewing this metric within their Divisions.

Sepsis compliance – based on February data

The **screening compliance for inpatient child** decreased to 83.30% (target 90%). 35 children out of 43 that had PEWS of 5 or above were screened for sepsis within 60 minutes. No Harm was found in the harm reviews completed as the children had a viral illness or non-infective cause for illness / raised PEWS.

IVAB ED Children – The administration of IVAB for children in ED decreased to 40% (target 90%). 4 children out of 10 were treated with IV antibiotics within the 60 minute timeframe. Harm reviews were completed for all children with delayed treatment and no harm was found.

Duty of Candour (DoC) – February Data

DoC compliance in February for verbal and written was 100%. Dedicated members of the Incident Team have been aligned to Divisions to improve compliance.

Operational Performance

This report evaluates the performance metrics observed during the month of March 2025.

In March, there was a notable increase in attendance across the Urgent and Emergency Care (UEC) pathways, reflecting a 6.76% rise compared to the average attendance recorded during March for the years 2022, 2023, and 2024. Furthermore, an upward trend in patient acuity was observed, with 13% of patients scoring 4 or higher on the National Early Warning Score (NEWS) during their initial assessments.

The paediatrics department reported significant seasonal variation, with attendance in the emergency department (ED) rising by 6.62% in comparison to the average attendance for March across the years 2022, 2023, and 2024, which corresponds to an increase of 113 patients. Seasonal infections continue to exert pressure on our services. By the conclusion of March, the Trust had documented 16 PCR confirmed inpatients with positive COVID-19 test results, which represents an increase of 1 case compared to the previous year.

Throughout the month, a total of 613 flu tests were administered, indicating a 15.56% increase relative to March 2024. Of these tests, 11 yielded positive results, resulting in a positivity rate of 1.79%. In comparison, among the 573 patients tested for respiratory syncytial virus (RSV), 8 were found to be positive, leading to a positivity rate of 1.4%. Additionally, the month of March witnessed a 12.5% increase in the number of RSV tests conducted in comparison to the previous year.

A & E and Ambulance Performance

The annual performance target for the 4-hour wait time has been established at 78%, with monthly progress assessments conducted. In March 2025, the trust recorded a performance rate of 78.21%, signifying a 4.49% improvement compared to February 2025 and a 5.88% increase to March 2024.
The (SPC) chart included in the report delineates the performance targets for the 2023/24 and 2024/25 fiscal years, focusing on Type 1 and Type 3 activities.
It is important to note that there has been a change in the reporting of metrics related to Type 1 and Type 3 activities at the Lincoln and Pilgrim Hospital sites. The following information is based on these updated principles and has been applied retrospectively to ensure fair comparisons in the narrative.

Significant improvements have been observed in Type 1 performance, with the Lincoln Emergency Department demonstrating an increase from 59.60% to 63.74%. Similarly, the Pilgrim Emergency Department experienced a rise from 58.37% to 66.43%. Overall, Type 1 performance achieved an increase of 5.86%, culminating in a final performance rate of 64.91%.

In response to the ongoing challenges faced within the Urgent and Emergency Care (UEC) pathways, the Emergency Department has prioritized efforts to reduce the duration of patient stays within the department. Unfortunately, 7.30% of patients exceeded the 12-hour

benchmark (Type 1 only); this figure indicates a 5.95% decrease compared to February 2025, equating to 739 less patients surpassing this threshold.

In March, the average mean response time for Category 2 cases was approximately 33.04 minutes, reflecting a decrease of 1.56 minutes compared to February 2025 and remaining above the targeted 30 minutes. It is noteworthy that the overall mean response time for Category 2 cases includes instances in which patients did not attend (ULTH), despite their postcodes falling within the designated catchment area. The Statistical Process Control (SPC) chart included in the report illustrates the frequency of patient handovers exceeding 59 minutes; however, it does not provide data regarding the number of presentations during the same period or the acuity of patients upon arrival. Notably, more than 21% of patients recorded a score of 4 or higher on the National Early Warning Score (NEWS) at the initial observations documented on the (WEBV) system. Specifically, 29.96% of paediatric patients arriving via the East Midlands Ambulance Service (EMAS) scored 4 or greater, while the percentage for adult patients was 20.68%.

Fractured Neck of Femur 48hr Pathway (#NOF)
After a dip in performance over the winter months driven by increased Trauma demand and reduced theatre staffing, March saw a slight improvement in performance to 55.26%.

Length of Stay
In March, the Non-Elective Length of Stay experienced a reduction of 0.06 days compared to February 2025, with the current performance level recorded at 4.52 days, which surpasses the maximum threshold by 0.02 days. The average bed occupancy rate, with respect to "Core General and Acute," stood at 91.95%. To maintain safe and efficient operational flow within acute care settings, an average of 12 escalation beds or boarding spaces has been allocated, resulting in an occupancy to escalation ratio of 90.89%, which complies with the national standard of less than 92%. Additionally, approximately 44 beds have been ringfenced for elective patient flow at Grantham. Excluding this facility from the metrics indicates that the core occupancy would result in 94.69%, while the core plus escalation occupancy would yield 93.49%.
The identification of timely support to facilitate discharges from the acute care setting for pathways 1 to 3 continues to pose significant challenges for System Partners. In response, the Trust has implemented several new processes aimed at addressing the needs of both recently admitted and long-waiting patients, emphasizing the importance of identifying reasons for delays and escalating issues earlier when appropriate. Additionally, System Partners are now provided with daily updates regarding new admissions that could potentially lead to prolonged stays. This proactive approach allows for the realignment of base packages of care to accommodate new patients in a timely manner, thereby ensuring a continuous flow of service provision.

Referral to Treatment
A fifth consecutive month of improvement saw February's performance at 53.72%. The Trust continues to report patients waiting over 104, 78, 65 & 52 weeks. At the end of February, the Trust reported zero patients waiting longer than 104 weeks. The trust exited February with

0 patient waiting more than 78 weeks. The trust exited February with 32 patients waiting over 65 weeks which was better than forecast for a fifth consecutive month

The trust was an early adopter of the Further Faster programme which is a national initiative to reduce patients waiting over 52 weeks. At the end of February the Trust reported 1,461 patients waiting over 52 weeks which demonstrates a fifth consecutive month of improvement.

Waiting Lists
Whilst the trust has made huge improvements in reducing long waiting patients, total waiting list size has remained relatively static at 72-75k since November 2022. The waiting list started to reduce in November 2024 with February recording 71,248

As of 2^{9th} March 2025, ASI sat at 985. Whilst this is higher than the agreed trajectory of 550, the number fluctuates week on week and is a significant improvement overall. Additional resource has been directed to resolving missing outcomes which is having a positive effect on the bookings team being able to move the ASIs to open referrals.

DM01
The report for DM01 in March showed a slight deterioration, reducing to 68.34% MRI performance remained strong with the most pressured diagnostics now being Dexa, NOUS and Audiology with Nous being the main contributor to the reduction in performance.

Cancelled Ops
March outturn for cancelled operations on the day Improved to 1.70%. Lack of time and lack of theatre staff were again the main reasons for cancellations.

Included in the 1.70% of on the day cancellations, 29 patients were not treated within the 28-day standard and this continues to be driven by the pressure to date long waiters and Cancer patients.

The continuous review of the effectiveness of the 6:4:2 theatre scheduling meetings continues along with the pre-op improvement work stream, both of which are expected to drive down on the day cancellations.

Cancer
28-day Faster Diagnosis Standard (FDS) for February sat at 80.3% This is a slight improvement and is still above the 75% target.

31 day performance for February improved to 92.9%

62-day classic performance for February deteriorated to 59.8%. Nationally, organisations see an increase in >62 day backlog in Jan Feb which ULTH also saw and this has impacted in 62 day performance. Backlog has now stabilised so improvement is now expected in performance over the coming months

104+ day waiters increased slightly to 78 at the end of February. The highest risk specialities are colorectal, head & Neck and prostate. The divisions are working hard to resolve but are facing challenges from a high number of complex and disengaged patients.

Workforce

Mandatory Training – Our March 2025 Core Learning Rate is 92.95% against a Target of 90.00%. This is a slight decrease in compliance when compared to last month, although we are exceeding our overall target. Compliance will continue to be monitored as we move into 2025/26 to ensure that we remain in line with our overall trajectory.

Our biggest challenge is to offer time to our colleagues to be able to complete all mandatory training as required for the role they do. Work continues to ensure that all areas and individuals are given the time to complete core learning modules, with focussed support being offered to those with low compliance (50% and less)

Sickness Absence – Our March 2025 Sickness Rate is 5.31% against a Q4 Target of 5.50%. This has seen us achieve the end of year target, as well as maintain a stable absence rate in 2024/25.

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 March 2025 appraisal rate is measured against a Q4 Target of 90.00%, and in month we have achieved a Trustwide position of 78.79%. This is a slight increase when compared to the previous month but is ending the year outside of target. 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 also 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 March 2025 Turnover Rate is 9.40% against a Q4 Target of 9.00%, is within the tolerance levels at the end of year.

Operational pressures, staffing and culture are continued challenges. With the introduction of the Equality, Diversity & Inclusion Group, Culture & Leadership Group, Education Oversight Group, and the refresh of the Workforce Strategy Group across Lincolnshire Community Hospitals Group (LCHG) there are additional platforms where retention of staff can be considered through various workforce lenses.

We continue to work closely with Divisional colleagues and support reduction in vacancies to reduce the impact of staffing and associated operational pressures.

Vacancies – Our March 2025 Vacancy Rate is 6.91% which has increased slightly in month although this is to be expected with the Vacancy Control Processes we currently have in place in response to the National Planning Guidance for 2025/26.

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.

Finance

The Group had planned a deficit for 2024/25 of £6.9m inclusive of a £47.1m cost improvement programme.

- **2024/25 Revenue position**
  The Group did not achieve its' planned £6.9m deficit for 2024/25; while an outturn deficit of £18.2m was £11.3m adverse to plan, it was within a revised control total of £18.5m agreed with NHSE.

- **2024/25 Capital position**
  The Group did achieve its' capital programme for 2024/25 with capital expenditure of £93.3m (99.7% of plan)

- **2024/25 CIP position**
  The Group did achieve its' CIP target of £47.1m for 2024/25; the Group exceeded the target by £0.7m (1.6%).

- **M11 Cash position**
  The Group did not achieve its' planned cash £55.3m cash position for 2024/25; however, the Group has managed a very challenging cash position to minimise the impact of this upon supplier payments.

	Group performance			LCHS performance			ULTH performance		
Month 12 Position	Year To Date			Year To Date			Year To Date		
	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m
Surplus / (Deficit)	(6.9)	(18.2)	(11.3)	(0.0)	0.0	0.1	(6.9)	(18.3)	(11.4)
CIP Delivery	47.1	47.9	0.7	7.0	7.4	0.4	40.1	40.5	0.4
Capital Spend	93.5	93.3	0.2	5.4	5.2	0.2	88.1	88.1	0.0
Agency Spend	(17.6)	(24.0)	(6.4)	(2.7)	(1.4)	1.3	(14.9)	(22.6)	(7.7)
Cash Balance	55.3	46.3	(9.1)	30.0	27.1	(2.9)	25.3	19.2	(6.2)

Daren Fradgley
Group Chief Integration Officer
April 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.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-25	Feb-25	Mar-25	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	11	7	9	100	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	1	3	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.02	0	0.01		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.02	0.02	0.04	0.04		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	Data Not Available	Data Not Available	Data Not Available			
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.11	0.12	0.05	0.13	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	6	2	7	51	?	
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	1	0	5	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95.00%	93.90%	92.66%	92.56%	95.09%	F	L
	Never Events	Safe	Patients	Director of Nursing	0	0	0	1	3	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.30	5.07	3.96	4.66	4.63	P	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-25	Feb-25	Mar-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%	19.60%	8.30%	10.50%	13.01%	F	
	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100.00%	0.00%	None due	0.00%	33.33%	F	
	Hospital Standardised Mortality Ratio - HSMR+ (basket of 41 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	98.41	100.84	98.98	N/A		
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 5 month time lag)	Effective	Patients	Medical Director	100	107.29	108.53	109.53	N/A		
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100.00%	100.00%	100.00%	100.00%	100.00%	P	H
	eDD issued within 24 hours	Effective	Patients	Medical Director	95.00%	90.70%	90.90%	88.60%	90.68%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	93.49%	93.59%	Data Not Available	92.51%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	72.70%	83.30%	Data Not Available	79.87%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90.00%	96.37%	99.20%	Data Not Available	96.88%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90.00%	100.00%	100.00%	Data Not Available	86.46%	P	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	90.60%	93.61%	Data Not Available	92.41%	P	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Quality

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-25	Feb-25	Mar-25	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90.00%	93.20%	90.00%	Data Not Available	92.73%	P	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90.00%	93.20%	93.50%	Data Not Available	94.45%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90.00%	64.28%	40.00%	Data Not Available	69.10%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	3.80	3.16	3.17	3.18	2.82	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%	96.00%	100.00%	Data Not Available	94.36%	?	
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100.00%	74.00%	100.00%	Data Not Available	90.18%	F	

Performance Overview - Quality

Mar-25
7
Variance Type
Common cause variation
Target
4.3
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Director of Nursing

Background:
Category 3
Pressure Ulcers

What the chart tells us:
The Trust recorded 7 Category 3 incidents against a target of 4.3 per month.

Issues:
The number of Category 3 incidents in March have increased by 5 from February 2025. 6 of the 7 Category 3 incidents this month would have previously been classified as unstageable.

Themes identified as areas of focus for improvement are:
• Ensuring clinical teams assess all pressure areas including those under devices or dressings
• Ensuring specialist advice is sought when teams are unfamiliar with medical devices and their management.

Actions:
All Category 3 incidents will be reviewed at the weekly Pressure Ulcer Support and Supervision Panel meeting.
The Tissue Viability and Quality Matron Team undertake a detailed review of these incidents to identify any additional learning.
Utilise Tissue Viability Matters Information and Learning (TVMIL) educational forums to improve staff knowledge regarding the potential risks associated with medical devices and what to observe for.
Embed the requirement to follow patient's specialist management plans in place to prevent skin deterioration and seek advice where needed.

Mitigations:
As above

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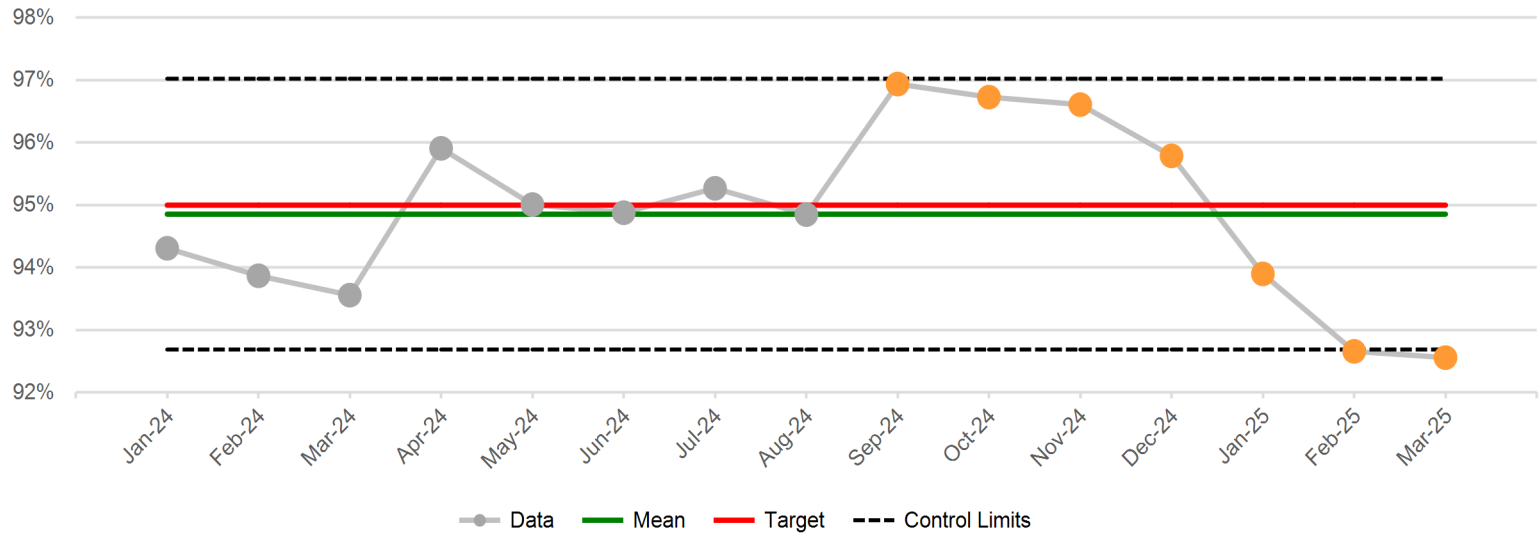
Performance Overview - Quality

NHS United Lincolnshire Teaching Hospitals NHS Trust

Venous Thromboembolism (VTE) Risk Assessment



Mar-25
92.56%
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:
Venous Thromboembolism (VTE) Risk Assessment remains a critical patient safety measure, requiring completion within 14 hours of admission as per NHSE guidance.

What the chart tells us:
We are currently reporting 92.56% against a 95% target.

The definition of "admission" remains open to local interpretation. To strengthen compliance, we continue to integrate data from all three systems (Careflow, ePMA, WebV) and closely align our processes with national data collection standards.

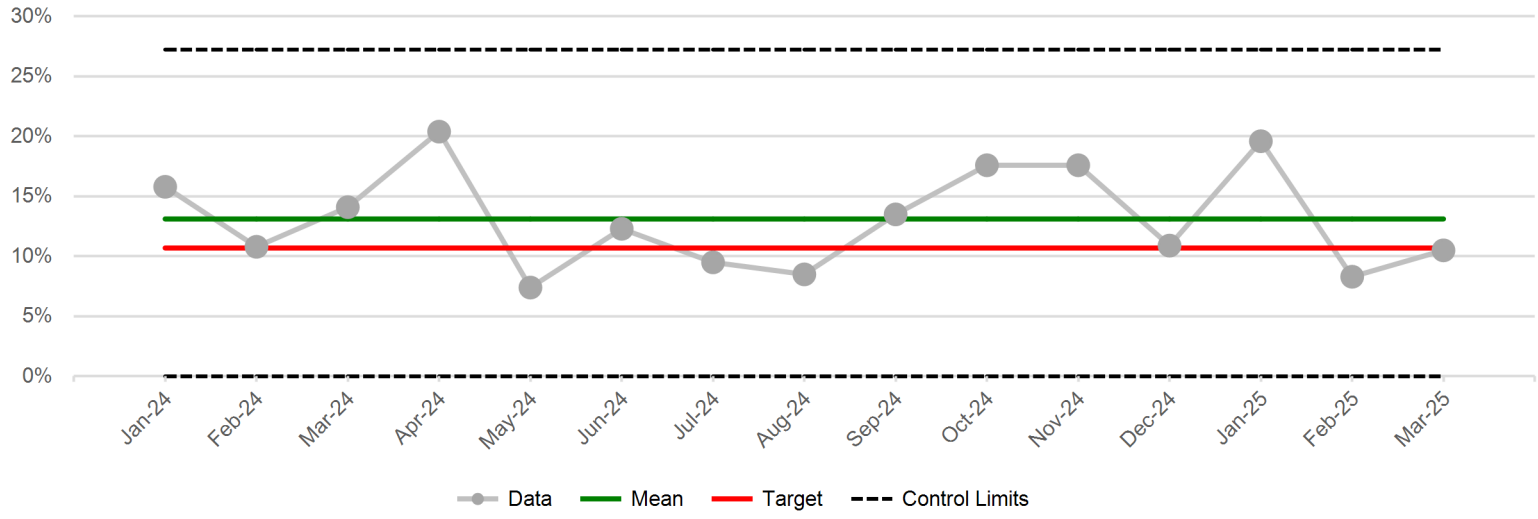
Issues:
In March, compliance remained below the 95% target, reaching 92.6%. While this may indicate that assessments are not being completed in the 14-hour timeframe, a key issue is the discrepancy between the actual time of assessment completion and the time recorded in Careflow. Currently, the time recorded in Careflow reflects when ward clerks input the data rather than when the assessment was completed. Since ward clerks are unable to amend the recorded time, this results in an inaccurate representation of compliance. Additionally, the only system that accurately captures the assessment time is ePMA, where the timestamp reflects the actual time of completion. However, not all clinicians use ePMA for VTE risk assessment, leading to inconsistencies in data accuracy. To address this, reminders will be sent to clinical leads of each speciality to reinforce the importance of using ePMA for risk assessment documentation.

Actions:
To improve compliance accuracy, we are exploring solutions to ensure that the recorded time in Careflow reflects the actual assessment time. Discussion on defining "admission" for the 14-hour timeframe will take place at the next VTE Committee meeting at the end of April. In the meantime, reminders will be issued to encourage wider adoption of ePMA, which provides the most reliable timestamp for assessment completion.

Mitigations:
Efforts are focused on establishing a clear local definition of admission to standardise compliance measurement. Additionally, we are working on identifying a viable solution to amend Careflow timestamps to reflect actual completion times. These measures
will help ensure more accurate reporting and improve compliance rates moving forward. Through these actions, we aim to address the current discrepancies, enhance data accuracy and support adherence to VTE risk assessment requirements.

Performance Overview - Quality

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



Mar-25
10.50%
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 March the number of medication incidents reported was 170. This equates to 4.66 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 10.5% which is below the national average of 11%.

Issues:
The majority of incidents are at the point of prescribing and administration of medication and the main errors are omitting medicines and incorrect dose prescribed.

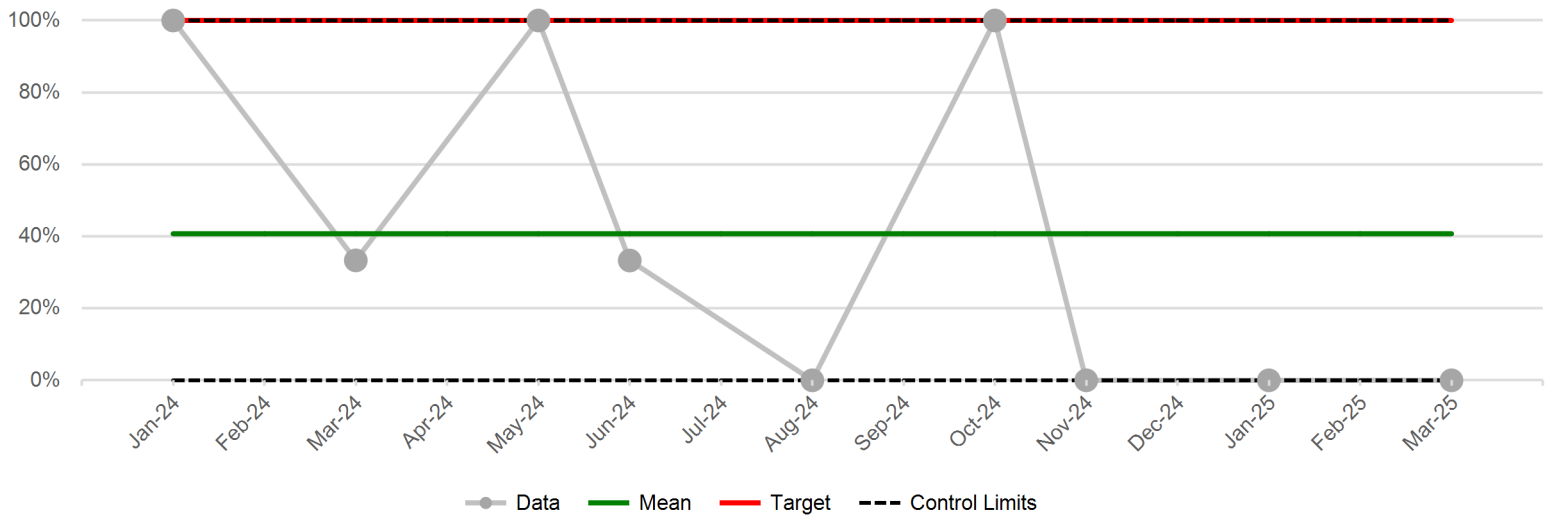
Actions:
Improving medication incidents from omitted medicines is a work stream as part of the Patient Safety Incident Response Framework (PSIRF). Additionally medication incidents are escalated through medicines quality group. Pharmacy support is offered to areas where it has been identified through the data that there may be need for additional training or support.

Mitigations:

Performance Overview - Quality

United Lincolnshire Teaching Hospitals NHS Trust

Patient Safety Alerts responded to by agreed deadline



Mar-25
0.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Patient safety alerts responded to by agreed deadline.

What the chart tells us:
There was 1 Safety Alert with a deadline for completion in March which remains open. 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.

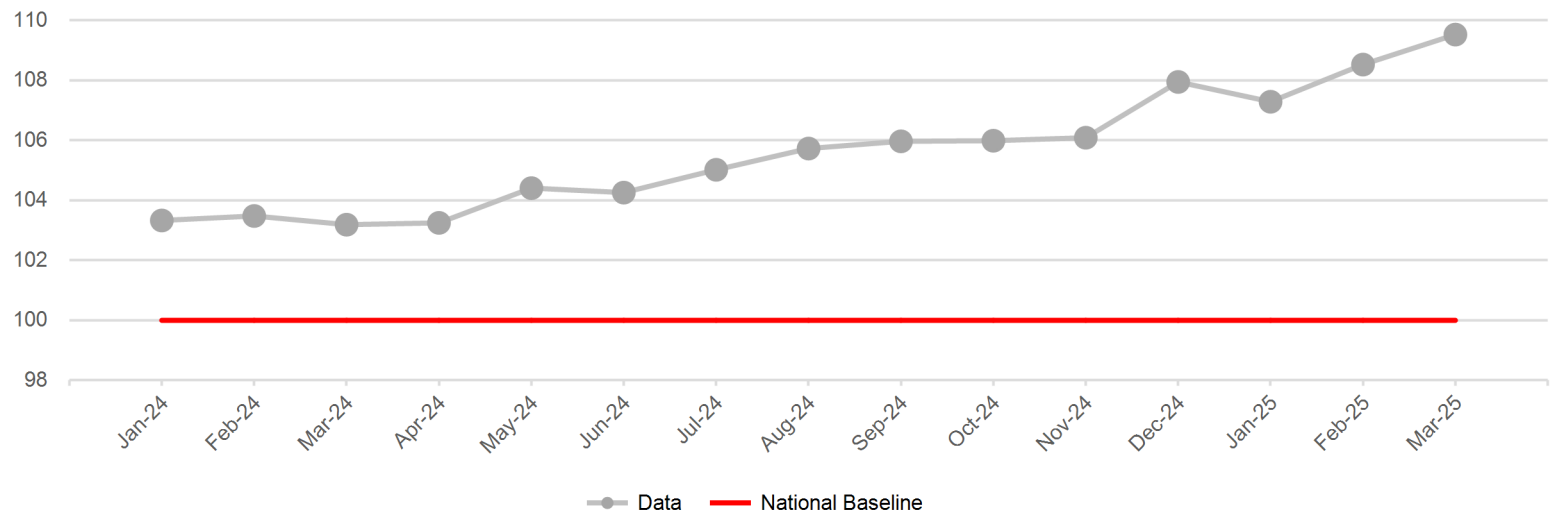
A CAS/FSN Alerts Oversight Group convenes monthly to discuss issues which may arise and prevent the Trust meeting the deadlines and to put plans in place to mitigate.

Use of Dashboards for monitoring compliance on Alerts Module on DatixIQ.

Performance Overview - Quality

United Lincolnshire Teaching Hospitals NHS Trust

Summary Hospital Mortality Indicator (SHMI) (rolling year data 5 month time lag)



Mar-25
109.53
Variance Type
Target
To remain in 'as expected' range
Achievement
Executive Lead
Medical Director

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

What the chart tells us:
SHMI is in band 2 'as expected'.

Issues:
The data includes deaths within 30 days. Legislation came into effect from 9 September 2024 for all deaths in Lincolnshire to be reviewed by an ME.

The SHMI methodology has changed, the data is being reviewed as the Trusts SHMI has increased.

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

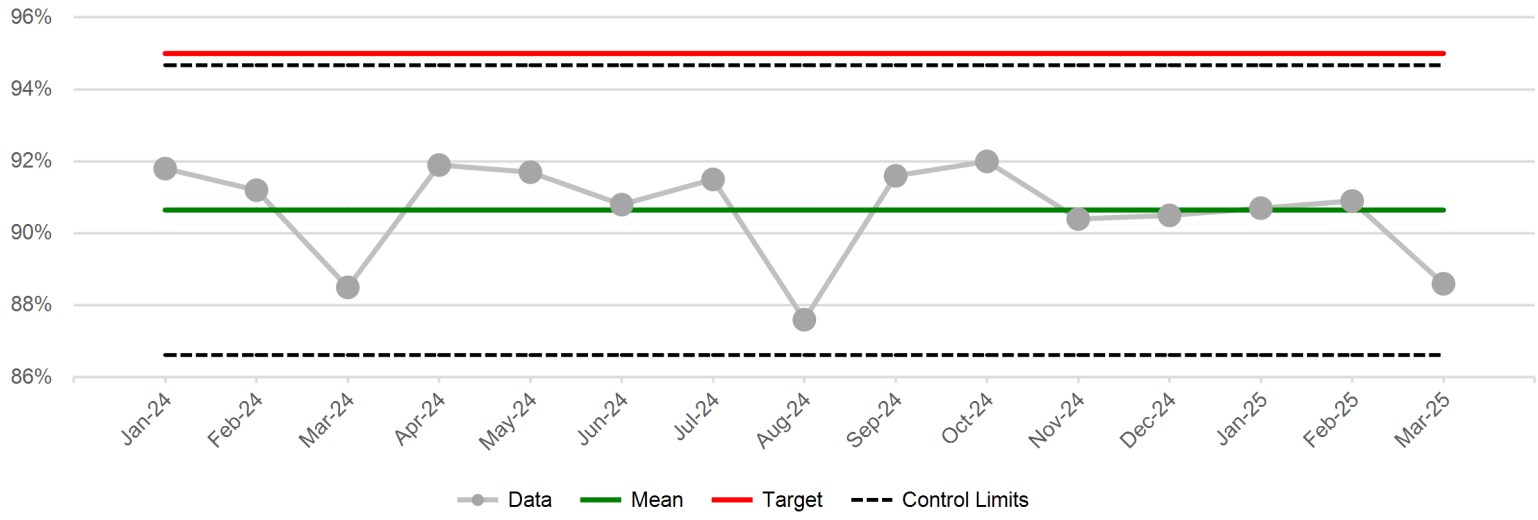
Mortality reviews are discussed at either Speciality Governance or M&Ms to aid learning.

Mitigations:
The MEs 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

United Lincolnshire Teaching Hospitals NHS Trust

eDD issued within 24 hours



Mar-25
88.60%
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 88.6%.

Issues:
Ownership of completion of the EDD remains an issue, including the timely completion.

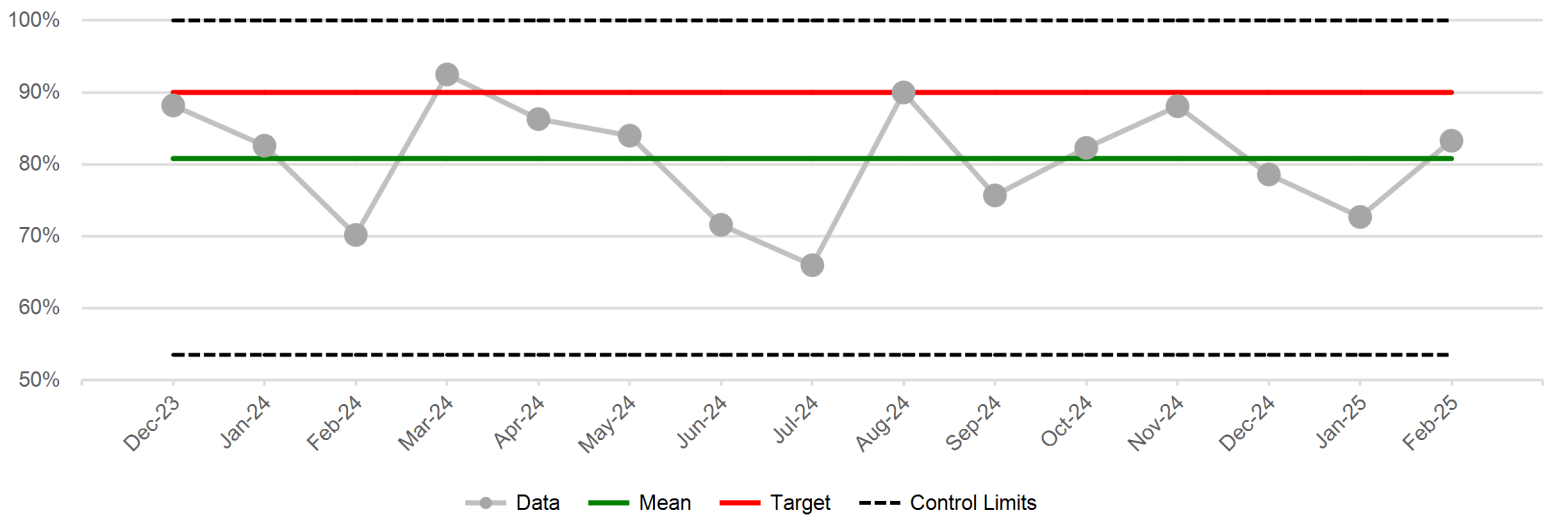
No Narrative owner

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)



Feb-25
83.30%
Variance Type
Common cause variation
Target
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of Nursing

Background:
Sepsis screening (bundle) compliance for inpatients (child)

What the chart tells us:
The Sepsis screening compliance this month was 81.3%, which is below the 90% target. 35 of 43 patients were screened within the 60-minute timeframe.

Issues:
There were 8 patients this month with delayed sepsis screening. screens are being added to the system when patient scored but they were not being completed. One screen was not done on a child with fracture, raised PEWS score was due to pain. There were 7 screens not completed on the Pilgrim site.

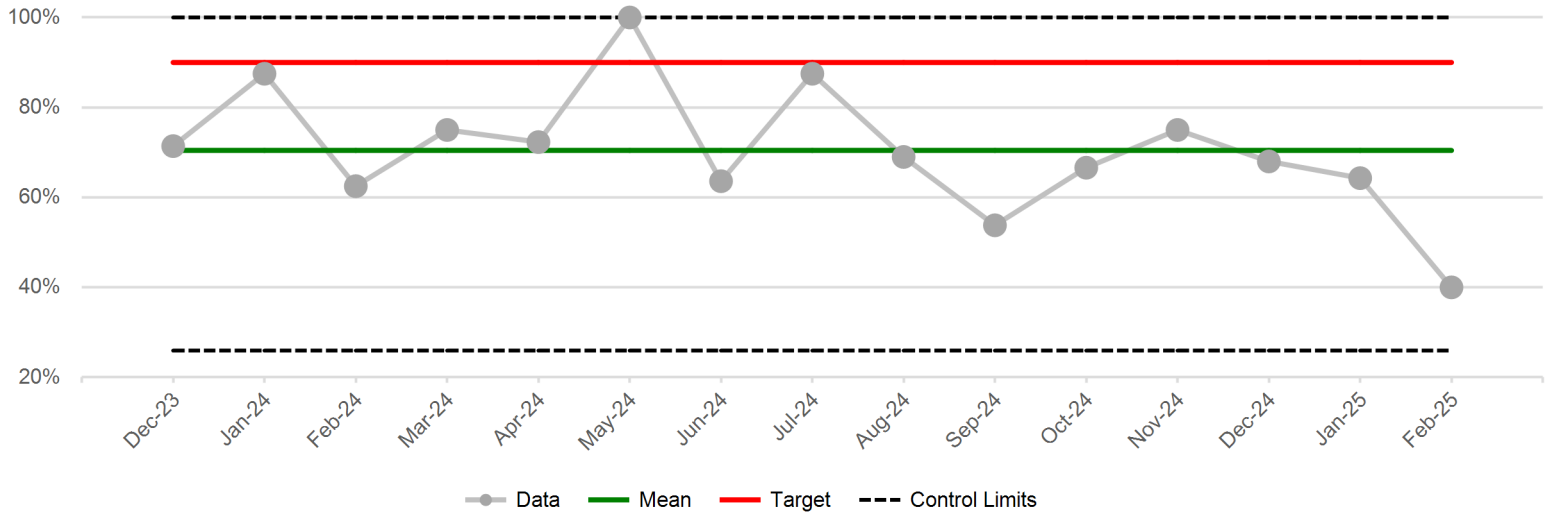
Actions:
Ward Managers / clinical Educators are reviewing patient notes to see how long patients were waiting for a medical review.
There is a new ward Manager starting at Pilgrim in March 25 – Meeting arranged with her at beginning April to discuss issues relating to Sepsis.

Mitigations:
No Harm found in harm reviews done. Patients found to have viral illness or non-infective cause for illness / raised score.

Performance Overview - Quality

United Lincolnshire Teaching Hospitals NHS Trust

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



Feb-25
40.00%
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 40%, which is well below the 90% standard. 4 out of 10 patients received their antibiotics within a timely manner.

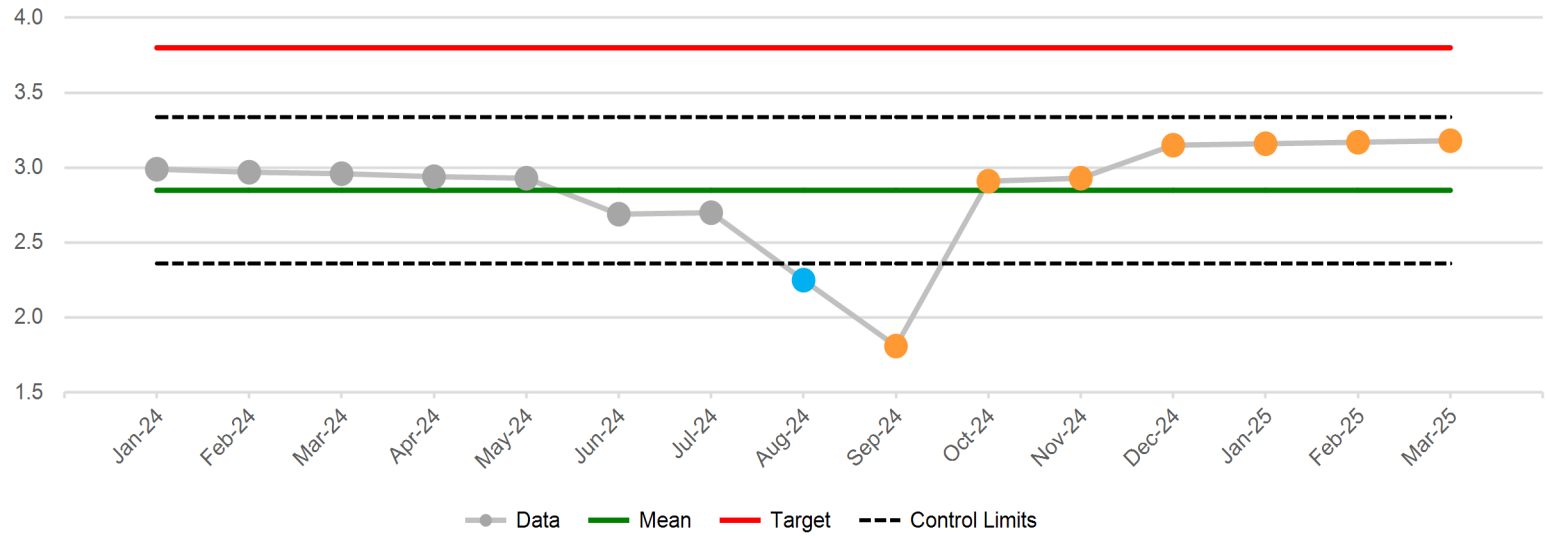
Issues:
There were 6 patients this month with delayed Sepsis treatment. There were delayed treatments across all 3 sites
- 1 child from Grantham UTC was transferred to Lincoln before treatment was started. This is there current plan if they can get an ambulance.
1 – child received antibiotics at 76 minutes.
4 children waited for a paediatric review before decision made – one of these patients had a long delay between antibiotics prescribed and given.

Actions:
Themes escalated to ED manager, Sepsis link nurses and Consultant. Paediatric teams are planning some joint training with ED team.
Staff are reviewing notes.
Meeting held with Consultant in March 25 and training plan discussed.

Mitigations:
Harm reviews completed for all patients with delayed treatment – No harm found.

Performance Overview - Quality

Rate of stillbirth per 1000 births



Mar-25
3.18
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 3.18 against a threshold of 3.8. We are consistently below the target and investigate all stillbirths that occur.

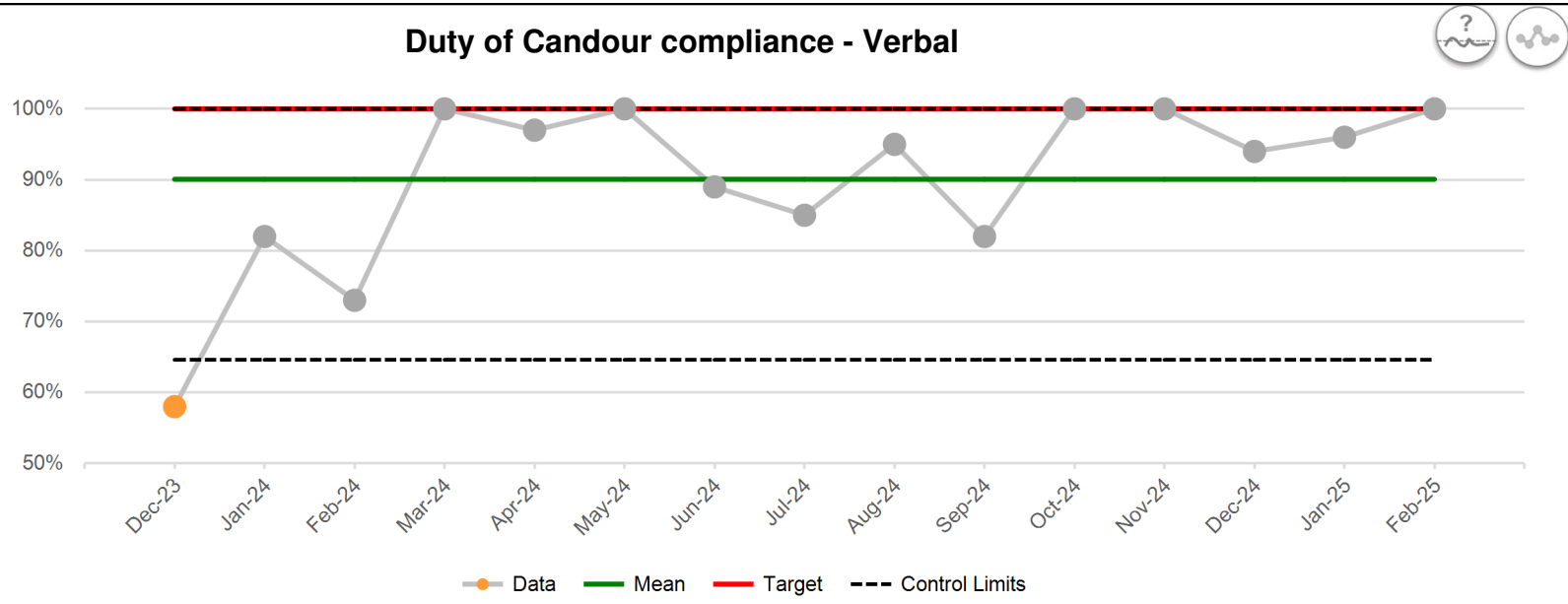
Issues:
We are consistently below the national threshold however are aware that this is now displaying a special cause of concerning nature.

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 thematic review will be completed over the last 12 months.

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.

Performance Overview - Quality

United Lincolnshire Teaching Hospitals NHS Trust



Feb-25
100.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates inconsistently passing and falling short of the target
Executive Lead
Medical Director

Background:
Verbal Duty of Candour, which applies to all patient safety incidents where harm is moderate or above, is a statutory requirement.

What the chart tells us:
Compliance remains consistently high.

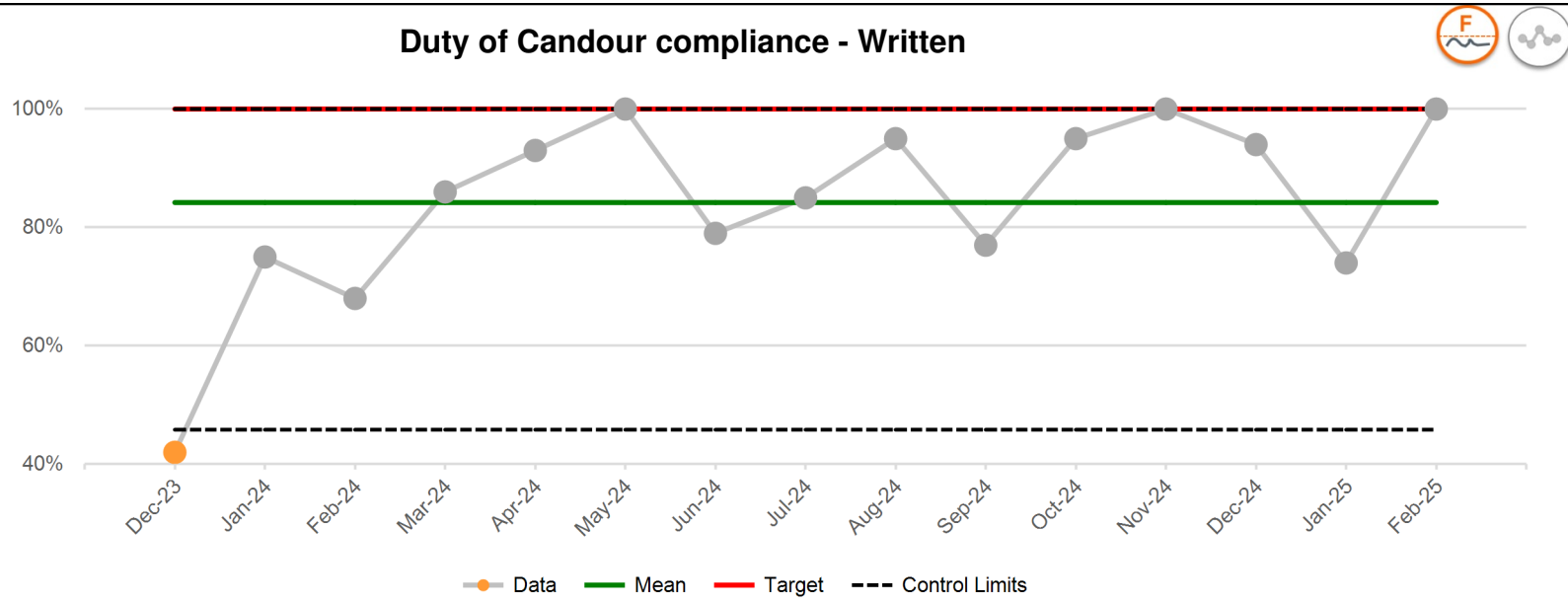
Issues:
From March 2024, a new parameter in DatixIQ has been used to monitor Duty of Candour compliance to ensure accuracy of data. This enables the incident team to ensure the grading of harm is accurate to enable the Duty of Candour regulation to be triggered.

Actions:
Divisional position for each service now provided and business partners working with divisions to complete and monitor ongoing compliance.

Weekly tracking in progress by the incident team.

Mitigations:
Dedicated members of the incident team have been aligned to divisions which has improved compliance.

Performance Overview - Quality



Feb-25
100.00%
Variance Type
Common cause variation
Target
100.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Medical Director

Background:
Written follow up to Duty of Candour, which applies to all patient safety incidents where harm is moderate or above, is a statutory requirement.

What the chart tells us:
Compliance remains consistently high.

Issues:
From March 2024, a new parameter in DatixIQ has been used to monitor Duty of Candour compliance to ensure accuracy of data. This enables the incident team to ensure the grading of harm is accurate to enable the Duty of Candour regulation to be triggered.

Actions:
Divisional position for each service now provided and business partners working with divisions to complete and monitor ongoing compliance.

Weekly tracking in progress by the incident team.

Mitigations:
Dedicated members of the incident team have been aligned to divisions which has improved compliance.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-25	Feb-25	Mar-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.38%	0.27%	0.20%	0.28%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	78.00%	73.47%	73.72%	78.21%	73.46%	76.13%	F	H
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	1,317	1,070	573	11,584	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	74.96%	73.70%	78.25%	78.83%	88.50%	F	
	52 Week Waiters	Responsive	Services	Chief Operating Officer	144	1,552	1,461		N/A	N/A	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	30	29		N/A	N/A	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	53.68%	53.72%		52.30%	84.10%	F	H
	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	71,636	71,248		N/A	N/A	F	
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	75.20%	80.30%		78.32%	75.00%	P	
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	62.00%	59.80%		61.93%	85.39%	F	H
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	82.00%	89.20%		77.50%	93.00%	F	H

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-25	Feb-25	Mar-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	36.70%	40.90%		58.57%	93.00%	F	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	87.30%	92.90%		91.26%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	85.80%	96.80%		91.10%	98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	65.80%	68.60%		75.45%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	64.30%	81.30%		85.41%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	47.50%	76.90%		66.05%	90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	66.30%	71.60%		70.88%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	67.62%	73.15%	68.34%	71.67%	99.00%	F	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.58%	1.84%	1.70%	1.78%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	35	28	29	375	0	F	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	58.76%	52.00%	55.26%	64.84%	90.00%	F	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

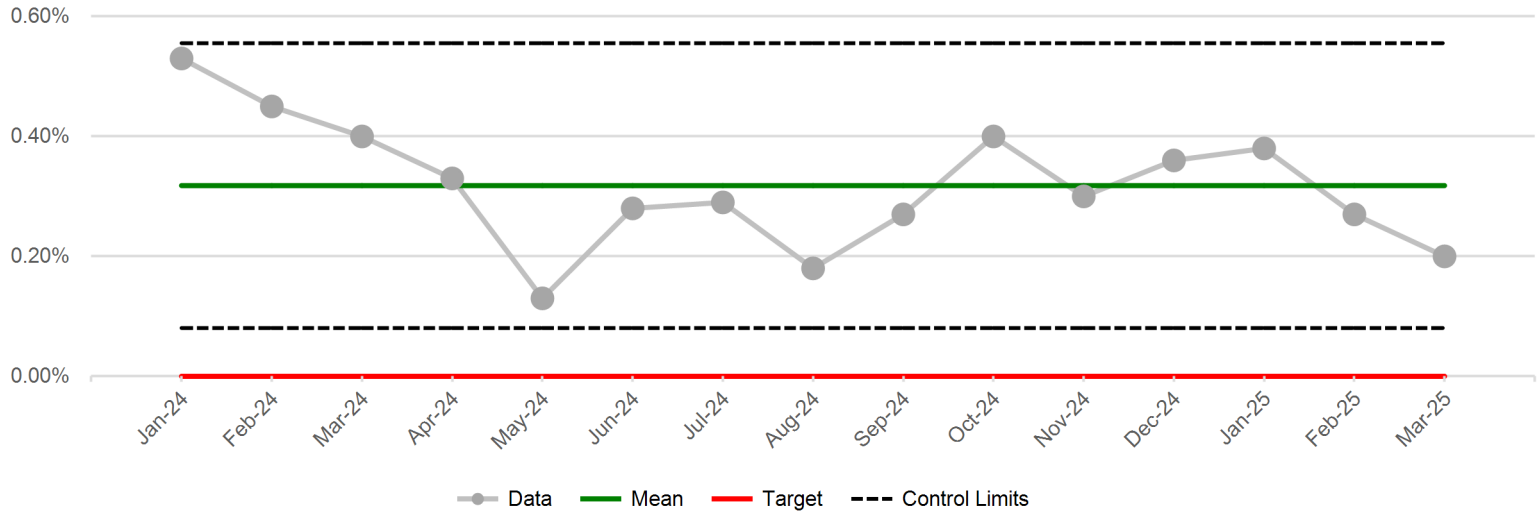
5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-25	Feb-25	Mar-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	40.21%	24.00%	38.16%	39.43%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,556	4,191	4,521	4,615	4,657	P	
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	1,085	514	128	516	0	F	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	90	76	78	N/A	N/A	F	H
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.82	2.83	2.85	2.70	2.80	F	
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.59	4.66	4.52	4.67	4.50	F	
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.50%	Submission suspended	Submission suspended	Submission suspended				
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	34,661	35,622	37,147	33,218	4,524	F	H
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	38.65%	40.73%	36.67%	38.87%	45.00%	F	

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

% Triage Data Not Recorded



Mar-25
0.20%
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:
March reported a non-validated position of 0.20% of data not recorded versus the target of 0%. To note, 89.2% 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 36 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.

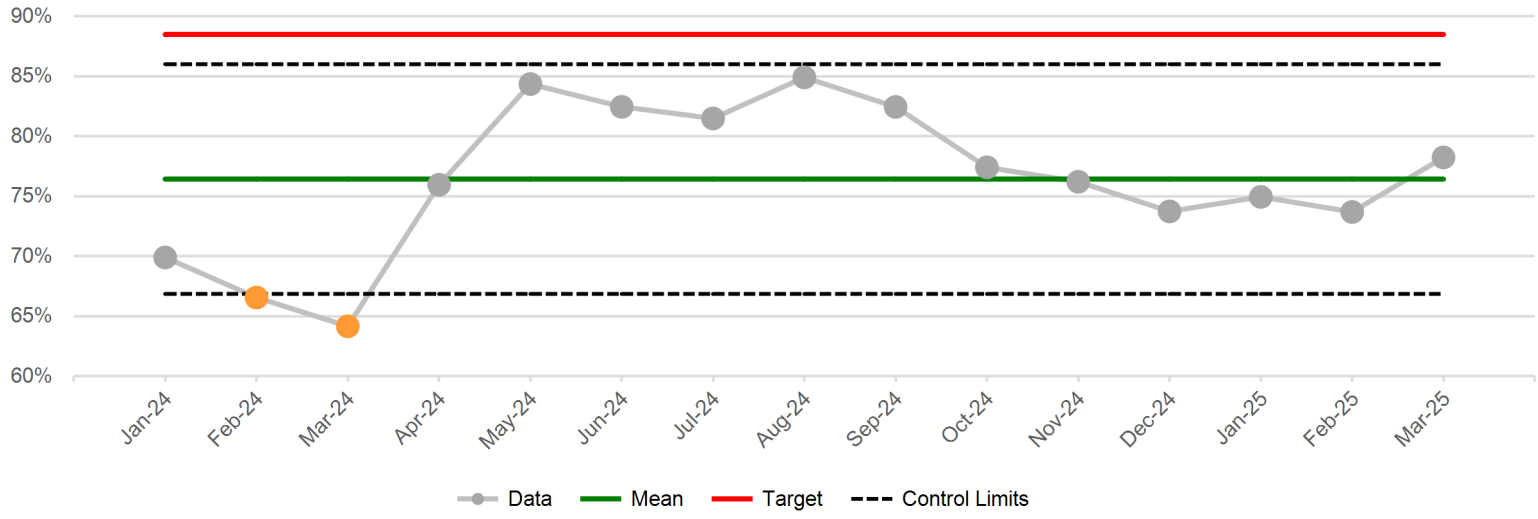
Mitigations:
- 3 daily capacity and performance meetings to identify recording delays early, along with confirmation through tailored daily updates from the (UEC) team.
- Twice-daily staffing reviews to ensure the appropriate allocation of the Emergency Department (ED) workforce to meet performance indicators.
- The Urgent and Emergency Care Clinical Business Unit is continuing to perform daily interventions to ensure compliance with recording and operational requirements

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

%Triage Achieved under 15 mins



Mar-25
78.25%
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:
March's outturn was 78.25%, compared to 73.70% in February (validated). This represents a negative variance of 10.25% from the target of 88.50%. March's performance shows a 14.08% improvement compared to the same month in 2024.

Issues:
- Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 has deteriorated.
- There is a recording issue for UTC transfers of care to ED that skews that data on occasion.
- Dual department roles. For example, the second triage nurse is also the allocated paediatric trained nurse, whilst reduced is still on occasion, problematic.
- Inability to maintain agreed staffing template, particularly registrants, due high to sickness and agency cancellations at short notice.
- Increased demand in the Emergency Depts. and overcrowding.

Actions:
Increased access to MTS2 training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
The metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings
New escalation process in place
UEC Sprint commenced also in August 2024.

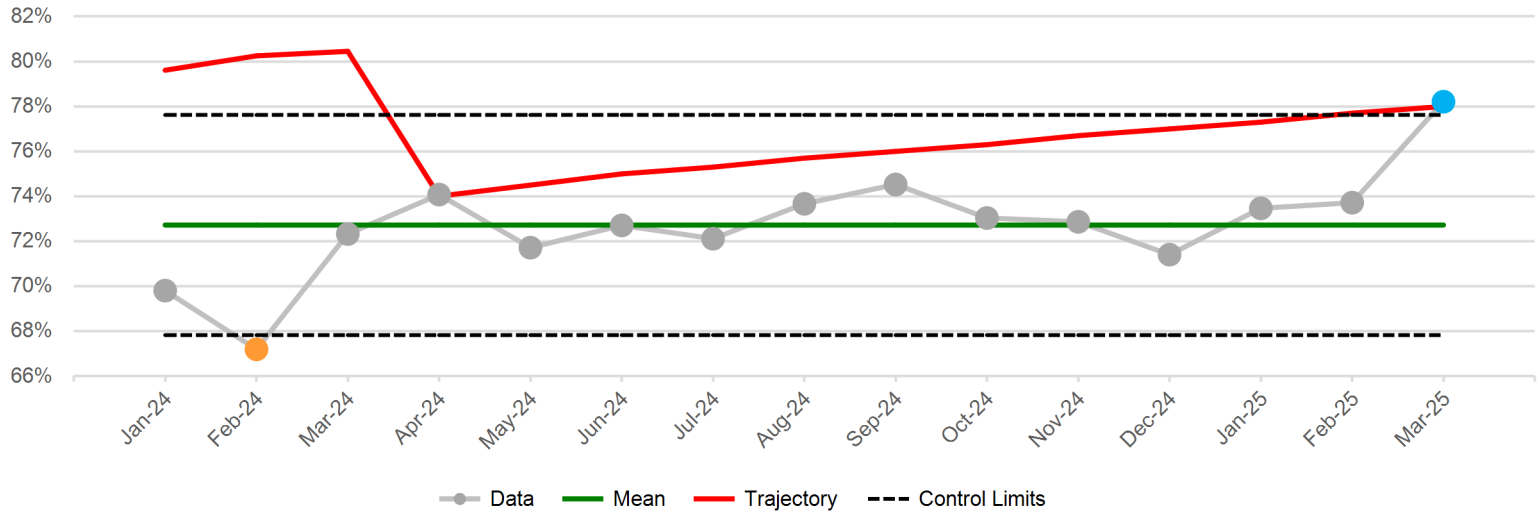
Mitigations:
The Senior Nurse Leads maintain oversight and support in periods of either high attendance demand or when the second triage stream is compromised due to duality of role issues.
The confirmation of 2 triage streams is ascertained at the 4 x daily Capacity meetings.
Early escalation and rectification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

Performance Overview - Operational Performance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Teaching Hospitals NHS Trust

4hrs or less in A&E Dept



Mar-25
78.21%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Trajectory
78.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
The 24/25 target has been set at 78% with a rolling trajectory by month to achieve by year end.

What the chart tells us:
The 4-hour transit performance for Type 1/3 combined was recorded at 78.21%, representing an improvement over Februarys performance of 73.72%. It is important to note that the chart does not account for the increased volume and acuity of presentations to the department.

Issues:
In March 2025, Type 1 witnessed an average daily patient volume of 534, reflecting a decrease from the 528 patients attended to in February 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. Furthermore, the closure of beds on the wards due to COVID19, Influenza and RSV impacted the availability of resources for movement and cleaning, thereby affecting timely movements.

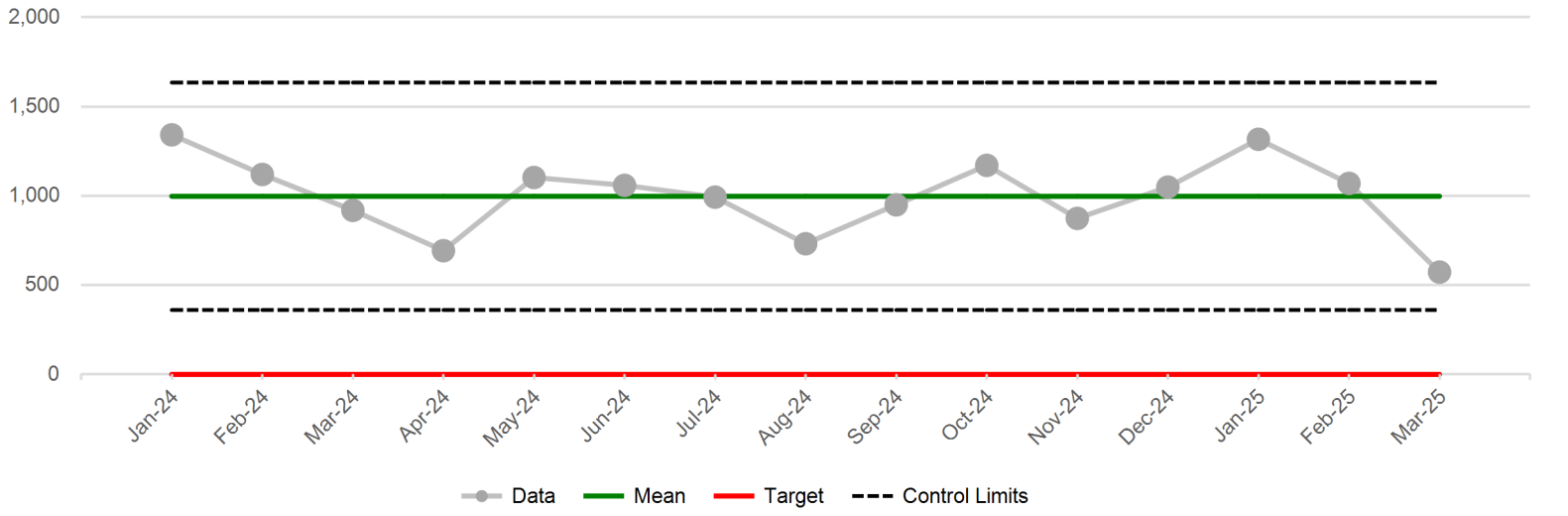
Type 3 (All locations) observed an average of 429 daily patients, representing a 7.70% increase to the preceding month

Actions:
UEC dedicated programmes of work looking at admission avoidance, ED process, acute medicine and direct pathways to reduce overcrowding in EDs and the length of time patients are waiting to be seen. Divisional/organisational action plans monitored weekly by senior leaders from across ULTH and LCHS.
A new Group UEC & Discharge Board has also been set up to focus on the discharge agenda and flow throughout the hospital. The group is chaired by the Chief Nurse and COO and has senior attendees from across the group.

Mitigations:
EMAS continue to enact a targeted admission avoidance process, including no Cat 4 conveyances should arrive at the Emergency Department.
The Discharge Lounge at LCH and PHB continues operating, where possible, a 24/7 service provision to release the burden placed on the Emergency Departments in terms of patients awaiting AIR/CIR and transport home.
Increased CAS and 111 support especially out of hours.
EPIC to Specialty Consultant reviews to ensure DTA applied appropriately.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.

Performance Overview - Operational Performance

12+ Trolley waits



Mar-25
573
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:
March experienced 573 breaches, an improvement from 1070 in February, marking a decline of 46.4% (497 less patients). The 573 breaches accounted for 3.5% of all type 1 attendances. Additionally, the chart did not capture the adhoc internal decisions made to prioritise total time in the Emergency Department, aimed at minimising exposure risk and mortality rate.

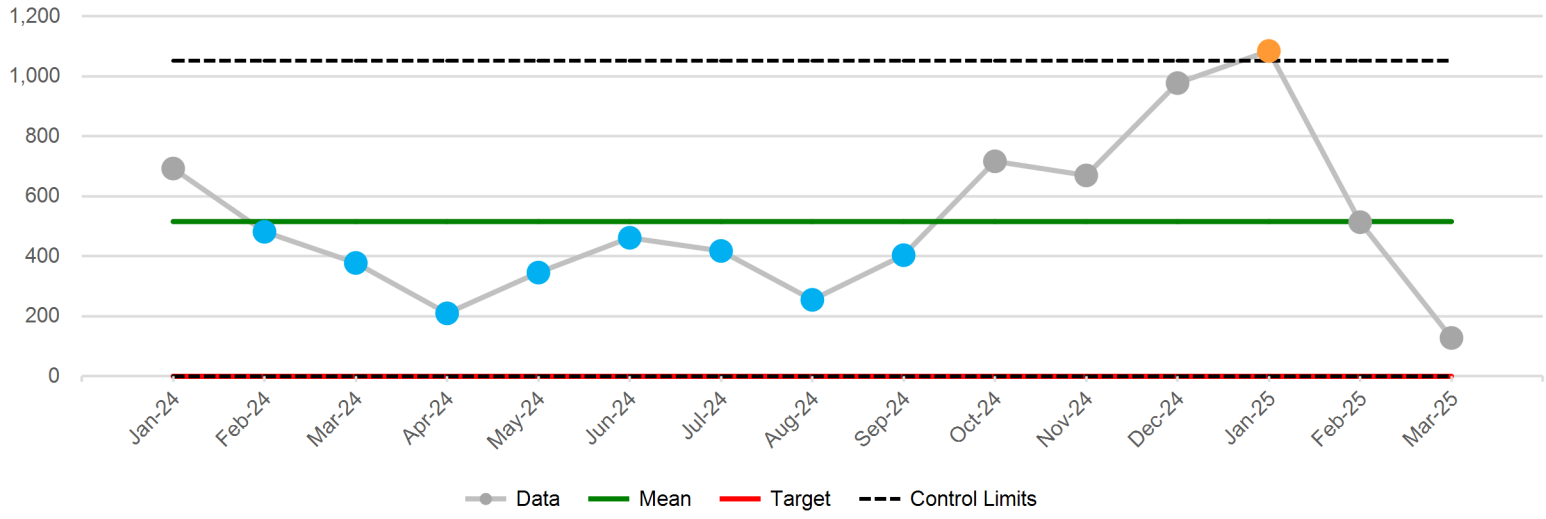
Issues:
Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings.

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

Mitigations:
A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support.
A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.
An additional consultant shift was funded by winter monies to review all DTAs every day to ensure that they still require admission
Rapid Assessment and Treatment consultant shifts are in place at both ED front doors to assist with length of stay in department and appropriateness of referrals/navigation.

Performance Overview - Operational Performance

EMAS Conveyances Delayed >59 mins



Mar-25
128
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Delays in offloading patients following a conveyance has a known impact on the ability of EMAS to respond to outstanding calls.

What the chart tells us:
Ambulance handovers exhibited a further improvement in March with 128 arrivals recorded in contrast to the 378 arrivals documented in 2024. This accounted for 3% of all handovers in March 2025. 21% of patients arriving were already scoring above 4 on (NEWS) at the time of presentation.

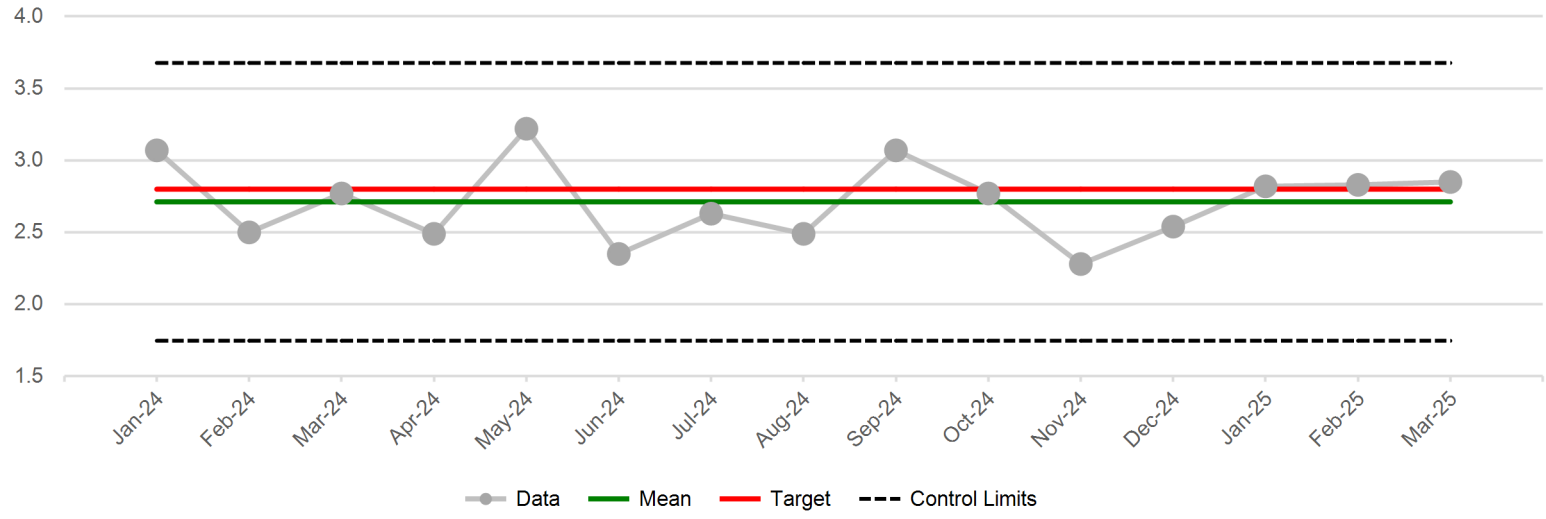
Issues:
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
An increasing number of category 1 and 2 patients being conveyed.
Inadequate flow and sub-optimal discharges continue to result in the emergency departments being unable to completely de-escalate due to a number of patients waiting for admission, although this number reduced.

Actions:
All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager in hours and SOC out of hours
Daily communication with EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond.
Rapid handover protocol, designated escalation areas have been identified/confirmed to assist in reducing delays in handover.
Plus 1/2 Process active to alleviate pressure/capacity in ED.

Mitigations:
Early intelligence of increasing EMAS demand has allowed for planning and preparedness to receive and escalate.
Contact points throughout the day and night with the Clinical Site Manager and Tactical Lead (in and out of hours) to appreciate EMAS on scene (active calls) and calls waiting by district and potential conveyance by site.

Performance Overview - Operational Performance

Average LoS - Elective (not including Daycase)



Mar-25
2.85
Variance Type
Common cause variation
Target
2.80
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
The average length of stay for Elective inpatients.

What the chart tells us:
The average LOS for Elective stay has decreased to 2.9 days compared to 2.8 days in the preceding 2 months. This represents a negative variance of 0.05 days against the agreed target.

Issues:
The complexity of patients currently being admitted is rising, which will have implications for post-operative recovery and length of stay (LOS). There has also been an increase in the number of elective patients within pathways 1, 2, and 3. Furthermore, the data concerning outliers in the previously designated elective beds and coding has been skewed.

Actions:
The reduction in waiting times is being assessed on a weekly basis. Our attention is directed towards specialty waiting lists, particularly for patients who have been identified as experiencing increased morbidity, as this condition may result in an extended length of stay (LOS). Moreover, we are prioritizing the timely transition of patients from Intensive Care Unit (ITU) level 2 care to level 1 "wardable" care.

Mitigations:
The weekly 6-4-2 theatre scheduling meetings will identify patients who may require an extended length of stay (LOS) and will consider strategies for increased optimization to reduce the predicted LOS.

All elective areas are now required to pre-operatively escalate any post-operative needs that could lead to an extended LOS beyond what is typically expected.

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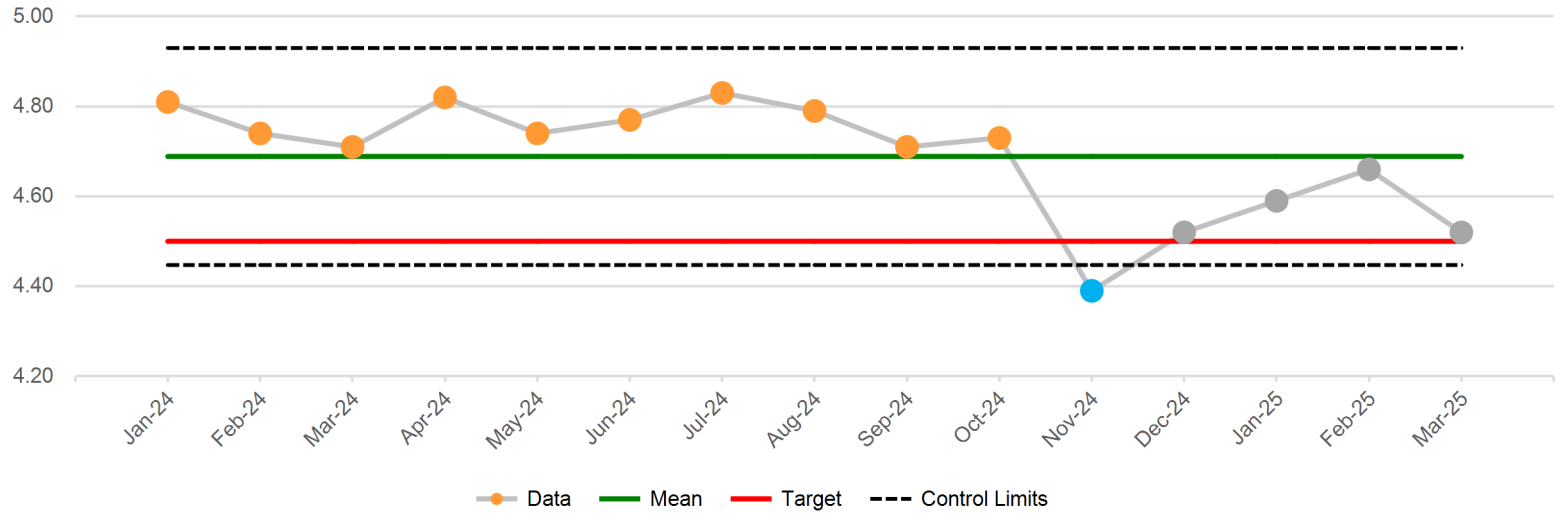
Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

Average LoS - Non Elective



Mar-25
4.52
Variance Type
Common cause variation
Target
4.50
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
March outturn of 4.52 is a decline 0.06 days and a 0.02-day negative variance against the agreed target.
What the chart doesn't tell us is the change by pathway:
Pathway 0 (1.0) less days
Pathway 1 (3.2) less days
Pathway 2 (1.6) less days
Pathway 3 (7.1) less days

Issues:
In March, there was an increase in performance in the number of super-stranded patients, with the daily average decreasing to 143 from 161. This is replicated with the number of stranded patients (14 days) decreasing from 249 daily to 229. Weekend discharges consistently remained lower than weekdays, with a 40.85% reduction and an average of 58 less patients discharged. This reduction in weekend discharges presents a challenge in meeting the capacity and demand for emergency admissions.

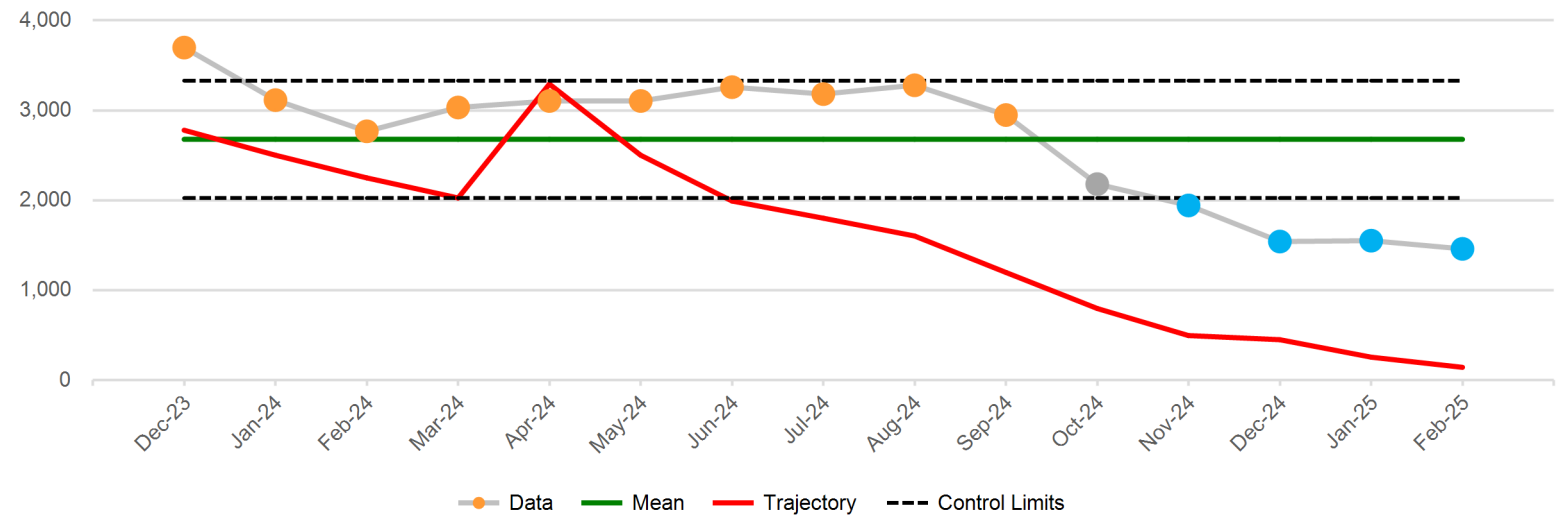
The Transfer of Care Hub continues to gain traction in moving discharges forward at an improved pace. There is a higher acuity of patients requiring a longer period of recovery.

Actions:
- Ensure that patient discharge is efficiently managed on a daily basis.
- Discuss the progress of No Criteria to Reside patients with system partners twice daily, 7 days a week to ensure timely planning and zero tolerance for delays exceeding 24 hours.
- Make full use of all community and transitional care beds when it's not possible to secure onward care promptly.
- Conduct a thorough review of all pathways, ensuring that patients who do not meet the residency criteria are identified.
- Weekly review of Long Stay Patients
- Daily Updates to ASC regards new admissions whose package of care can be realigned to other patients due to expected spell duration

Mitigations:
Divisional Leads are providing support for addressing delays in patient discharges. Efforts to streamline corporate and divisional meetings are underway to prioritise the increase of daily discharges
An automated daily site update notification is now distributed at 6 AM to notify Key Leaders of the Emergency Department (ED) status, patient flow, and the operational pressures escalation level (OPEL) by site.
Transitioning to a 5-day workweek over a 7-day period is in progress.
A revised recurring schedule for Managing Ambulatory and Discharge Events (MADE) has been approved, with an agreed frequency of every 8 weeks.

Performance Overview - Operational Performance

52 Week Waiters



Feb-25
1,461
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
144
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Number of patients waiting more than 52 weeks for treatment.

What the chart tells us:
The Trust reported 1,461 incomplete 52-week breaches for February 2025, a decrease of 91 from January's 1,552.

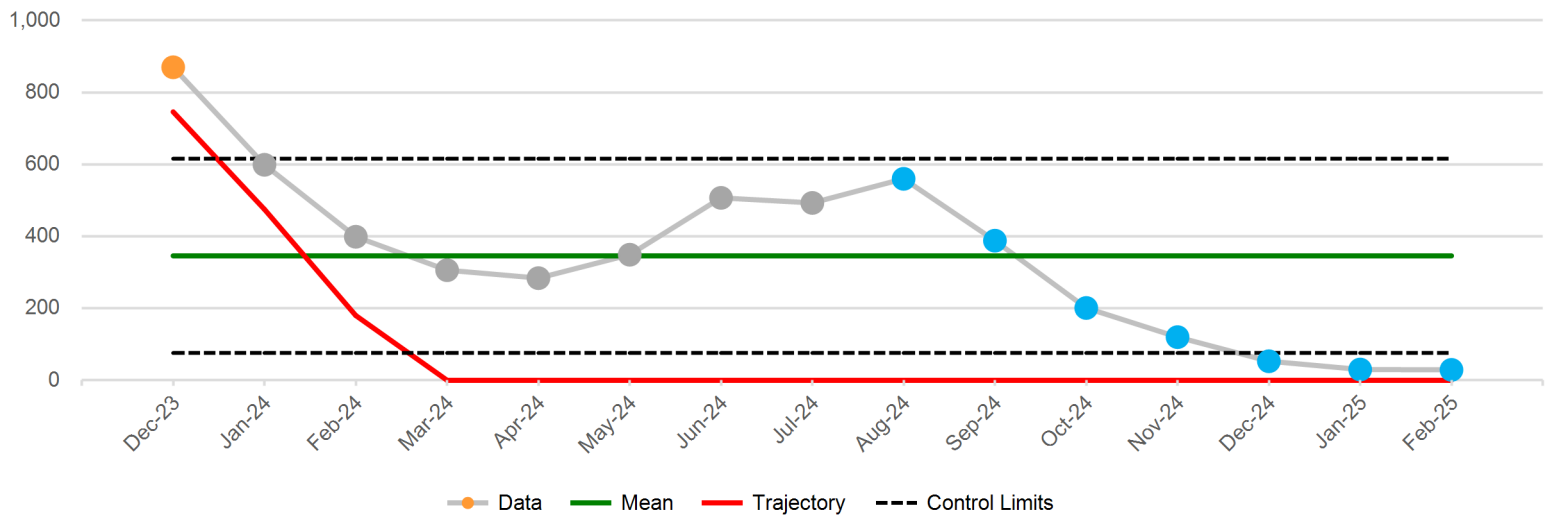
Issues:
As shown above, 52 week waiters are positively performing against trajectory, with a decrease in numbers from last month. Both admitted and non-admitted patients sit within this wait band, however, the most significant pressure is in the non-admitted pathways. ENT continues to be the specialty under greatest pressure, which together with audiology, accounts for 46.48% of patients in this wait band. An increase of 1.18% from last month.

Actions:
Insourcing for additional ENT clinics continues has now been extended for a further six months. The additional clinics have reduced both total waiting list size and long waiters.
Additional DMC clinics for Gastroenterology have also been extended for a further six months.

Mitigations:
ULTH 52 week position in current data (W/E 23rd March '25) ranks 4th for this metric within the Midlands region (11 Providers).

Performance Overview - Operational Performance

65 Week Waiters



Feb-25
29
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 29 incomplete 65-week breaches for February 2025, a decrease of 1 from January's 30.

Issues:
ULHT's 104 week wait position was zero for February.
As shown above, 65 week waiters have decreased again this month.

Actions:
Incomplete patient pathways are discussed with individual specialities weekly, through PTL meetings.
This meeting is currently focusing on patients in the 65w cohort for the current month. Due to the high volume of patients, this is being held twice a week.

Mitigations:
Current data (W/E 23th March '25) ranks ULTH 2nd for 65w cohort metrics within the Midlands region (11 Providers).

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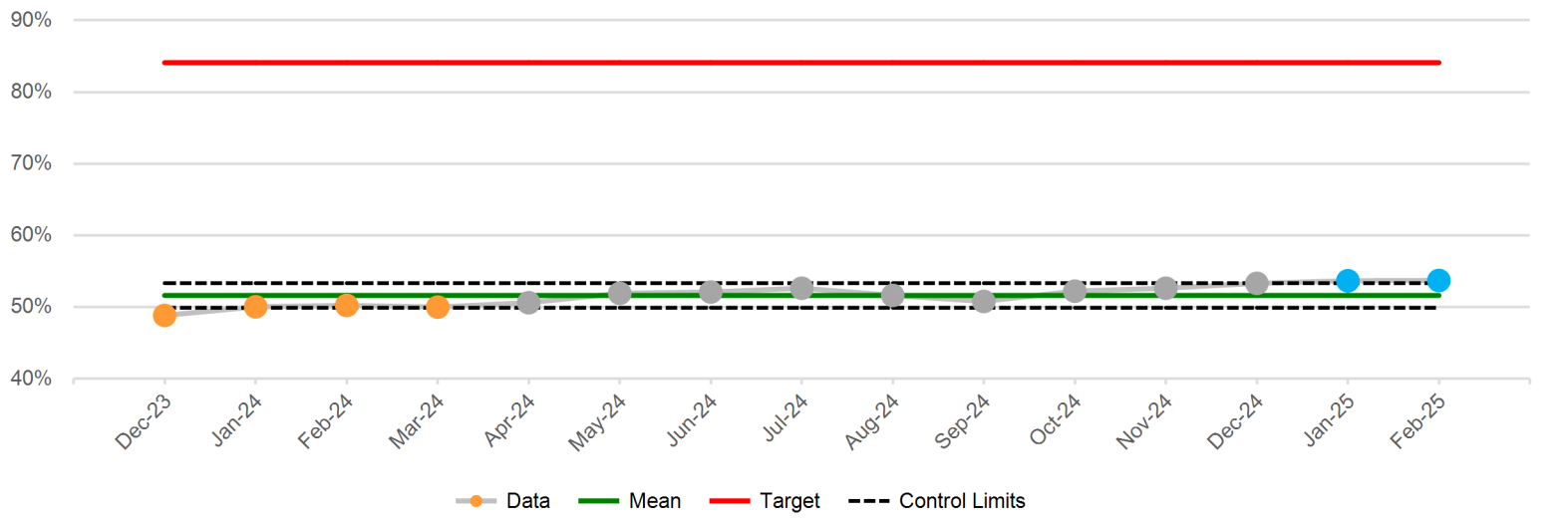
Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust



Feb-25
53.72%
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. February 2025 saw RTT performance of 53.72% against an 84.1% target, which is 0.04% up from January.

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– 6,009 (decreased by 13)
Gynaecology – 3,097
(increased by 91)
Ophthalmology – 2,702 (increased by 55)
Gastroenterology – 2,633 (decreased by 43)
T&O–2,489 (increased by 211).

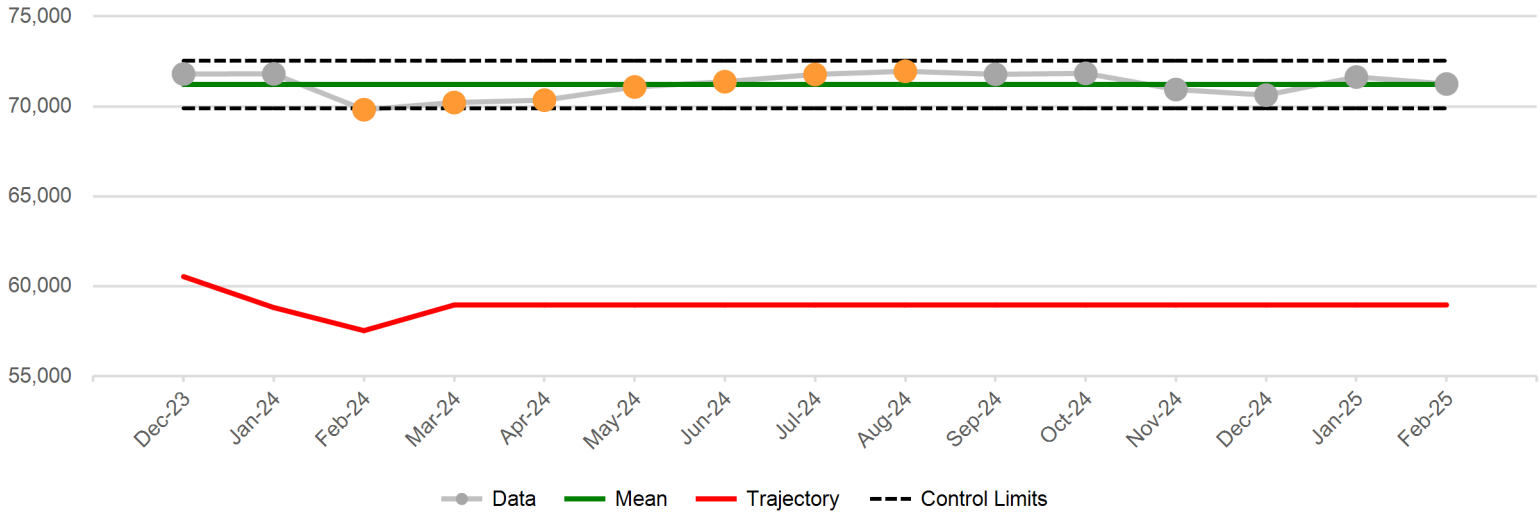
Actions:
Priority remains focussed on clinically urgent and Cancer patients. National focus is on patients that are waiting 65 weeks and over, with the target to achieve zero by the end of the current month. Resource is targeted at patients who have the potential to be >65 weeks.
Schemes to address the backlog include;
1. Outpatient utilisation
2. Tertiary capacity
3. Outsourcing/Insourcing
4. Use of ISPs
5. Reducing missing outcomes

Mitigations:
To support delivery of actions and to maintain drive on recovery,
focus continues on capturing all activity. This includes clinical prioritisation of patients using theatres. Current data (W/E 23rd March '25) ranks ULTH 9th for RTT performance metrics within the Midlands region (11 Providers).

Performance Overview - Operational Performance

United Lincolnshire Teaching Hospitals NHS Trust

Waiting List Size



Feb-25
71,248
Variance Type
Common cause variation
Trajectory
58,965
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Overall waiting list size has decreased from January, with February showing a decrease of 388 to 71,248.
This is more than double the pre-pandemic level reported in January 2020.

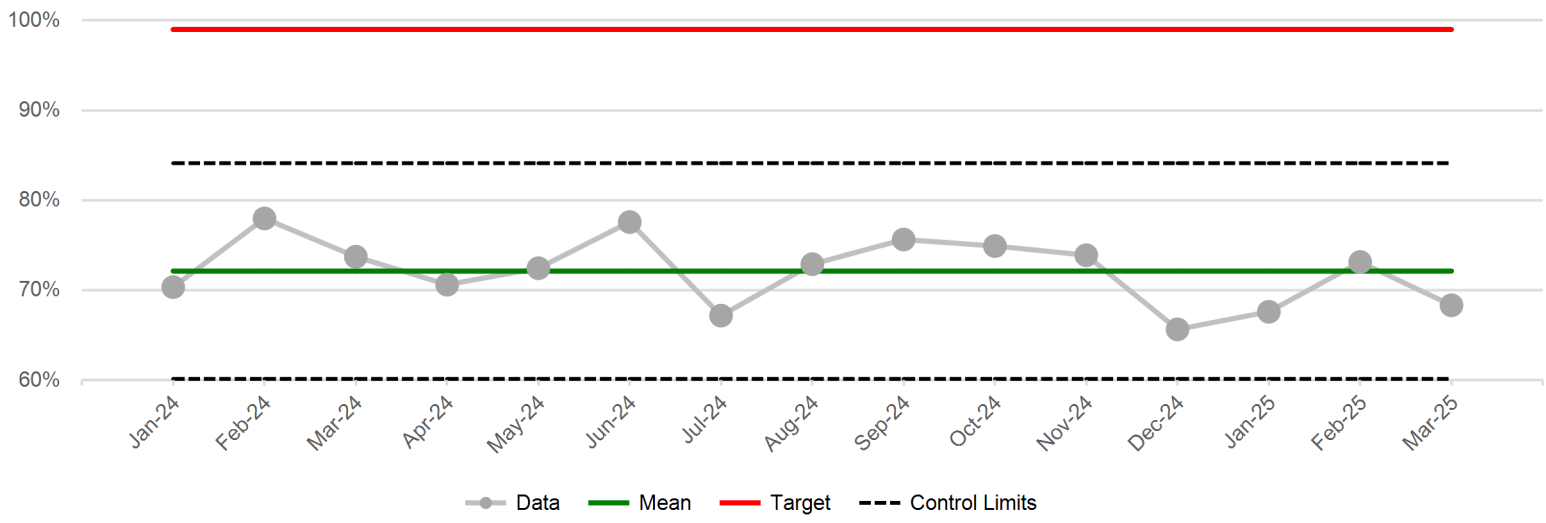
Issues:
Following the backlog increase from the pandemic, there have been additional pressures that have affected capacity, including urgent care pressures.
The five specialties with the largest waiting lists are;
ENT – 10,042
Ophthalmology – 6,213
Gynaecology – 6,113
Trauma & Orthopaedics 5,868
Gastroenterology – 5,773

Actions:
Improvement programmes as described above for RTT performance. Recruitment continues for the internal validation team.
Fortnightly outpatient waiting list CBU meetings.
Outpatients continue to work with specialties to facilitate extra activity.
Improvement team working with specialties to increase PIFU uptake.

Mitigations:
The number of patients waiting over 78 weeks continues to be zero. Current data (W/E 23rd March '25) ranks ULTH =1st for this metric and 4th for total waiting list size within the Midlands region (11 Providers)
Appropriate admitted and non-admitted patients continue to be transferred out to ISP's or insourced.

Performance Overview - Operational Performance

Diagnostics achieved



Mar-25
68.34%
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 March was 68.34% against the 99.00% target.

Issues:
The majority of diagnostic breaches sit in ultrasound, and Audiology. A full recovery trajectory has been submitted and is being monitored closely. Reduction in the waiting list will reduce the overall percentage of the DM01.
The long waiters demand is stopping any audiology recovery.

Actions:
Radiology are working to their recovery plans. Dexa has experienced significant sickness and vacancies. In the process of reprofiling staffing and training there should be an increase in performance in March 2025
Ultrasound are using agency where possible and additional shifts,

Mitigations:
Patients are being seen in clinical priority.

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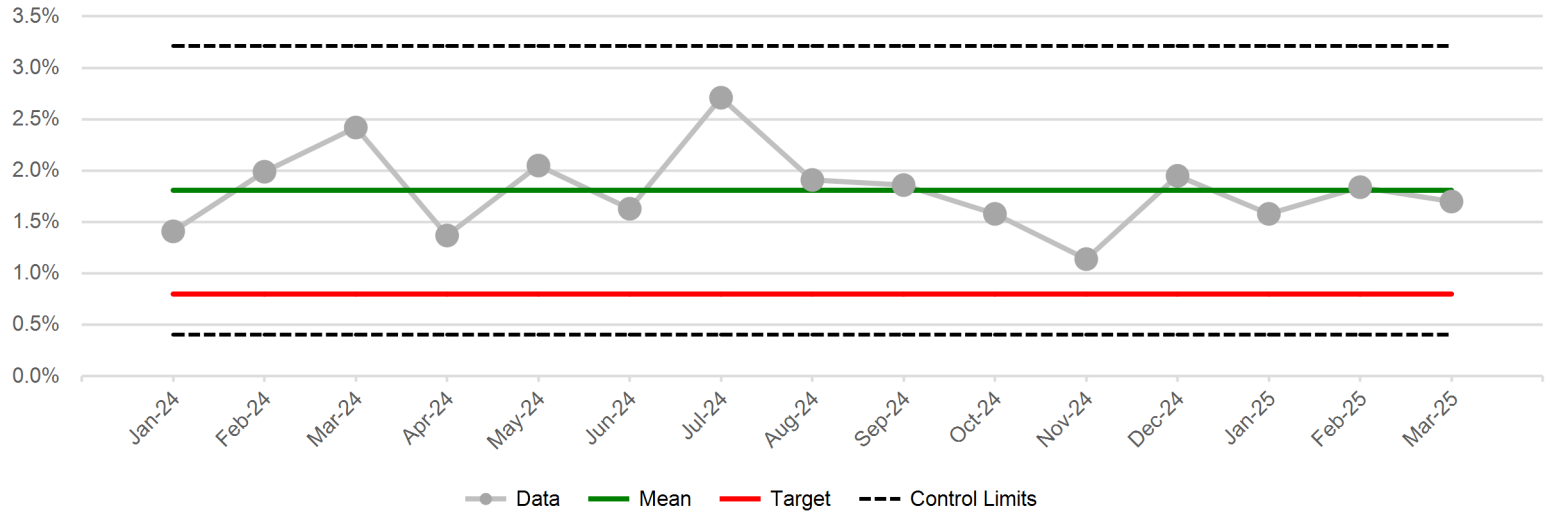
Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

Cancelled Operations on the day (non clinical)



Mar-25
1.70%
Variance Type
Common cause variation
Target
0.80%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There has been a decrease in the number of non-clinical cancellations in March from 1.84% in February, though this remains over the 0.80% target.

Issues:
Top 3 theatre cancellations for March were:

Lack of time
DNA
Theatre staff unavailable

Actions:
Deep dive requested into DNA patients (12 this month which is higher than previous months).

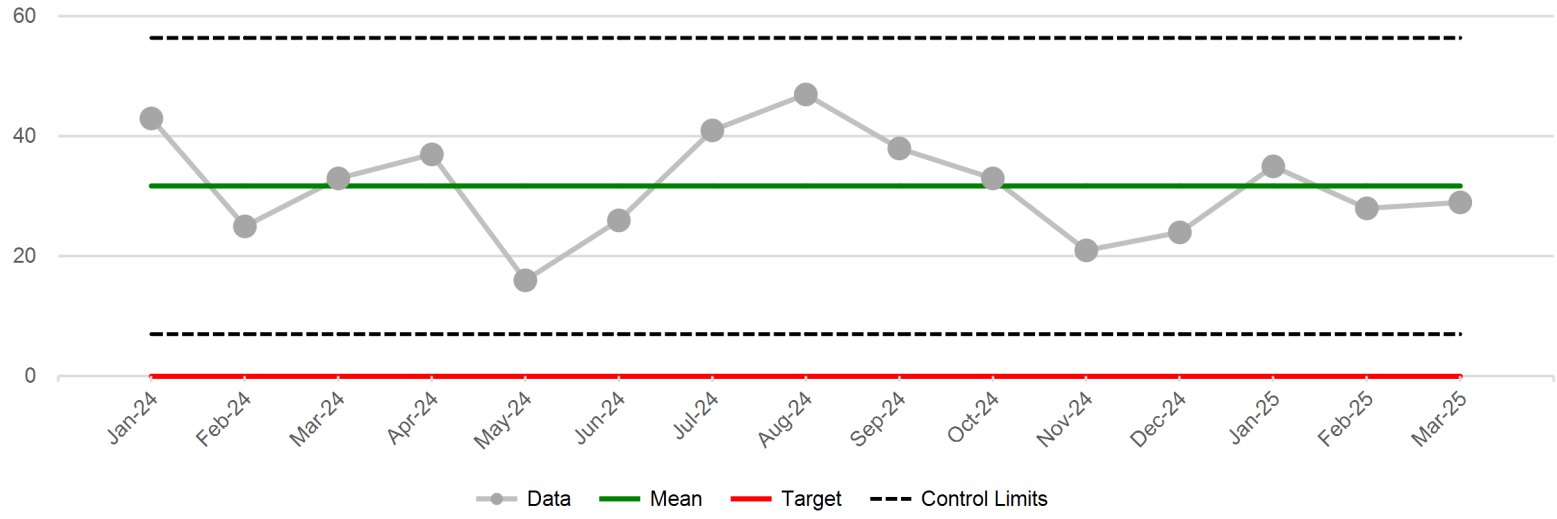
Highest theatre staff unavailable was due to sickness and included robot trained and laser trained staff. Theatres to look to increase training amongst the team to improve cross cover.

Mitigations:
51% of our elective lists started late in March, which is lower than last month though this will account for a portion of the patients cancelled due to lack of time.

Performance Overview - Operational Performance

United Lincolnshire Teaching Hospitals NHS Trust

Not treated within 28 days. (Breach)



Mar-25
29
Variance Type
Common cause variation
Target
0
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There has been a slight increase from 28 in February to 29 in March.

Issues:
March always presents issues with increased leave and therefore fewer lists.

There continues to be a focus on long waiters and the trauma backlog which both have an impact on elective lists and has made rebooking patients more challenging.

Actions:
Focus to remain on improved utilisation on our lists using 642. Pre meets provide actions which are monitored daily within the waiting list and specialty teams.

Implementation of standby patients pushed in more specialties which will provide the ability to reduce breach patients.

Mitigations:
New role within waiting list team to support improved list fill and identification of space across multiple specialities.

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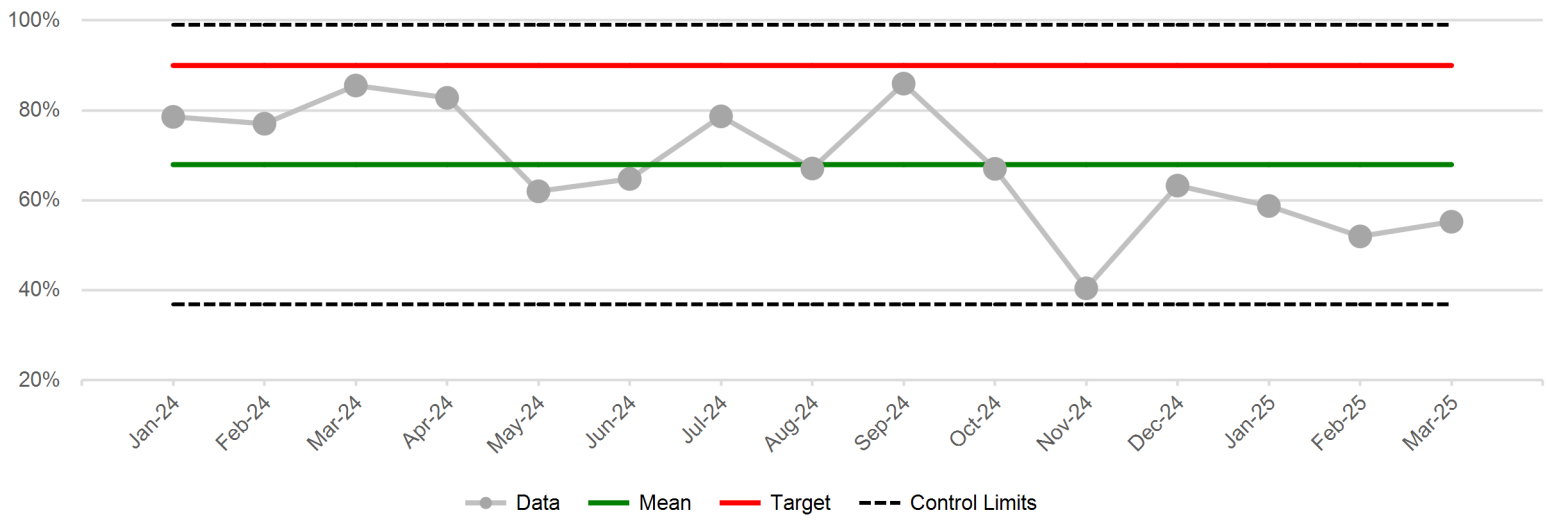
Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

#NOF 48 hrs



Mar-25
55.26%
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 March was 55.26%.

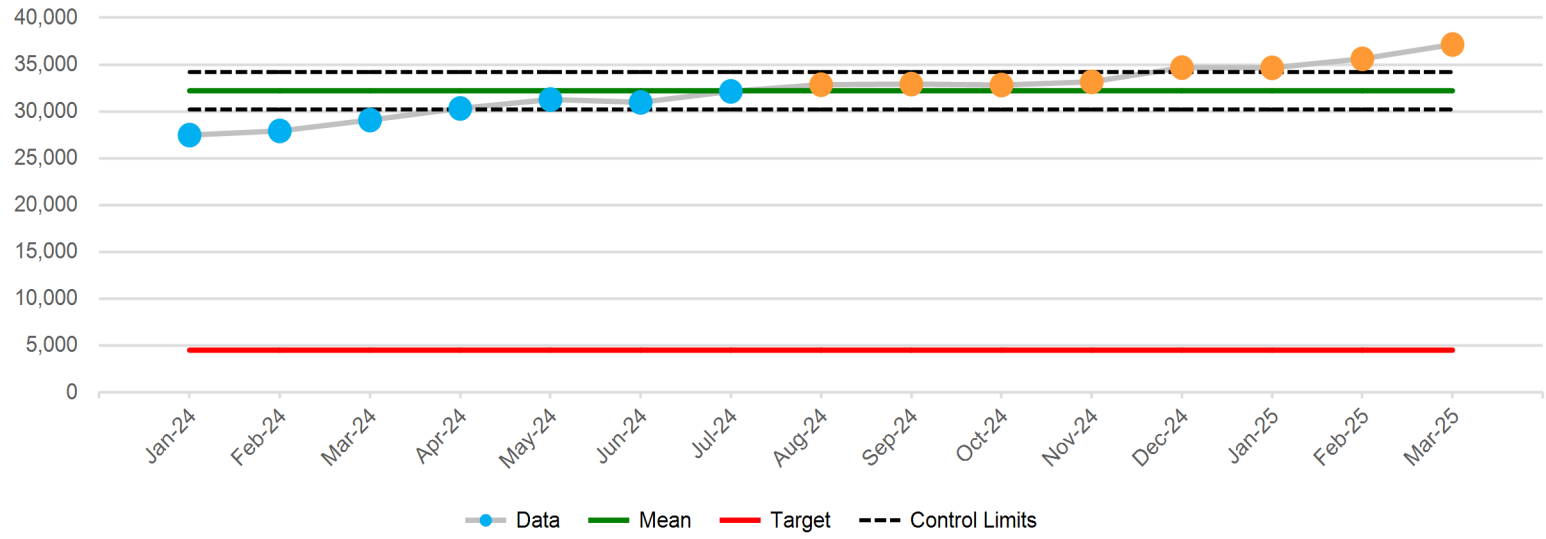
Issues:
- Lack of theatre space to accommodate Femur fractures.
- ULHT continue to have a high demand of trauma patients admitted with one trauma list planned daily on both sites.
- Lack of theatre staff to provide additional trauma capacity.
- ULHT breaching the NHFD best practice tariff for femur fractures.
- Patients not being medically fit for surgery
- Awaiting specialist surgeon
- Delays for MRI and CT scan prior to surgery

Actions:
- 'Golden patient' initiative to be fully implemented.
- Additional Trauma lists to be planned on both sites
- Review of additional trauma lists through job planning process to see if additional trauma lists can be available for Femur fractures to avoid breaches.
- Trauma coordinator team to ensure that femur fractures are listed on the trauma list to avoid breaches.
- Daily Trauma huddles via MS teams with the trauma coordinators and the CBU to discuss extra theatre capacity on all sites
- Aqua to be accessed daily by the trauma coordiators 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



Mar-25
37,147
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.

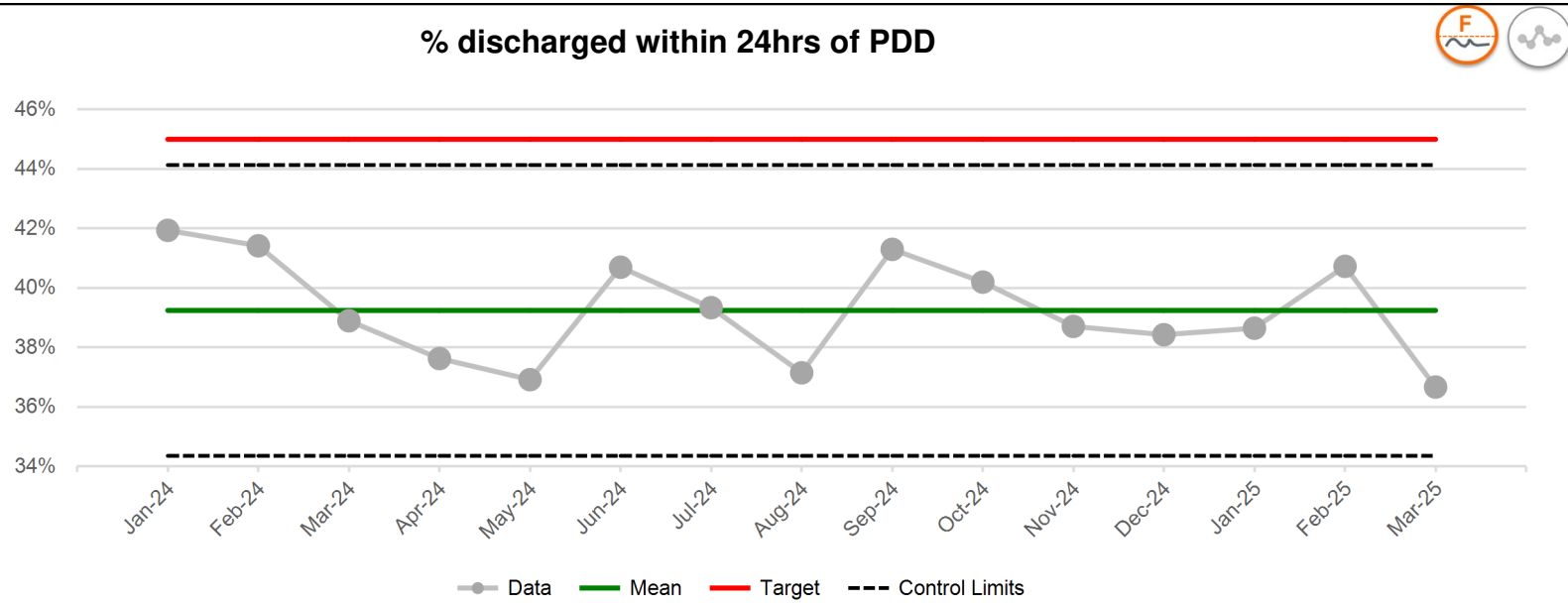
What the chart tells us:
Currently at 37,147 against a target of 4,524. During Covid the number of patients overdue significantly increased and the trend has seen a steady increase since, an exception being Aug 23 – Nov 23. More recently Oct 24 saw a slight decrease on previous months, however continued to increase since Nov 24.

Issues:
The organisation has several competing priorities. The current focus is on the long waiting patients (> 65 and >52 weeks) and potential cancer patients The current PBWL demand outweighs the current capacity which is being impacted by available capacity and resources.

Actions:
Regular Outpatient Waiting Lists (OWL) meeting with speciality CBU's to improve focus, and discussions continue regarding reduction of non-tariff f/ups. PIFU uptake continues to be an area of focus for specialties. The 642 process is currently being rolled out to improve capacity and vacant slots. Clinic Scheduler x 2 in post. Digital room booking system procured and at initial project phase (projected go live Q1 2025/26) to improve clinic utilisation and maximise capacity.

Mitigations:
Booking team priorities are to support rebooking due to short notice patient cancellations and hospital cancellations, the Personalised Outpatient Plan and the booking of the 65-week, 52-week and urgent suspected cancer patient cohort.

Performance Overview - Operational Performance



Mar-25
36.67%
Variance Type
Common cause variation
Target
45.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
% discharged within 24 hrs of Predicted Date of Discharge.

What the chart tells us:
The current performance metrics reveal a sharp improvement in March's results, which stand at 36.67%. This marks a further improvement from May 2024 notable achievement of 36.92%, highlighting a shift in performance over the past month.

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.

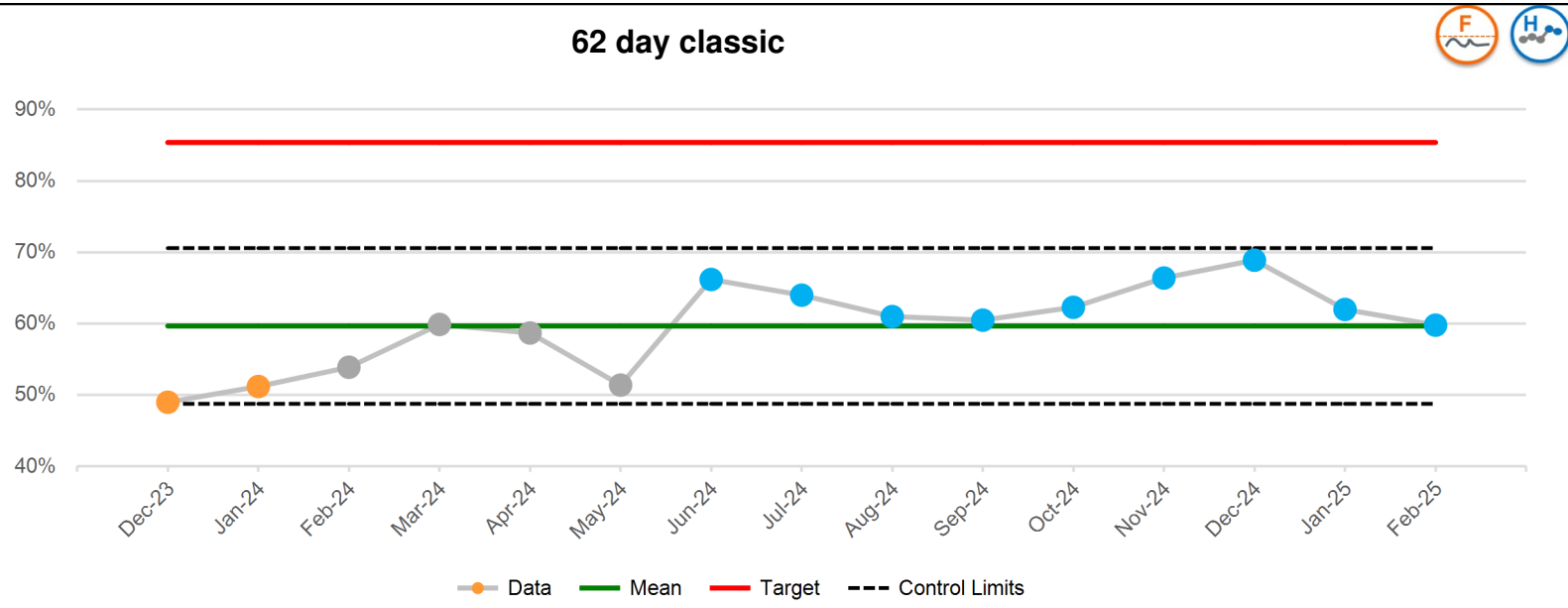
New processes have been established in conjunction with the weekly non-criteria to reside situational reports to ensure that the data recorded regarding the wards accurately reflects the patients' true conditions. Additionally, themes and trends are identified in real-time to enable timely interventions.

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.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust



Feb-25
59.80%
Variance Type
Special cause variation - improvement (Indicator where high is good)
Target
85.39%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients to start a first treatment within 62 days combined.

What the chart tells us:
We are currently at 59.80% against a 85.39% target.

Issues:
Limited theatre capacity continues to impact cancer pathways across the Trust and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice. In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment start dates. NHSE led target to achieve 75% compliance in the 62 day combined standard by the end of March 2026.

Please also see Issues on accompanying pages.

Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing and posts are out to advert.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations. Additional slots for cancer specialties to increase from 2 to 3 slots per day starting from July. Performance – Intensive Support Meetings continue to take place twice weekly to understand and resolve the themes and issues in 62 day performance in a number of tumour site specialties. Deep Dives are being undertaken by each CBU to understand how diagnostic turnaround times for positive cancers can be improved as this will be key to achieving the NHSE target of 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.

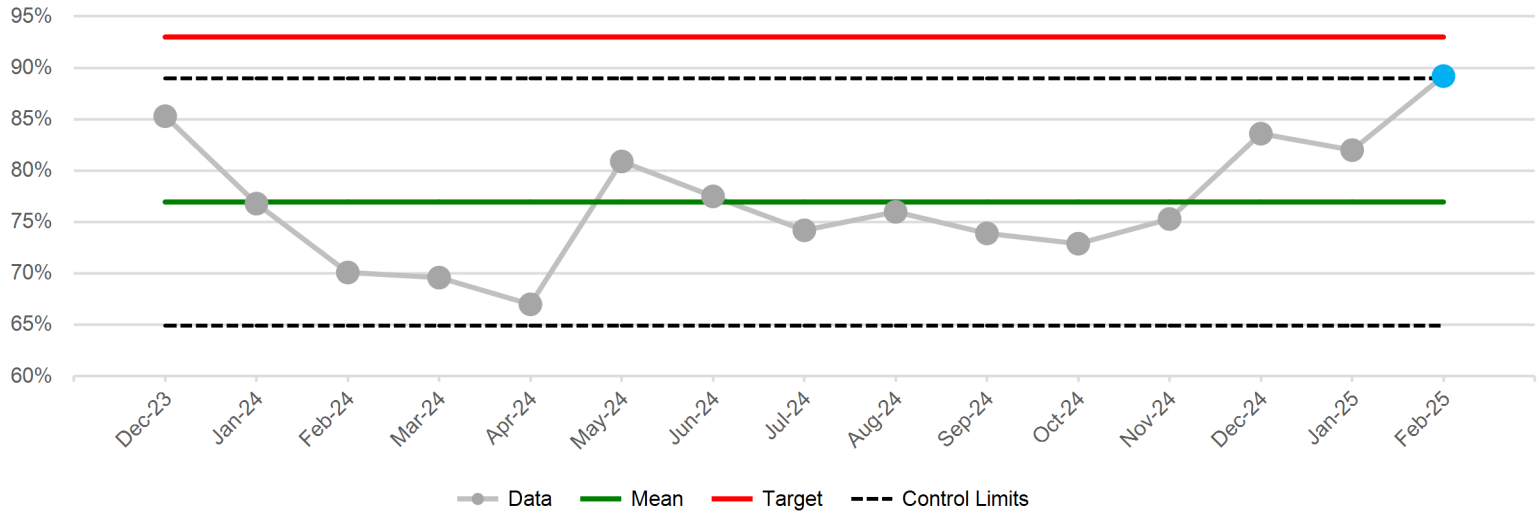
Please also see Mitigations on accompanying pages.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

2 week wait suspect



Feb-25
89.20%
Variance Type
Special cause variation - improvement (Indicator where high is good)
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 89.20% 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 45.88% of the Trust's 14 day breaches. We should see an improvement moving forward
Additionally, Gynaecology speciality were responsible for 17.2% of the Trust's 14 day breaches due to clinician annual leave during February.
Skin tumour site accounted for 4.3% of the Trust's 14-day breaches in February which is a significant improvement on previous months.

Actions:
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues.
Respiratory Consultant capacity is ongoing as well as the BC for an increase in consultant workforce to 10-15 consultants. 2 x Lung Cancer CNS posts (funding until March 25) for risk stratification to reduce unnecessary CT scans demand on consultant triage are now established. The Lung Rapid Access pathway will now include CT referrals to accurately reflect performance and has recently been implemented. We have seen the impact of this in improved FDS performance since May. UGI Triage CNS has started in post and further job planning underway. Gastro admin team are now cross referencing USC referrals while the CBU work towards sustainable solutions to managing the start of the UGI USC referrals.

Mitigations:
Haematology is in fragile services due to vacancy/capacity. Issues with inappropriate referrals and GP engagement continue to be escalated and supported by the ICB and Cancer Navigators will be able to streamline this process. Delays in the booking and utilisation of appointment slots which continue to be addressed with C&A and the Divisions.
In Gynae, the urgent PMB pathway progress and impact is being monitored. An HRT programme of work is underway with support from ICB colleagues.

The process to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention / support is currently being reviewed.
Processes – SOPs relating to DNAs, multiple cancellations and Escalation's are currently being developed and taken through CBU Governance processes for approval.

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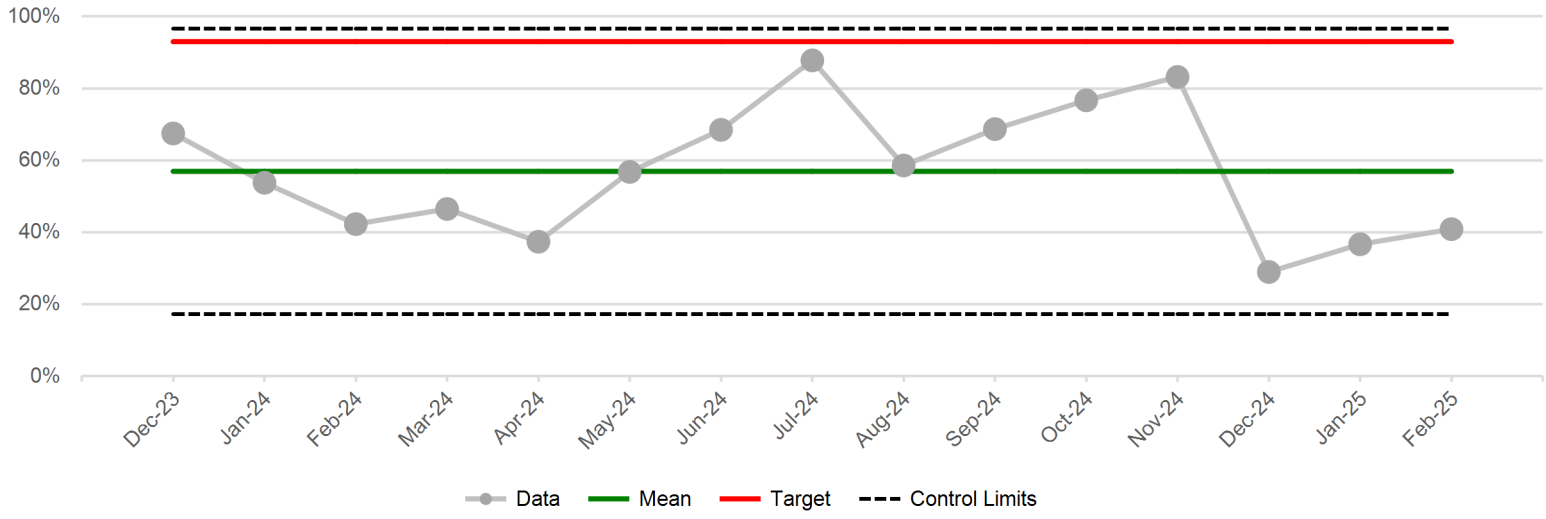
Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

2 week wait breast symptomatic



Feb-25
40.90%
Variance Type
Common cause variation
Target
93.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients urgently referred for breast symptoms (where cancer was not initially suspected) seen within two weeks of referral.

What the chart tells us:
We are currently at 40.90% 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.

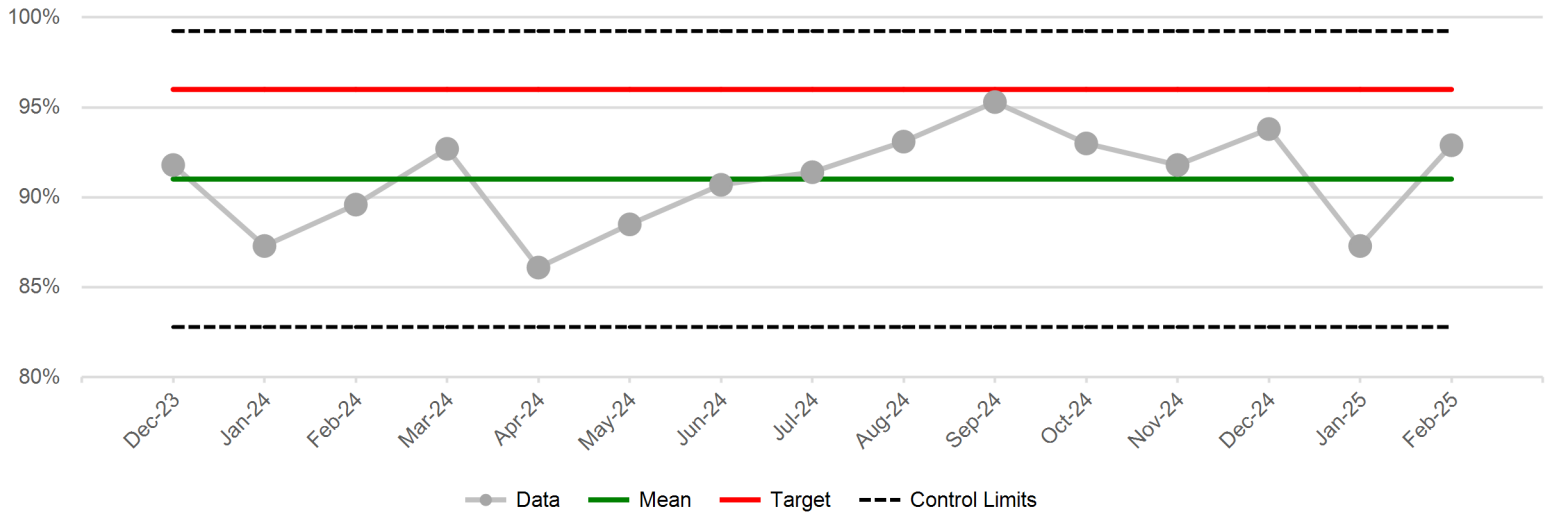
The Radiology Recruitment Strategy and intensive support meetings are in place to address the fragile Breast Service One-Stop appointment alignment issues

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

United Lincolnshire Teaching Hospitals NHS Trust

31 day first treatment



Feb-25
92.90%
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 92.90% against a 96% target.

Issues:
The failure of the 31 Day standards was primarily attributed to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
In Oncology, recent Linac breakdowns and pharmacy staffing shortages have resulted in delayed treatment start dates.
Colorectal – Current activity complexity is causing delays in allocating surgery dates, e.g. the increase in anterior resections that require 2 surgeons.

Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce is ongoing and recruitment is underway.
OMF Capacity issues continue to impact both Head and Neck and particularly Skin pathway performance – escalated as a risk.

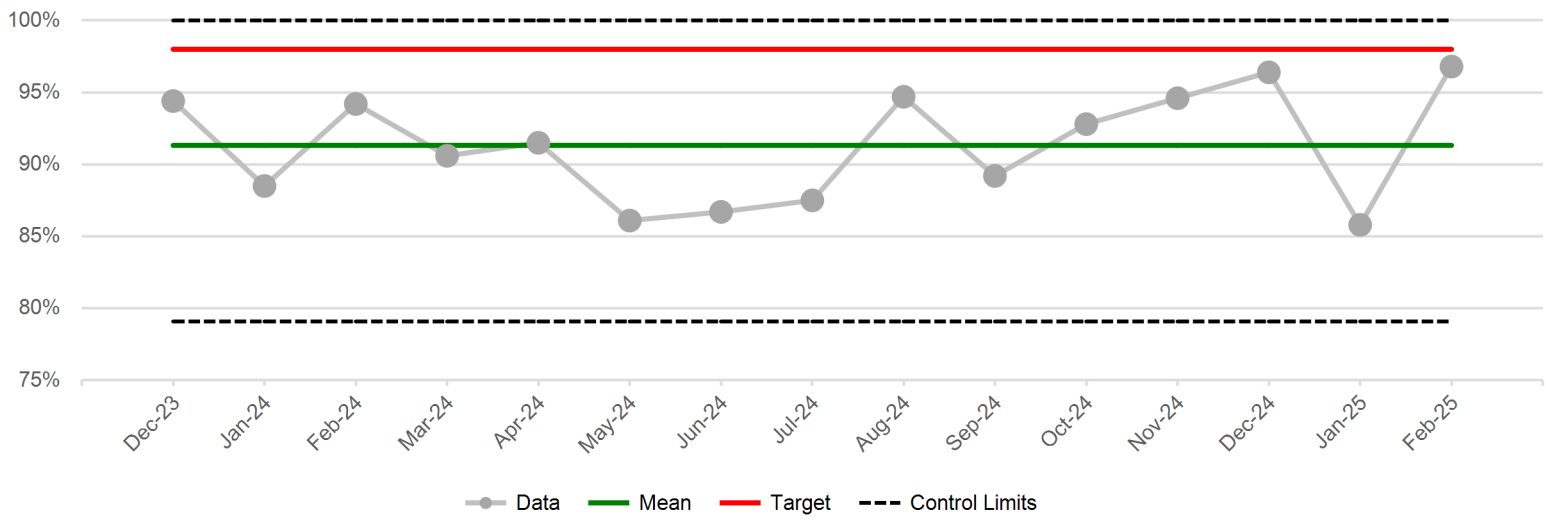
Mitigations:
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to pre-op and anaesthetic assessment capacity. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations.
In Dermatology, a Minor Op Clinic process review, alongside SpDr training, is underway to increase capacity. A training plan for Skin Surgery nurses to support with head and neck lesions is being developed.
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.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

31 day subsequent drug treatments



Feb-25
96.80%
Variance Type
Common cause variation
Target
98.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 96.8% against a 98% target.

Issues:
In Chemotherapy, staffing shortages, treatment capacity and recent pharmacy staffing shortages have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce is ongoing and recruitment is underway.
A deep dive is being undertaken to ensure shared access to information to ensure breach reasons and adjustments are recorded accurately.

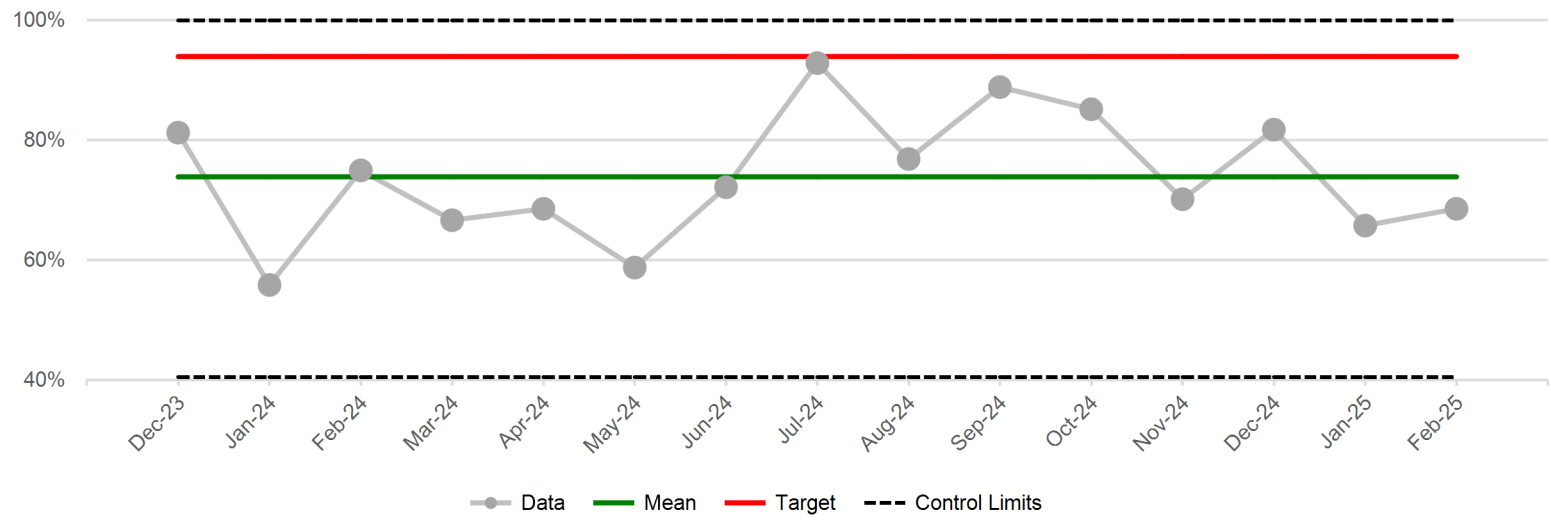
Mitigations:

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

31 day subsequent surgery treatments



Feb-25
68.60%
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.

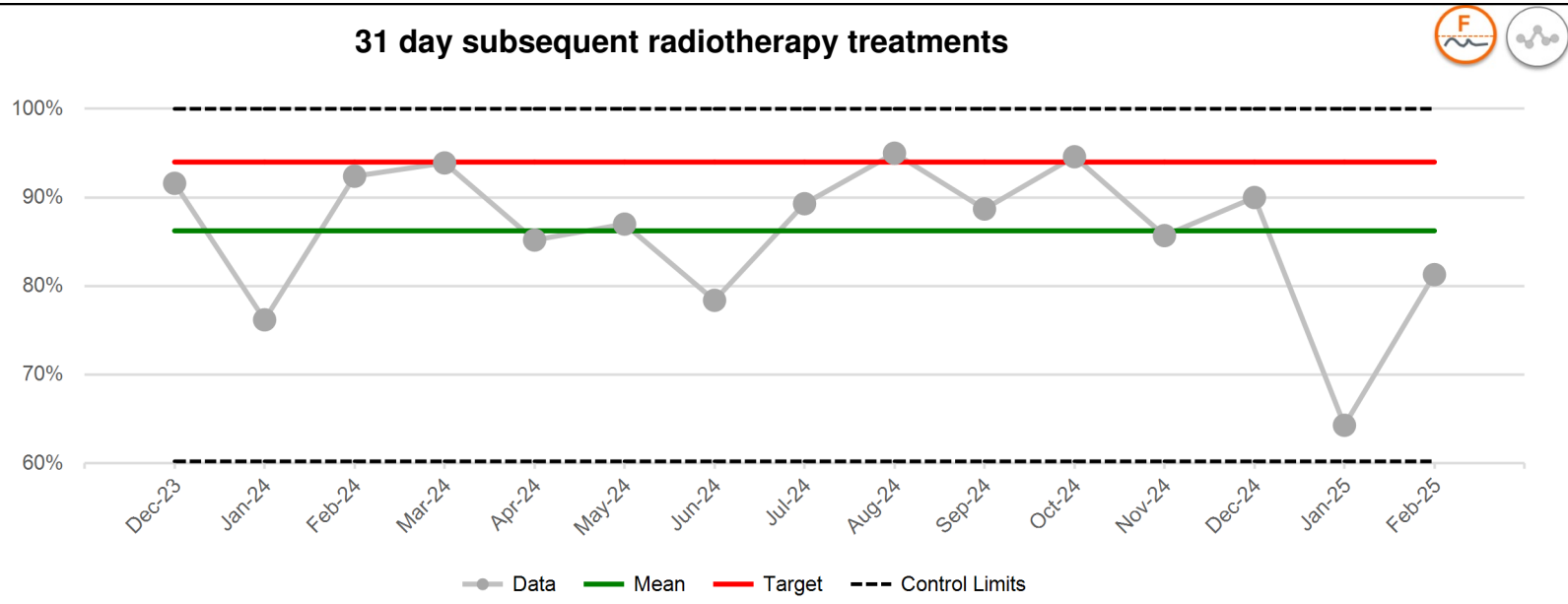
What the chart tells us:
We are currently at 68.60% against a 94% target.

Issues:
The failure of the 31 Day surgery standard was due to limited theatre capacity and limited AA and pre-op capacity impacts the ability to be able to populate lists at short notice.
Colorectal – Current activity complexity is causing delays in allocating surgery dates, e.g. the increase in anterior resections that require 2 surgeons.

Actions:
Theatre / Pre-op / AA Capacity – Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations. Theatre workforce issues have impacted capacity and lists remain difficult to populate at short notice if there are cancellations due to anaesthetic assessment and Pre-op capacity. These delays have been escalated and are being reviewed.

Mitigations:
In Dermatology, a Minor Op Clinic process review, alongside SpDr training, is underway to increase capacity. A training plan for Skin Surgery nurses to support with head and neck lesions is being developed.
In Head and Neck, an ENT consultant has recently commenced in post and further recruitment is under planning. Locum consultant currently taking on non-cancer Thyroid cases to release capacity for cancer.

Performance Overview - Operational Performance



Feb-25
81.30%
Variance Type
Common cause variation
Target
94.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 81.30% against a 94% target.
.

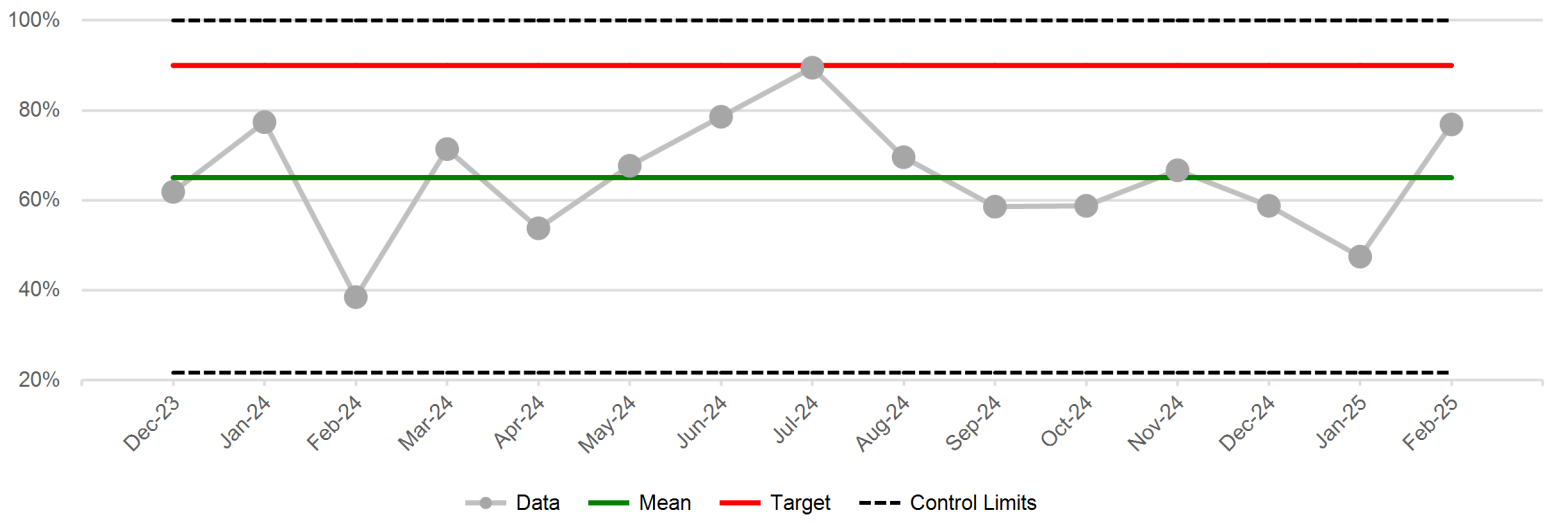
Issues:
Radiotherapy – Recent Linac breakdowns have resulted in delayed treatment start dates.

Actions:
Oncology Fragile Service - A piece of work on right-sizing the Oncology service workforce is ongoing and recruitment is underway.
A deep dive is being undertaken to ensure shared access to information to ensure breach reasons and adjustments are recorded accurately.

Mitigations:

Performance Overview - Operational Performance

62 day screening



Feb-25
76.90%
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 76.90% 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.

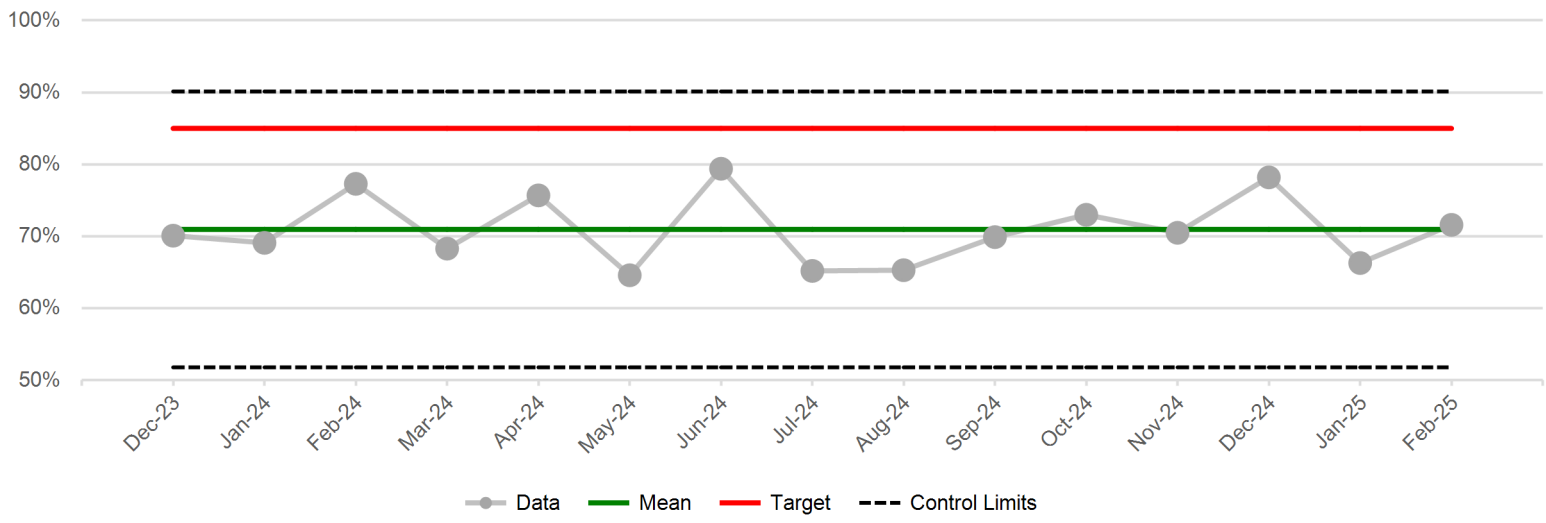
Actions:
Oncology Fragile Service – A piece of work on right-sizing the Oncology service workforce is ongoing and posts are out to advert.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations. Additional slots for cancer specialties to increase from 2 to 3 slots per day starting from July.

Please also see Actions on accompanying pages.

Mitigations:
Please also see Mitigations on accompanying pages.

Performance Overview - Operational Performance

62 day consultant upgrade



Feb-25
71.60%
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 71.60% 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 and posts are out to advert.
Robotic Lists are progressing well, though proving difficult to populate at short notice if there are cancellations due to the lack of trained staff within theatres, pre-op and anaesthetics. Tumour site specialties are working with TACC to ensure the best possible utilisation of lists, including a process for last minute cancellations. Additional slots for cancer specialties to increase from 2 to 3 starting from July.

Please also see Actions on accompanying pages.

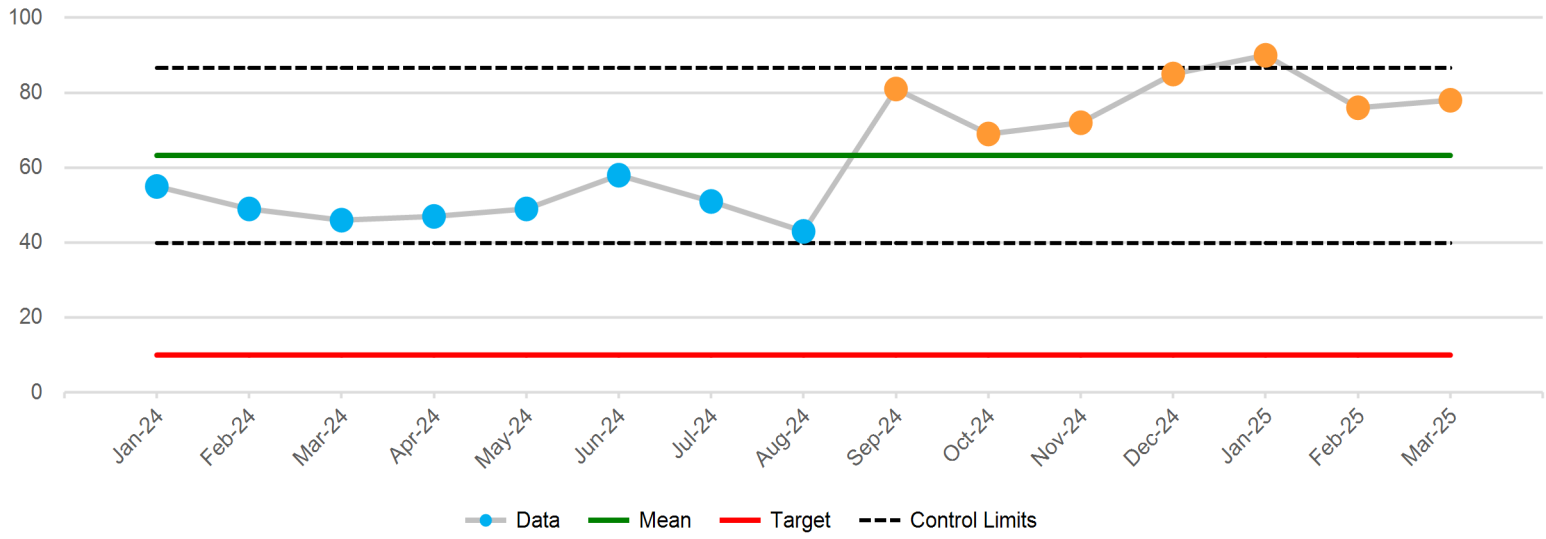
Mitigations:
Please also see Mitigations on accompanying pages.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Operational Performance

NHS United Lincolnshire Teaching Hospitals NHS Trust

104+ Day Waiters



Mar-25
78
Variance Type
Special cause variation - cause for concern (Indicator where high is a concern)
Target
10
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Chief Operating Officer

Background:
Number of cancer patients waiting over 104 days.

What the chart tells us:
As of 9th April the 104 Day backlog is at 78 patients.
There are 4 main tumour sites of concern:-

Colorectal 28
Head and Neck 14
Urology 11
Lung 10

Issues:
The impact of ongoing pathway, staffing and capacity challenges.
Patients not willing to travel to where our service and / or capacity is available.
Reduced OP, diagnostic and theatre capacity across the Trust, all Specialties vying for additional sessions.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Head & Neck, Gynaecology, and Lung.
Approximately 19.23% 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.

OUTSTANDING CARE personally DELIVERED

Performance Overview - Workforce

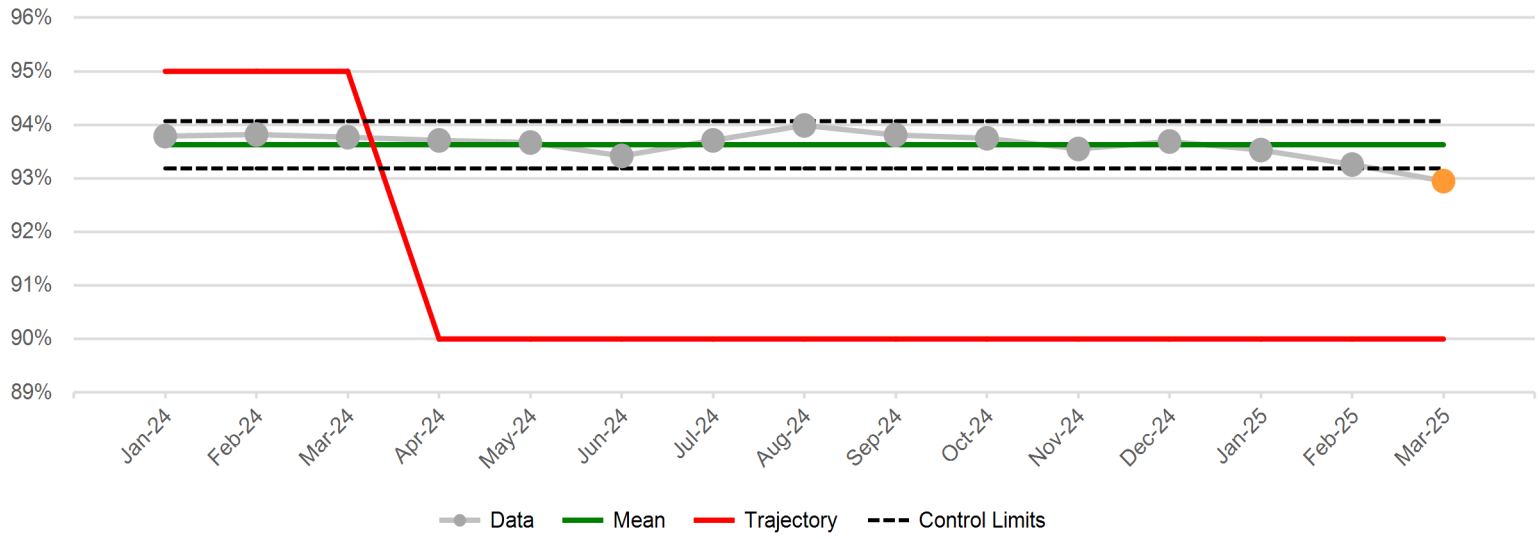
NHS United Lincolnshire Teaching Hospitals NHS Trust

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-25	Feb-25	Mar-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%	93.53%	93.26%	92.95%	93.59%	90.00%	P	L
	Number of Vacancies	Well-Led	People	Director of HR & OD	4.50%	6.10%	5.97%	6.21%	6.70%	6.91%	F	
	Sickness Absence	Well-Led	People	Director of HR & OD	5.50%	5.26%	5.28%	5.31%	5.31%	5.51%	P	L
	Staff Turnover	Well-Led	People	Director of HR & OD	9.00%	9.34%	9.47%	9.40%	9.85%	10.86%	F	L
	Staff Appraisals	Well-Led	People	Director of HR & OD	90.00%	78.31%	77.25%	76.50%	78.16%	83.39%	F	

Performance Overview - Workforce

United Lincolnshire Teaching Hospitals NHS Trust

Overall percentage of completed mandatory training



Mar-25
92.95%
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:
March 2025 reported Core Learning Rate is 92.95% against a Q4 target of 90.00%.

What the chart tells us:
That there has been a reduction in month., although still within target.

Issues:
Our biggest challenge is to offer time to our colleagues to be able to complete all mandatory training as required for the role they do.

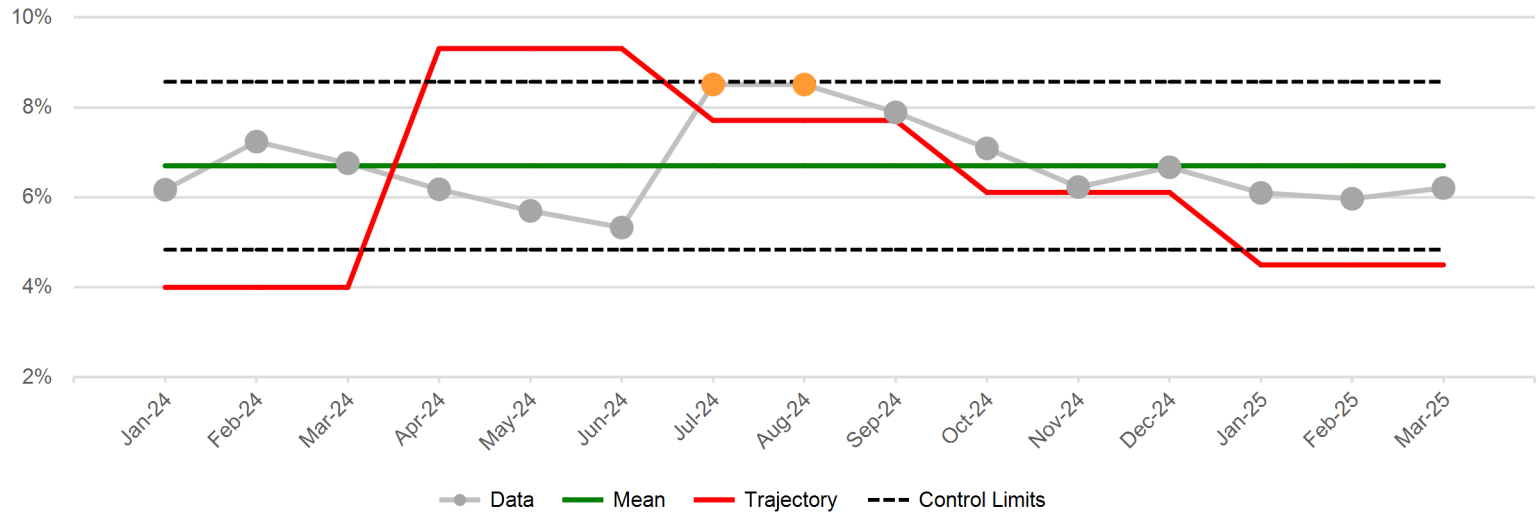
Actions:
• Report compliance rates in monthly performance meetings.

• Carry out deep dives where required to further understand trends.

Mitigations:
Work continues to ensure that all areas and individuals are given the time to complete core learning modules, with focussed support being offered to those with low compliance (50% and less).

Performance Overview - Workforce

Number of Vacancies



Mar-25
6.21%
Variance Type
Common cause variation
Trajectory
4.50%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
March 2025 reported Vacancy Rate is 6.21% against a Q4 target of 4.50%.

What the chart tells us:
That we are not within the Q4 target for although we are within 2% of year-end target.

Issues:
• The increase in vacancy rate in July 2024 was due to the budgets being finalised and translating into reporting.

• AHP recruitment remains an area of focus in response to the implementation of Community Diagnostic Centres.

Actions:
• Work is in progress to review our overall establishment with our Divisional Teams as we further develop Workforce Plans in response to the 2025/26 National Planning Guidance.

• Continued focus within key roles where the vacancy rate is largest. our Community Diagnostic Centres across Lincolnshire

Mitigations:
• Ongoing work to ensure compliance with Vacancy Rate targets, and to ensure that our establishment levels remain in line with our overall Workforce Plan.

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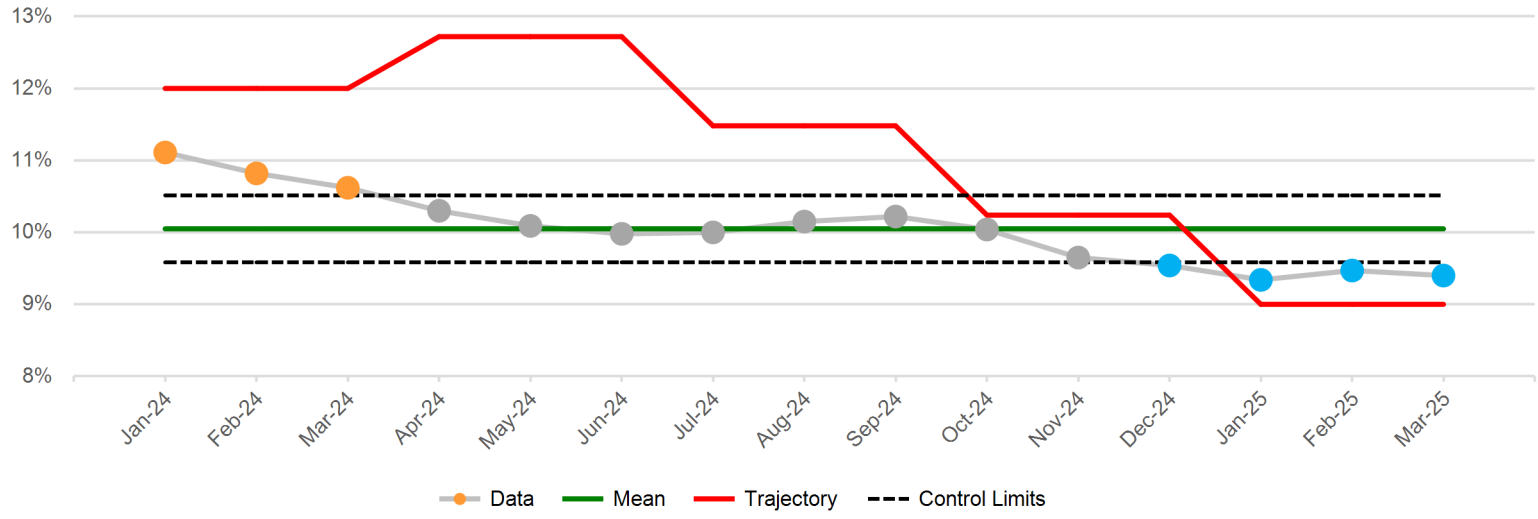
Performance Overview - Workforce

NHS United Lincolnshire Teaching Hospitals NHS Trust

Staff Turnover



Mar-25
9.40%
Variance Type
Special cause variation - improvement (Indicator where low is good)
Trajectory
9.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
March 2025 reported Turnover Rate is 9.40% against a Q4 target of 9.00%.

What the chart tells us:
That we have not achieved the target in month although are within tolerance levels.

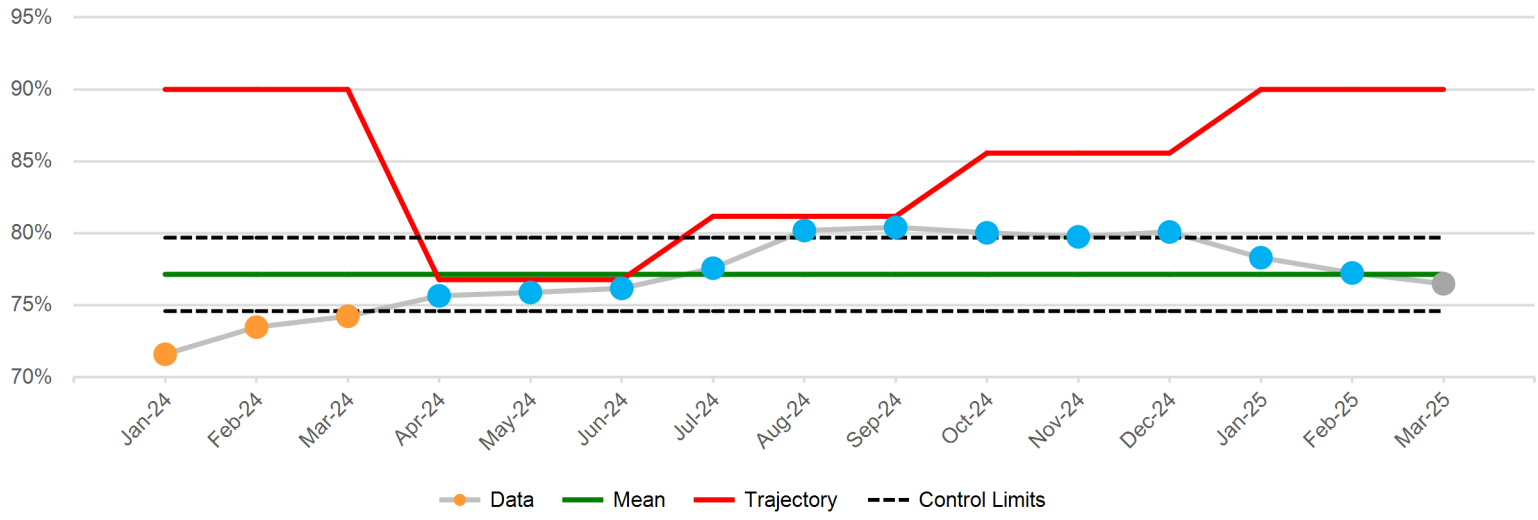
Issues:
Operational pressures, staffing and culture are continued challenges.

Actions:
With the introduction of the Equality, Diversity & Inclusion Group, Culture & Leadership Group, Education Oversight Group, and the refresh of the Workforce Strategy Group across Lincolnshire Community Hospitals Group (LCHG) there are additional platforms where retention of staff can be considered through various workforce lenses.

Mitigations:
Continue to monitor Turnover rate in lien with plan.

Performance Overview - Workforce

Staff Appraisals



Mar-25
76.50%
Variance Type
Common cause variation
Trajectory
90.00%
Achievement
Variation indicates consistently falling short of the target
Executive Lead
Director of HR & OD

Background:
Completion is currently 76.50% for Agenda for Change staff which is outside of the Q4 target of 90.00%.

What the chart tells us:
We are not meeting the quarterly target for AfC appraisal in month.

Issues:
- Increased accountability with Managers is needed for appraisal compliance across the Trust's leaders.
- A lack of protected time for the completion of appraisals.
- Service pressures and staffing challenges continue to have an impact on compliance.
- Area of improvement is required within Non-Medical staff groups.

Actions:
- Launched 90 minute appraisal 'how to' sessions to improve overall compliance.
- Ensuring that all completed appraisals have been captured in ESR.
- Raising awareness of the importance of an appraisal with a focus on areas of low compliance.
- Paper approved by our Executive Leadership Team with approval given to move to an annual cycle in line with other Trust Reporting and Planning.
- Contacting staff and team managers who are <50.00% for compliance.

Mitigations:
See actions, and continued focus with Divisions through robust monthly monitoring.

In addition, in 2025/26 we will be introducing an appraisal cycle window which supports staff having their appraisal in Quarter 1. This is expected to improve the position, and mirrors best practice seen within our Group Model.

NHS
Lincolnshire Community and Hospitals NHS Group

LCHS Integrated Performance Report (March Data)

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

Meeting	*Integrated Performance Report*
Date of Meeting	*6th May 2025*
Item Number	

Report Title

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	
Author(s)	*STORER, Ben*
Recommendations/ Decision Required	*The Board is asked to:-*

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

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

Executive Summary

Performance up until the end of March is set out in the report. The Quality Committee and Finance, Performance, People, and Innovation Committee reviewed January performance in their April meetings.

The number of metrics in each cell in the SPC grid is as follows:

Target Capability	SPC Variation: Special Cause Improvement	SPC Variation: No Variation	SPC Variation: Special Cause Deterioration
Consistently Capable	2	10	0
Inconsistently Capable	0	13	2
Not Capable	2	1	0
No Target	1	18	0

3 indicators are not statistically capable of achieving performance targets without redesign:

1. Home Visiting

The compliancy for Home Visiting continues to improve as demonstrated, however we are still working through a process for validating the breeches for Home Visiting and after manual breach validation for March the overall compliance is 85% (urgent 84% and less urgent 88%). The activity is reflective of that seen in CAS. The Home visiting service will work collaboratively with the UCR service on a pilot basis effective from 15.04.25.

2. Ethnicity recording in A&E data sets.

As reported previously changes to this process were being made to stop using local codes for ethnicity not stated and remove old codes.
Issues have been identified where SystmOne doesn't export patient's ethnicity if the data is not something added by the user onto the system. This has caused problems with us being unable to pull our ethnicity activity from within the extract. The months during July and August where we reported 100%, were due to a miscommunication between ourselves and NHS England during the validation period, where we were advised to reset blank ethnic codes. Since discovering these inaccuracies, we have resubmitted our activity and it is now reflected on a new download from SUS.

The increase from 67% to 87% is through a process developed to download an extra patient dataset from SystmOne which reports on Ethnicity for all patients. Following this validation process, 87% is a more reflective position on actual completion. Further work is still required with our UTC colleagues to continue to work towards improving the collating of our ethnicity data at the point of source.

We have initiated a new Data Quality system "RINSE" introduced to support managers to monitor and manage who hasn't completed ethnicity population. The FBI team continue to with digital health to ensure that any SOPs or training emphasis' the importance of completing the data.

3. Patient Incidents

The graph shows LCHS patient safety incidents per 1000 WTE from 1 November 2023 to 31March 2025. The sharp decrease is because as of May'24, only patient safety incidents related to LCHS are being reported on the divisional dashboards and therefore the benchmarking chart that is being submitted into Quality Committee was re-aligned. The benchmarking data is always available on the 10th of each month, and it will therefore be added to the graph retrospectively every month.
At the time of reporting:

- CYPSS & IUEC are meeting trajectory around overdue Datix. The remaining divisions are taking actions to realign to trajectory by weekly quality review meetings with leadership oversight.
- Duty of a candour continues to be tracked weekly. There continues to be improvement in the timeliness of Duty of Candour compliance.
- There are zero Never Event investigations ongoing, nor have any been declared.

2 indicators are showing special cause deterioration currently:

1. Ops Centre Calls: Abandoned

March 2025 saw 16,625 calls come through the Ops Centre, compared to 14,994 in March 2024 – an 11% increase as well as this we saw 7,759 emails into ops compared to 6,542 March 24 which is a 19% increase YoY.
Our average daily contacts were 743 (calls and emails) in March 24 increasing to 787 in March 25 a 6% increase
Priority calls were answered at 70% within SLA (3% increase on Feb 25) and Standard calls were above the SLA and achieved a strong month 87% (4% up on Feb 25) within SLA abandonment rate reduced by 0.5% to 12.4% whilst all email contacts achieved the SLA. (100% within SLA) at 7759 answered emails with an average email handling time of 03:57 (March 25) compared to 05:39 in March 24.

Focus continues to be around how we can work differently and more efficiently to mitigate the impact of the current vacancies on performance.

2. Average Length of stay

We have had a recent peak of quick turn around patients who have reached the end of their rehab journey and reached discharge. Unfortunately this comes with the ebb of patients requiring rehab to return home, with a particularly complex patient at Scotter Ward who is the result of increased LoS. We also have a number of other very complex patients with elongated lengths of stay which are affecting the figures. They remain subject of daily discussions to progress their discharge.

5 indicators are currently showing special cause improvement, which is a strong indication of our continuous improvement culture:

1. Patient Incidents per 1000 WTE;
2. GU Patients seen within 2 working days;
3. Staff Turnover;
4. Virtual Wards: Cardiology Referrals
5. Ethnicity in A&E Data Sets

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

Purpose

Key messages

Conclusion/Recommendations

Lincolnshire Community Health Services NHS Trust

INTEGRATED PERFORMANCE REPORT

March 2025 Performance Data

Contents

SPC Scorecard

E4B2:F23B2:F20B2:F18B2:F17B2:F15B2:F14B2		SPC Variation		
		Special Cause Improvement	No Variation	Special Cause Deterioration
Target Capability	Consistently Capable	GU Patients seen within 2 working days Staff Turnover	UTC Discharge Summaries MRSA Screening Vacancy Rate Environmental Cleanliness Community Hospital Falls per 1000 OBDs Community Hospital Bed Occupancy Training Compliancy Completion Of NHS Numbers for A&E Data Sets Chlamydia Screening Positivity Rate Compliance Vacancy Rate	
	Inconsistently Capable		Complaints - Rate per 1000 WTE Injurious Community Hospital Falls per 1000 OBDs Friends & Family Test Long Term Sickness Sickness Absence 15 Minute Ambulance Handover Urgent Community Response - 2-Hour Response Better Payment Practice Code UTC 4 Hour UTC 15 minute Assessment Ops Centre Calls: Answered in Timescale Agency Expenditure Community Hospital Discharge Summaries	Ops Centre Calls Abandoned Average Length of Stay
	Not Capable	Patient Incidents Per 1000 WTE Ethnicity in A&E Data Sets	Home Visiting Compliancy	
	No Target	Virtual Wards: Cardiology Referrals	Discharge to Assessment: Distinct Patient Contacts Discharge to Assess Accepted Referrals Ops Centre Calls Answered UTC Activity Urgent Community Response - Accepted Referrals Out of Hours and CAS Cases Closed Home Visiting Activity CAS Activity Total Medication Incidents Transitional Care Activity Complaints Compliments Overdue Datix Children in Care Community Hospital Pressure Ulcers - Rate per 1000 OBDs (C2, C3 & C4 CHPPD Community Pressure Ulcer - Rate per 1000 contacts (C2, C3 & C4 Total Falls	

Executive Summary

Safe

✓ Total LCHS Patient Medication Incidents has decreased this month from 54 in January to 45 in March

✓ Total Community Hospital Falls performance rates per 1000 OBD on target.

✓ Injurious Community Hospital Falls performance rates per 1000 OBD below March benchmark

✓ MRSA compliance achieving target.

X Patient Incidents Community Rate per 1000 WTE increased from 233.03 in February to 249.72 in March and is above the benchmark.

Caring

X FFT scores not achieving 95% target.

X Complaints have increased from previous month.

✓ Compliments increased from previous month.

Responsive

X Performance against the UTC targets-4-hour waits is not achieving the 95% target, however March's performance was 93.79%

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.

X Urgent Community Response is not achieving the 97% target for 2-hour response compliance.

X Ops Centre Calls Answered in Timescale is not achieving 90% target.

X Ops Centre Calls Abandoned is not achieving 8% target.

X Discharge Summaries – Community Hospitals, not achieving target.

✓ Discharge Summaries – Urgent Treatment Centres achieving target.

Effective

✓ Chlamydia positivity rate of 15-24 years old achieving target.

✓ LiSH GU patients seen within 2 working days continues to meet target.

X Community Hospitals Pressure Ulcers rate per 1000 OBDs – reporting above the benchmark.

✓ Environmental Cleanliness achieving target.

✓ Bed Occupancy rate achieving 91% while the target is at 85%.

X Average Length of Stay is not achieving the 16 Day target

Well-Led

✓ Valid NHS Numbers for A&E Data Sets achieving the 95% target.

X Ethnicity in A&E Data Sets not achieving 95% target

✓ Staff Turnover is within the 15% target.

✓ Year to date agency expenditure is within plan.

✓ Month 12 Trust's YTD surplus is a £31k favourable variance to plan.

✓ Overall efficiency (CIP) ahead of plan.

✓ Cash balances are ahead of the original plan

X Better Payment Practice Code (by volume) is not achieving the 95% target

✓ Capital expenditure is ahead of plan.

✓ Vacancy rate within the 8% target and beating the national benchmark.

✓ Training Compliance is achieving the 90% target.

X Total Sickness Absence is not achieving the 5% target.

X Long-Term Sickness Absence is not achieving 3% target.

Medicine-related Incidents

Background

Medication is one of the most common medical interventions. LCHS deals with medicines on a day-to-day basis. LCHS has robust polices, training programmes and audit to ensure medicines are managed safely. Due to the high volume of activity involving medicines, complexity of the procedures and the human component, some medicine-related incidents do occur.

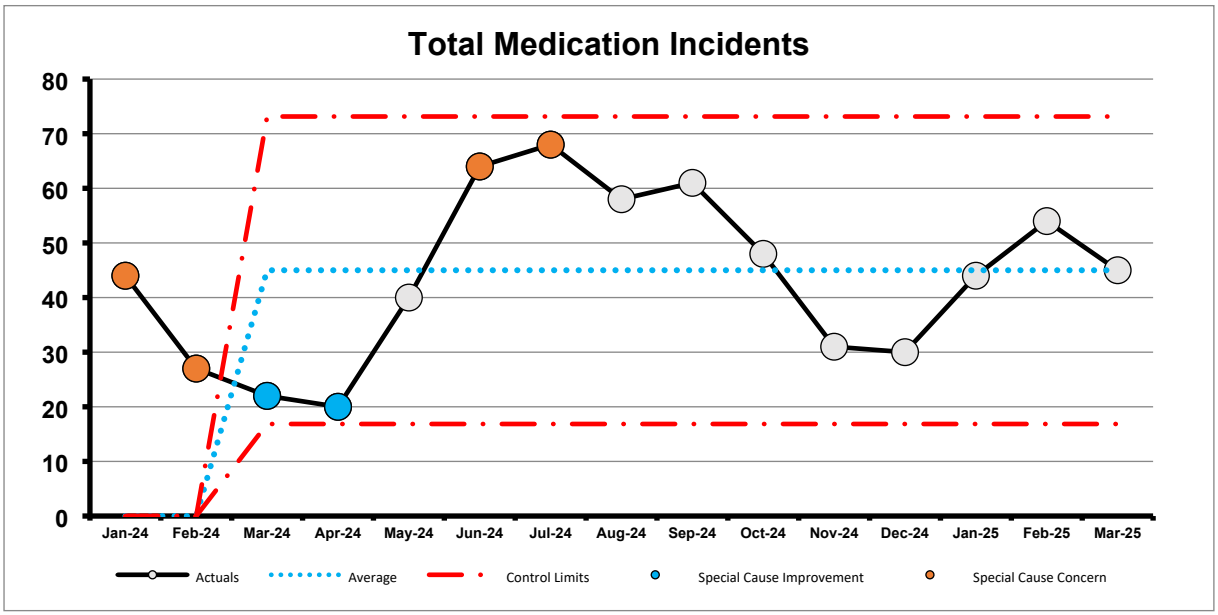
A medicine-related incident can pose a threat to the patient as well as the organisation. The member of staff who made the error can also be affected. Broadly speaking, medicine-related incidents encompass prescribing, preparation, dispensing, administration, and monitoring.

Reducing medicine-related incidents across the Trust remains an ongoing improvement priority.

Benchmark / Target

NHS Benchmarking have not yet published the community dataset for the reporting period.

Current Performance



Narrative

In LCHS, Co-operative pharmacy is the contracted pharmacy service provider to our community hospitals. There is an emerging theme around administration of time critical medication. To mitigate this, the in-house medicines management pharmacy team supported the community hospitals and the contracted pharmacy service provider to develop and implement processes to ensure that time critical medications are administered within a defined time frame. Work has commenced to strengthen the guidance within the medicines policy and introducing fit for purpose audits within community hospitals that will track practice. Clinical staff have been encouraged to complete a Datix whenever time critical medications are administered outside the defined time frame. This has led to a significant increase in the number of incidents reported in June & July when compared to previous months. Administration of time Critical medicine incidents will continue to be tracked to ensure that improvement is embedded & sustained. Examples of time critical medicines include antiparkinsons, psychotropics, blood thinners such as warfarin and antiepileptics.

The inhouse pharmacy team has worked closely with the effective practice facilitator to ensure that time critical medicines are covered in the medicines management training.

LCHS have employed an Associate Chief Pharmacist who is also the trusts medicines safety officer. Part of this role entails improving the reporting and learning from medication incidents. He has been attending various steering groups reiterating and reinforcing the importance of encouraging staff to report medicines related incidents. He also supports teams with action plans ensuring that learning is cascaded and used to improve practice.

SPC

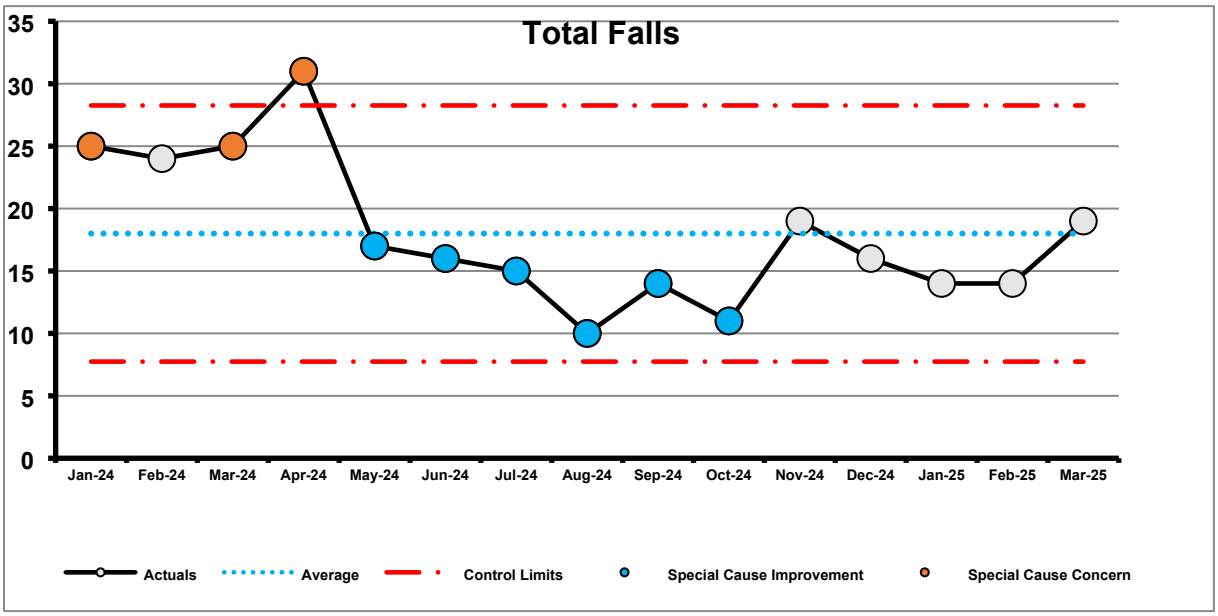
SPC shows that the Trust's total medication incidents have not varied significantly in the period.

Total Trust Falls

Background

A fall can be devastating for a patient, not least because it can cause ‘distress, pain, injury, loss of confidence, loss of independence and increased morbidity and mortality’ (Source: The incidence and costs of inpatient falls in hospitals, NHS Improvement June 2017).
The graph below shows the total falls across the Trust.

Current Performance



Narrative

We see a month with about average falls. To strengthen personalised falls care planning templates on S1 are in the process of being reviewed to facilitate this.

SPC

SPC shows that the Trust’s total falls have not varied significantly in the period. Showing common cause no variation.

Falls in Community Hospitals

Background

Falls take place in many services, but most falls take place in our community hospitals where the patients have additional levels of frailty and health related conditions which pose additional risk of falling whilst unwell and in an unfamiliar environment.

Falls are categorised and captured as the following: -

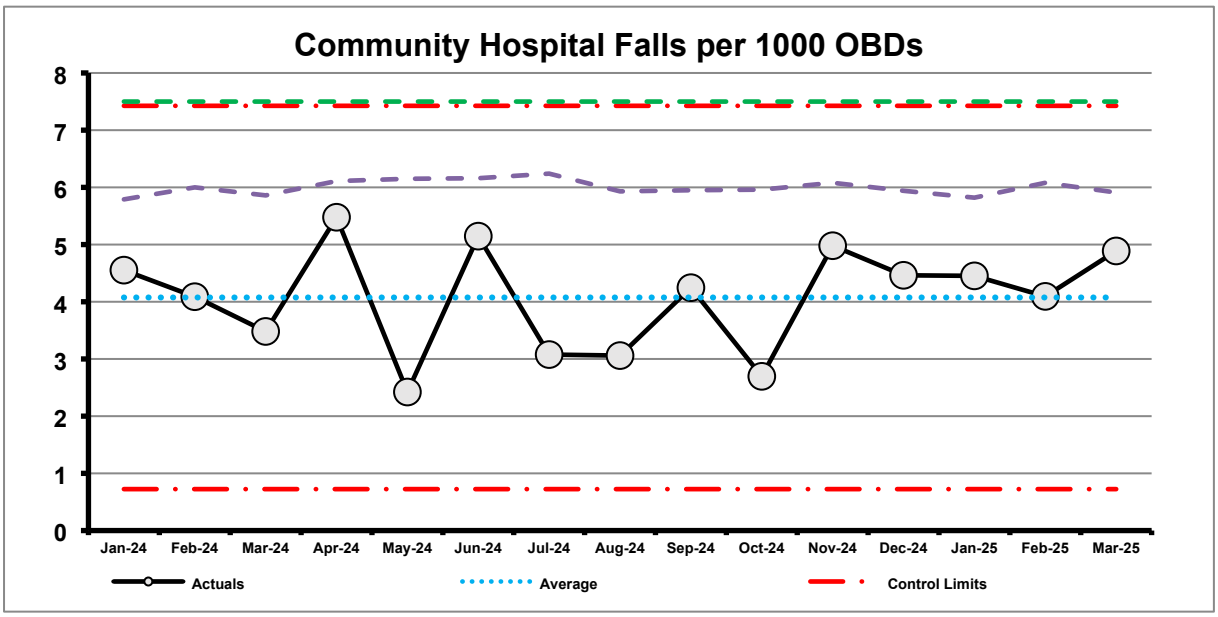
- Fall from a height / bed / chair (these falls tend to result in the highest level of injury of harm
- Slip / trip / fall on level ground.
- Supported lower to ground/ bed / chair / other (many of these are during direct patient care or therapeutic interventions)

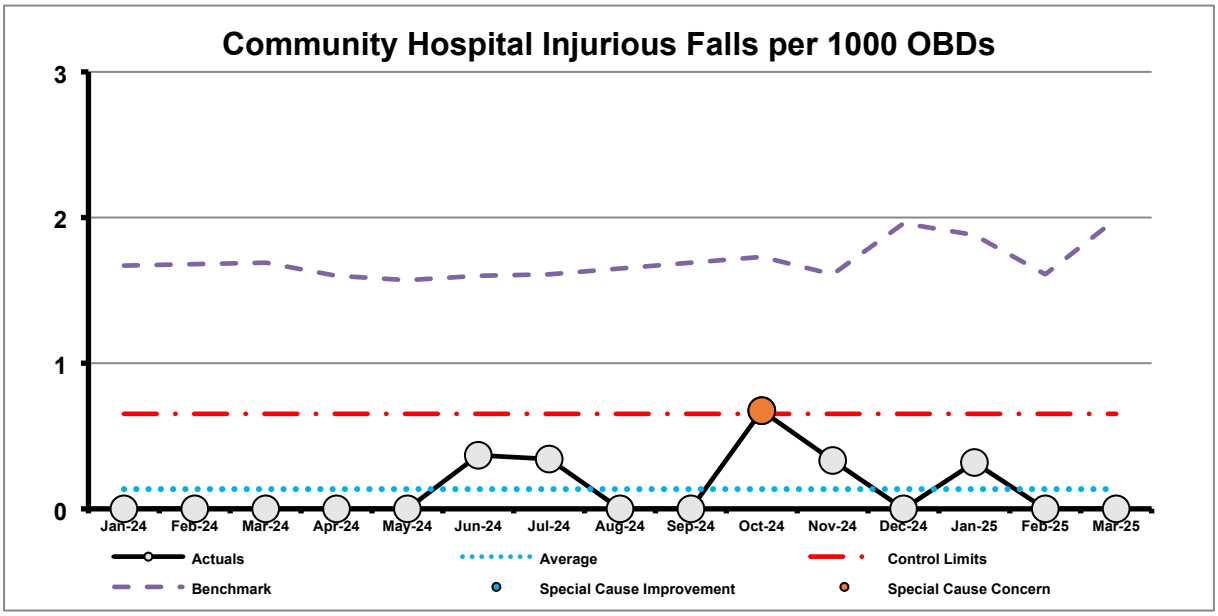
Benchmark / Target

There are 2 benchmarks available for falls within Community Hospitals. Both are measured on a 6-monthly average per 1000 OBD and are both in the Community Trust Benchmarking group.

The latest available monthly benchmark for all Community Hospital falls is 5.91. The latest monthly benchmark of injurious falls is 1.99.

Current Performance





Narrative

We are also beginning to roll out a Falls Training Package from NHS England, starting with Welland Ward, which we are hoping will reduce these. There are no other changes to note the slight increase this month, but further proactive work is on-going in the background, including a new falls SOP for CoHo which the training is a part of.

SPC

Community Hospital Falls per 1000 OBDs

SPC shows the Community falls per 1000 OBDs have not varied over the period.

Community Hospital Injurious Falls per 1000 OBDs

SPC for Community Hospital Injurious falls per 1000 OBDs shows common cause no variation for March 2025.

MRSA Screening

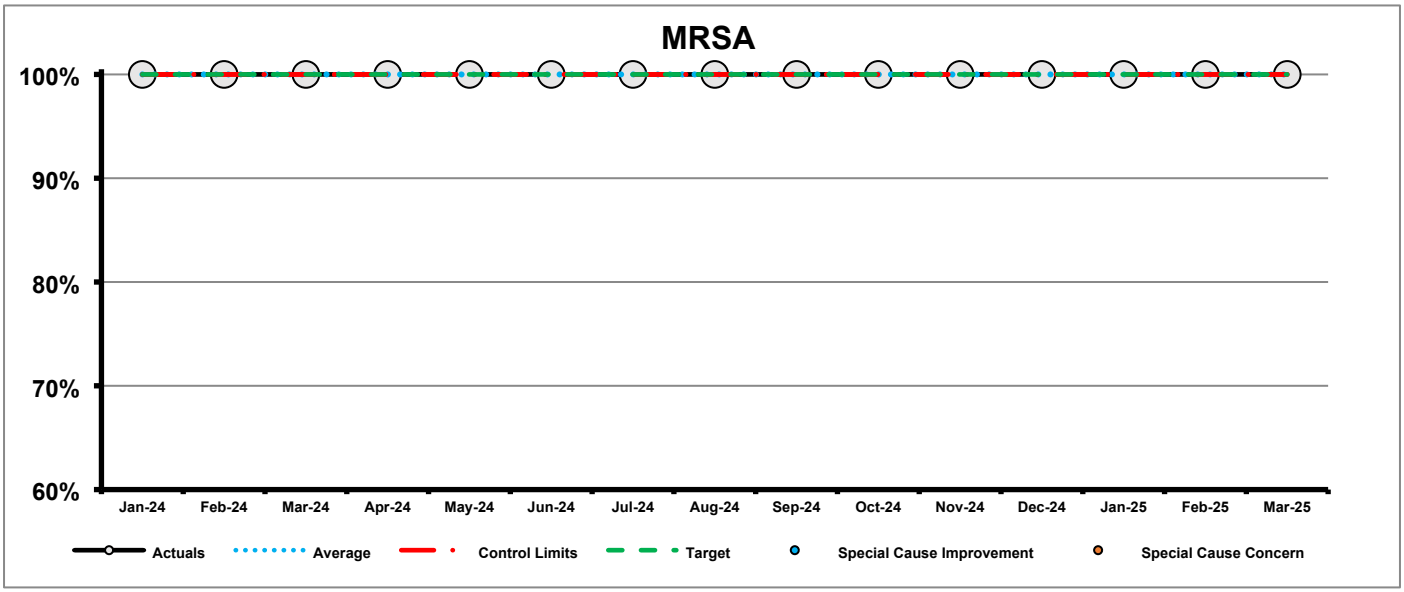
Background

The Trust undertakes targeted MRSA colonisation screening for inpatients and surgical patients in line with the DH “Implementation of modified admission MRSA screening guidance for NHS (2014)”.
The guidance advocates that those patients previously identified as MRSA positive, and those patients admitted to high-risk units are screened.
Across LCHS those patients known to be previously MRSA positive or from high-risk groups are identified on admission/or at pre-admission screening and
necessary infection prevention risk management strategies applied.

Benchmark / Target

The target range for screening is 100% of eligible patients.

Current Performance



Narrative

Of the 144 patients admitted across all sites, 15 patients were eligible for MRSA screening, of which all 15 were screened.

SPC

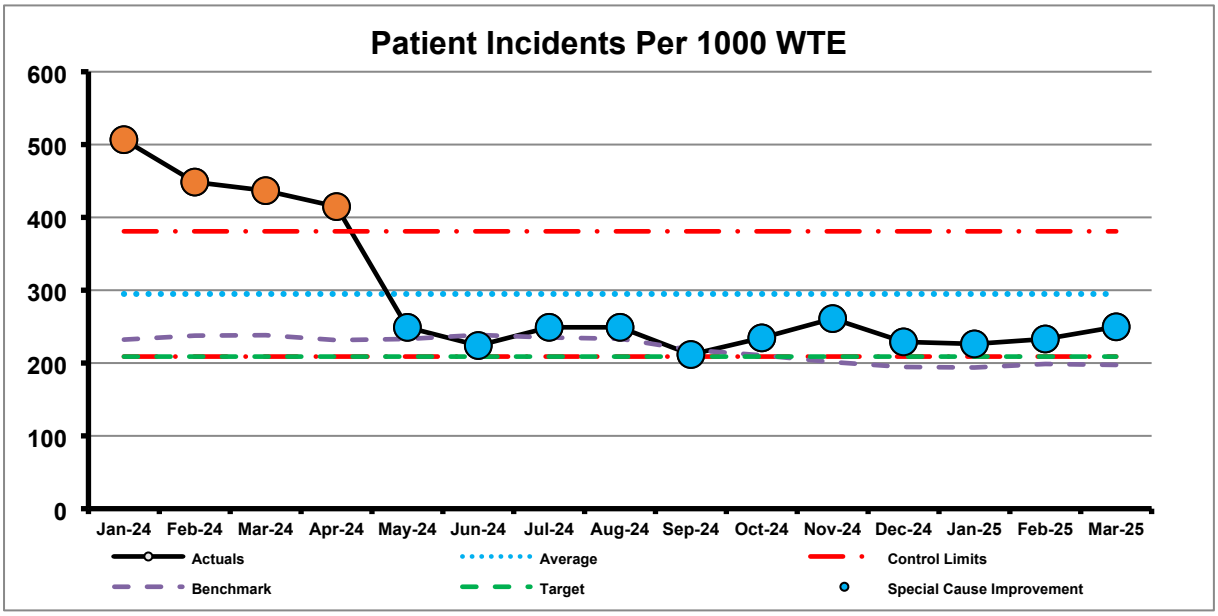
SPC shows MRSA screening compliance has not varied over the period.

Patient Incidents

Background
From 18 June 2017 NHS Improvement moved from six monthly reporting and began publishing monthly data by reporting organisation on the numbers of incidents reported to the National Reporting and Learning System (NRLS).

Benchmarking / Target
LCHS has been consistently a high reporter of incidents using the Datix system.
The latest available 6 monthly average numbers of incidents per 1,000 WTE staff in the Community Trust Benchmarking group was 197.38.

Current Performance



Narrative

- The graph shows LCHS patient safety incidents per 1000 WTE from 1 November 2023 to 31March 2025. The sharp decrease is because as of May'24, only patient safety incidents related to LCHS are being reported on the divisional dashboards and therefore the benchmarking chart that is being submitted into Quality Committee was re-aligned. The benchmarking data is always available on the 10th of each month, and it will therefore be added to the graph retrospectively every month.
- At the time of reporting:
  - CYPSS & IUEC are meeting trajectory around overdue Datix. The remaining divisions are taking actions to realign to trajectory by weekly quality review meetings with leadership oversight.
  - Duty of a candour continues to be tracked weekly. There continues to be improvement in the timeliness of Duty of Candour compliance.
  - There are zero Never Event investigations ongoing, nor have any been declared.

Actions

Each Service Line reviews the incidents monthly at their Quality Scrutiny Group meetings to identify any trends and themes.

The themes are considered to support triangulation of themes from incidents, claims, serious incidents, complaints, and other quality datasets.

Upgrade and redevelopment of the Datix system to Datix IQ is currently being implemented to bring LCHS in line with ULHT partners.

SPC
Patient Incident SPC has shown special cause improvement since May 2024.

Community Pressure Ulcers – Rate per 1,000 contacts

Background
All pressure ulcers grade's 3 and 4 are classified and recorded as serious incidents. There is no distinction between avoidable and unavoidable in cause.

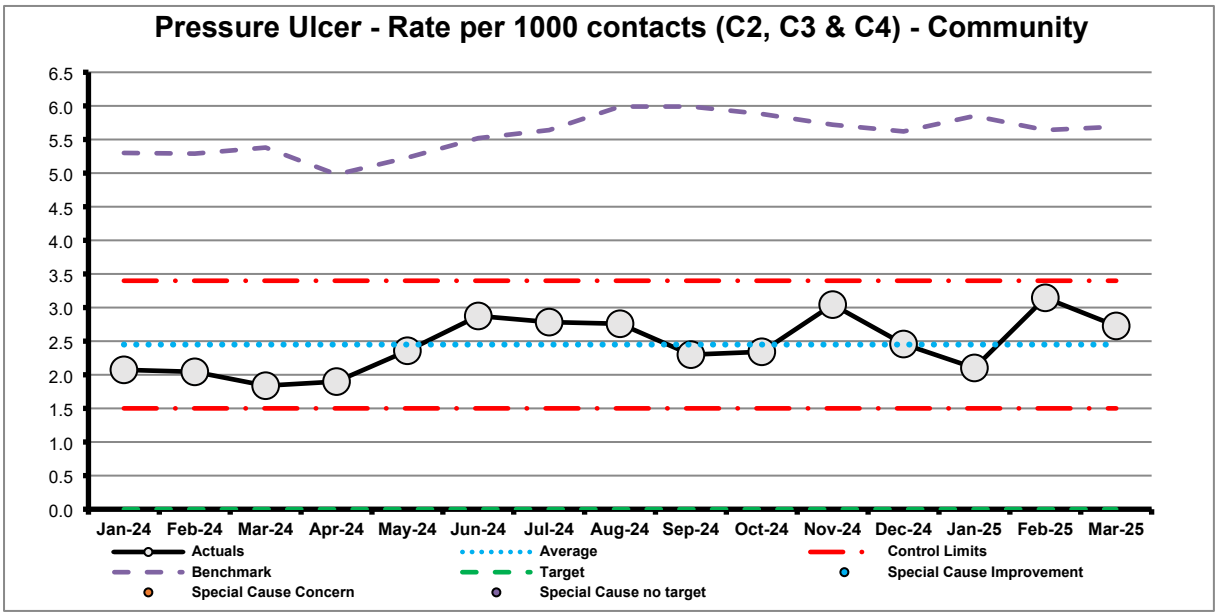
Reduction in patient harm related to pressure damage is the highest priority objective for the Lincolnshire Safeguarding Adults Board.

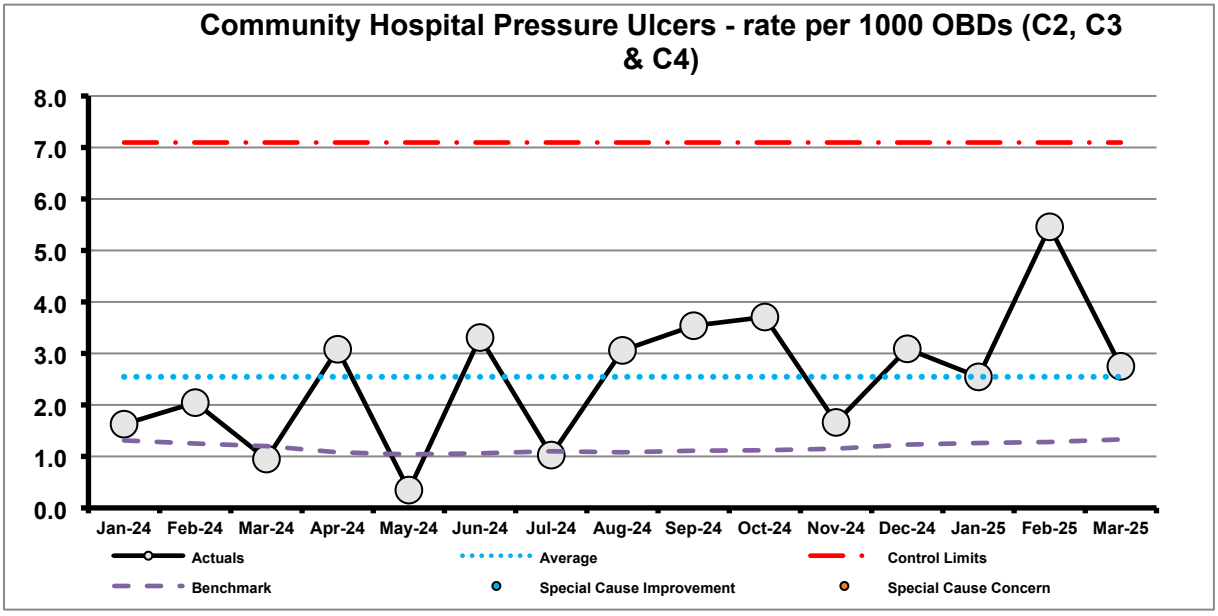
The Lincolnshire System Quality Group have agreed their first quality priority to be pressure damage – eradication of harm, standardising and improving care.

Benchmark
Benchmarking will continue to be calculated in community teams by 1,000 patient contacts – currently the national benchmark is 5.69.

Community Hospital benchmarking is calculated by 1000 Occupied Bed Days (OBDs) – currently the national benchmarking rate is 1.33.

Current Performance





Narrative for Community:

Ongoing work on PU across all Community Nursing Teams. Weekly PU audit continues to show improvements in PU care and prevention.

Narrative for Community Hospitals:

Since the change to reporting standards a new average needs to be established. Community Hospitals continues on the same trajectory as previous months.

SPC

Pressure Ulcers - rate per 1000 contacts (C2, C3 & C4) – Community
SPC for Pressure Ulcer rate/1000 there has been a slight decrease for the reporting month of March and shows common cause no variation.

Pressure Ulcers – rate per 1000 OBDs (C2, C3 & C4) - Community Hospitals
SPC shows Community Hospital Pressure Ulcers – rate per 1000 OBD has shown a decrease during the reporting month, showing common cause no variation.

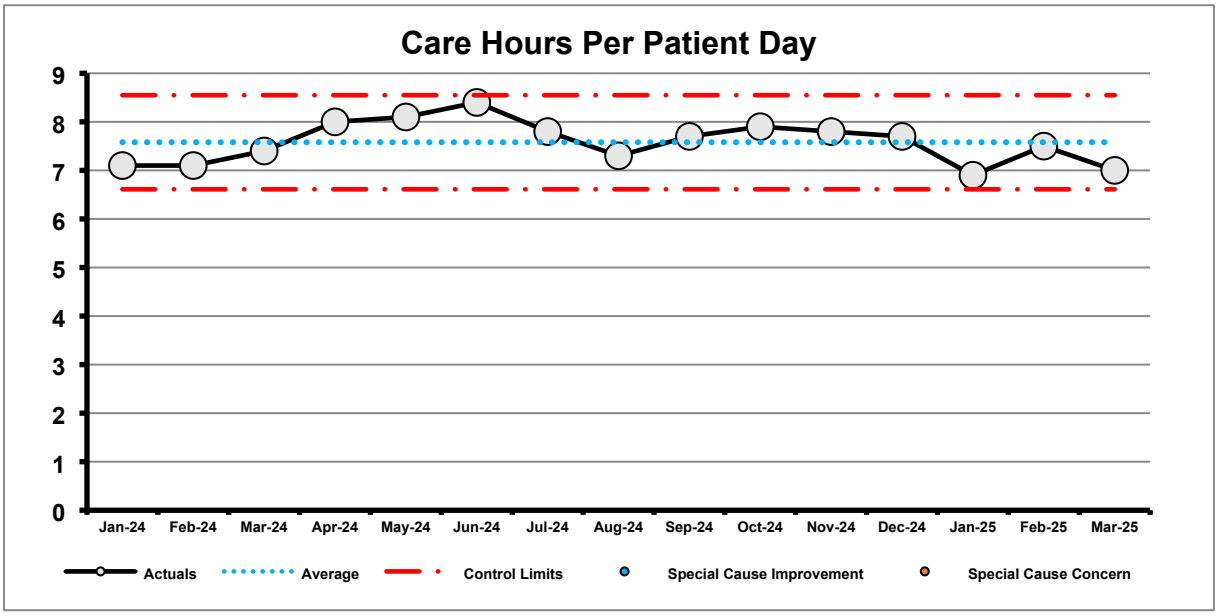
Care Hours Per Patient Day (CHPPD)

Background
Care Hours per Patient Day (CHPPD) is a simple calculation derived from dividing the number of actual care hours provided by the number of inpatients in a 24-hour period used as measure across inpatient areas.

While it is recognised that the needs of patients using these community services are often quite different, the CHPPD measure provides a representation of the number of care hours available to patients and is a measure that enables wards/units of a similar size, speciality, and patient group to be compared.

Benchmark / Target
There is no available benchmark – NHSEI have confirmed this will not be progressed.
There is no agreed target, but the CHPPD rate should be considered alongside other quality and safety metrics contributing to safe staffing.

Current Performance



Narrative

Awaiting narrative for March

SPC

Care hours per patient day shows no significant variation over the period and is within the control limits.

Patient Facing Time

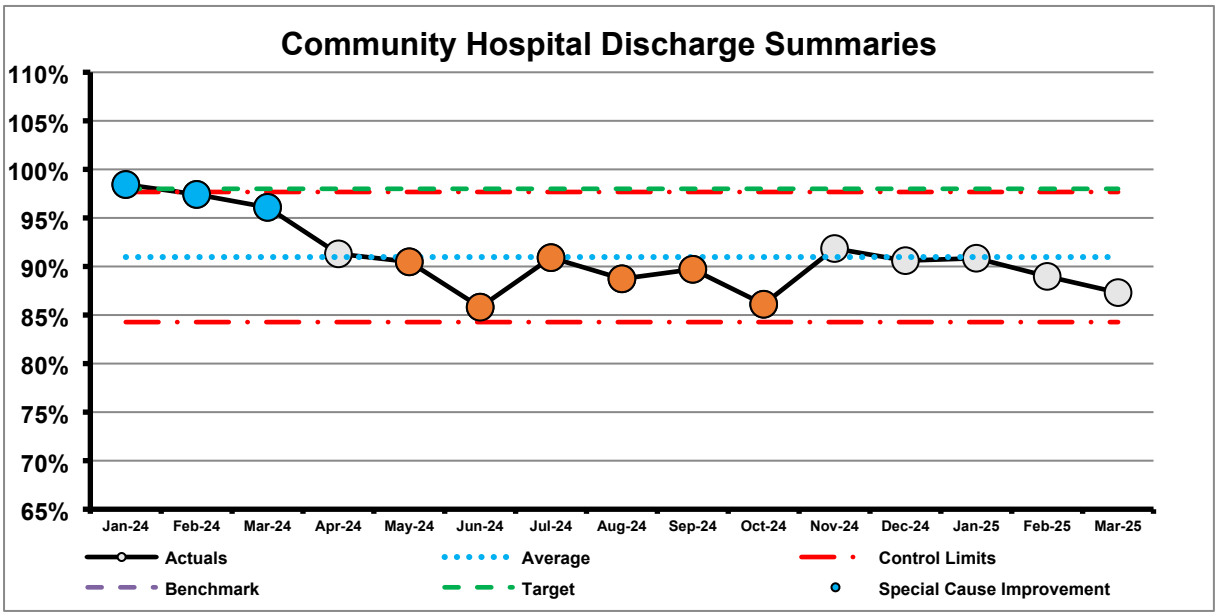
The process for capturing the data to report PFT and the relevancy of the metric is under review.

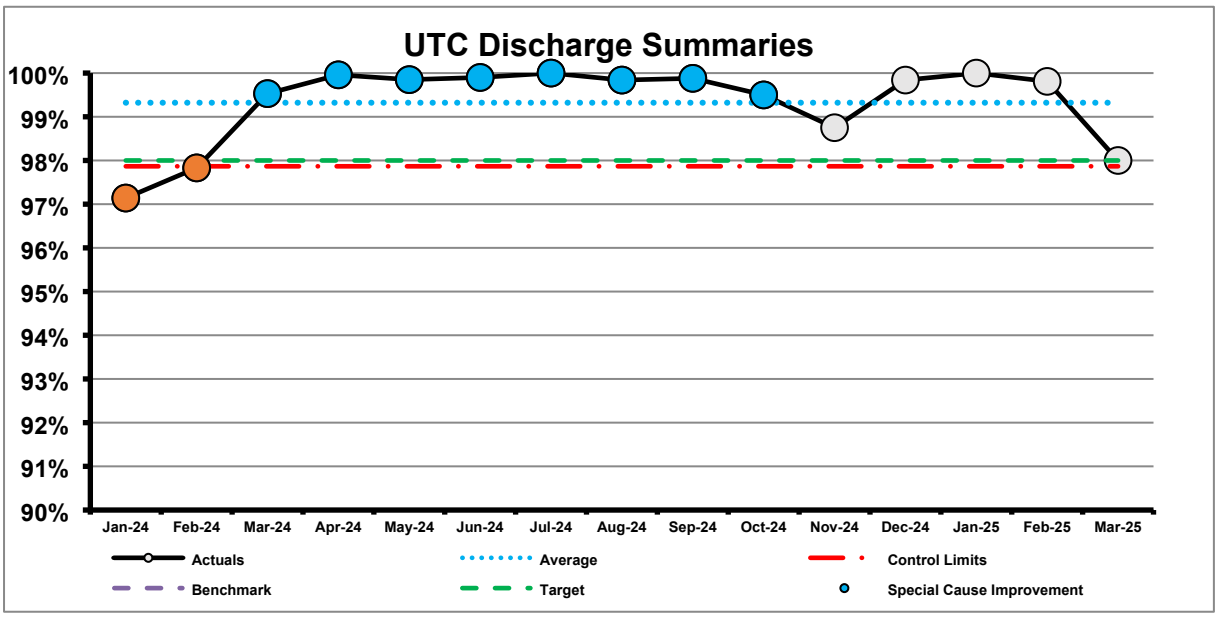
Discharge Summaries

Background
It is a requirement of the Quality Schedule part 6 to the NHS Standard Contract that discharge summaries issued by the ward doctor are issued from Community Hospitals to the patients GP within 24 hours of discharge. As the Trust medical staff currently work Monday to Friday this performance measure is adapted.

Benchmark / Target
Discharge summaries should be issued by the ward doctor in Community Hospitals to the patients GP within 24 hours of discharge – target 98%.

Current Performance





Narrative

Community Hospitals

Working as an MDT the Community Hospitals are seeking to address this with clearer ownership of responsibilities in the process. Community Hospitals are seeking further support for Patient Flow which would improve resilience around this process.

Urgent Treatment Centres

The discharge letter back to the GP's remains stable with a slight drop in percentage to 98% from 99% previous month. This was around Spalding that achieved 96%, we are scrutinising Spalding UTC to ensure the discharge letters get sent back to the GP's in a timely manner

SPC

Discharge Summaries - Community Hospitals
SPC Community Hospital Discharge Summaries has not varied significantly for this period and is showing common cause no variation.

Discharge Summaries – Urgent Treatment Centres
UTC Discharge Summaries has shown a very slight reduction variation in the period.

Overdue & Reported Datix

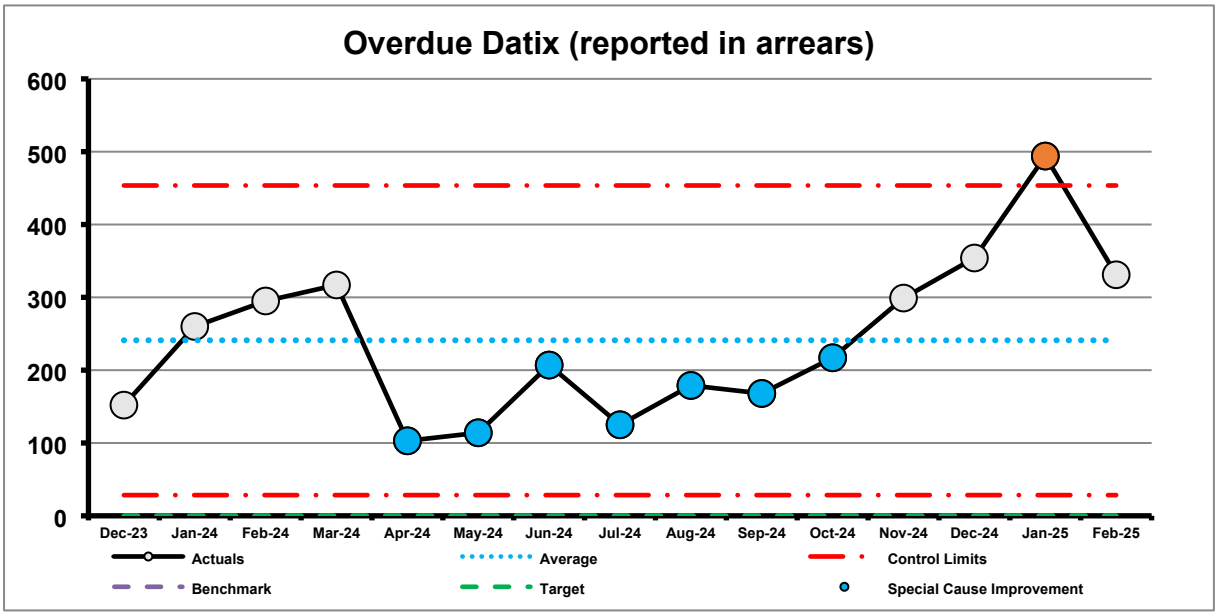
Background
When a Datix is raised to alert or escalate an incident (IR1 form) – it is imperative that the details are reviewed and considered in terms of any immediate actions that have or should be taken particularly regarding patient and staff safety.

A Datix is used as part of many governance processes and learning form the incidents when an investigation or exploration is complete should be considered, captured and changes enacted from the learning (IR2 form) A final review and closure of the Datix is completed by a senior manager where wider themes are also considered.

Benchmark/Target
The **recommended** timescale for optimum learning is 30 days.

Datix are reported as at the end of the preceding month (i.e., below is the position for November 2024). Reported Datix are reported at the end of the reporting month.

Current Performance



Narrative

The timescale covering the period between an incident being reported to it being reviewed and finally approved is one calendar month. An incident is marked overdue if it has not been finally approved within 31 days of the incident being reported.

Historically a target of 10% of all reported incidents has been used as the tolerance threshold.

CYPSS & IUEC divisions are meeting trajectory around overdue Datix.
The other divisions are taking actions to realign to trajectory by weekly quality review meetings with leadership oversight.

Within Community nursing there are a number of ‘overdue Datix’ that are pending approval (‘Being Approved’) because they are awaiting steering group (PUs) and thematic review (Medicines) validation. These numbers are consistent each month however relate to different events awaiting the monthly review which happens after PSG in the reporting cycle. These events are reviewed at steering group and then closed.

Within Community Hospitals overdue Datix marked as ‘Awaiting final approval’ have been fully investigated by the clinical team and are awaiting final sign off by Clinical Service Lead. Community Hospitals and services have agreed on a timeline of 2-3 months to close the oldest outstanding Datix reports within the division.

SPC

The SPC for Overdue Datix has not varied over the period.

Children in Care (reported one month in arrears)

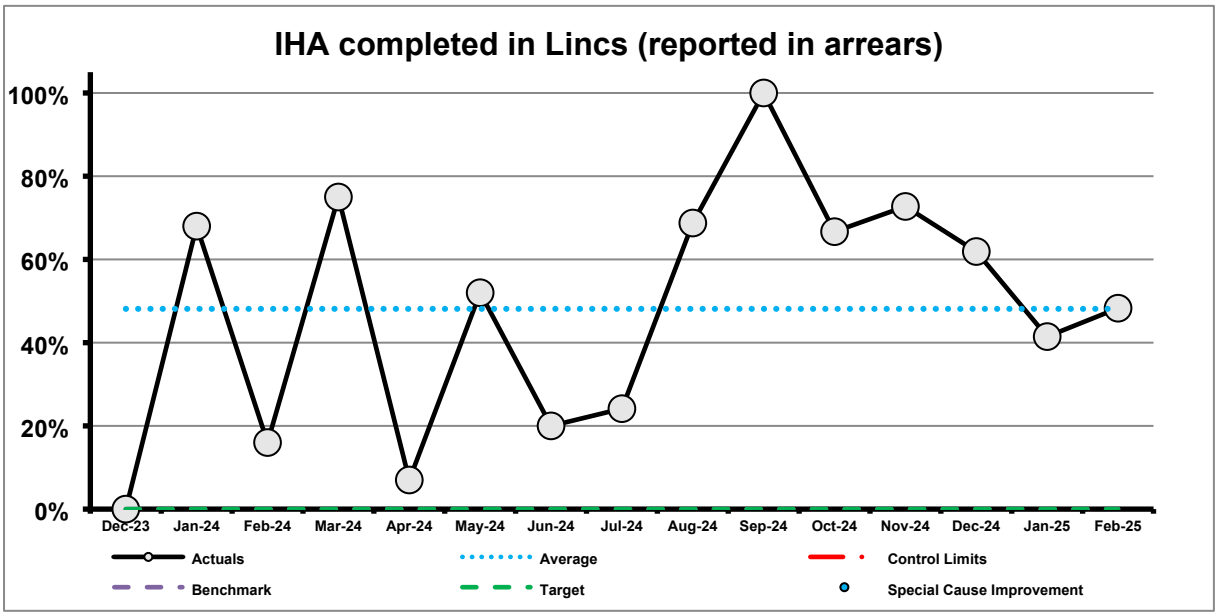
Background

From the 1st August 2019 LCHS reporting of the management and completion of Initial Health Assessments (IHA) for Children in Care (CiC) was included in this report. The performance report includes children looked after in Lincolnshire local authority and those placed in Lincolnshire by external authorities.
The quarterly and annual reports provide details on Children in Care in Lincolnshire who are placed outside of county, having their IHA with alternative providers.

Benchmarking / Target

All Children in Care are required to have an IHA undertaken and completed within 20 working days of becoming looked after. Lincolnshire County Council (LCC) has a target to complete and submit Consents and Coram BAAF forms to LCHS within 3 working days of a child becoming looked after. LCHS are required to administer the completion of an IHA within the statutory 20 working days of the child becoming looked after.

Current Performance



Narrative

We have now been able to reinstate the 17:00 – 17:00 reporting group on SystmOne which includes the Children in Care unit, meaning we have a direct feed for the data in the daily strategic reporting extract.

The reporting logic was updated to reflect children who underwent evaluations during the reporting month, regardless of when they were looked after; instead of children who became looked after within the reporting month and when they had their assessments

In February, 30 children were in cohort to be assessed in Lincolnshire, and 14 received an initial health assessment within 20 working days of them becoming looked after.

SPC

The SPC for IHA Performance is slightly below average in February.

Environmental Cleanliness

Background
The cleaning company contract with provider OCS through NHSPS shared services began in 2022.

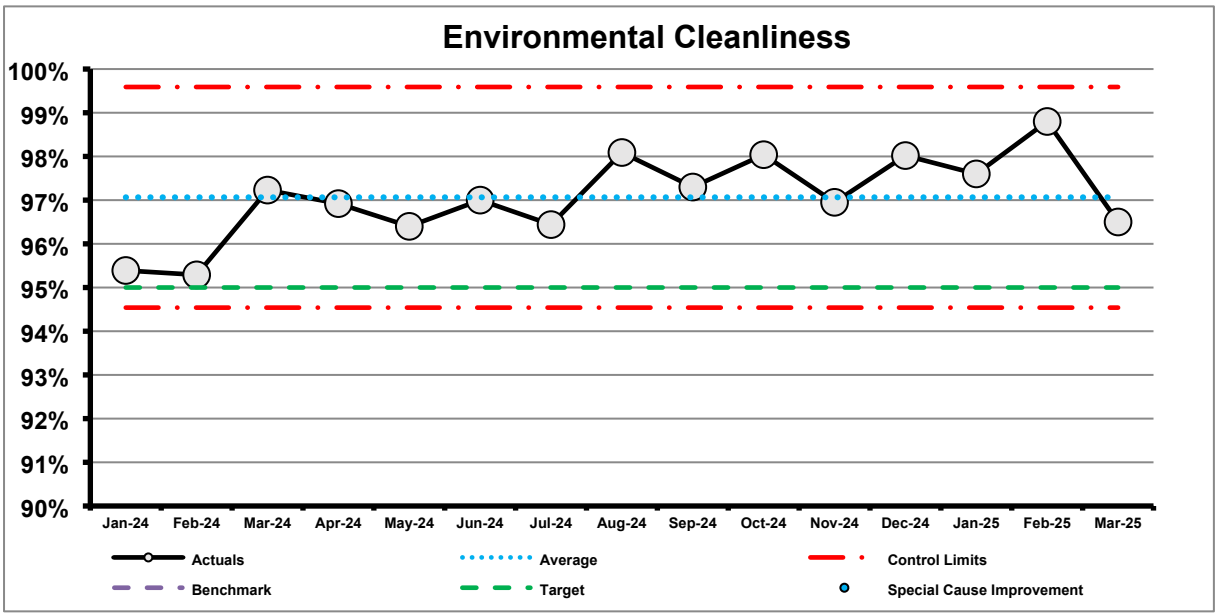
The requirements of the new National Standards of Healthcare Cleanliness that were published at the end of April 2021 have been rolled out across all LCHS community premises by OCS as well as being adopted by NHSPS and the in-house teams at the hospital sites.

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 96.50% compliance of cleanliness audits and has achieved the 95% target every month. Visible improvements in the cleaning standards across all the community premises are being sustained. During the quarter, all sites achieved scores that would rate them as either 4 or 5 stars, in accordance with the new Healthcare cleaning standards.

There are currently no cleaning vacancies across the LCHS sites, and all current staff training is up to date.

Actions
Cleanliness audits and monitoring continue to facilitate appraisal of concordance with expected cleanliness standards. One area of development continues to be the cleaning contract review at Louth Urgent Care Centre.

SPC

SPC shows that cleanliness audits performance has not varied over the period.

Community Hospital Bed Occupancy

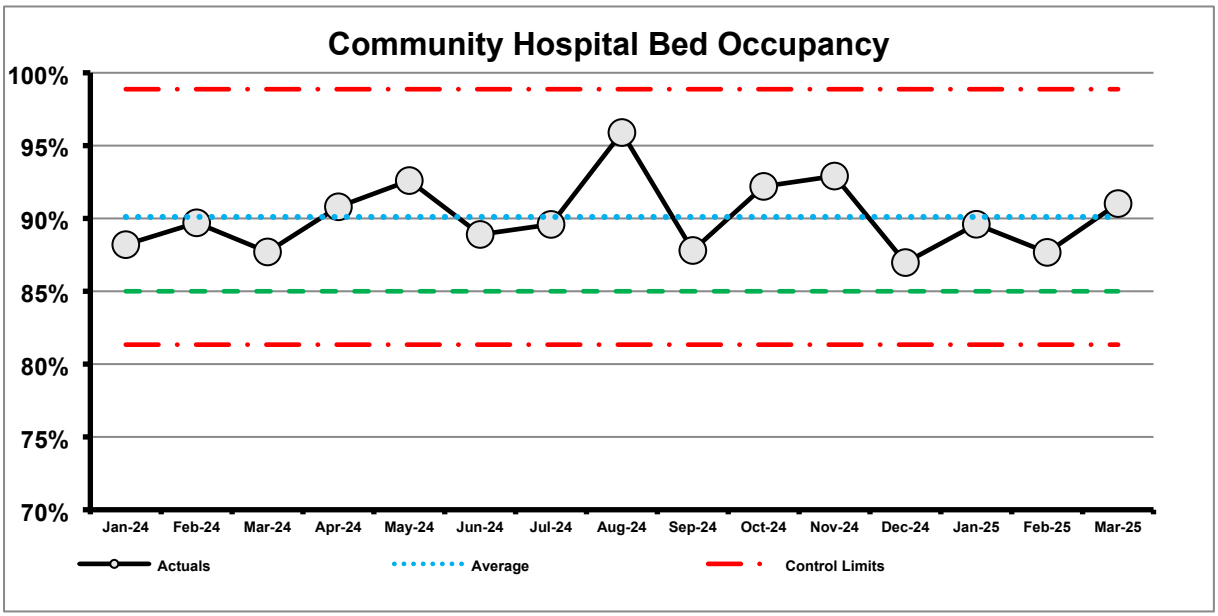
Background

Bed occupancy is measured in terms of open beds and does not include any chair-based activity.
The calculations for bed occupancy also include increases in beds at time of surge or pressure when additional beds are opened. Bed occupancy is a patient safety and patient flow measure.

Benchmark/Target

In July 2023 the bed occupancy target was moved from 90% to 85%. NHS Benchmarking have not yet published the community dataset for the reporting period. Bed occupancy target for the community hospitals is to be reviewed with a proposal for PMR that the target to be set at 85% in line with NICE guidance this proposal has been accepted and target implemented. However, from a patient flow perspective the proposed strategy is to 'fill the beds' which in practice means aiming for a bed occupancy of 95% or so.

Current Performance



Narrative

In reality for March all beds were filled at all times but because of the delay in a patient arriving post acceptance some beds are empty at midnight but do have names against them. In addition to this the occupancy of palliative care beds remains less than that of rehab beds. In future months we hope to report these figures separately.

SPC

SPC shows the Community Hospital bed occupancy performance has not varied significantly over this period and continues to be above the target of 85%.

Average Length of Stay

Background

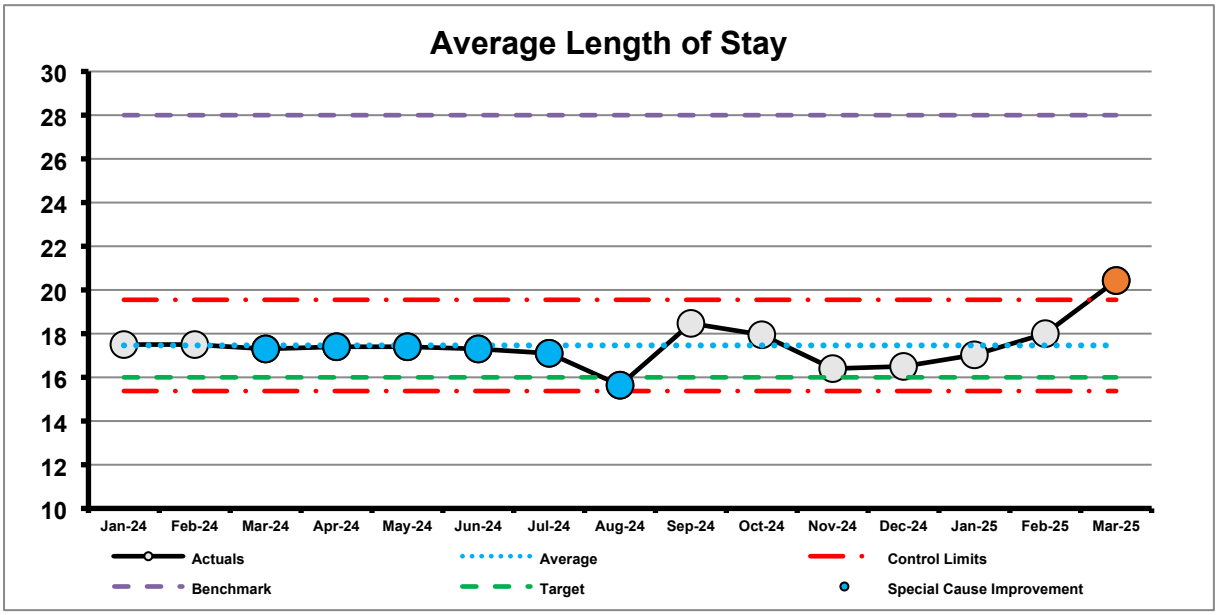
This measure is defined as the difference in days between the date the patient was discharged from the hospital, and the date they were admitted. The average time in hospital in days for all the patients who underwent a procedure in an NHS trust is then calculated (NHS Digital, 2018).

Benchmark/ Target

NHS National Benchmark for Average Length of Stay is currently 28 days.

Target length of stay is 16 days.

Current Performance



Narrative

We have had a recent peak of quick turn around patients who have reached the end of their rehab journey and reached discharge. Unfortunately this comes with the ebb of patients requiring rehab to return home, with a particularly complex patient at Scotter Ward who is the result of increased LoS. We also have a number of other very complex patients with elongated lengths of stay which are affecting the figures. They remain subject of daily discussions to progress their discharge.

SPC

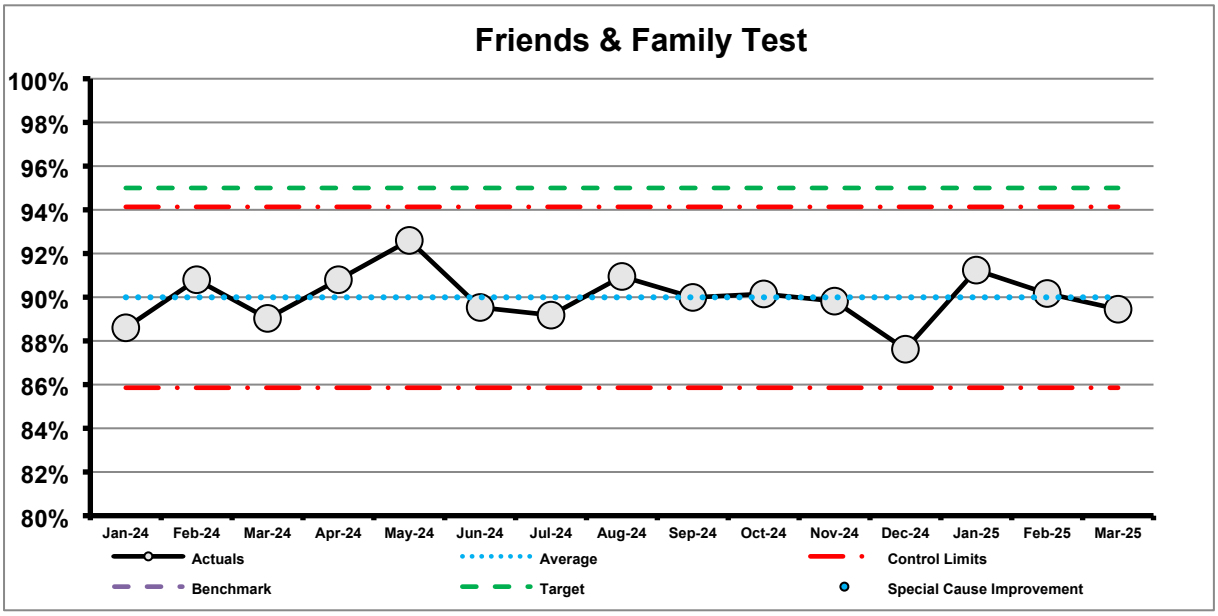
Average length of stay SPC shows a slight increase for the reporting month of March.

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 March (89.45%) shows a decrease on last month's performance activity (90.17%).

11 FFT QR codes have been generated with bespoke alignment to the community nursing teams for patient engagement and feedback. The Patient Experience Support Officer is working within each of the 11 community nursing teams for an enrichment data collation experience. The FFT intelligence acquired will formulate a 'you said we did' feedback method - which will be incorporated into the weekly bulletin, screensaver, team meetings and QSG for dissemination.

Actions

Additional contractual oversight remains in place to continue to improve the roll out and reporting of the service provided.

SPC

SPC shows that Friends and Family performance has shown no variation in the period.

Compliments

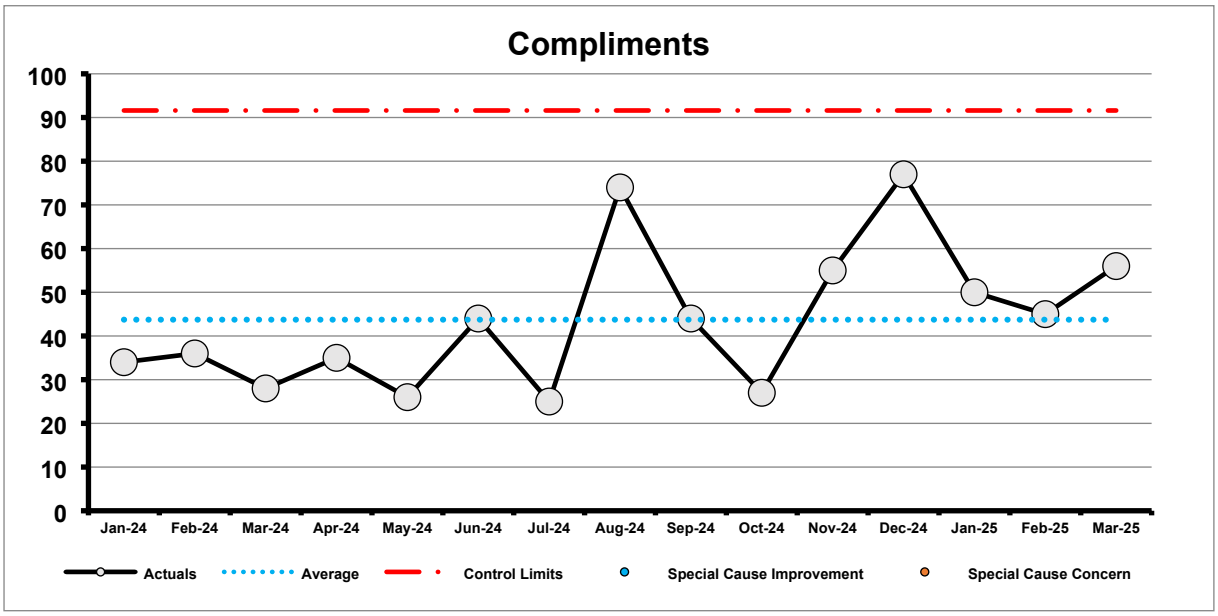
Background

Compliments are received by the Trust through services directly which are then shared with the PALS, Complaints and Claims Team, through NHS Choices, Healthwatch, alternative partners or directly into PALS. Work continues to accurately capture the compliments received by the Trust.

Benchmark / Target

There is no available benchmarking. A proposed target of 50 compliments each month across the Trust is currently being discussed with divisions.

Current activity



Narrative

There seems to be a slight increase in March with 56 recorded. These are mainly Community Hospitals (33) Childrens and Specialist Services (11), Collaborative CC (3) and Urgent Care (5). The pals and complaints team also received 4 this month.

SPC

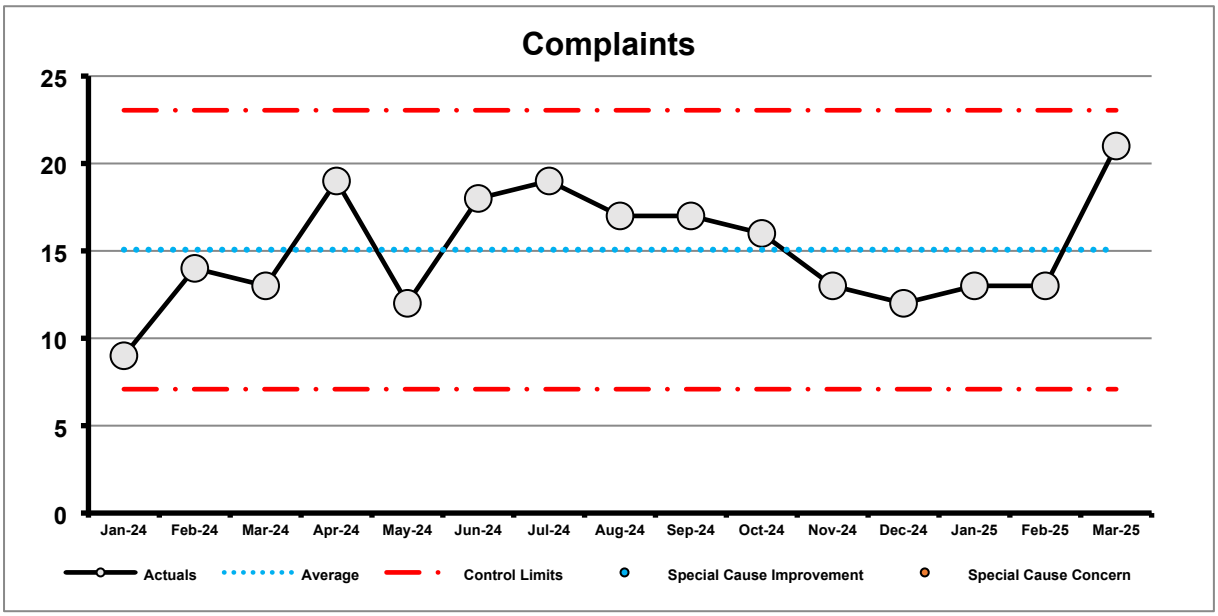
SPC shows that compliments have not varied significantly.

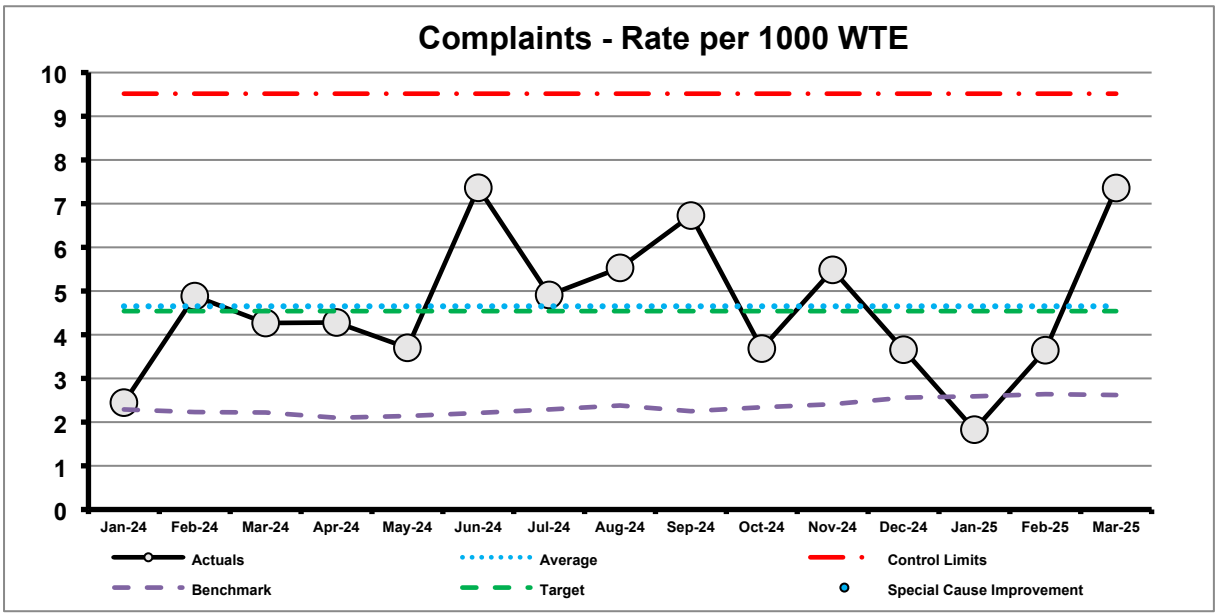
Complaints

Benchmark / Target

LCHS is benchmarked by the number of complaints reported per 1,000 WTE budgeted staff.

Current Performance





Narrative

As a Trust we are keen to resolve any complaints or issues concerning contact that patients or family members have with our services.

We are currently working with divisions to streamline the complaints process; we have implemented a complaint handler for each complaint who will work more closely with the investigator of the complaint. Significant work will take place over the coming months to improve the flow of the complaint

process across the Trust and align the complaints process with colleagues at ULHT. Discussions are being held with the divisions to gain feedback before implementing a new process.

Actions

The complaints team are continuing to improve the complaints process. There will be more changes to the current process over the next few months and talks have started with some of the divisions regarding the planned new process.

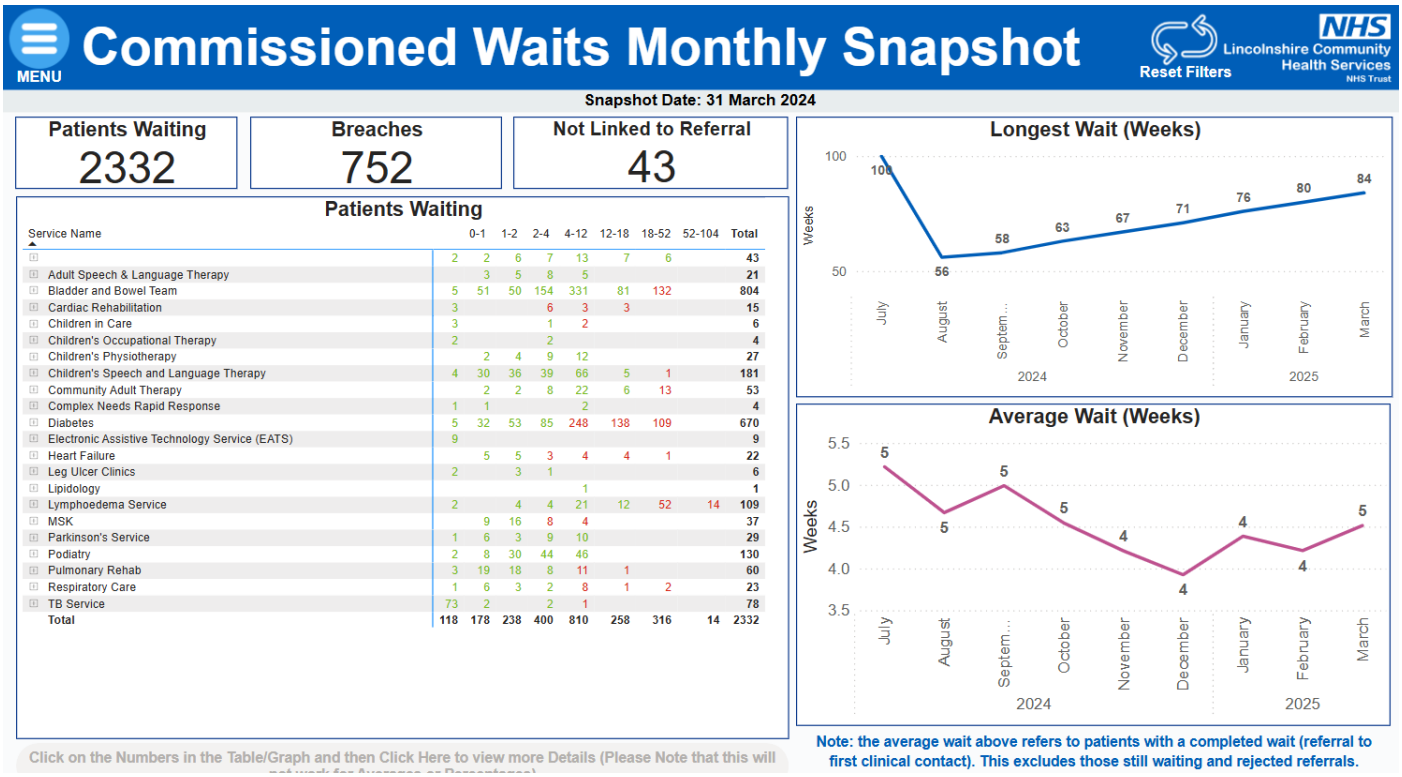
SPC

SPC for complaints has not varied significantly in the period. Complaints rate per 1000 WTE has also not varied significantly in the period.

LCHS Commissioned Waits

Background

LCHS Commissioned waits are the agreed target waits set out by each service level agreement and therefore not all services will be aligned to an 18 week wait target.



Narrative

This is the current LCHS Commissioned Wait position based on the data for those services using the clock, and where the clock has not been 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 March 2025, 8 services are offering initial clinical contacts within their service target wait times. 12 services have patients waiting in excess of the service's maximum target wait time including one service, Lymphoedema, that has 14 patients waiting longer than 52 weeks. 85.9% of patients are waiting less than 18 weeks. Current operational target is to keep this figure above 65%. 0.6% of patients across services are waiting more than 52 weeks. Current operational target is to keep this figure below 1%.

Lymphoedema has seen an increase in urgent referrals which has meant that those referred and triaged as routine must unfortunately wait longer. The service has reviewed referral criteria, works collaborative with Essity and is exploring a possible opportunity to expand clinics to Sleaford. All services have Safe Waiting Plans in place including safety netting and harm reviews for patients that have waited longer than commissioned wait times. Services continue to adapt and work flexibly to mitigate challenges at an operational level through prioritisation, skill mix, innovative practice and integrated collaborative working with partners. Business cases for Lymphoedema, TB, Children in Care and Children's Speech and Language Therapy have not been successful in attracting additional resource and services continue to explore ways to manage overwhelming demand and mitigate risks. Adult Community Therapy are exploring significant changes in model, criteria and delivery, identifying potential opportunities for additional resource or capacity in group and opportunities for amalgamation with services such as community hospital therapy and discharge to assess.

The agreed target waits for those services currently utilising the clock are outlined below.

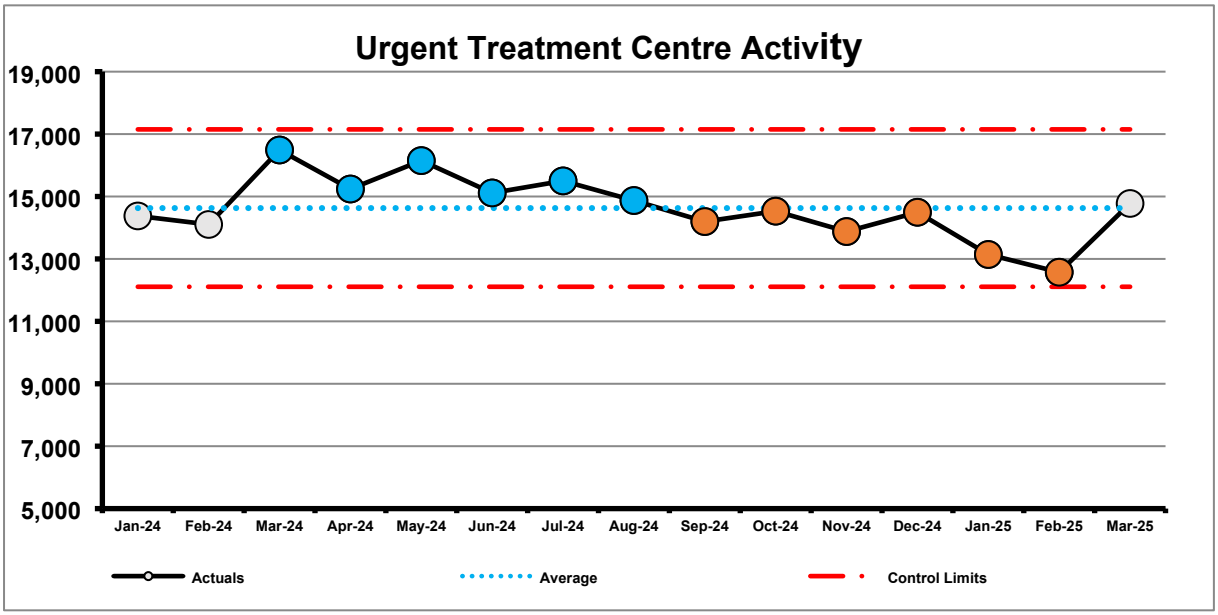
Service	**Target Wait**
Adult Speech and Language Therapy	18 Weeks
Bladder and Bowel	6 Weeks
Cardiac Rehabilitation	10 Working Days
Child Therapy	18 Weeks
Children in Care	20 Working Days
CNS Continence	18 Weeks
Diabetes	4 Weeks
Electronic Assistive Technology Service	6 Weeks
Heart Failure	2 Weeks
Musculoskeletal Physiotherapy	15 Working Days
Parkinson’s	18 Weeks
Podiatry	18 Weeks
Post Covid	6 Weeks
Pulmonary Rehab	10 Weeks
Complex Needs Rapid Response	18 Weeks
Respiratory (CCM, Oxygen, Physiotherapy)	4 Weeks
TB	6 Weeks

The function of the clock is to provide a true wait for those patients with a new referral awaiting an initial clinical contact and should not be confused with the Waiting Lists on SystmOne which will run alongside the clock. The Waiting Lists show the position of the patients wait but does not take into consideration where the patient has been offered an appointment they have refused and cannot be paused for any reason. This is likely to have a negative impact on the services performance.

Urgent Treatment Centre Activity

Background

This metric measures UTC activity across the Trust. Note that all LCHS Minor Injury Units (MIUs) have now transitioned to Urgent Treatment Centres, in line with national requirements. Activity from June 2021 onwards excludes Peterborough UTC after the cessation of this contract. The figures also exclude the support that LCHS provided to United Lincolnshire Hospitals at Grantham (running a UTC from July 2020 – June 2021).



Narrative

The data for March 2025 indicates a significant increase in footfall compared to the previous two months. However, this increase remains within the expected activity ranges for this time of year. Nationally, UTC attendances continue to fluctuate, with seasonal variations playing a significant role.

In Lincolnshire, we are closely monitoring attendance patterns to identify when peak footfall occurs at UTCs. With the onset of warmer weather, we anticipate a slight increase in activity due to the expected summer migration, particularly in our coastal areas.

We will continue to monitor trends closely to ensure that resources are aligned with demand and to assess whether variations in footfall reflect broader national patterns or are specific to local dynamics. National data indicates that in 2023/24, attendances at type 2 and type 3 urgent and emergency services increased by 7% compared to the previous year, highlighting the growing importance of UTCs in managing patient flow

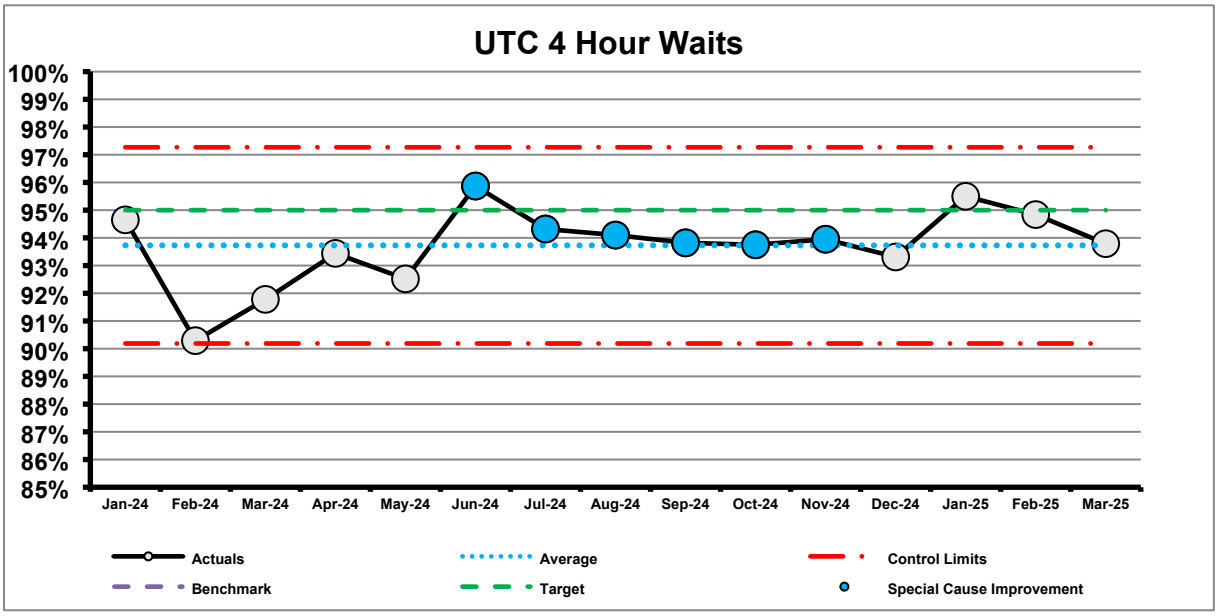
SPC

UTC activity has not varied significantly since September 2024.

UTC 4 Hour Waits

Background

The Quality Schedule requires the Trust to achieve a target of 95% of UTC attendances where the Service User was admitted, transferred, or discharged within 4 hours of their arrival at an A & E department.



Narrative

In March 2025, there has been a modest decrease in performance, with 4-hour wait times standing at 93.79%, a 1.05% drop from the previous month's 94.84%. Despite efforts to improve, UTCs continue to face challenges in consistently achieving the 95% target.

One of the key contributors to the fluctuating performance is the time to departure at co-located sites, particularly at Lincoln UTC and Boston UTC. Delays in specialty referrals, limited access to x-ray services, and the need for acute admissions have been ongoing obstacles. These challenges are compounded by the pressures faced by our acute hospital partners, who are also grappling with issues related to bed availability. Specialty wait times for orthopaedic consultations, blood tests, and x-ray access remain significant barriers, and these issues have been escalated for urgent resolution within the system.

Although the data indicates that UTCs have been inconsistent in meeting the 95% target, it is essential to recognize the broader context of UTC activity. We continue to work closely with system partners to improve performance, aiming to achieve above 76% performance across the system. This involves validating breaches daily, identifying potential delays early in the patient journey, and streamlining pathways into specialties. We remain hopeful that as this work progresses, performance will become more consistent and sustained.

The demand for UTC services remains high, reflecting the ongoing efforts to improve patient pathways and system partnerships. In addition to this, we are now prioritizing workforce modelling for the future to ensure that we can maintain and enhance performance across all areas. However, as the data shows, UTCs continue to struggle with delivering consistent results, with the 95% target being missed more often than not. The work to address these issues is ongoing, and we anticipate gradual improvements moving forward.

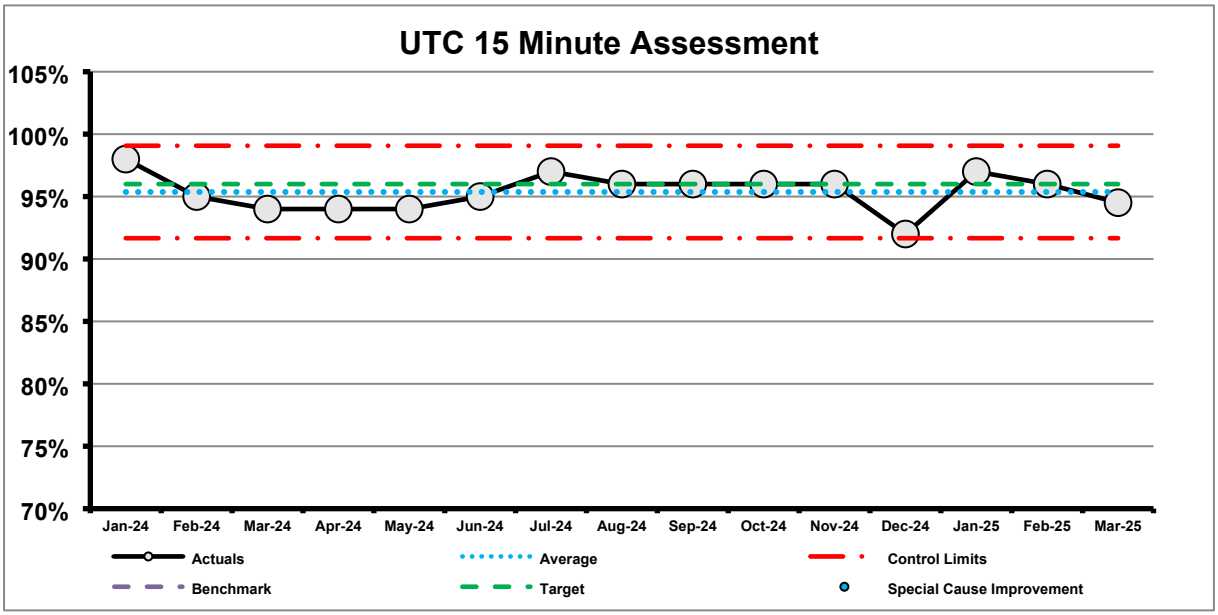
SPC

UTC 4-Hour Wait performance has not varied significantly over the period. UTC 4-Hour Wait performance is inconsistently capable of achieving the 95% target. The target is missed more often than not.

UTC 15-Minute Assessment

Background

Urgent Treatment Centre specifications state that patients who walk-into a UTC should be clinically assessed within 15 minutes of arrival. Following a 2019/20 CQC visit it was agreed that the Trust would ensure that all patients attending A&E (for then Urgent Care Streaming services), regardless of which method of transport they used to arrive, should be assessed within 15 minutes.



Narrative

The 15-minute assessment performance has decreased by 0.49% to 94.51%. This slight decline coincides with an increase in UTC attendances but also reflects the ongoing dedication of UTC staff.

Work continues to ensure that the successes achieved in recent months are not only maintained but also made sustainable in the long term. This month, 94.51%% of UTC patients were triaged within 15 minutes, dropping slightly below the target of 95%.

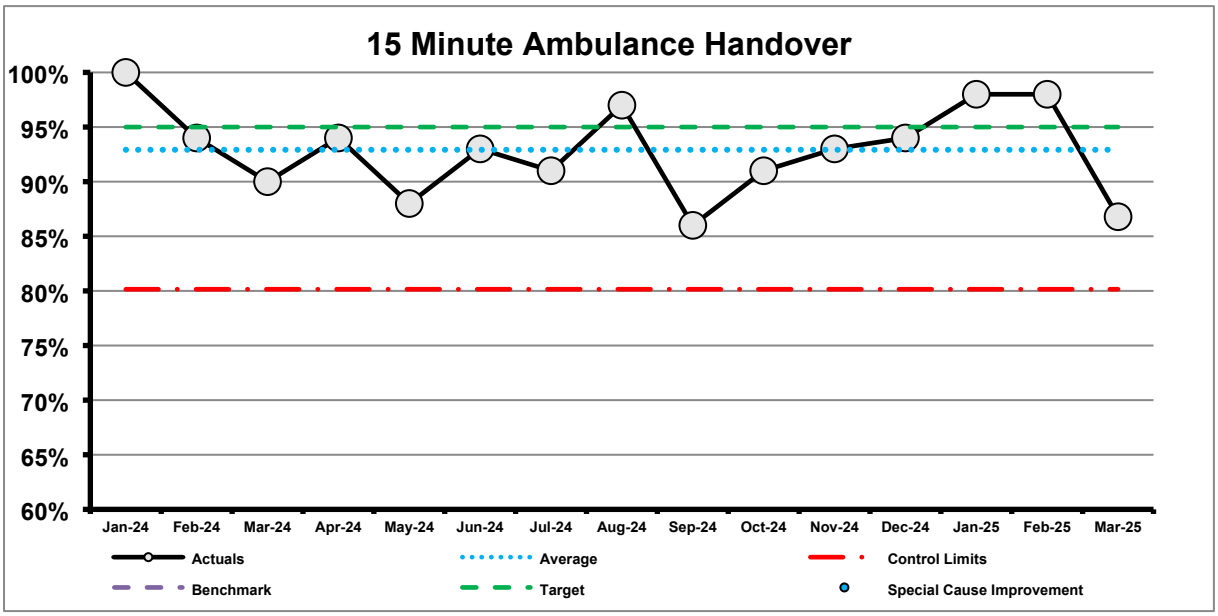
SPC

Since December 2024, there has been significant improvement in UTC's 15-minute assessment performance. Teams remain focused on sustaining this level of performance in the coming months.

15-Minute Ambulance Handover

Background

The NHS standard contract requires that handovers between ambulances and A & E must take place within 15 minutes with no patient waiting more than 30 minutes. Locally the 95% target is used to indicate and highlight where this is not delivered.



Narrative

15-minute Ambulance Handover performance has decreased since the last reporting period. We continue to work closely and meet regularly with EMAS partners to enhance admission avoidance pathways.

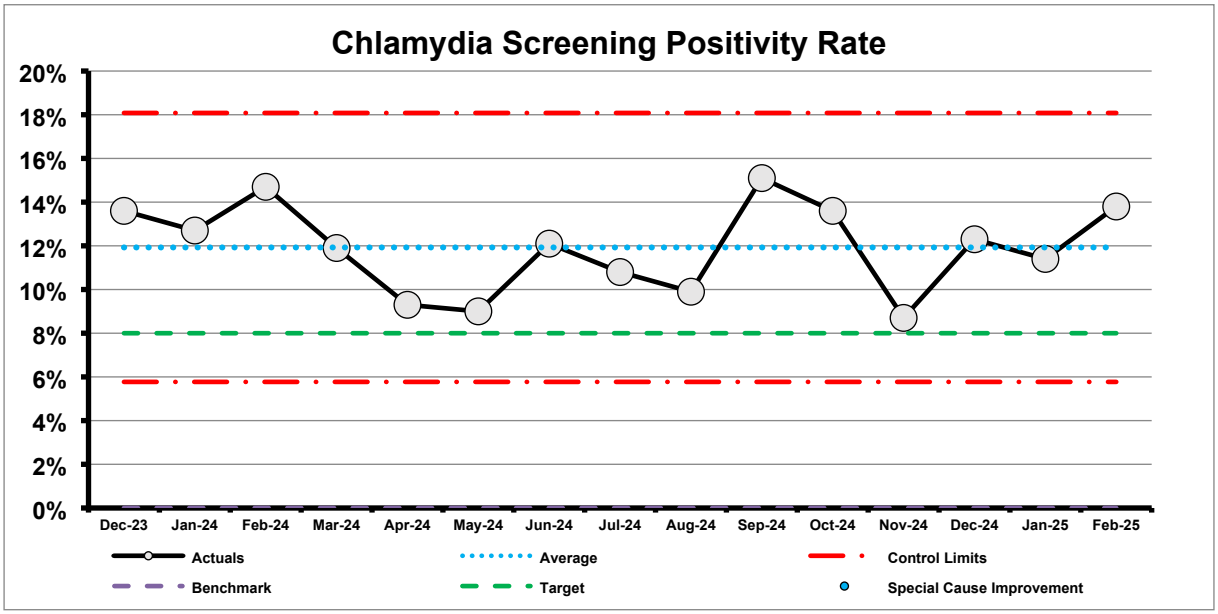
SPC

Although 15-minute Ambulance Handover has inconsistently been capable of achieving the 95% target over the last 12 months, performance is continuing in an upward trajectory.

Chlamydia Screening Positivity Rate

Background

The Trust is commissioned with a positivity target of 8% of young adults aged 15-24 years who have accepted a screen, and to ensure that 80% of the GU patients are seen or assessed within 2 working days of first contacting the LiSH service. Both these measures have historically had financial service credits (penalties) attached in achieving the target, although these have been suspended in the Covid-19 response period and no confirmation has been made with regards to reinstatement.



Narrative

Positive screening rates have continued to exceed the target rate.

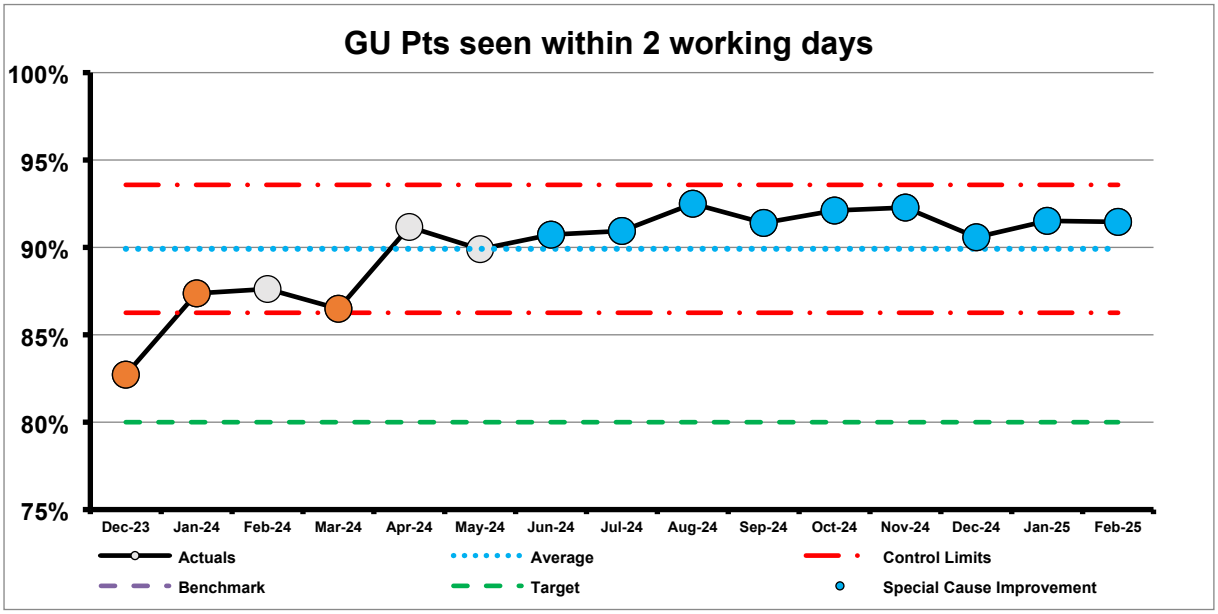
Actions

To continue developing and raising awareness of the service within the younger population.

SPC

Chlamydia screening positivity rates are consistently capable of achieving the 8% target but are expected to achieve the target more often than not, as they have in each of the last 15-months.

GU Patients seen or assessed within 2 working days



Narrative

Performance levels and activity are stable for GU clients seen within two working days.

Actions

Discussions continue to understand how the team can further improve on this level of performance.

SPC

GU patients seen within 2 working days shows special cause improvement since April 2024. This measure is consistently capable of achieving the 80% target.

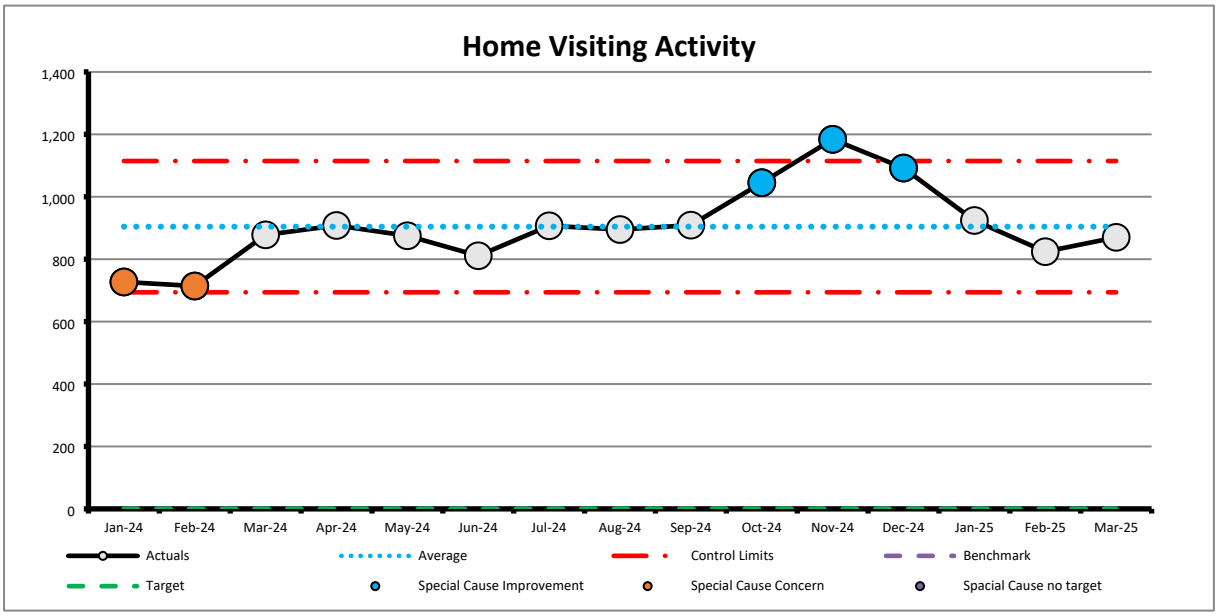
Home Visiting Report

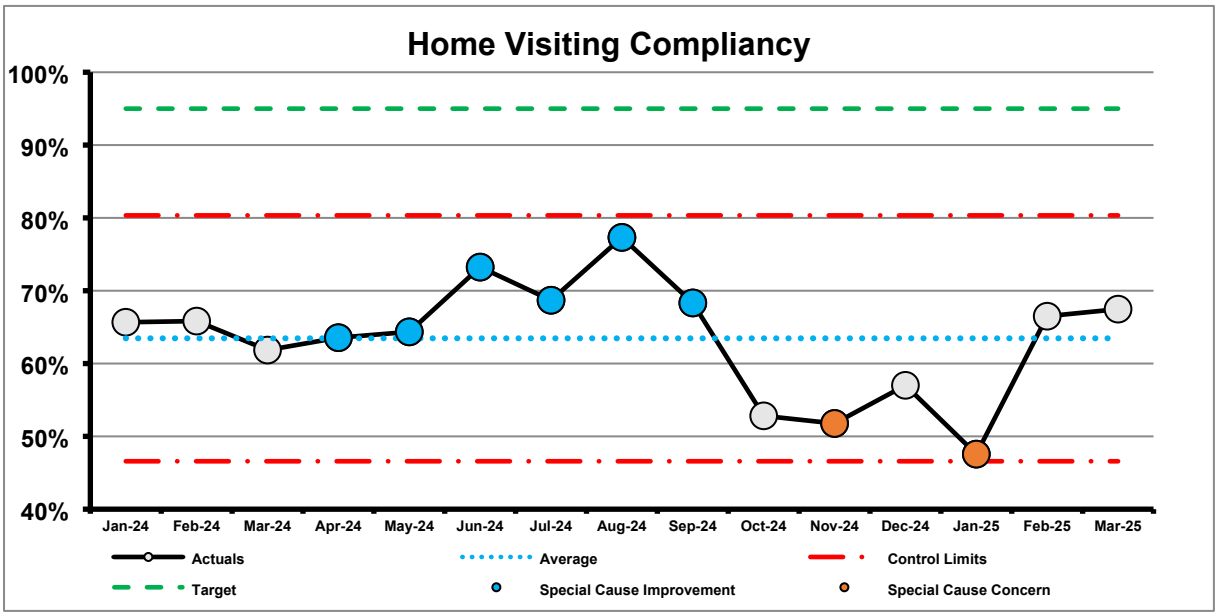
Background

Patients are offered a face-to-face consultation most appropriate to meet their needs and, where applicable, in the patient's home.

Patients are Lincolnshire citizens who become LCHS patients when triaged and accepted by the Home Visiting / Integrated Urgent Care Team and can be accessed via the 111 Service, CAS, and referrals from Community Teams.

The Service avoids admission to Emergency Departments, prevents ambulance call outs and provides reassurance for patients when GP surgeries are closed.





Narrative

The compliancy for Home Visiting continues to improve as demonstrated, however we are still working through a process for validating the breeches for Home Visiting and after manual breach validation for March the overall compliance is 85% (urgent 84% and less urgent 88%). The activity is reflective of that seen in CAS. The Home visiting service will work collaboratively with the UCR service on a pilot basis effective from 15.04.25.

SPC

Home Visiting activity has not varied significantly over the period.

Compliance has also not varied significantly over the period.

Home visiting Compliance has increased from 66.50% in January to 67.47% in March 2025.

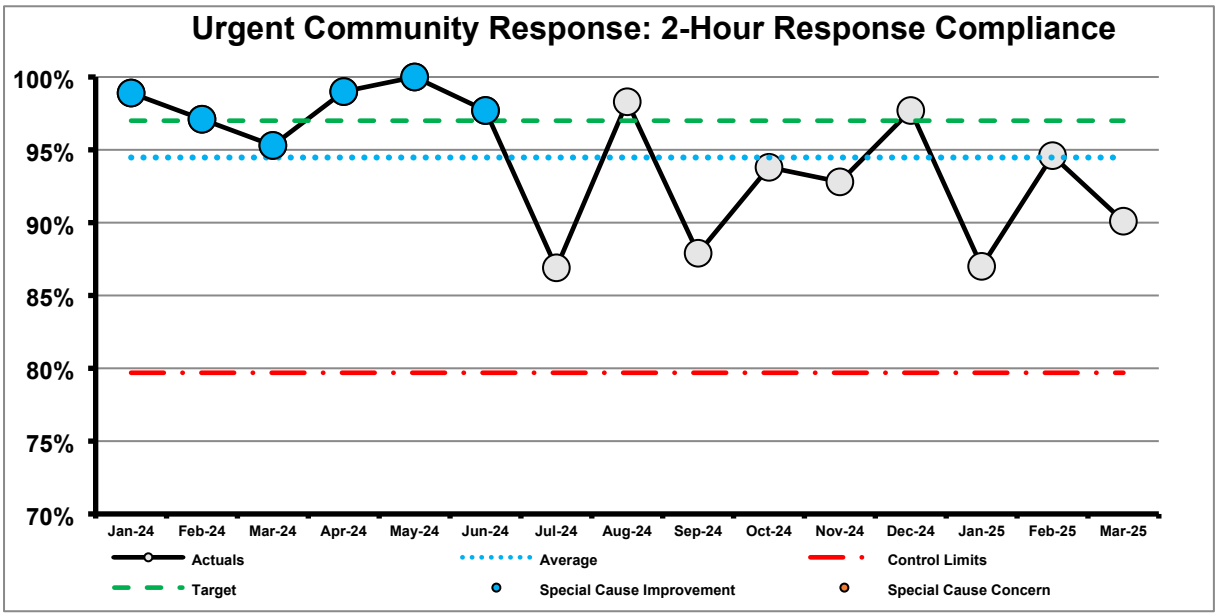
Urgent Community Response

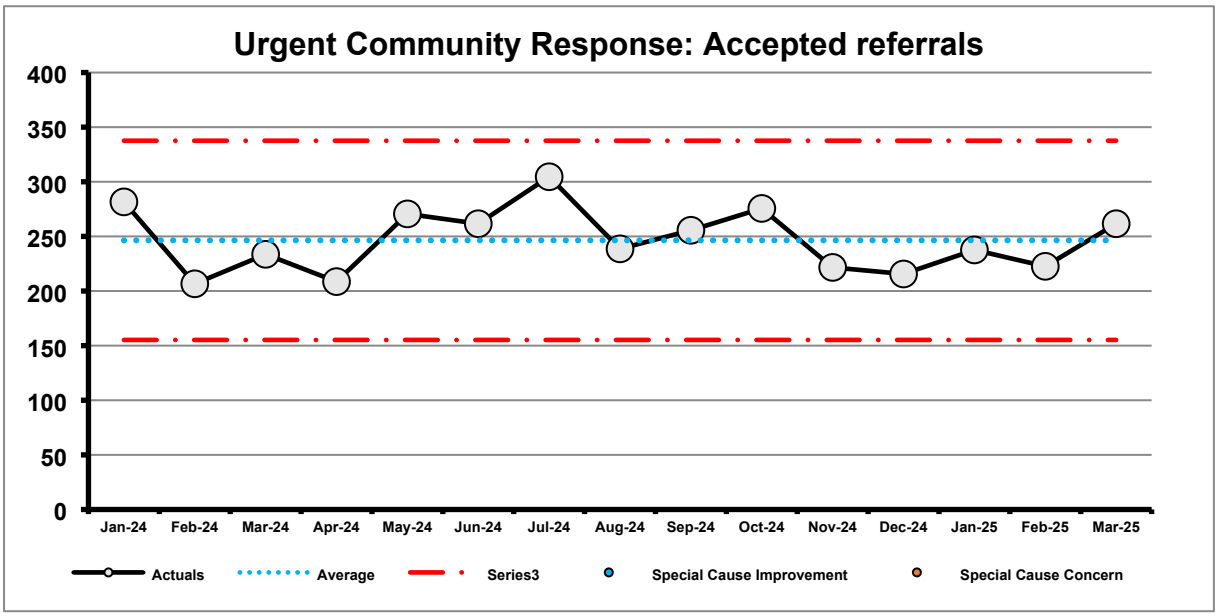
Background

Urgent Community Response is a nationally directed service. The Urgent Community Response Team receives referrals from a variety of sources to support urgent response care services.

The target for each referral is to respond and reach the patient within 2 hours.

It is a collaborative service working closely with Lincolnshire County Council and Social Care.





Narrative

Slight increase in accepted referrals received to UCR this month, bringing rate of referrals to just above average. The UCR service will integrate on a 3 month pilot effective from 15.04.25 to ensure all patients receive a clinical assessment and appropriate interventions. This will also provide opportunities for staff to

develop skills. The highest referral in reasons remain to be equipment provision and reduced function. The 2-hour compliance has decreased slightly as the service still continues with staffing challenges.

SPC

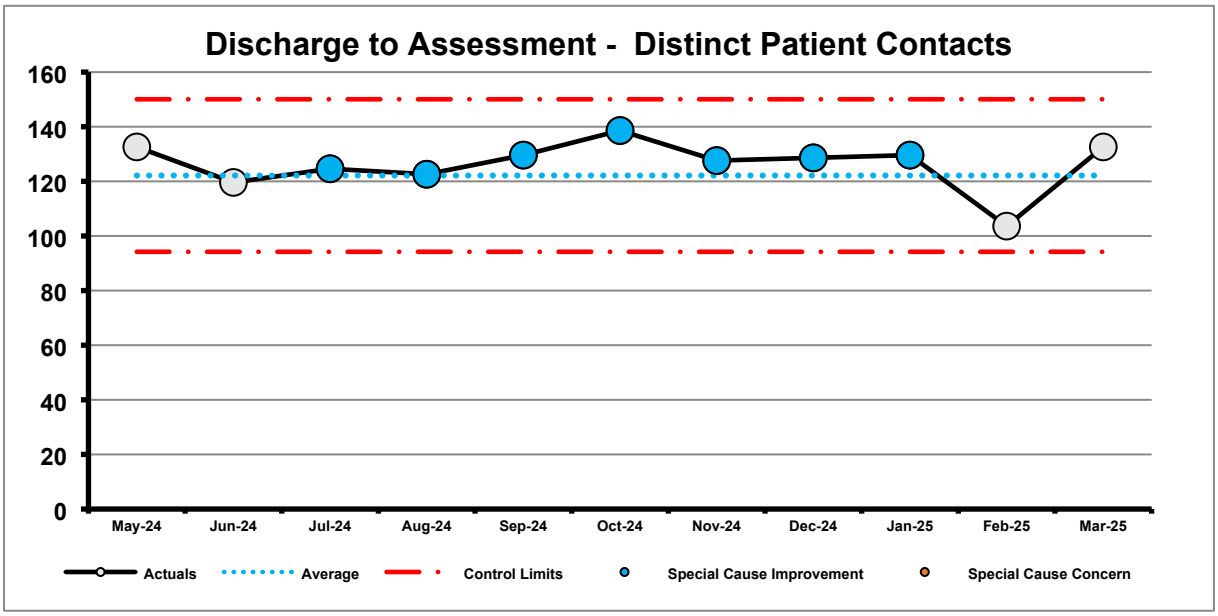
The 2-hour response rate has not varied significantly over the period. This measure is inconsistently capable of achieving the 97% target and is expected to miss the target more often than not. The number of accepted referrals for Urgent Community Response has not varied significantly over the period.

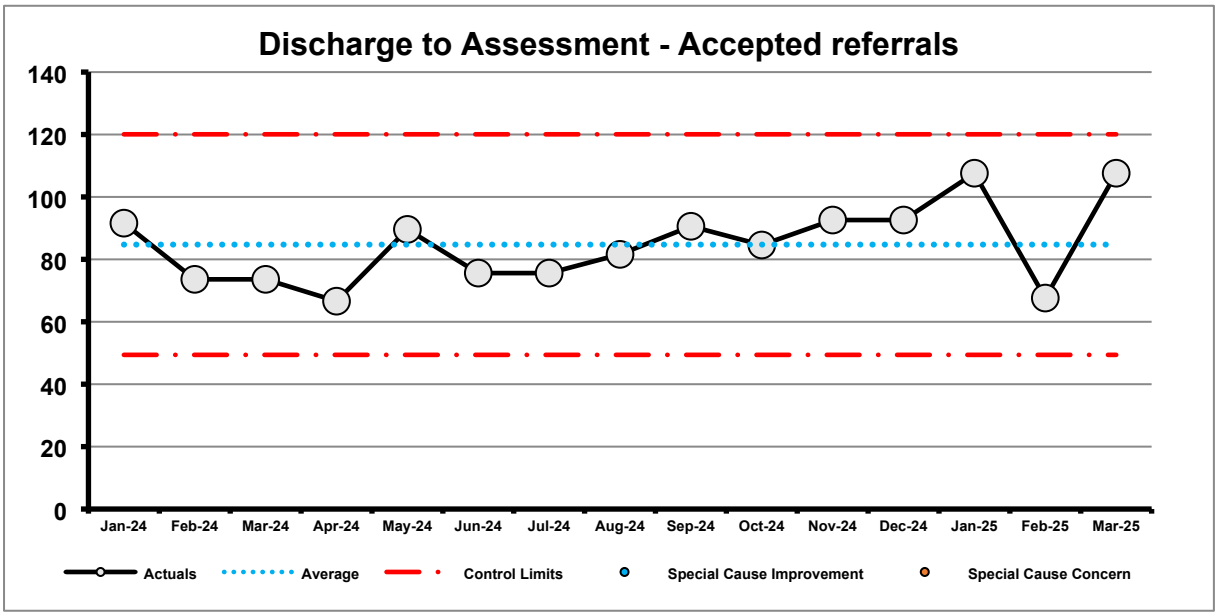
Discharge To Assessment

Background

The Discharge to Assessment programme has been introduced to expedite patients to leave acute care and return to their own home for reablement.

The service works closely with Adult Social Care and supports patients with a wide range of needs.





Narrative

The number of referrals accepted into the Pathway 1 D2A service increased in March and remained within control limits.

Continued work with the ULTH Front Door Therapy Service and LCC HBRS service supports the improvement of pathways, in addition to trialling new ways of working between the D2A and LCHS community hospital and discharge hub teams.

Actions

Recent recruitment has been successful for B5 and B6 therapy posts, and the new B4 practitioner posts. Should all recruits commence in post as planned, D2A will be at establishment with respect to current AHP vacancies.

SPC

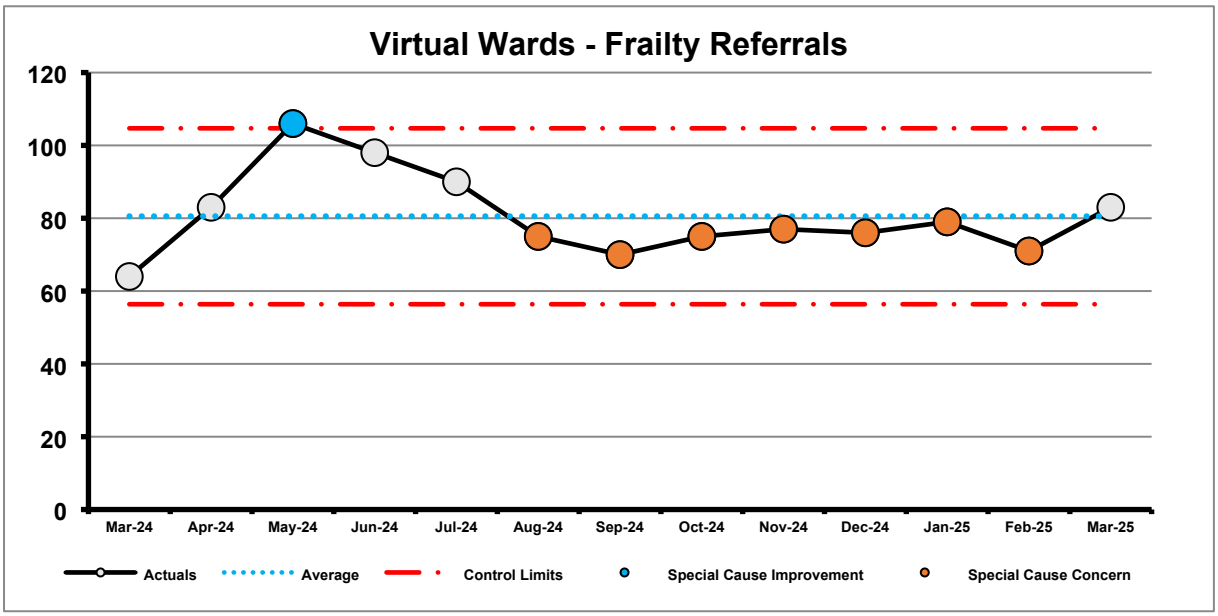
The number of distinct patient contacts has not varied significantly over the period and remains above average.

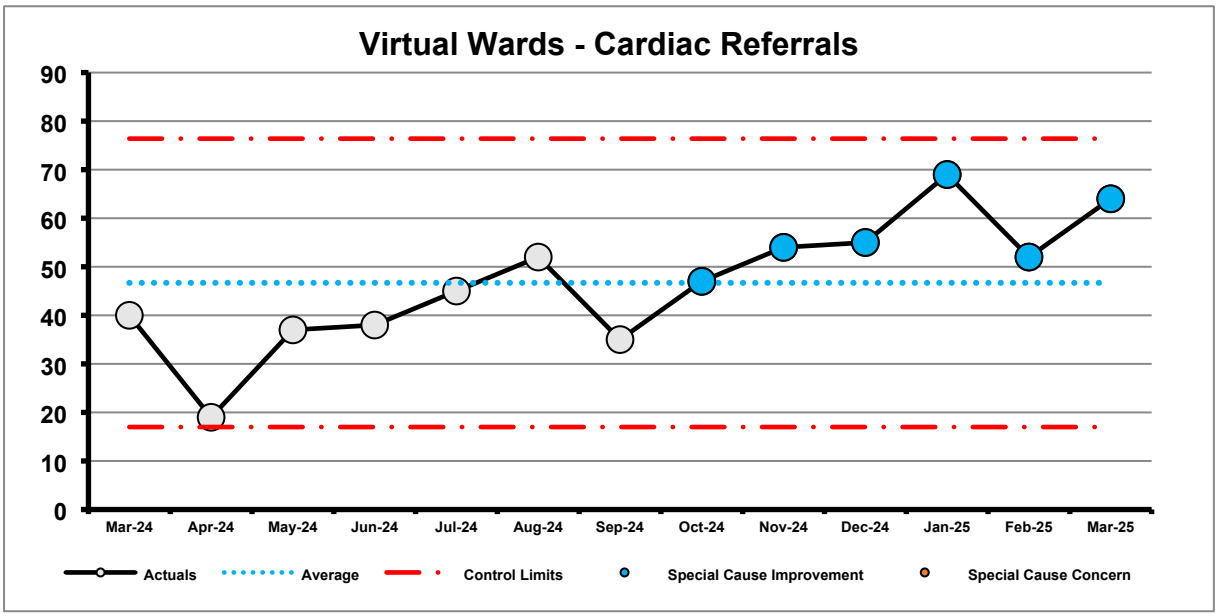
The number of D2A accepted referrals has not varied significantly and remains above average.

Virtual Wards

Background

The Trust's current virtual ward offering includes frailty, cardiology and respiratory. The service closely collaborates with ULHT, and patients are cared for in the community, with guidance from ULHT consultants.





Narrative

Reporting continues to encompass frailty, respiratory and cardiology virtual wards. OPAT & SDEC data is being progressed with ULHT. FBI are supporting the virtual ward team, cross referencing the different reporting that currently takes place (e.g., NHSE, SHREWD and internal reports) to make sure that the data is consistent and that all virtual wards are included in all our reporting.

SPC

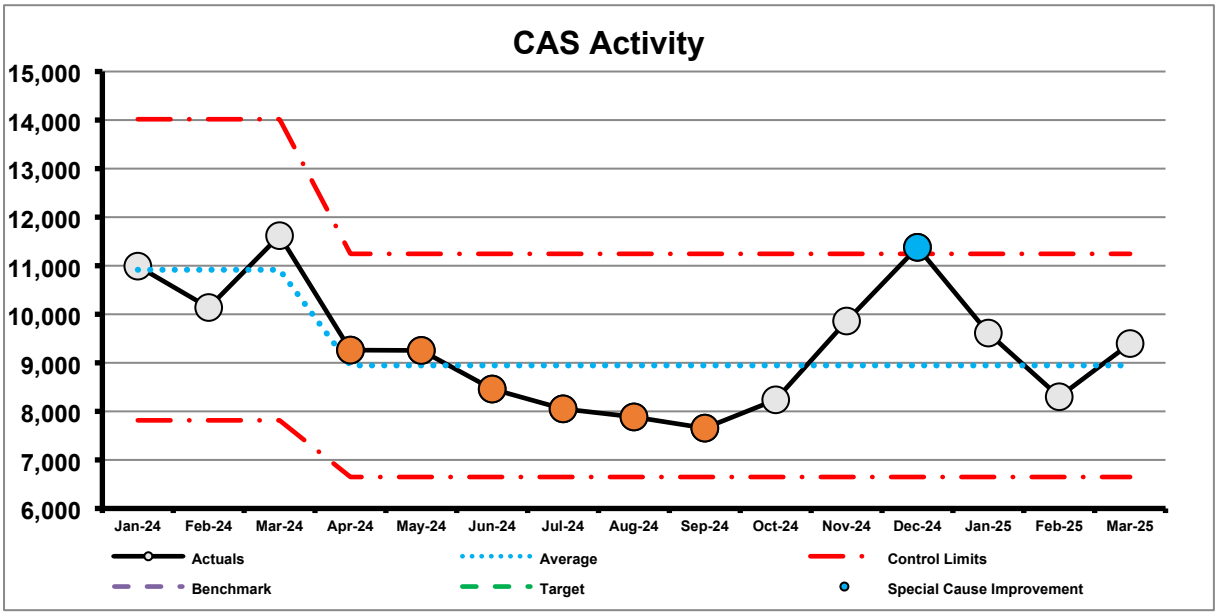
The number of referrals to the frailty virtual ward has not varied significantly during this period and is now showing special cause no variation.

The number of referrals to the cardiology virtual ward has shown special cause improvement since October 2024.

CAS Activity

Background

The CAS was initially commissioned as a proof of concept and commissioners asked providers to collaborate to develop an Alliance Agreement. The service has since demonstrated significant positive system impacts in supporting and reducing A&E attendances. This is now an integral part of the LCHS and Lincolnshire System Integrated Urgent Care offer.



Narrative

March activity has increased, seeing similar activity to that of January 2025. Effective from 21.03.25 CAS supported the UCR service to complete the first clinical assessment/triage to ensure patients are receiving the appropriate outcomes.

There has been significant work within CAS to ensure we are using the established resource and increasing utilisation. This has included various projects.

· Ongoing pilot of CAS physically basing themselves within EMAS. This has now been extended to 7 days a week.

· CAS for Care Homes successful relaunch (impact of which can be seen in increased referral numbers throughout October and November)

· Healthcare SPA went live 14.10.24

· Same Day Access Pilot went live 18.11.24.

There are ongoing discussions with the ICB regarding the return of interim dispositions and ED validations from DHU to CAS following significant concerns about DHU's performance and patient safety/experience with the new pathway. This may mean pausing some of the ongoing pilots discussed above but this is yet to be confirmed.

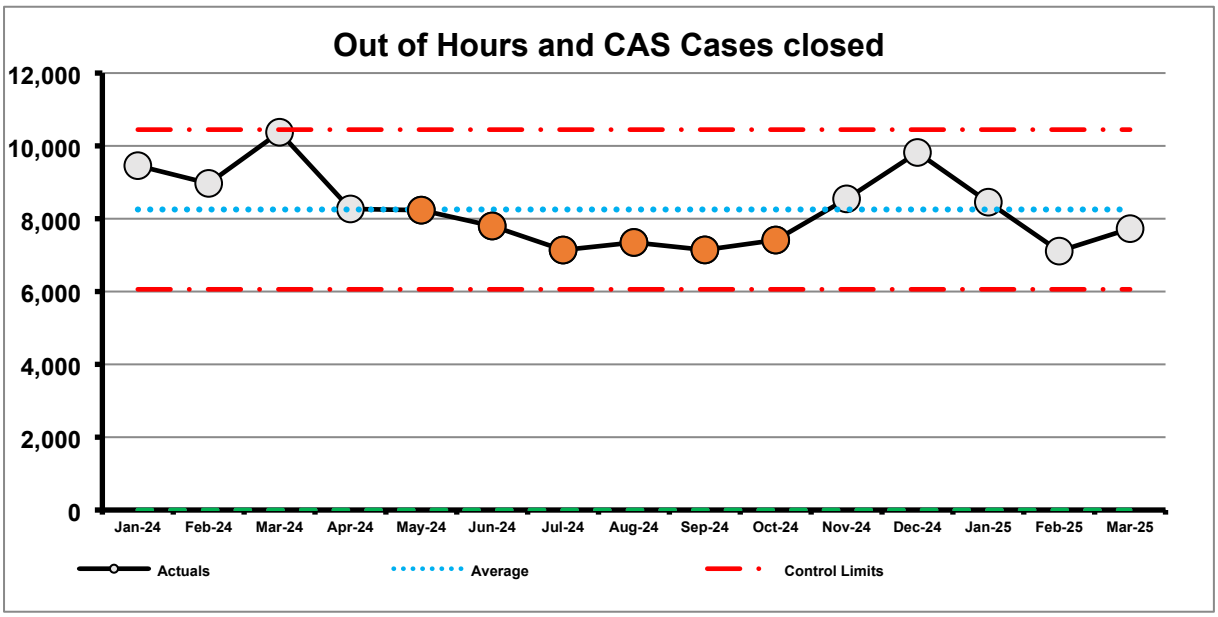
SPC

CAS activity has not varied significantly in the period.

OOH and CAS Cases Closed

Background

LCHS on average has around double the attendances of ULHT's type 1 attendances. This includes Out of Hours services and CAS.



Narrative

This metric shows the combined number of cases closed within the Stamford Out of Hours and CAS services and is directly correlated to the level of activity seen within those services (additional narrative is featured within the CAS activity). March has seen a positive trajectory towards the expected average. We are still awaiting DHU contract changes to return to Lincs CAS.

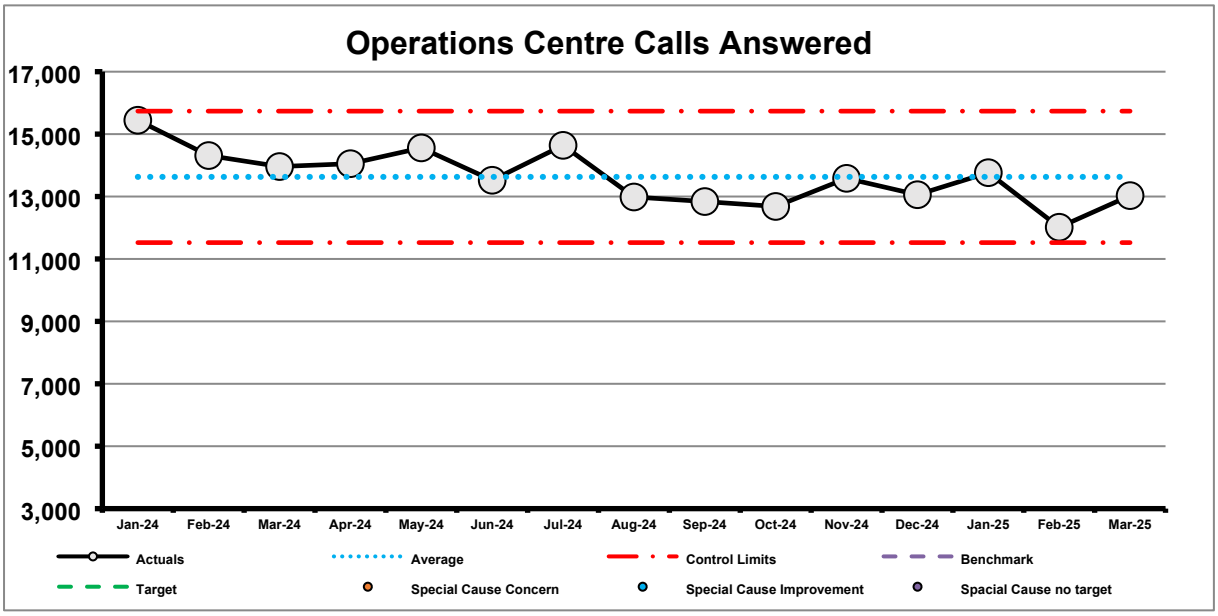
SPC

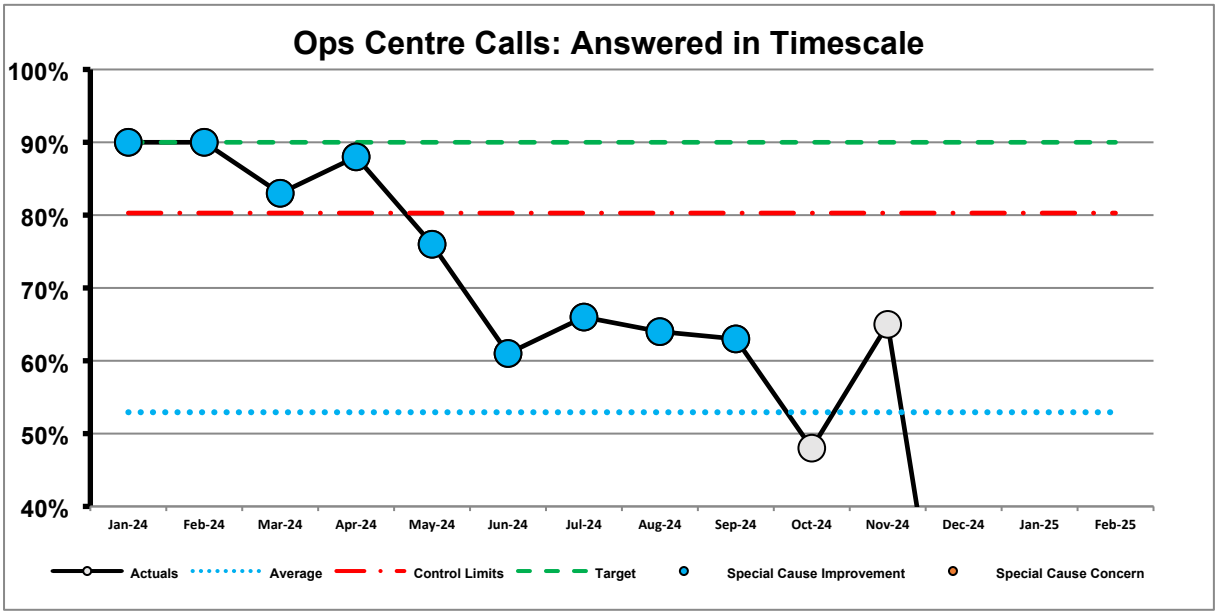
OOH & CAS Cases Closed has not varied significantly in the period.

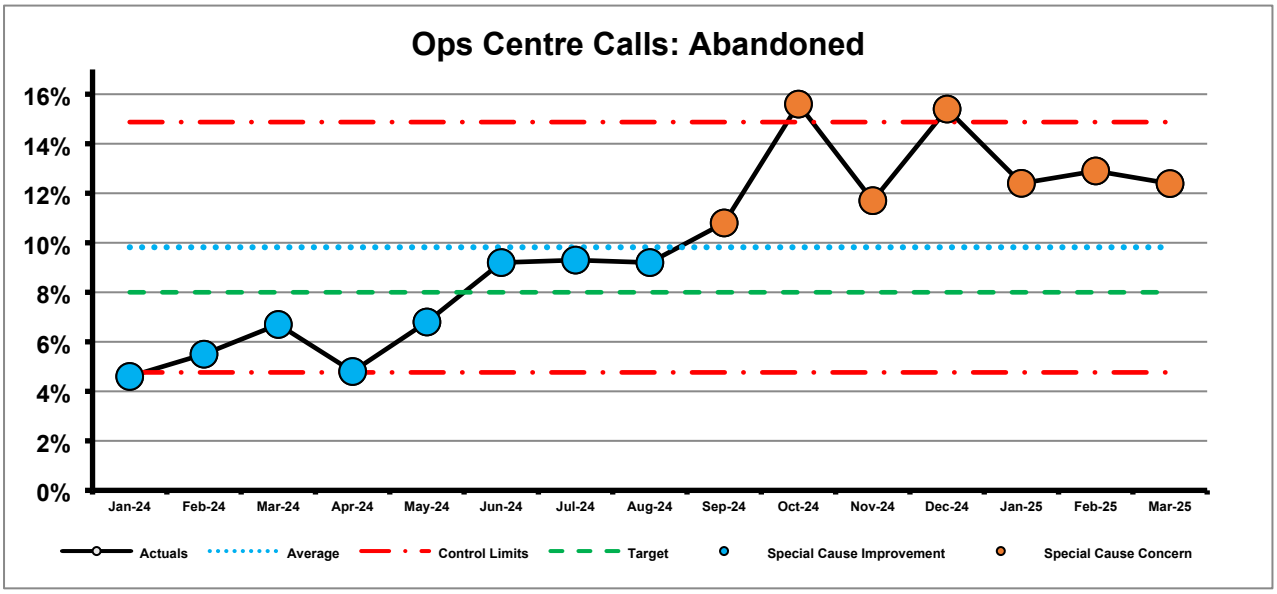
Operation Centre Calls Metrics

Background

The Operations Centre was opened in December 2016 and provides a 24/7 multi-disciplinary team for LCHS. It was developed on the principle of a 'one call does it all' model and is a critical service that holds the Trust's services together e.g., community nursing, community hospitals, urgent care, transitional care, and our Clinical Assessment Service.







Narrative

March 2025 saw 16,625 calls come through the Ops Centre, compared to 14,994 in March 2024 – an 11% increase as well as this we saw 7,759 emails into ops compared to 6,542 March 24 which is a 19% increase YoY.
Our average daily contacts were 743 (calls and emails) in March 24 increasing to 787 in March 25 a 6% increase
Priority calls were answered at 70% within SLA (3% increase on Feb 25) and Standard calls were above the SLA and achieved a strong month 87% (4% up on Feb 25) within SLA abandonment rate reduced by 0.5% to 12.4% whilst all email contacts achieved the SLA. (100% within SLA) at 7759 answered emails with an average email handling time of 03:57 (March 25) compared to 05:39 in March 24.
Focus continues to be around how we can work differently and more efficiently to mitigate the impact of the current vacancies on performance.

SPC

The number of calls answered within the Ops Centre has not varied significantly since December 2023.

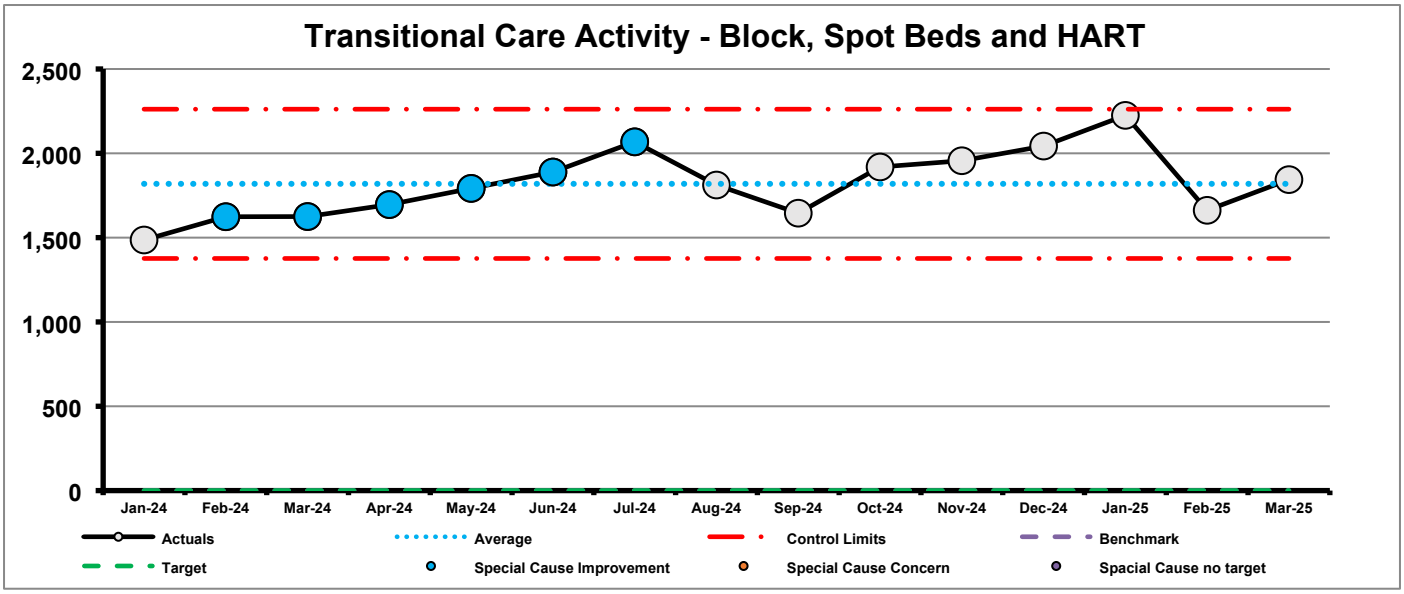
Ops Centre Calls Abandoned shows special cause concern since June 2024. It is inconsistently capable of achieving the 8% target but achieves target more often than not.

Ops Centre Calls Answered within Timescale – This is no longer being reported but remains on the report for the time being as a reference point. New Measures for the Operations centre are to be included in the April report for March data in April report.

Transitional Care Activity

Background

LCHS has a now established and commissioned a Hospital Avoidance Response Team (HART) service, via Age UK to focus on admission avoidance and reduction of Delayed Transfers of Care (DToC). The HART service has demonstrated some excellent quality outcomes, as well as consistently achieving their targets around the number of cases managed each month. HART continue to achieve their monthly key performance indicators and work as a key system partner.



Narrative

Use of block bed stock remains high. The number of scheduled HART visits has fallen, reflecting a shift in capacity (as agreed as part of the recent contract extension).

Actions

Our Commissioned service HART's productivity is being regularly scrutinised, with work related to KPIs ongoing. The core contract has been extended to 31st March 2026, to mirror the system ask around the 'Intermediate Care Review'.

SPC

Transitional care activity has not varied significantly in the period.

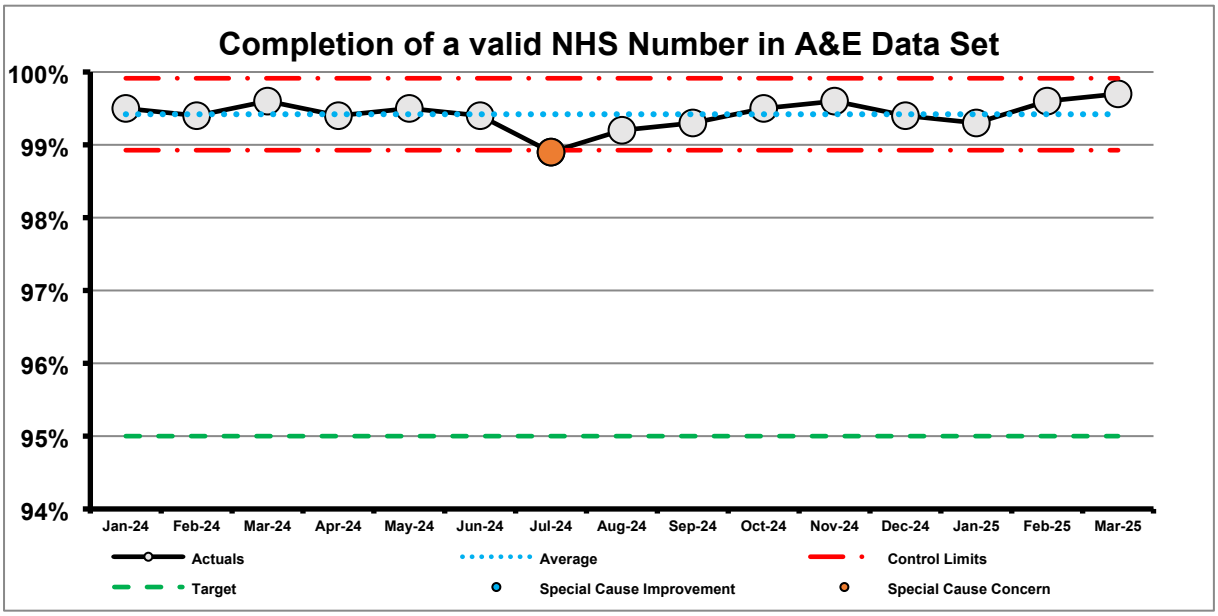
Completion of a Valid NHS Number in A&E Data Set

Background

The Data Quality Dashboards are a national resource to support the improvement and completeness of data flows by reporting on the validity of key data items in Secondary Uses Service (SUS) in accordance with published data standards. The information is provided by The Health and Social Care Information Centre and the areas applicable to LCHS are:

- Accident and emergency

The dashboards are reviewed against the national attainment and any data items that fall below the national attainment rate are highlighted for consideration and action planning.



Narrative

The latest available data demonstrates the completion of a valid NHS number for A&E Data Sets. The Trust maintains a high level of compliance – above 98% since April 2021. This is higher than the national average. Remarkably, July's figure would normally show concern, but this must be seen in context against the outstanding figures across the rest of the year.

Actions

The completions of NHS numbers within the A&E datasets continue to be raised with services, to ensure issues around data quality are addressed. The data system used is linked to the NHS Spine. Patients with no NHS number are not registered with a GP.

SPC

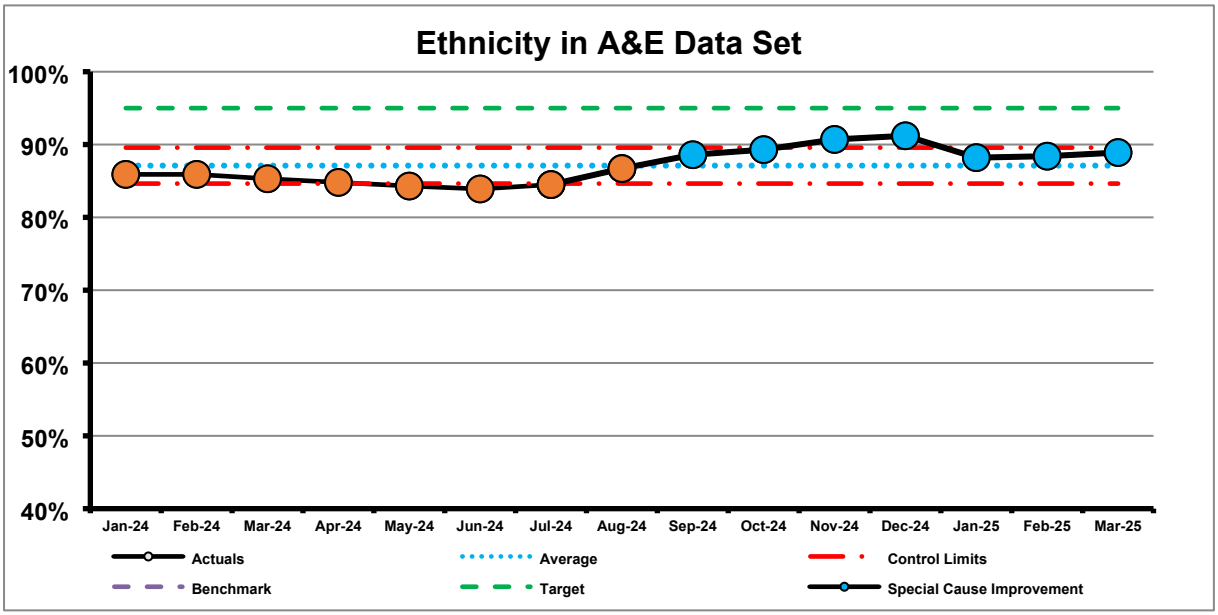
Completion of a valid NHS number for A&E datasets has not varied significantly since June 2024 and is consistently capable of achieving the 95% target.

Completion of Ethnicity in A&E data set

Background

The Data Quality Dashboards are a national resource to support the improvement and completeness of data flows by reporting on the validity of key data items in Secondary Uses Service (SUS) in accordance with published data standards. The information is provided by The Health and Social Care Information Centre and the areas applicable to LCHS are:

- Accident and emergency



Narrative

As reported previously changes to this process were being made to stop using local codes for ethnicity not stated and remove old codes.

Issues have been identified where SystmOne doesn't export patient's ethnicity if the data is not something added by the user onto the system. This has caused problems with us being unable to pull our ethnicity activity from within the extract. The months during July and August where we reported 100%, were due to a miscommunication between ourselves and NHS England during the validation period, where we were advised to reset blank ethnic codes. Since discovering these inaccuracies, we have resubmitted our activity and it is now reflected on a new download from SUS.

The increase from 67% to 87% is through a process developed to download an extra patient dataset from SystmOne which reports on Ethnicity for all patients. Following this validation process, 87% is a more reflective position on actual completion. Further work is still required with our UTC colleagues to continue to work towards improving the collating of our ethnicity data at the point of source.

We have initiated a new Data Quality system "RINSE" introduced to support managers to monitor and manage who hasn't completed ethnicity population. The FBI team continue to with digital health to ensure that any SOPs or training emphasis' the importance of completing the data.

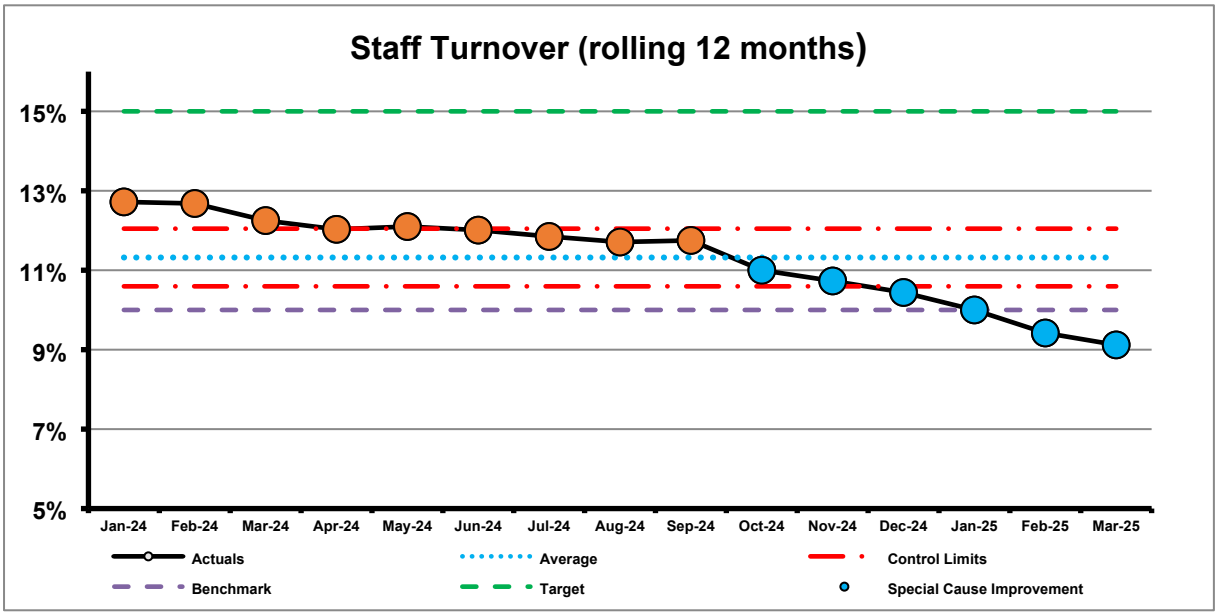
SPC

Ethnicity in A&E dataset has shown special cause improvement since September 2024. 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 9.42% for the period. The “target” level of 15% represents a ceiling to stay within. A healthy level of staff turnover is positive for refreshing the workforce and securing new or additional talent into the organisation, however rising turnover would be indicative of potential staff dissatisfaction and impacts on service delivery.

Actions

Staff turnover is managed by leaders at local levels with supportive frameworks to enable staff to maintain health and wellbeing, freedom to speak up and engage with changes to their service delivery.

SPC

Staff turnover has shown special cause improvement since September 2024 and is consistently capable of achieving the 15% target.

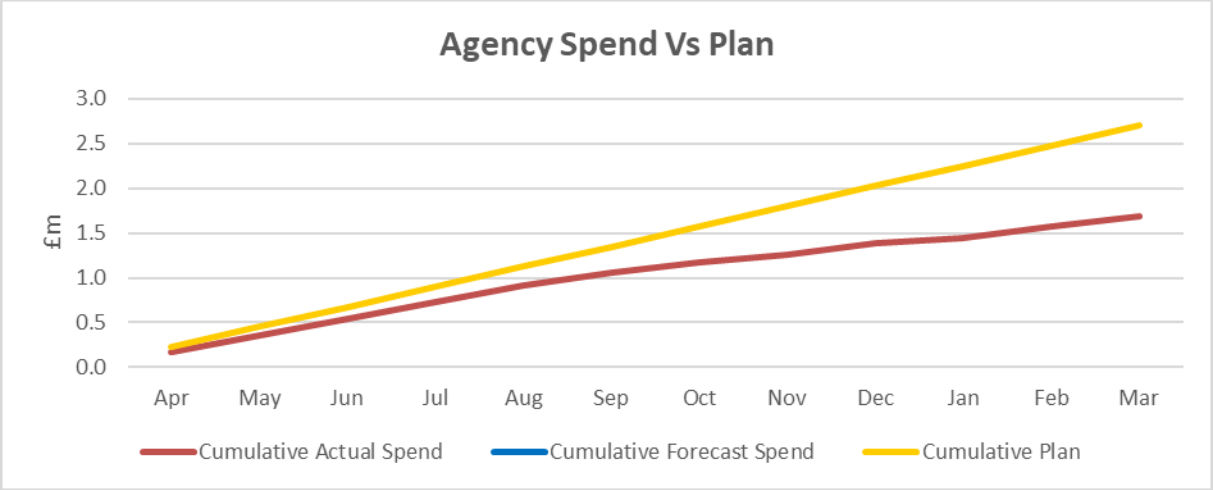
Financial Performance Summary

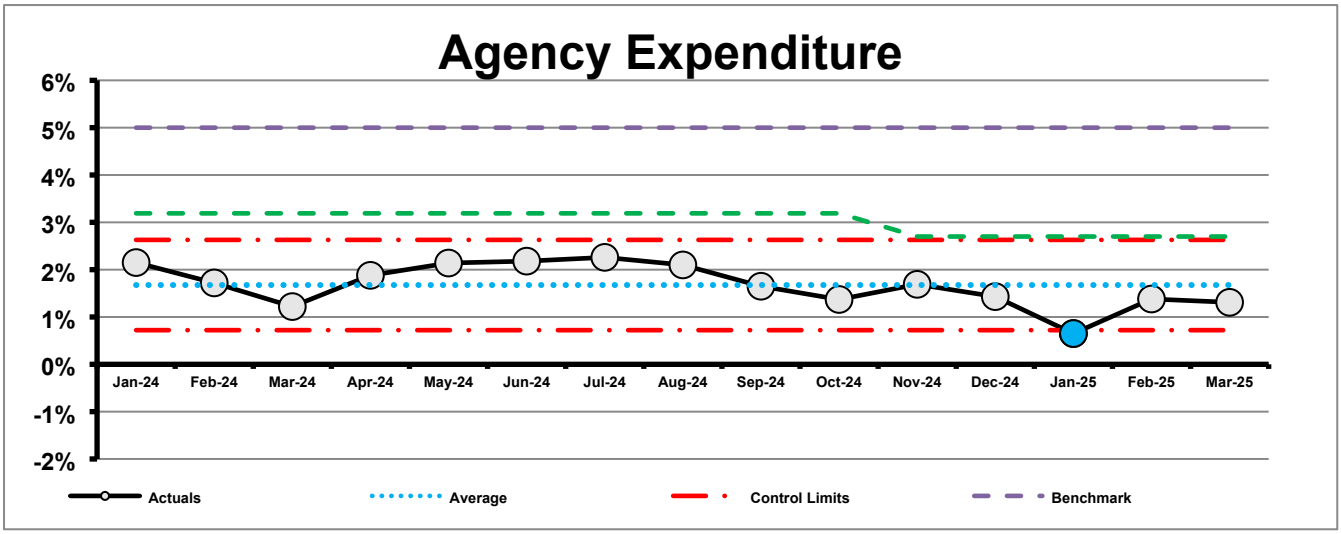
Financial Summary Table (Month 12)	
Description	**Narrative**
Position in March	£-4k deficit
Position YTD	£31k surplus
Position FOT	Breakeven
CIP in March	£669k against plan of £797k
CIP YTD	£7.406m against plan of £7.030m
CIP FOT	£7.401m against plan of £7.030m
Agency in March	£114k against plan of £225k
Agency YTD	£1.694m against plan of £2.7m
Agency FOT	£1.694m against plan of £2.7m
Capital in March	£938k against plan of £2.806m
Capital YTD	£5.152m against plan of £2.580m
Capital FOT	£5.152m against plan of £4.386m
Cash	£27.063m against forecast plan of £26m

Agency Expenditure

Background

For both 2023/24 and 2024/25 there is an agency ceiling at Lincolnshire System level rather than organisational level. The Trust planned for a 3.19% agency level in 2023/24 and is planning for a 2.70% agency in level in 2024/25 as its contribution to achieving the system agency ceiling.





Narrative

- M12 agency spend was £114k compared to £225k plan, this was a favorable result in month.
- Full year agency spend was £1.7m noting that this excludes the benefit of £143k accrual release (M3) and £169k accrual release (M8) relating to prior year invoicing to show a true comparison. This is in line with expected CIP savings for agency.
- In 23/24agency spend was £2.6m, the 24/25 utturn represents a 47% reduction in cost of agency in a year.
- In respect of the split of Agency spend:
    - Collaborative Community Care - £917k (66%)
    - UEC Collaborative - £406k (29%)
    - Agency Nursing represented 52% of Agency costs YTD

SPC

Agency expenditure has not varied significantly in the period. It is inconsistently capable of achieving the 2.7% target but expected to achieve target more often than not.

Efficiencies Plan (CIP)

Background

This information represents year-to-date delivery against the planned Cost Improvement Plan (CIP).

	Aspyre	Plan Month 12 £000	Actual Month 12 £000	Variance Month 12 £000	Plan YTD £000	Actual YTD £000	Variance YTD £000	Annual Plan £000	Forecast £000	Variance £000	Overall Delivery of Savings RAG
Interest - GBS Bank Account		£108	£49	-£59	£1,300	£1,245	-£55	£1,300	£1,245	-£55	R
LCHS income to cover initiatives without System support		£97	£97	£0	£1,159	£1,159	£0	£1,159	£1,159	£0	NR
Procurement		£55	£61	£6	£300	£329	£29	£300	£329	£29	R
Non-Pay Savings		£33	£26	-£7	£140	£272	£132	£140	£272	£132	R/NR
Estates Savings		£23	£22	-£1	£150	£135	-£15	£150	£135	-£15	R/NR
Delay to POCT Project		£25	£42	£17	£125	£333	£208	£125	£333	£208	NR
Continence products		£8	£8	£0	£70	£37	-£33	£70	£37	-£33	R
Service Redesign		£100	£138	£39	£1,177	£1,177	£0	£1,177	£1,177	£0	R
Agency Reduction	✓	£126	£111	-£15	£1,100	£1,008	-£92	£1,100	£1,008	-£92	R
Use of ULHT GP cover overnight		£51	£11	-£39	£127	£139	£12	£127	£139	£12	R
POCT and FBI posts removed		£27	£10	-£17	£107	£90	-£17	£107	£90	-£17	R
Vacancy Savings (additional 1%)		£110	£55	-£55	£992	£540	-£452	£992	£540	-£452	NR
Bank and Overtime Reduction		£30	£39	£9	£105	£124	£19	£105	£124	£19	NR
Unidentified Gap		£5	£0	-£5	£178	£0	-£178	£178	£0	-£178	R/NR
Technical CIP		£0	£0	£0	£0	£818	£818	£0	£818	£818	NR
2024-25 CIP Programme		**£797**	**£669**	**-£127**	**£7,030**	**£7,406**	**£376**	**£7,030**	**£7,406**	**£376**	

Recurrent		£508	£402	-£105	£4,296	£4,064	-£232	£4,256	£4,083	-£173
Non-Recurrent		£289	£267	-£22	£2,734	£3,342	£608	£2,774	£3,323	£549
		£797	**£669**	**-£127**	**£7,030**	**£7,406**	**£376**	**£7,030**	**£7,406**	**£376**

Narrative

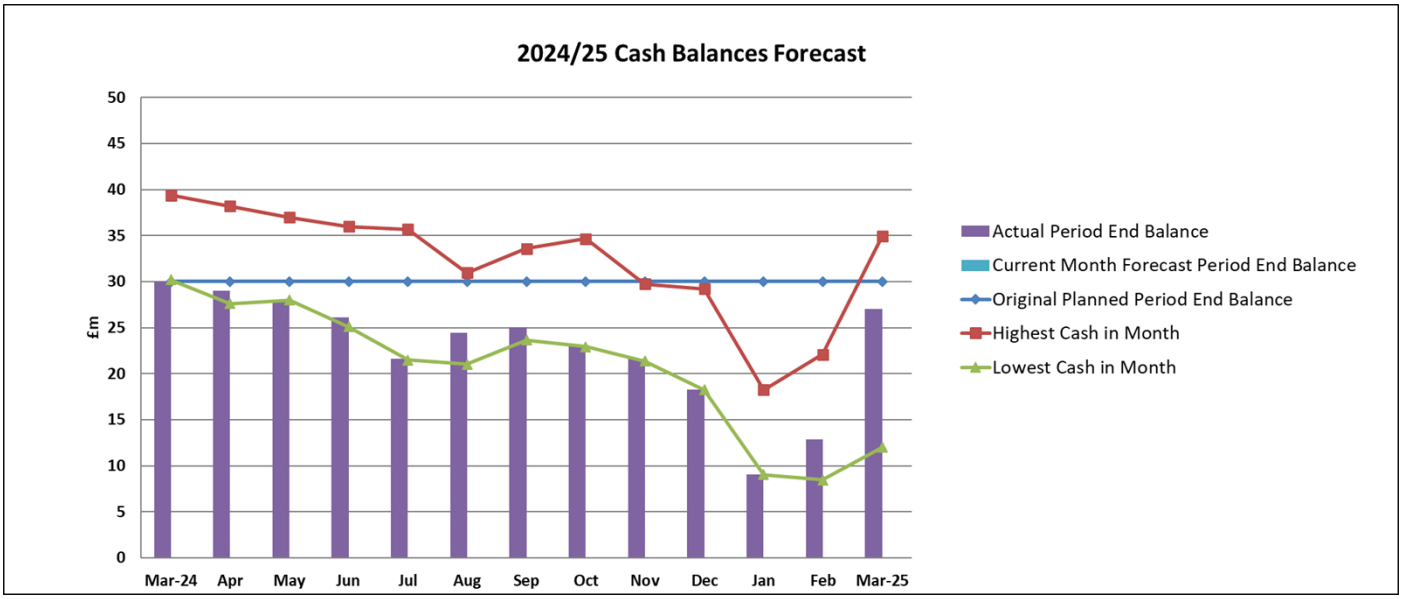
- Full year CIP delivery in line with increased forecast of £7.4m
- Full year forecast increased from £7.0m to £7.4m due to Technical CIP releases.
- No red rates initiatives.
- M12 delivery £127k adverse to plan, £5k ahead of forecast.

Cash Balances

Background

This metric tracks the Trust performance of cash balances against planned levels of cash at each month end. Management of cash is important to ensure the Trust can adequately meet its liabilities to stakeholders. As part of the interim financial arrangements in place for Covid-19, a formal plan for cash was not mandated or collected but providers manage cash positions to remain stable.

Cash Balances for 2024/25 are as below:



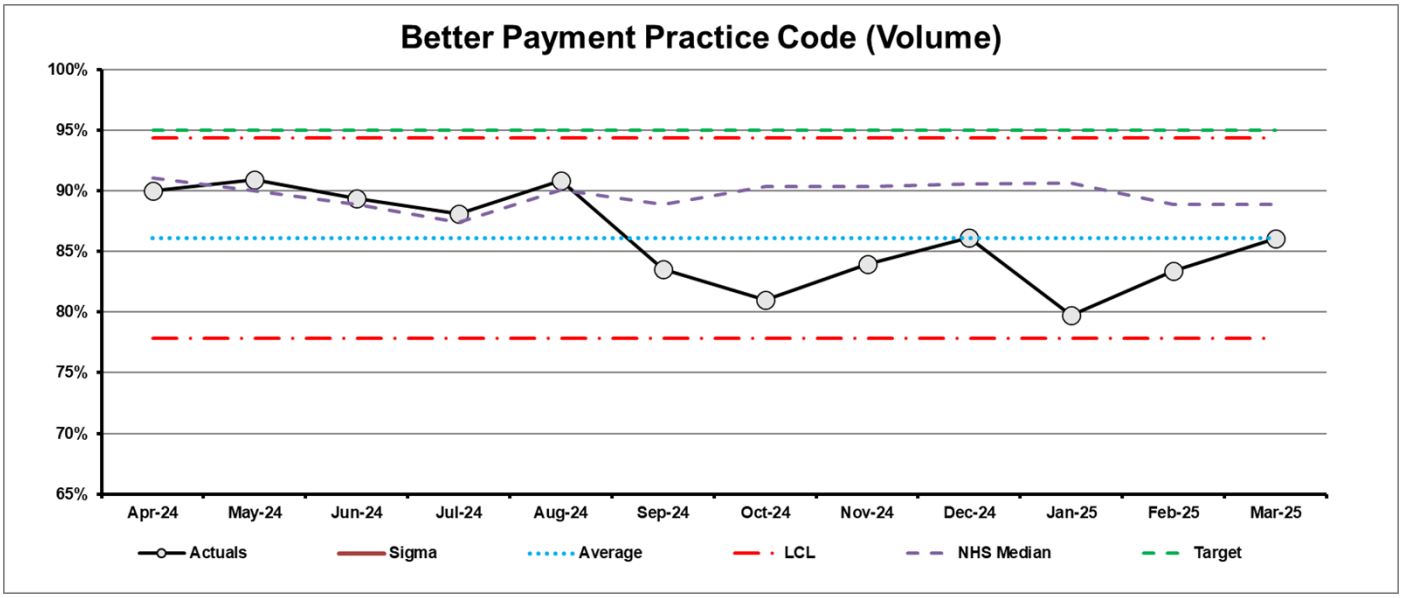
Narrative

- The LCHS cash balance for M12 was £27m, the support to the group cash position and awaited pay award income was received in March, and therefore the cash balance has ended the financial year at slightly more than forecast.
- The reduction from 24/26 starting position of £30m relates largely to prior year invoices and NHSPS that affected cash position.

Better Payment Practice Code

Background

This metric represents the performance of our invoices paid within the agreed terms. The target Better Payment Practice Code (BPPC) is 95%.



Narrative

- BPPC by number of invoices for March at 86%, an increase of 3% versus prior month and below the target of 95%.
- BPPC has continued to pick up in the last 2 months, with a renewed focus on monitoring. Showing an improvement of 6.3% over the last 2 months of the year.
- Finance are reviewing ASD access, and training members of staff to pick up the monitoring of BPPC, so that there is a renewed focus on achieving 95% working closely with ULTH accounts payable team to understand areas of concern and agreed actions to address.

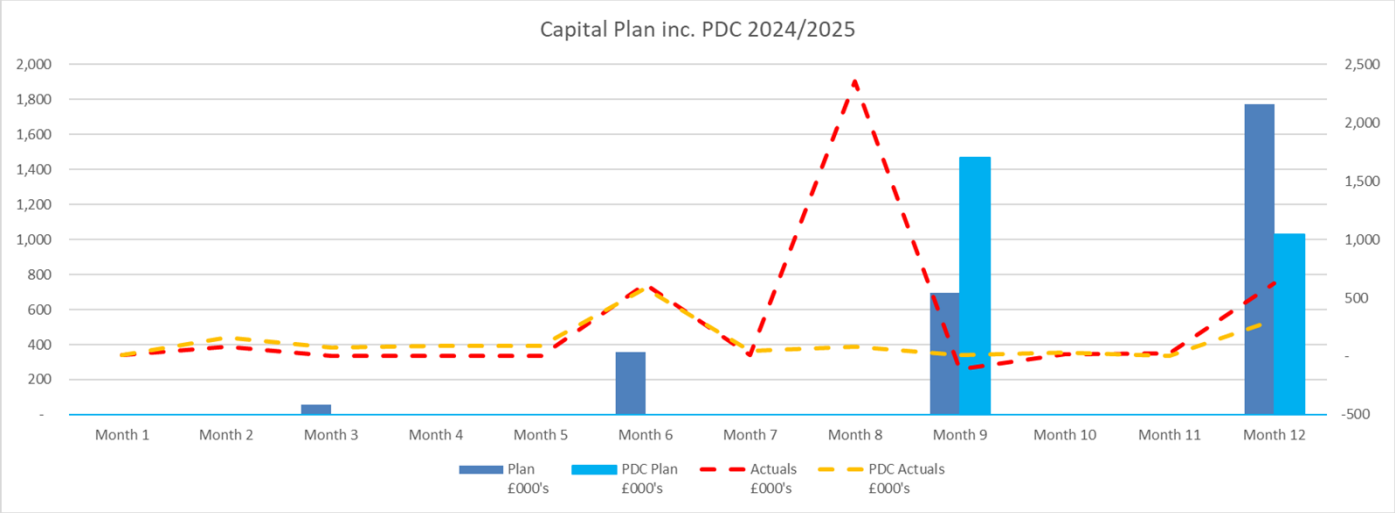
SPC

Monthly Better Payment Practice Performance by volume has not varied significantly over the period. This metric is inconsistently capable of achieving the 95% target and is expected to miss the target more often than not.

Cumulative Capital Expenditure Plan vs Actual (£000)

Background

This metric tracks year-to-date expenditure of the Trust Capital Programme against plan. Capital Expenditure includes investment in maintaining, replacing, and transforming the Trust asset base. The Trust has a capital plan of £2m for 2024/25.



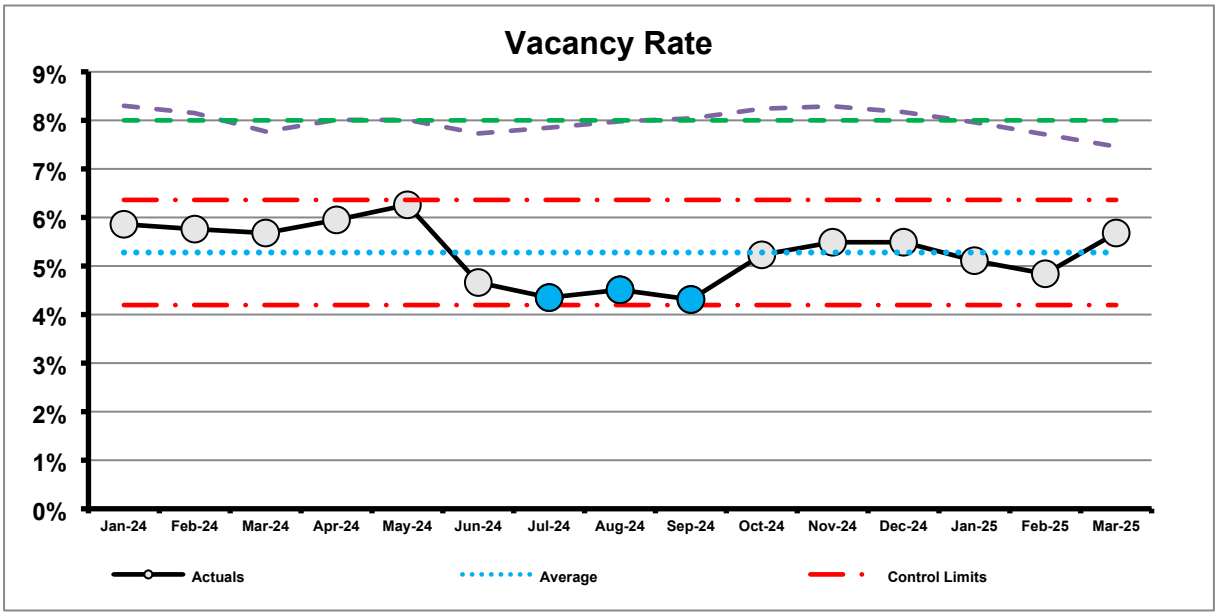
Narrative

- The LCHS capital plan for the financial year totals c£5.386m, £2.086m of capital allocation, £2.5m of PDC and £800k of IFRS16 funding.
- 24/25 full year spend equated to £5.212m.
- The Plan assumed that capital spend would be incurred in M9 (£1.0m) and M12 (£1.1m) with spend phased towards the end of the year to allow plans to be fully developed.
- £1m of PDC was agreed to be deferred to 25/26, reducing the total spend in 24/25 to £1.5m spend.
- There is a YTD underspend (£0.234m) against plan, however with the deferred PDC per the above the actual outturn is an overspend of £0.8m, this has been agreed to be offset in year by an additional £0.9m budget allocation.
- The year to date spend has been incurred in the following areas (bracketed numbers are full year plan)
    - Information Management & Technology - £22k (£650k)
    - Estates investment schemes - £370k (£816k)
    - Clinical Equipment schemes - £495k (£620k)
    - IFRS16 - £2.765m (£800k)
    - PDC – £1.501m (£2.5m)

Vacancy Rate

Background

The Vacancy Rate target for LCHS is 8%.



Narrative

Following the TUPE transfer of the Mass Vaccination Centre staff into LCHS from the ICB, this affected the Trust vacancy rate bringing this artificially lower whilst work was undertaken to align the budgets and establishment. This work has now been completed and the budget/finance system and ESR have been fully balanced.

Actions

On target – the Trust has a low overall vacancy rate compared to both the 8% target and the national benchmark figure. The national benchmark figure is published by the NHS Benchmarking Network's community indicators project monthly.

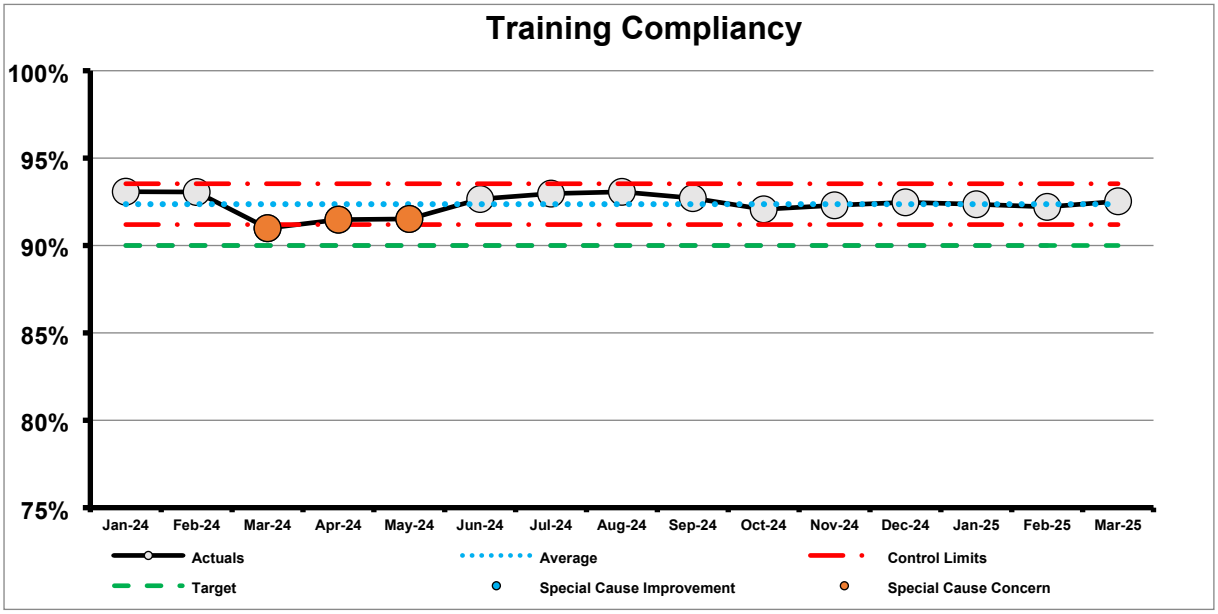
SPC

The vacancy rate has not varied significantly in the period and is consistently capable of achieving the 8% target.

Training Compliancy

Background

The national benchmark for Training Compliance is 90%. In November 2022, the Trust Board approved the recommendation to reduce the target to match this. This new target of 90% is reflected within the data below.



Overall mandatory compliance as of 31st March 2025:

The overall mandatory training compliance rate which includes all core and role specific modules has increased very slightly to 92.53% which exceeds the local and national target of 90%.

Core mandatory training compliance (requirements for all staff):

Overall compliance for the core mandatory modules has increased very slightly to 95.83% which exceeds the national/local target of 90%.

The 25-26 Mandatory season, Apr-Jun, commenced on 3rd April. Currently 1568 bookings (67.75%) and reminder communications taking place on a regular basis. There is a range of delivery methods to suit all, Microsoft Teams, Face to Face and the eLearning module that will be uploaded to ESR towards the end of April for staff to access at a time of their choice and support those returning to work from long term absence to update during the year.

Most divisions/directorates have overall compliance remaining above the national/local target of 90% except for IUEC and Operational Leadership who remain under target.

Children's, Young People's, and Specialist Services	94.21%	↑
Collaborative Community Care	91.87%	↑
Corporate Services	96.87%	↓
Integrated Urgent and Emergency Care	88.90%	↑
Operational Business Services	98.49%	↓
Operational Leadership	82.39%	↑

System	93.24%	↑

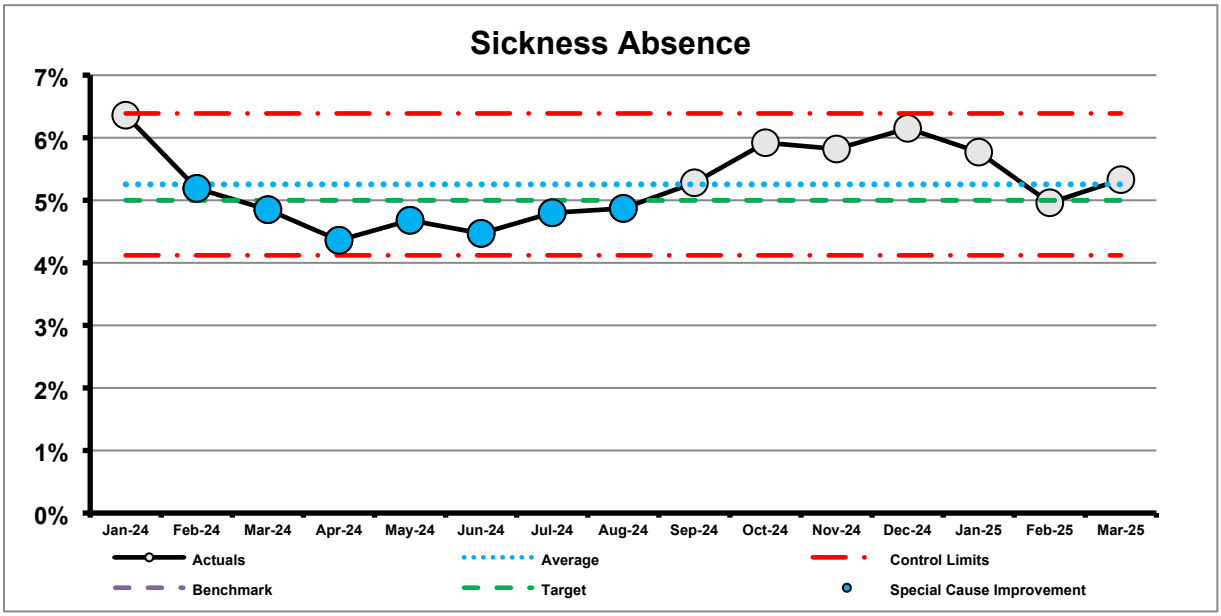
SPC

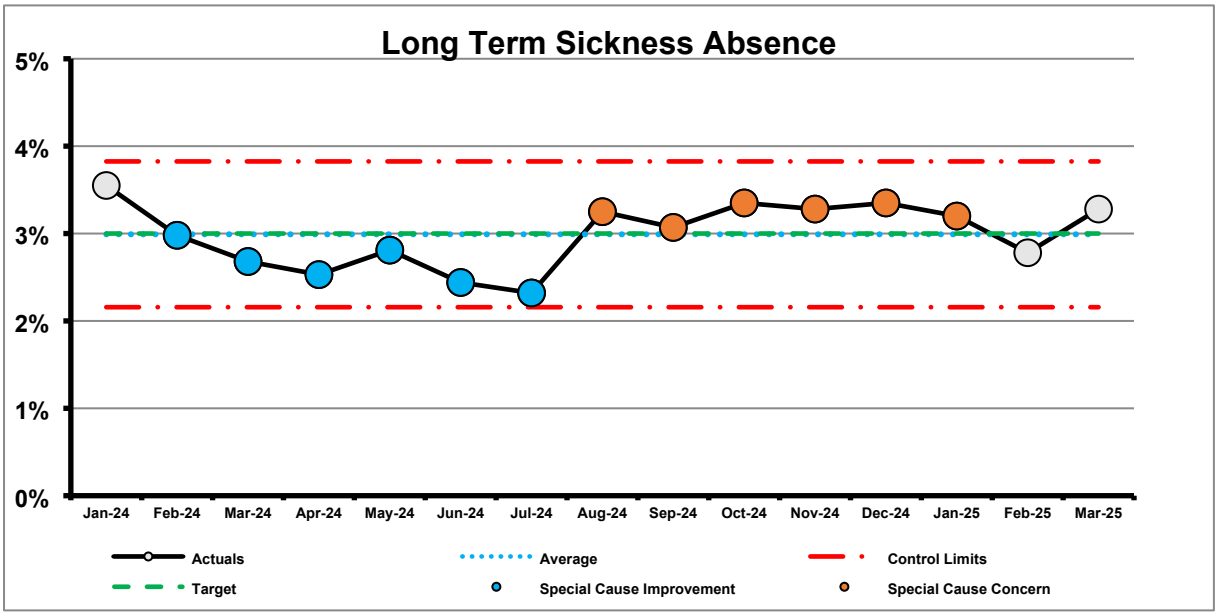
Mandatory Training compliance has not varied significantly since March 2024. The measure is consistently capable of achieving the 90% target.

Sickness Absence

Background

The Trust target for total sickness absence is 5%.





Narrative

The overall sickness levels in March have Increased to 5.33% compared with 4.93% in February and is therefore slightly above the agreed target of 5%.

For overall sickness absence, there are three areas which are above target as of March: Operational Business Services (8.17%), Integrated Urgent and Emergency Care (7.89%) and Collaborative Community Care (5.55%).

The top three reasons accounting for overall sickness absence in March were anxiety, stress and depression, other musculoskeletal and gastrointestinal problems, which is consistent with previous months.

Long Term

The long-term sickness level in March has seen an increase to 3.28% from 2.69% in February, which is above the agreed target of 3%.

In relation to long term absence, there are three areas above target: Collaborative Community Care (3.39%), Integrated Urgent & emergency Care (4.67%) and Operational Business Services (5.99%).

The top three reasons for long term sickness absence for March were: Anxiety/stress/depression (42.94%), other musculoskeletal (11.85%) and Gastrointestinal problems (7.5%).

Short Term

The short-term sickness level in March has also decreased to 2.05% from 2.23% in February, although this remains just above the 2% target.

In respect of short-term sickness, there are Three areas which remain above target: Collaborative Community Care (2.17%), Integrated Urgent and Emergency Care (3.22%) and Operational Business Services (2.18%).

The top three reasons for short term sickness absence in March were: anxiety/stress/depression (23.55%), Cold, Cough, Flu (16.22%) and gastrointestinal problems (15.3%).

Actions

- 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. Additionally providing advice and guidance on managing short term sickness, encouraging the earliest possible return to work date, and supporting managers to develop support plans where required and to issue sanctions where appropriate in line with our Your Attendance Matters policy.

- 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 HR Team proactively promotes all of these at all given opportunities and advises Occupational Health referrals for all absences in connection with work related mental health illnesses or conditions.

- The HR team continue to offer leaders coaching, advice and guidance in the appropriate and timely management of absence in line with the Your Attendance Matters policy and a number of bespoke attendance management workshops have been held with leaders. HR are encouraging managers to hold early wellbeing conversations with individuals to identify health and wellbeing support, adjustments, and flexible arrangements as appropriate, to support individuals to remain in work and/or return to work and to reduce the number of absence cases becoming long term. The attendance management workshops are being held bi-monthly with the latest having been held in February however only 6 attendees were present. The next workshop is scheduled for April.

- LCHS Attendance policy is currently under review as part of the Group Policy Committee to bring together our attendance policy with that of ULTH to crate one group attendance policy which is mirrored across both organisations. This is an extensive price of work which will require some changes to the ways we currently manage absence and will be supported by the appropriate training, upskilling, familiarisation, and coaching sessions when the policy is due to be launched.

- 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.

SPC

Overall sickness rate has not varied significantly in the period and is inconsistently capable of achieving the 5% target. The target is expected to be missed more often than achieved.

Long-Term Sickness Absence has not varied significantly since July 2024 and is inconsistently capable of achieving the 3% target. The target is expected to be missed more often than achieved.

Workforce Dashboard

March 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	551.31	501.95	49.36	8.95%	9.26%	1.15%	4.14%	1.64%	2.51%	94.21%	95.46%	93.10%
⊞ Collaborative Community Care	758.44	772.19	-13.75	-1.81%	6.48%	0.31%	5.55%	2.17%	3.39%	91.87%	86.06%	82.83%
⊞ Corporate Services	223.76	214.61	9.15	4.09%	17.39%	0.57%	2.45%	0.86%	1.59%	96.87%	98.95%	83.33%
⊞ Integrated Urgent & Emergency Care	435.17	364.06	71.11	16.34%	6.05%	0.81%	7.89%	3.22%	4.67%	88.90%	96.35%	93.08%
⊞ Operational Business Services	111.44	104.10	7.34	6.59%	13.04%	3.88%	8.17%	2.18%	5.99%	98.49%	97.03%	
⊞ Operations	15.90	10.18	5.72	35.97%	29.47%					82.39%	100.00%	83.33%
⊞ System	19.00	27.81	-8.81	-46.39%	34.04%	3.60%	0.23%	0.23%		93.24%	90.91%	93.33%
Total	**2,115.02**	**1,994.90**	**120.12**	**5.68%**	**9.12%**	**0.87%**	**5.33%**	**2.05%**	**3.28%**	**92.53%**	**92.41%**	**87.96%**

Corporate Services

Division	FTE Budgeted	FTE Actual	FTE Vacant	Vacancy Rate	Annual Turnover Rate	Monthly Turnover Rate	Total Absence Rate	Short Term Absence Rate	Long Term Absence Rate	Training Compliance Rate	Appraisals Rate	Supervision Rate
⊟ **Corporate Services**	223.76	214.61	9.15	4.09%	17.39%	0.57%	2.45%	0.86%	1.59%	96.87%	98.95%	83.33%
⊞ Chief Exec	20.95	10.45	10.50	50.10%	38.27%					99.37%	100.00%	
⊞ Finance & Business Intelligence	54.20	48.53	5.67	10.46%	23.08%	2.06%	2.35%	0.30%	2.05%	97.38%	97.37%	
⊞ Medical Directorate	21.25	26.19	-4.94	-23.23%	9.55%		1.39%	1.39%		92.24%	100.00%	75.00%
⊞ People & Innovation	84.77	91.36	-6.59	-7.77%	12.71%	0.23%	2.74%	1.21%	1.53%	97.43%	100.00%	100.00%
⊞ Quality	42.59	38.08	4.51	10.59%	21.01%		3.31%	0.61%	2.70%	97.98%	97.30%	88.46%
Total	**223.76**	**214.61**	**9.15**	**4.09%**	**17.39%**	**0.57%**	**2.45%**	**0.86%**	**1.59%**	**96.87%**	**98.95%**	**83.33%**

NHS
Lincolnshire Community and Hospitals NHS Group

Group Board Risk Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6 May 2025*
Item Number	*12.1*

Group Risk Report

Accountable Director	*Kathryn Helley, Group Chief Clinical Governance Officer*
Presented by	*Kathryn Helley, Group Chief Clinical Governance Officer*
Author(s)	*Helen Shelton, Group Deputy Chief Clinical Governance Officer* *Lorna Adlington, Head of Patient Safety and Quality Governance, LCHS* *Sarah Davy, Risk and Datix Manager, ULTH* *Rachael Turner, Risk & Datix Facilitator*
Recommendations/ Decision Required	*The Group Board are invited to review the content of the report. There are no further escalations at this time.*

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

Executive Summary

The following report includes information pertaining to risks scoring 15 – 25 which are in relation to the highest risks across the Group.

For this report, the strategic objectives for 2024-2025 have been utilised as these are in line with the reporting arrangements into the committees for April 2025. Work is currently underway to align the new Group Strategic Objectives for 2025-2026 within DatixIQ across the Group for reporting into the sub-committees of the Group Board from May 2025.

As part of a Board Risk Appetite workshop, the risk appetite against the revised LCHG strategic objectives for 2025/26 has been agreed in principle. Work is now underway to update the strategic objectives within the DatixIQ systems, meet individually with the Executive and Non-Executive Directors to strengthen risk alignment across the committees and review current risk reports to incorporate risk appetite and strengthen current reporting arrangements.

As of 2nd April 2025, there are 758 (129 LCHS and ULTH 629) risks recorded on the Group risk registers.

LCHS

There is 1 Very High risk (20 - 25) reported to the Quality Committee. This is a decrease of 1 from the previous reporting period. This relates to:

- 403 - Children SLT Therapy Treatment Delays

395 TB Demand and Capacity was presented at Risk Confirm and Challenge in March 2025 and agreed closure as it has been superseded by a new risk **783 - TB Service Provision** - (Risk score 4 x 4 = 16). This new risk was validated at March RRC&C meeting.

There are no Very High risks (20-25) reported to the Finance, People and Integration Committees this month.

ULTH

The are 9 Very High risks (20-25) reported to the Quality Committee this month, remaining stable from last month's reporting period, these relate to:

- 4731 - Reliance on paper medical records
- 4828 - Reliance on manual prescribing processes
- 4879 - Recovery of planned care cancer pathways
- 4947 – NICE Medicines reconciliation compliance
- 5016 - Patient flow through Emergency Departments
- 5100 - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- 5101 - Delivery of paediatric epilepsy pathways-community
- 5143 - Removal of lift in H Block PHB affecting service delivery to patient records
- 5450 - Risk of Gastro service not being viable due to current fragility of consultant workforce

There are 5 Very High risks (20-25) reported to the People Committee this month, remaining stable from the previous reporting period:

- 4844 - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- 4948 - Pharmacy workload demands
- 4996 - Consultant workforce capacity (Haematology)
- 4997 - Service configuration (Haematology)
- 5447 - Cancellation of elective lists due to lack of theatre staff

There are 4 Very High risks (20-25) reported to the Finance Committee this month, remaining stable from the previous reporting period:

- 4664 - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- 4665 - Failure to meet 24/25 CIP
- 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
- 4657 - Compliance with Subject Access Requests - **Following review this risk has been realigned to Finance Committee; this was previously aligned with Integration.**

The following risk was presented to Risk Register Confirm and Challenge in February and was validated for closure:

- 5277 - Risk of additional financial pressures from possible application of national profiles to existing Job Descriptions.

There are currently no Very High risk (20-25) reported to the Integration Committee

Purpose

The purpose of this report is to enable the Group Board to review the management of significant risks to strategic objectives and consider the overall extent of risk exposure within the Group at this time.

1. Introduction

1.1 The Group's risk registers are recorded on Datix. This report is focussed on significant risks to each objective, those with a current rating of Very High risk (a score of 20-25). For this report, the strategic objectives for 2024-2025 have been utilised as these are in line with the reporting arrangements into the committees for April 2025. Work is currently underway to align the new Group Strategic Objectives for 2025-2026 within DatixIQ across the Group for reporting into the sub-committees of the Group Board from May 2025.

1.2 Full details of all active Very High and High risks (those with a current risk score of 15-25) are included in **Appendix A (LCHS) and Appendix B (ULTH)**, and a summary of Very High risks is provided in Section 2 below. Moderate and Low risks (those with a score of 12 and below) are overseen at divisional level.

1.3 The Risk Register Confirm and Challenge Group continues to meet on a monthly basis, reviewing all High and Very high risks as well as receiving presentations from clinical and corporate business areas on a rotational basis to enable constructive feedback to be provided.

2. Group Risk Profile

2.1 There are 758 (LCHS 129 and ULTH 629) active and approved risks reported to lead committees in April 2025.

2.2 LCHS

There is 1 risk with a current rating of Very High risk (20-25) and 13 rated High risks (15-16) reported to lead committees. **Table 1** below shows the number of active risks by current risk rating and proportion of the overall Trust risk profile:

Very low (1-3)	**Low** (4-6)	**Moderate** (8-12)	**High** (15-16)	**Very high** (20-25)
5 (4%)	**32** (25%)	**78** (60%)	**13** (10%)	**1** (1%)

2.3 ULTH

There are 18 risks with a current rating of Very High risk (20-25) and 64 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)
54 (-) (9%)	**154 (+1)** (24%)	**339 (+12)** (54%)	**64 (-1)** (10%)	**18 (-1)** (3%)

Strategic objective 1a: Deliver high quality care which is safe, responsive and able to meet the needs of the population

2.4 **LCHS**

There is 1 Very High risk, a decrease of 1 from the previous reporting period and 6 High risks recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	Title	Risk score	Division	Progress Update	Date of latest review
403	Children SLT Therapy Treatment Delays	20	Children, Young People, and Specialist Services	The business case is not being progressed. The service are completing sustainability framework with the planning department. Consideration is being given to how the service can match its activity against the financial envelope. No change to score	17/04/25

2.5 **ULTH**

There are 7 Very High risks, remaining stable and 25 High risks recorded in relation to this objective. A summary of the Very High risks is provided below:

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
4879	Recovery of planned care cancer pathways	Very high risk (20-25)	Clinical Support Services	The Cancer right-sizing Business Case for Haematology and Oncology was prioritised by CSS Care Group and submitted in line with the Trust's programme for 25/26, aligned to the health System process. At the request of the Execs, QIAs have been refreshed for all investment business case, including this one.	27/03/2025
4947	NICE medicines reconciliation targets	Very high risk (20-25)	Clinical Support Services	RCEM/ED pharmacy case developed and submitted for winter pressures funding- this was unsuccessful. The case will be resubmitted for the next financial year (25/26).	22/04/2025
5016	Patient Flow Through Emergency Departments	Very high risk (20-25)	Medicine	Four hour standard being improved to enable patients to move through pathway quicker. AAR's being completed on all 12 hour breaches to enable any learning opportunities. Some pathways being changed and there will be a 4 week trial for streaming at Lincoln, commencing on the 24th March and a 4 week trial at Pilgrim, which will utilise chair space in SDEC, commencing on the 19th March.	03/04/2025

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
5100	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards	Very high risk (20-25)	Family Health	Business case has been submitted to PMO office, still awaiting outcome from CRIG. Using bank B5 nurses to support some of this work, which adds to cost pressures and not sustainable.	10/04/2025
5101	Delivery of paediatric epilepsy pathways-community	Very high risk (20-25)	Family Health	Business case has been submitted to PMO office, awaiting date for presentation to CRIG. If business case approved, risk can be reduced. Risk to be raised as part of PRM process.	18/02/2025
5143	Removal of lift in H Block PHB affecting service delivery to patient records	Very high risk (20-25)	Clinical Support Services	The new lift is in and is currently being tested in readiness to be handed over to the health records team by the end of March Once handed over the team will review processes and SOP's for the new ways of working with the lift, alongside working through the backlogs that have been created with no lift to the department.	24/04/2025
5450	Risk of Gastro service not being viable due to current fragility of Consultant workforce	Very high risk (20-25)	Medicine	An additional consultant has started at Pilgrim with another possible for late 2025. Workforce business case has been submitted. Risk remains in fragile position, currently awaiting feedback from Trust/ICB.	01/04/2025

Strategic objective 1b: Improve patient experience

2.6 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.7 **ULTH**
There are no Very High risks, remaining stable and 4 High risks, remaining stable since the last reporting period.

Strategic objective 1c: Improve clinical outcomes

2.8 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.9 **ULTH**
There are 2 Very High risks and 6 High risks, both remaining stable, in relation to this objective. A summary of the Very High risks is provided below:

ID	Title	Risk level (current)	Division	Progress update	Date of latest risk review
4828	Reliance on manual prescribing processes	Very high risk (20-25)	Clinical Support Services	Badgernet roll out is imminent, until completion the issues with Outpatients, ICU and Paeds will not be considered and risk will remain the same.	22/04/2025
4731	Reliance on paper medical records	Very high risk (20-25)	Corporate	Until EDMS in in place and ePR alongside it, this remains a risk as there is a potential for information not all in one place. An example of this is that we no longer file blood results in the notes but refer to WebV. Therefore, it is not always feasible to add to the paper notes and a reliance on the clinician to check all digital solutions.	08/04/2025

Strategic objective 1d: Deliver clinically led integrated services

2.10 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.11 **ULTH**

There are no Very High risks and 5 High risks recorded in relation to this objective. The 5 High risks have been realigned following risk review.

Strategic objective 2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise

2.12 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.13 **ULTH**

There are 5 Very High risks, remaining stable, and 16 High risks, a reduction of 1, in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date added to register and latest review:
4844	The ability to provide a seven day a week pharmacy service requires a level of staffing above the current levels. Benchmarking has taken place against peer Trusts for staffing levels. Until this is funded the seven day a week service is unobtainable and this puts patients at risk.	Very high risk (20)	Case submitted to CRIG in November 24 and one page summary submitted in Feb 25, currently awaiting further instruction from CRIG.	22/04/2025

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)	ELT request for ICB Business Case- submitted in Feb 2025. Due to financial situation no further update.	16/04/2025
4997	Service configuration - single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites	Very high risk (20)	ELT request for ICB Business Case- submitted in Feb 2025. Due to financial situation no further update.	16/04/2025
5447	Nurse staffing in theatres does not support current activity. There is a risk of elective lists being cancelled due to lack of theatre staff. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill.	Very high risk (20)	Staffing template reviewed and amended to support nine theatres at LCH-roster templates will reflect the change from July 2025. Awaiting confirmation of Theatre floor plans from Business Unit. Review of PBH Theatres to commence in April 2025.	13/03/2025
4948	Workload demands within Pharmacy persistently exceed current staffing capacity which leads to longer working hours (inc weekends), work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Very high risk (20)	Risk to be presented at April Risk Register Confirm and Challenge for approval of closure-risk combined with Risk ID 4844.	25/03/2025

Strategic objective 2b. To be the employer of choice

2.14 **LCHS**

There are no Very High risks and no High risks recorded in relation to this objective.

2.15 **ULTH**

There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3a: Deliver financially sustainable healthcare, making the best use of resources

2.16 **LCHS**

There is no Very High risk and 3 High risks recorded in relation to this objective.

2.17 **ULTH**

There are 4 Very High risks (20-25), remaining stable and 4 High risks (15-16), an increase of 3, recorded in relation to this objective. A summary of the Very High risks is provided below:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
5020	If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Very high risk (20)	Implementation of tier 2 rota has not materialised- escalated to Exec Level.	03/04/2025
4664	The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services.	Very high risk (20)	Trust financial plan requires similar level of reduction to agency expenditure as previously made in 2023/24, focus is to reduce expenditure in relation to medical & dental staffing.	17/04/2025
4665	The Trust has a £40.1m Financial improvement target for 24/25. If the Trust fails to deliver the CIP Plan, this will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to deliver its breakeven financial plan for the year. This represents a 5% target which is greater than any financial improvement the trust has delivered in previous years. In addition to this target, invest to save investments required to deliver the savings plan will need to be funded via more CIP identification/ delivery. Failure to deliver the CIP plan will have an adverse impact on the trusts ability to decrease its underlying deficit and build towards a sustainable pipeline of cost improvement for the future.	Very high risk (20)	CIP forecast is £40.1m which represents achievement of the 2024/25 plan, identified through non-recurrent mitigations forecast to deliver in last two months of year.	17/04/2025

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4657	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, 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.	Very high risk (20)	Weekly compliance monitoring being carried out- reporting to SIRO/ Dir of Corp Affairs. Compliance for newer requests is doing well with resource available but won't meet national targets. Central IG resource continues to be reallocated to support team. Ongoing discussion with LCHS as to any possible support they can provide. Number of current cases of lost personnel files for staff SARs- adds to risk of legal action/ complaints/ etc. HR advise to add to corporate risk register.	10/03/2025

Strategic objective 3b: Drive better decision and impactful action through insight

2.18 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.19 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3c: A modern, clean and fit for purpose environment across the Group

2.20 **LCHS**
There are no Very High risks and 4 High risks recorded in relation to this objective.

2.21 **ULTH**
There are no Very High risks (20-25) and 4 High risks (15-16), a reduction of 5, recorded in relation to this objective.

Strategic objective 3d: Reduce waits for patients who require urgent and emergency care and diagnostics and ensure we meet all constitutional standards

2.22 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.23 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3e: Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards (ULTH)

2.24 There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3f - Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards (ULTH)

2.25 There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 3g – Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards (LCHS)

2.26 There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 4a: Establish collaborative models of care with all our partners Including Primary Care Network Alliance (PCNA), GPs, health and social care and voluntary sector

2.27 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.28 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 4b: Successful delivery of the Acute Services Review

2.29 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.30 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 4c. Grow our research and innovation through education, learning and training

2.31 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.32 **ULTH**
There are no Very High risks and 1 High risks remaining stable, in relation to this objective.

Strategic objective 4d: Enhanced data and digital capability

2.33 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.34 **ULTH**
There are no Very High risks (20-25), a reduction of 1, and no High risks (15-16), a reduction of 4, recorded in relation to this objective.

- 4657 – Subject Access Request Compliance – **Risk has been re-aligned to objective 3a.**

Strategic objective 5a - Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS

2.35 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.36 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 5b: Co-create a personalised care approach to integrate services for our population that are accessible and responsive

2.37 **LCHS**
There are no Very High risks and no high risks recorded in relation to this objective.

2.38 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 5c: Tackle system priorities and service transformation in partnership with our population and communities.

2.39 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.40 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

Strategic objective 5d: Transform key clinical pathways across the group resulting in improved clinical outcomes.

2.41 **LCHS**
There are no Very High risks and no High risks recorded in relation to this objective.

2.42 **ULTH**
There are no Very High risks and no High risks recorded in relation to this objective.

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3.0 Conclusions

3.1 As of 2nd April 2025, there are 758 (129 LCHS and ULTH 629) risks recorded on the Group risk registers.

3.2 **LCHS**

The is 1 Very High risk (20 - 25) reported to the Quality Committee this reporting period:

403 - Children SLT Therapy Treatment

There are no Very High risks (20-25) reported to the Finance, People and Integration Committees this reporting period.

3.3 **ULTH**

There are 9 Very High risks (20-25) reported to the Quality Committee this reporting period:

- 4731 - Reliance on paper medical records
- 4828 - Reliance on manual prescribing processes
- 4879 - Recovery of planned care cancer pathways
- 4947 – NICE Medicines reconciliation compliance
- 5016 - Patient flow through Emergency Departments
- 5100 - Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards
- 5101 - Delivery of paediatric epilepsy pathways-community
- 5143 - Removal of lift in H Block PHB affecting service delivery to patient records
- 5450 - Risk of Gastro service not being viable due to current fragility of consultant workforce

There are 5 Very High risks (20-25) reported to the People Committee this reporting period:

4844 - Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
4948 - Pharmacy workload demands
4996 - Consultant workforce capacity (Haematology)
4997 - Service configuration (Haematology)
5447 - Cancellation of elective lists due to lack of theatre staff

There are 4 Very High risks (20-25) reported to the Finance Committee this reporting period:

- 4664 - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- 4665 - Failure to meet 24/25 CIP
- 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
- 4657 - SARs Compliance and access to Health records in accordance with statuary requirements

There are no Very High risks (20-25) reported to the Integration Committee this reporting period:

3.4 The Group Board is invited to review the content of the report. There are no further escalations at this time.

Appendix A - Group Board Very High and High risks April 2025

ID	Group Risk Type	Risk Lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Title	There is a risk that:	Caused by:	Resulting in	Controls in place	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
403	Physical or Psychological Harm	Griffiths, Claire	Quality Committee	13/09/2022	9	Children, Young People, and Specialist Services	Children's Therapy	Children SLT Therapy Treatment Delays	Children & young people will not receive the speech and language support they require to meet their social, emotional, educational, and health needs in a timeframe appropriate for their development.	Demand has increased nationally & regionally for SLT support overwhelming commissioned capacity. Referrals 188% higher in 2023/24 than in 2019.	Untreated speech, language, and communication needs (SLCN), which leads to: Children 6-11 times more likely to be behind educationally & more likely to be excluded from schools; 60-70% of young offenders reported to have poor language skills; 81% children with emotional behaviours problems have SLCN; SLCN children are twice as likely to be unemployed as an adult due to poor cognitive & social outcomes increasing lifelong health inequalities. Reputational damage from increased complaints & appeals to MPs & press	1. Advice and activities are given the patient's family and/or educational setting, ensuring they are safe to wait. 2. An appropriate skill mix is used, for example assessments are carried out by SLT and most therapy blocks completed by SLTAs. 3. Mix of face to face and virtual sessions 4. Increased the referral acceptance criteria: focused on highly complex patients only	20/03/2025	Extremely likely (5) >90% chance	Severe (4)	Very High Risk (20-25)	20	20/03/2025 Reviewed at CYPSS Quality SMT 20/03/2025: the business case is not being progressed. The service are completing sustainability framework with the planning department. Consideration is being given to how the service can match its activity against the financial envelope. No change to score. 20/02/2025 Discussed at CYPSS Quality SMT 20/02/25: the longest wait is currently at 41 weeks, and it assumed that it will go over 52 weeks. No change to score. 20/01/2025 Discussed at CYPSS Quality SMT 16/01/25: noted that one more staff member (1 x B6 WTE) had handed in their resignation. No change to score. 17/12/2024 Discussed at CYPSS divisional Quality Scrutiny Group 16/12/24: Business case has been written up on the ICB template and is awaiting further sign off. No change to score. 29/11/2024 Discussed at RRCC 27/11/24: agreed to increase the score from L4 x C4 = 16 score to L5 x C4 = 20. 14/11/2024 Discussed with DDL KJK 14/11/24: Propose to increase the score from L4 x C4 = 16 score to L5 x C4 = 20, based on the below narrative: • Referrals 188% higher in 2023/24 than in 2019 (average 354 / month 12/23-04/24) • Waiting times breaching the 18 week wait requirement – follow up and therapy waits over a year. • Decrease of staff morale & staff retention – from fully staffed at the end of 2023 to 4.3 WTE vacancies, staff citing service challenges as reason • Service working in OPEL 4 since Sep'23 and activating BCP, with no plans to reinstate lower level referrals	Low Risk (4-6)	17/04/2025	No change
681	Regulatory Compliance	Griffiths, Claire	Quality Committee	05/02/2024	20	Children, Young People, and Specialist Services	Children in Care	Children in Care - unable to meet IHA and RHA timescales	There is a risk that there is insufficient capacity within the children in care service to meet the current demand for Initial Health Assessments (IHAs) and Review Health Assessments (RHAs). Initial Health Assessment is required within 20 days of a child coming into care. Review Health Assessments are required annually for children over 5 years of age, and twice yearly for children under the age of 5 years.	At the end of 2023 there were 728 children in the care of Lincolnshire County Council, this number continues to increase year on year (increased by 7% from the previous year alone and 18% over the last 5 years). The introduction of the National Transfer Scheme in November 2021 has also triggered a significant rise in Unaccompanied Asylum-Seeking Children receiving support from the service. The number of children and young people placed into Lincolnshire by external authorities also continues to rise significantly putting additional pressure on the team (22% increase over the last 5 years). The current budget for the Children in Care Service has not been reviewed for several years and is no longer sufficient to meet this increasing demand.	This means there is a significant increase in the number of children in care in Lincolnshire resulting in an increased demand for IHA and RHAs. These assessments are statutory and the service will be unable to meet the timescales these should be completed within. This will impact on the health needs of children in care living in 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 than expected for these assessments.	The number of children under the care of Lincolnshire County Council continues to grow year on year increasing the demand for IHA and RHA assessments. The service has only been able to offer the amount of IHA appointments needed to meet this demand at significant cost pressure to LCHS. LCHS are unable to continue to cover this additional financial support needed from 01.04.24. An options appraisal has been completed to identify the increase in funding to meet the increased demand for IHA and RHAs, this is attached to the record.	20/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	20/03/2025 Reviewed at CYPSS Quality SMT 20/03/2025: the outcome of the business case is still awaited. Score remains the same. 17/12/2024 Discussed at CYPSS Quality Scrutiny Group 16/12/24: outcome of business case awaited. No change to score. 23/11/2024 Discussed at CYPSS Quality SMT 21/11/24: reduced concerns this month because there have been fewer referrals combined with increased availability from the doctors; however this is normal activity fluctuation consistent with last year's around the same time. Temporary doctor starting in Jan'25. No change to score. 17/10/2024 Discussed at CYPSS Quality SMT 17/10/24: no change to score. 20/09/2024 Discussed at CYPSS Quality SMT 19/09/24: update from Director of Safeguarding CF was acknolwedged. No change to score. 28/08/2024 Paper presented to ELT (27.08.2024) agreement given for overspend to be increased as per Option 2 - If the service were to recruit a substantive Specialist Paediatric Doctor from September 2024, the projected overspend for 2024/25 would be: £90,020. Five months bank paediatrician (£26,320) and seven months Specialist Doctor (£63,700). Service will now open discussion with ULHT family health to procure a senior paediatrician at the earliest opportunity	Very Low Risk (1-3)	19/06/2025	No change
714	Physical or Psychological Harm	Brunton, Michael	Quality Committee	16/05/2024	16	Collaborative Community Care		Delivery of pressure ulcer care in the community	Patients are not always receiving the correct level of care for pressure ulcers within community nursing settings	Variability in the delivery of care for pressure ulcers across community Lack of consistent senior clinical case review Variable clinical skill set of team members in delivering pressure ulcer care	Deterioration in pressure ulcers Increasing referrals for S42 safeguarding responses Poor patient and family/carer experience ICB/CQC oversight of pressure ulcer care	Daily BeSafe reviews of patient care Service action plan to improve pressure ulcer care implemented ICB oversight Educational training plan for all community clinicians initiated Assurance programme commenced Monthly thematic review of pressure ulcers highlighting themes and risks in care	09/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	05/11/2024 - Keeping current score, we are seeing improvements but this is not consistent across all of the county. Data evidencing this is being shown in QA audit processes. 08/10/2024 - Made improvements using data collected from weekly audits, increase in Purpose T, Obs, and using the safe guarding checklist. Need to look at patients with convenience issues. Seen a reduction in Cat 4 PU's. Further suspected S42. Score to remain the same currently. We have moved the Consequence score in the target risk matrix table as this will always stay the same and likelihood will move after mitigations. 10/09/2024 Increase in Cat 2's in the month. Cat 3's have now gone up due to unstagables are now included in Cat 3. No reduction in score at this time. 23/08/2024 Whilst there are some improvements can be seen in assurance standards there is insufficient progress against the action plan for this risk to be confident that a reduction in score is currently warranted 25/07/2024 This has 2 workstreams ongoing. 1 for immediate actions in relation to current increase in S42's in specific teams. 2 is for overall improvement to PU care across all teams. Current weekly meetings being held and auditing of teams has started. A3 thinking has been completed with some areas which has supported development of quality improvement plans. This has been roll out now to all ICT Teams. Workshops mapping out pathways has been completed and themes that will improve care have been identified. These have been through the A3 thinking process and action plans for improvements are being created. 20/05/2024 New risk agreed at Risk Register Confirm & Challenge	Moderate Risk (8-12)	01/03/2025	No change

695	Service Disruption	Brunton, Michael	Quality Committee	12/03/2024	16	Collaborative Community Care		Lack of District Nurse Specialist Practice qualified staff in community nursing affecting the quality of care	Community nursing teams fail to provide high quality care due to reduced levels of District Nurse Qualified staff within the team structure	Lack of value placed upon the importance of the DNSPQ qualification within community nursing teams Failure to reimburse staff undertaking the role relevant to their responsibilities and thereby retaining them Failure to train sufficient number of DNSPQ qualified staff Lack of standard use of the Enhanced Practitioner role in community nursing teams and defined role Lack of qualified DN	Insufficient levels of qualified DNSPQ support for junior members of teams Lack of oversight for complex case management. Identified theme in case of patient harm Reduced safe management of caseload sizes in community nursing teams Lack of professional support and guidance for team development	BSAFE initiated for daily oversight of safe care BSAFE audits by CSL level staff Reallocation of qualified DNSPQ staff to teams with low levels to aid safety Identification of new assessors for DNSPQ trainees Allocation of trainers to training places for increased trajectory of DNSPQ training Recovery trajectory and commitment to model of care for excellence to be submitted to ELT as part of a wider strategy for service	04/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	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 - Increasing DNSPQ mentors and 6 people currently going through this process. 08/10/2024 - Update in 715 as these are linked. 10/09/2024 Still awaiting ELT conversation on proposed changes to CN structure. 23/08/2024 No change in the level of score currently. ELT conversation on business case for community nursing to be had 25/07/2024 Paper finalised which has been writen by Angie Davies and Michael Brunton. This has been shared with new Director of Nursing and Exec. Possibility of going to ELT either Aug/Sept 2024. This paper is proposing the need to increase DN speciality to band 7 and aligned with QNI caseload recommendation. 30/05/2024 New risk agreed at Risk Register Confirm & Challenge Group 29/05/2024	Low Risk (4-6)	04/06/2025	No change
783	Service Disruption	Humphreys, Julie	Quality Committee	04/03/2025	20	Community Partnerships	Tuberculosis Adult Services	TB Service Provision - Capacity & Demand	The TB service are unable to meet the demand on its resources due to the increase in active and latent TB (LTBI) cases.	Lincolnshire has a 55% increase in active TB cases (2024) compared to 2023. The national increase for the same period is 13%. In addition there are 200 latent TB cases (151 cases working in the healthcare system) which are adding significant pressure and service disruption and an ARAP site with 16% of residents with LTBI. Service specification is outdated (2021) & funding attached to the contract does not reflect the significant increase in LTBI and % increase in active TB in Lincolnshire.	Waiting list times are not been met (6 week target) and the longest wait is 42 weeks 5 days). Impact on treatment / risk of inappropriate treatment (evidence of LTBI patients starting treatment before specialist monitoring commences leading to potential harm). The service is working at cost pressure having recruited band 6 and two band 3s on fixed-term contracts (FTC). Inability to meet NICE guidelines (contact screening, raising awareness in underserved populations).	Additional temporary resource allocated from another budget (band 7 and band 3) to manage LTBI backlog. Cost pressure FTC resourcing has led to reduction in care units (active TB only) from 53.73 in July 2024 to 16.22 in Feb 2025. Specific pathway developed to manage Occupational Health LTBI staff.	26/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	26 March 2025 - RRCC agreed risk rating of 16 but required change of risk to service disruption / capacity	Moderate Risk (8-12)	26/07/2025	NEW RISK
715	Physical or Psychological Harm	Brunton, Michael	Quality Committee	16/05/2024	16	Collaborative Community Care		There is a risk that the Community nursing lacks capacity and skill set to meet community demand	The community nursing service is unable to meet the demand of patients within Lincolnshire	Increased demand for service of 8% Care unit allocation above the maximum of 15 care units daily Case load levels above 150 max levels Reduced numbers of DNSPQ qualified staff	Variance in care delivery Ineffective case load management Poor patient experience Reduced complex caseload efficiency Task based service provision with a lack of holistic care planning	Daily BSafe - escalation/oversight review Twice daily matron led safety huddles Re allocation of senior resource to at risk areas Operational oversight of risk daily Service evaluation of DNSPQ role Support from UCR and CYPSS services to aid meeting unplanned demand when required	04/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	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 - No change currently 08/10/2024 - paper has gone to ELT and has been backed by the board, awaiting information on if/how this can be financed to increase capacity and value DNSPQ workforce. 6 now DNSPQ students started in September. 6 practice teachers are now on the course. 10/09/2024 No change 23/08/2024 No change in score as capacity continues to not meet demand for service 25/07/2024 Paper evidencing need for increase in registered staff in Community Nursing has been finalised and share with new Director of Nursing and other Excs. This paper should go to ELT in Aug/Sept 2024. The establishment gap has been modelled on QNI 8Q/20 ratio. 30/05/2024 New risk agreed at Risk Register Confirm & Challenge Group 29/05/2024	Low Risk (4-6)	04/06/2025	No change
444	Finances	Taylor , James	Finance Committee	30/06/2022	15	Corporate	Finance	Failure to deliver financial plan 24/25 - Cost	The Trust fails to deliver breakeven duty aspect of its financial plan by failing to contain costs within planned levels	Service pressures, continued pressure in the system and level of demand being experienced, and/or failure to manage performance effectively or unforeseen events; Inflationary 'cost of living pressures	Reputational damage including reduction in the SOF rating and/or lack of financial sustainability going forward, and a failure to meet statutory financial duties.	1. Financial plan and budgets approved, including the capital plan 2. Financial control system 3. Executive oversight at TLT, through to FPPIC. 4. Monthly capital group meeting internal to LCHS 5. Monitored at PMR, monthly via FPPIC and , monthly contract meetings with Commissioners. LCHS aligned to system plan but maintaining own business and governance assurance. 6. Cost of living increase pressures funding influenced at Lincolnshire system and national levels.	25/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	25/11/2024 Costs continue to be tightly controlled. Greater grip and control implementation by association as part of LCHG group financial recovery plan. 17/10/2024 Maintain current score. Delivery of plan contingent on delivering 25% reduction in run rate spend on overtime, required to mitigate cost pressures associated with apprentices and international nurses 04/09/2024 Score reviewed at Risk Register Confirm and Challenge meeting 28/08/24 and agreed to increase likelihood to 4 and decrease consequence to the same, overall increase from L3 x C5 = 15 to final score L4 x C4 = 16. 23/07/2024 Monthly update. No change 20/05/2024 Decisions regarding cost pressures need to be made by ELT. 14/05/2024Risk decrease from 12 in December 2023 to 6. Risk updated on 29/04/2024 with Mike Pockett." At the start of the year there is a lot of people involved in bringing a quality efficiency program to be delivered. There were risks that didn't happen and as the year has gone on a lot of changes have happened because of financial benefits so the risk reduced. 9 months worth of efficiency financial measure allowed a more informed view of were the organisation is going for the next few months.	Low Risk (4-6)	01/03/2025	No change
754	Physical or Psychological Harm	Chaytor, Sarah	Finance Committee	09/10/2024	15	Corporate	Quality	Moving and Handling	Clinical staff are inadequately trained in moving and handling	Poor compliance with expected standards. Training content currently being re evaluated. As a consequence there has been a pause in delivery. Cohort of staff requiring training being reviewed	Risk of injury to staff and patients. Potential for claims and complaints. There will be a disruption to the planned training schedule (impact presently being evaluated)	Mutual support request to ULHT. Internal sources of alternate training support being identified. Reviewing training schedule and package. Action plan in place to increase attendance when training is reinstated. Engagement with operational colleagues to confirm appropriate staff requiring training.	13/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[13/02/2025 RF Meetings between LCHS and ULHT manual hander ling teams have been conducted, Peer review and cross party working is being implemented to embed one process and support compliance and improvements needed. Good progress being made and site information and asset data has been collected. Once training scores have been reviewed we can look at reducing risk score. [05/11/2024 Discussed at Risk Register Confirm and Challenge 30/10/24: agreed as new risk scoring L4 x C4 = 16.	Very Low Risk (1-3)	13/05/2025	no change

719	Physical or Psychological Harm	Mckee, Nat	Quality Committee	10/06/2024	6	Integrated Urgent & Emergency Care	Clinical Assessment Service (CAS)	Impact of DHU Contract Changes on CAS Model	That patients will come to harm or experience delays to their care due to clinical validation by external partners.	Regional agreement with no input from Lincs ICB. New contract for clinical validations of all interim dispositions and ED validation to DHU from CAS. Loss of approx 100 CAS calls per day	System impact will be significant (increased EMAS attendance, increased demand for ED). Reputational impact. Poor patient experience. Barrier to care. Potential for reduction in funding for CAS; reduction in booked appointments, unneeded attendance to UTCs, attendance to inappropriate UTC (non-collocated), reduced referrals to community services. Reduced staff morale.	Support and regular updates to staff Close monitoring of staffing levels Data monitoring Monitoring of Datix. CAS clinician sitting in EOC pilot. Conversations with ICB Dynamic redistribution of skill mix	11/03/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	17/03/2025 Risk reviewed at IUEC Quality Scrutiny Group pre-meet 11/03/25: noted decrease in acute presentations being sent to the non-collocated UTCs instead of ED. Recent presentations centred around patients not being sent to their nearest UTC. To keep open for another month and review Apr'25 with a view to decrease the score if improvement continued. No change to score. 29/11/2024 Discussed at RRCC 27/11/24 and agreed to increase the score from L3 x C3 = 9 to L3 x C5 = 15, based on new available evidence from incidents that the consequence score should be higher as detailed in narrative from 22/11/24. 22/11/2024 Risk updated by DL NMcK and DDL LA following request at RRCC to review the risk's consequence score; agreed consequence should be changed from 3 to 5. This is based on the high risk patients being inappropriately booked into the UTCs: •Complex pregnant patient with palpitations & dizziness post fall down the stairs •Patient with history of collapse who then collapsed in the UTC •Patient with severe chest pain who then had episode of asystole in the department •5/52 old baby with hx of sepsis •42wk old child with head injury post submersion in water For review at the Risk Register Confirm and Challenge meeting Nov'24. 18/10/2024 Discussed at IUEC Quality Scrutiny Group pre-meet 08/10/24: incidents have remained consistent and regularly reported, no change to score. 18/09/2024 Discussed at IUEC QSG pre-meet 10/09/24: No significant	Low Risk (4-6)	08/04/2025	No change
651	Finances	Bassi, Sangeeta	Finance Committee	22/09/2023	12	Medical	Medicines Management	Contracted Pharmacy Service - Co-op	Despite Co-op winning the tender for the contracted pharmacy service for LCHS from April 2023 (medicines supply and clinical pharmacy service), the contract is still unsigned 6 months later (it was signed in the beginning of 2024). Due to oversights during the procurement process, there is a requirement to go out to tender again at the end of March 2026 (ULTH Procurement JB).	Co-op have not signed the new contract & have requested to re-negotiate the spec & KPIs, despite bidding for and winning against these versions. Management costs have significantly increased.	LCHS not receiving a comprehensive pharmacy service in line with the new spec/CV. KPIs/audits for the clinical pharmacy service have not been agreed thus reporting/assurance is limited. Cost pressure.	Co-op continue to provide the pharmacy service against the previous spec, KPIs. Controls include: - Quarterly CD checks via Co-op - Monthly Chart Checker audits via Co-op - Safe and Secure Handling of Medicines/CD audits continue to be led by LCHS MMT on a quarterly basis - All medicines related incidents reviewed by Divisional Senior Pharmacy Technicians and by LCHS pharmacist Mitigating actions: - LCHS have chased and now (from October 2023) have in place monthly operational meetings with Co-op pharmacist lead (Claire Rogers) to discuss any issues of concern e.g., relating to patient safety - Snapshot audit completed (October 2023) in relation to	26/02/2025	Extremely likely (5) >90% chance	Moderate (3)	High Risk (15-16)	15	26/02/2025 Discussed at risk summit with DDMD SB and QPIL AM 26/02/25: a case is being developed for bringing the Clinical Pharmacy service in House. Increased challenges due to senior leadership team changes and staff leaving within Co-op, including the Lead Clinical Pharmacist for Community Hospitals and the dedicated HIV pharmacist. Currently working with Co-op around succession planning. No change to score. 15/11/2024 Discussed at risk summit with DDMD SB and QPIL AM 15/11/24: As part of planning for 2025/26, a case of need has been presented at CRIG and ELT in relation to taking the clinical pharmacy services in house. No change to score. 05/11/2024 Discussed at Risk Register Confirm and Challenge 30/10/24: agreed to increase the score from L4 x C3=12 to L5 x C3 = 15. 18/10/2024 Discussed at risk summit with DDMD SB and QPIL AM 18/10/24: priority of need not agreed by Finance in relation to funding (JT 03/10/24). 10/10/2024 Discussed at risk summit with Deputy Director of Medical Directorate SB: Risk to patient safety and quality of service (as evidenced by staff survey and recent evaluation of service) was discussed at Community SLT 19/09/2024, along with a proof of concept paper for a community hospital pharmacist - not approved due to funding. DDMD SB to discuss further with finance. This issue has been escalated to the Quality Committee through the upwards Patient Safety Group report in Aug'24. Propose to increase the score from L4 x C3=12 to L5 x C3 = 15 - for approval at RRCC Oct'24.	Very Low Risk (1-3)	26/05/2025	no change
649	Regulatory Compliance	Smith, Alan	Finance Committee	12/09/2023	15	Corporate	Estates	Fire Safety Core Risk	There is a risk of harm to building occupants (including patients)caused by fire. There is a risk that the Trust cannot demonstrate statutory compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO).	Inadequate fire protection systems, maintenance, training and procedures	Loss of facilities, services and injuries to patients and staff.	1. LCHS Fire Safety Operational Meeting 2. Planned Preventative Maintenance PPM 3. Fire Risk Assessments 4. Fire Safety Training 5. Fire protection system tests 5. Fire Emergency Plans 6. Yearly Fire audit 7. Appointed Authorising Engineer (AE) for Fire 8. Inpatient Fire evacuation plans and tests 9. Test Fire drills.	17/02/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	17/02/2025 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 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 10/09/2024 Fire updates are being presented at H&S committee and the action plan is still being worked through. No Change to score currently. 16/08/2024 The Group fire team continue to work against the FRA action plan and the risk score will be reviewed once this is complete. No change to score currently.	Low Risk (4-6)	17/05/2025	No change
390	Physical or Psychological Harm	Smith, Alan	Finance Committee	01/08/2020	10	Corporate	Estates	John Coupland Hospital Theatres ventilation	Patient safety/ infection control / loss of service and disrupted service to patients	Theatre one - The plant in JCH theatre 1 is running inconsistently resulting in temperatures being close to or over the limit of 22c and humidity at times being close to or breaching the limit of 60.	Creating a patient safety risk if not effectively monitored, theatre lists have had to be cancelled for patient safety at short notice, a risk to service delivery and LCHS reputation.	1. PPMs and recording undertaken by NHSPS. 2. Yearly survey reports on high risk equipment (theatres) undertaken by NHSPS. 3. Monitoring of compliance undertaken by Estates Shared Service. 4. Compliance information reported into LCHS Safety and Compliance Group (SACG) monthly and Health and Safety Committee Quarterly. 5. Weekly maintenance checks are being undertaken by NHSPS.	26/03/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	01/04/2025 Risk discussed at Risk Register Confirm and Challenge 26/03/2025, where the score was proposed for decrease to 8 from 15. Change not agreed. 03/03/2025 Please see update with regards to improvements works completed by NHSPS and have reduced the risk score to 8 from 15. 03/03/2025 17/02/2025 Replacement scheme has been undertaken on the AHU and commissioning results are being reviewed for HTM compliance. A couple of on going concerns are present and once NHSPS shares this information, a review of this risk can be conducted. 11/10/2024 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 12/09/2024 Local meetings have taken place with the project team and the work is still planned for start in the middle of October. No change to risk score and continues to be monitored. 16/08/2024 Project has now began to replace the air handling units. This is being planned for the middle of October. The risk can be reviewed completely when the work has been completed. Risk will continue to be monitored in the interim.	Very Low Risk (1-3)	26/07/2025	No change

393	Physical or Psychological Harm	Smith, Alan	Finance Committee	01/12/2022	20	Corporate	Estates	Skegness Hospital Water Safety	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective	Risk of harm from Legionella and other waterborne pathogens	1. Infection Control Group 2. NHSPS planned maintenance regime 3. Appointed Authorising Engineer (AE) for water 4. NHSPS is undertaking flushing of outlets. 5. Water sampling - with all results being sent to the Trust AE and Estates Shared Services 6. Estates shared service and AE follow up actions required on high count outlets. 7. Any positive counts have a filter fitted immediately	26/03/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	01/04/2025 Risk reviewed at Risk Register Confirm and Challenge meeting 26/03/2025, where it was proposed for decrease from L3 x C5 = 15 to L2 x C5 = 10. The change was not agreed. 03/03/2025 Score can be reduced to show the improvements made by NHSPS on managing the water systems on site. Two locations with adverse sample still and being monitored for usage and extra flushing conducted to mitigate low usage in the area that has been reported. Reduced to 10. 13/02/2025 Scores to stay the same as several resamples are needed to sign off as clear and no data has been presented to the compliance team for reassurance. 11/10/2024 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 16/08/2024 Awaiting results from NHSPS. No change to score and risk continues to be monitored.	Moderate Risk (8-12)	26/07/2025	No change
391	Physical or Psychological Harm	Smith, Alan	Finance Committee	01/12/2022	20	Corporate	Estates	John Coupland Hospital Water Safety	Water supply to patients, staff and visitors has been contaminated;	The regulatory routine maintenance of the landlord (NHSPS) being ineffective;	Risk of harm from Legionella and other waterborne pathogens	1. Joint Water Safety Group 2. NHSPS planned maintenance regime 3. Infection Control Group. 4. Appointed Authorising Engineer (AE) for water 5. NHSPS is undertaking flushing of outlets. 6. Water sampling - with all results being sent to the Trust AE and Estates Shared Services 7. Estates shared service and AE follow up actions required on high count outlets. 8. Any positive counts have a filter fitted immediately	26/03/2025	Reasonably likely (3) 31-70% chance	Severe (4)	High Risk (15-16)	15	01/04/2025 Risk reviewed at Risk Register Confirm and Challenge meeting 26/03/2025, where it had been proposed for decrease from L3 x C5 = 15 to L2 x C5 = 10. The score change was not agreed. 13/02/2025 PPM and L8 data being reviewed for concerns and reports provided by contractors and review meeting between AS & RF held monthly to support. No change in score as concerns and NHSPS performance is still poor. Some of LCHC buildings now on L8 guard also and monitoring will continue. 11/10/2024 After a conversation with Mike Parkhill this risk has been moved to Alan Smith with Mike having overall responsibility for the risk. 16/08/2024 NHSPS Update: Scotter ward decant is planned for September. Once the ward is empty the suspect pipework will be isolated and removed. This will eradicate the issue and the risk can be reviewed. 06/06/2024 NHSPS Update: positive counts low in the palliative suite in Scotter Ward. Recently thermally disinfected and awaiting the re sampling results. LCHS Update: seeking additional support from the group water safety team.	Moderate Risk (8-12)	26/07/2025	No change

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Strategic Objective							**1a. Deliver high quality care which is safe, responsive and able to meet the needs of the population**																		
5101	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Clinical Effectiveness Group	14/03/2023	20	Family Health	Children and Young Persons CBU	Children's Community Services	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Community Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	18/02/2025	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	[18/02/2025 13:19:19 Nicola Cornish] No progress, still awaiting decision about business case. [29/01/2025 13:03:36 Rachael Turner] Risk discussed as part of the RRC&C Deep Dive, risk score to remain at current level. If the business case is approved we can recruit and reduce the risk, if not the risk level will remain or increase with no additional resource. This risk to be raised as part of PRM process. [22/01/2025 13:37:02 Nicola Cornish] No progress, still awaiting outcome from CRIG. Using bank B5 nurses to support some of this work, but this is adding to cost pressures so not sustainable. [09/12/2024 13:21:53 Nicola Cornish] Business case has been submitted to PMO office, awaiting date for presentation to CRIG. [11/11/2024 15:06:06 Nicola Cornish] Business case has been completed, and the service has been added to the investment tracker for 2025/26. [14/10/2024 14:01:56 Nicola	8	14/03/2024	16/02/2024	18/03/2025

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4947	27	Physical or psychological harm	Sakthivel, Mr Kulandaivel	Saddick, Ahtisham	Clinical Effectiveness Group	17/06/2022	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of insufficient staffing establishment there is an inability to provide a safe and effective 7 day pharmacy clinical service at ULTH. Current funding allows for the clinical cover Monday to Friday 9-5. The clinical pharmacy workload exceeds the current pharmacy capacity. As a result of this under staffing the Trust is failing to meet NICE NG5 Medicines Reconciliation targets and there is no pharmacy capacity to review eDDs or provide specialist pharmacy advice. All of these risks have multiple implications such as harm to patients from omitted medicines, delayed discharge from hospital effecting the efficiency of the hospital, readmission to hospital, cost pressures from use of FP10s, long term effects on pharmacy staff health and wellbeing and the pharmacy department's ability to retain staff.	Prioritising the current clinical pharmacy service to direct admission areas. The dispensaries are open weekend mornings for urgent requests On call pharmacist service is available for urgent advice.	Medicines reconciliation audits Monitoring FP10 spend Monitoring on call access Reported medication incidents (including HPF) PALS Staffing levels / budget benchmarked against other similar trusts. Staff Survey results Staff exit interviews	20/03/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Business case for 7 day ED cover was submitted to CRIG 29th Nov 2024 and a one page summary was submitted 25th Feb 2025 as requested by CRIG, currently awaiting further instruction Ahtisham Saddick July 2025. Further business case development to be decided.	[20/03/2025 10:57:17 Lisa Hansford] Updated the risk description, controls and actions. [10/03/2025 09:53:16 Lisa Hansford] Risk review meeting arranged for 20.3.25 to update all risks relating to staffing. Risk remains the same at this time [10/02/2025 09:29:49 Lisa Hansford] Full business case was submitted in November and medicines reconciliation data collection process is under review. [09/01/2025 14:55:34 Lisa Hansford] No update [16/12/2024 10:27:27 Lisa Hansford] No further update [12/11/2024 14:24:12 Lisa Hansford] RCEM/ED pharmacy case developed and submitted for winter pressures funding- this was unsuccessful. The case will be resubmitted for the next financial year (25/26) [17/10/2024 09:41:28 Lisa Hansford] no further update [19/09/2024 12:57:45 Lisa Hansford] no further update, risk remains the	8	30/06/2023	30/04/2025	21/04/2025

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5016	22	Physical or psychological harm	Hamer, Fiona	Lentz, Blanche		02/09/2022	25	Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust .	Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's Introduction of "Pit stop" model. The development of a CDU in October 2024 will enable some flow from the emergency department to home for patients requiring treatment to discharge. This will be monitored through UEC improvement work to ensure area is fit for purpose. If CDU is utilised to enable ambulances to offload before 2 hours this will effect the flow through CDU.	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	04/03/2025	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Ongoing work in place for long lengths of stay. There is a discharge work progress team in place. 78% performance project currently in place which is supported by the improvement team. Safer Programme in place and SOP is being delivered for Operational meetings in the aim to process discharges and improve flow. Ongoing Care and Comfort project in place to mitigate both harm and risks.	[04/03/2025 15:04:42 Rachael Turner] We are improving our 4 hour standard to enable patients to move through pathway quicker. We are completing AAR's on all 12 hour breaches to enable any learning opportunities. We are changing some pathways, we are going to have a 4 week trial for streaming at Lincoln, this starts on the 24th March and also a 4 week trial at Pilgrim, this will utilise chair space in SDEC, this will start on the 19th March. [04/02/2025 15:35:52 Rachael Turner] Risk currently remains, we are seeing improvements due to work that's being undertaken. our 4 hour standard has improved over last couple of weeks but still needs to remain at current level. [07/01/2025 15:06:23 Rachael Turner] UEC refresh continues to focus on ED performance and tasks to improve performance delivery. Flow impacts on ED space,capacity and impedes performance. Striving to attain 78%, however due to demand impairments within the	10	02/09/2023	31/03/2024	04/04/2025

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5100	487	Physical or psychological harm	Rivett, Kate	Herath, Dr Durga	Clinical Effectiveness Group	14/03/2023	20	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Quality and safety risk from inability to deliver epilepsy pathways within Acute Paediatrics that meet National standards due to resourcing and capacity factors.	1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse; 2. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 4. Liaison with ICB and regional network to support development and improvement of local services	1. Audit of compliance with NICE guideline NG217 - Epilepsies in Children, Young People and Adults and NICE quality standard QS27 - Epilepsy in Children and Young People;	18/02/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	[18/02/2025 13:20:41 Nicola Cornish] No progress, still awaiting decision about business case. [22/01/2025 13:38:13 Nicola Cornish] No progress, still awaiting outcome from CRIG. Using bank B5 nurses to support some of this work, but this is adding to cost pressures so not sustainable. [09/12/2024 13:20:30 Nicola Cornish] Business case has been submitted to PMO office, awaiting date for presentation to CRIG. [11/11/2024 15:04:28 Nicola Cornish] Business case has been completed, and the service has been added to the investment tracker for 2025/26. [14/10/2024 13:59:49 Nicola Cornish] Draft businness case completed and submitted to Finance. Liaising with ICB regarding funding priorities for 2025/26. [09/09/2024 14:47:00 Nicola Cornish] No further progress. Received an outlier notice, action plan developed for delivering improvements - seeking approval	8	14/03/2024		18/03/2025

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4879	28	Physical or psychological harm	Carter, Mr Damian	Lynch, Diane		28/03/2022	20	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	As a result of National long waits post COVID there may be significant delays within the cancer pathway and as a consequence patients may experience extended waits for diagnosis and surgery which would lead to a failure in meeting national standards and potentially reducing the likelihood of a positive clinical outcome for many patients.	National policy: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group Intensive support meetings in association with the ICB - 2/52 Cancer Delivery and recovery - 2/52 Cancer Board - Monthly	Cancer patients awaiting surgery - all within 31 days New standards: 28 days for first diagnosis; 62 day max wait Diagnostic standard less than 6 weeks	27/03/2025	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	[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	8	31/03/2023	31/03/2023	28/04/2025

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Reportable to	Opened	Rating (initial)	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
5143	63	Service disruption	Lynch, Diane	Parkin, Mr Lee	ation Governance Group, Outpatient Improvement Group, Patient Safety Group, Information Go	13/04/2023	25	Clinical Support Services	Outpatients CBU	Choice, Access and Booking	Pilgrim Hospital, Boston	As a result of the demolition of H Block it removed facilities and amenities that the Health Record Teams (also Porters & Secretaries) utilised. The risk is that staff are now having to use dumbwaiters to transport notes between the main library and outpatient clinics with additional manual handling requirements, the impact on the staff has meant an increase in staff injuries, an increase in staff turnover with multiple vacancies and low staff morale. The impact on staff has meant to change to processes, an increase in workload and a more physically demanding role. Additional concerns are that the notes are being delayed to clinic which could cause the potential for appointments to be cancelled and also there is an IG issue with notes being transported in dumbwaiters that open in patient areas. With no lift to support the department if any large items fail i.e printer or racking, replacement items will be unable to be delivered.	There is addition of dumb waiter(x2). Health & Safety risk assessment on the dumbwaiters limits the capacity to two boxes in the coding dumbwaiter and with the upgrade to the dumbwaiter in Health record the limit has been increased to 4 boxes. Process in place to ensure notes are either with a member of staff or in lockable storage areas. Quality Impact Assessment completed Risk presented every month to PRM with an update Health and Safety guidance delivered to Team on regular basis	Patient cancellation, waiting times and waiting list increase for patients due to patient notes being unavailable or delayed. Staff survey results. Staff sickness/injury through Occupational Health and ESR.	27/03/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	New lift is planned to be commissioned in 2025 and at that point the risk will diminish. Dumb waiters upgrade completed, working with some minor changes in process needed to maximise use. Schedule of works received showing completion by March 2025. Initial work started, staff moved around to accommodate works. Working with Estates to ensure any works have minimal disruption to the service.	[27/03/2025 12:59:35 Gemma Staples] The new lift is in and is currently being tested in readiness to be handed over to the health records team by the end of the month. Once handed over the team will review processes and SOP's for the new ways of working with the lift, alongside working through the backlogs that have been created with no lift to the department. [27/02/2025 14:32:59 Gemma Staples] Risk remains the same. Work has started and is ongoing, working with Estates to ensure any works have minimal disruption to the service. On track for works to be completed by end March 2025. [31/01/2025 16:41:15 Gemma Staples] Risk remains the same. Work has started and is ongoing, working with Estates to ensure any works have minimal disruption to the service. On track for works to be completed by end March 2025. Requests for extra support elsewhere due to Health and Safety	1	31/03/2025		28/04/2025

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Reportable to	Opened	Rating (initial)	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
5450	659	Physical or psychological harm	Mooney, Mrs Katy	Highfield, Kimmi		05/06/2024	12	Medicine	Specialty Medicine CBU	Gastroenterology	Trust-wide	The capacity of the Gastroenterology Consultant workforce is reducing due to individuals wishing to take resign, retire or partially retire and return with reduce job planned activity. This is impacting the inpatient and outpatient activities of the service. However, as the drive to resign/retire/reduce job planned activity focuses on removal of all inpatient and on-call activity as a 'must' the primary impact is being felt in these area's. If the Consultant Medical workforce for Gastroenterology depletes further and/or does not recruit to vacancies within the workforce, the service will not be able to maintain a two site Gastroenterology inpatient cover, outpatient/ cancer performance and Upper GI Bleed On Call service.	-Recruitment - full time Gastroenterology gaps are out with Agency and on TRAC for NHS Locums. The Business Unit manage the gaps proactively and will put out a variation of gaps (for example, ward cover only) to seek cover for the gaps in the service. -When on-call bleed rota not covered at one site calls are diverted to the other, however this mitigation provides a lower level of service. -Management of UGI Guidelines policy. -Guidelines on Management of Upper Gastro-Intestinal Bleeding (UGIB)	Workforce gaps Capacity of the service Cover of rota's (inpatient ward cover and on-call bleed cover)	05/03/2025	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.	[05/03/2025 09:18:37 Rachael Turner] Risk reviewed, risk remains in current position at the same risk score. [04/02/2025 14:42:02 Rachael Turner] Risk reviewed, risk remains in fragile position currently still awaiting feedback from Trust/ICB. [08/01/2025 12:17:07 Charles Smith] Risk reviewed - No substantial update to current provision. No feedback from Trust/ICB on next steps re: investment cases [10/12/2024 14:52:10 Rachael Turner] Risk reviewed, one more consultant has started at Pilgrim with another possible for late 2025. Workforce business case has been submitted. Risk score remains and unchanged. [22/11/2024 10:23:18 Rachael Turner] Guidelines on Management of Upper Gastro-Intestinal Bleeding (UGIB) is currently under review. Controls for this risk have been updated. [18/11/2024 07:58:41 Charles Smith] Risk ongoing - Service sustainability	8	05/06/2025		05/04/2025

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5200	283	Physical or psychological harm	Rivett, Kate	Coghill, Piper	Children & Young Persons Oversight Group	30/06/2023	8	Family Health	Children and Young Persons CBU	Paediatric Cardiology		As a result of a backlog Paediatric Cardiology clinic appointments patients are at risk of undiagnosed cardiac conditions, lack of follow up within appropriate timeframes and subsequent delay in treatment, which could lead to life limiting outcomes or death. RTT Target is 18 weeks, best practice is to be seen within 6-8 weeks to ensure the risk of life limiting conditions and death is significantly reduced and treatment can be undertaken when necessary by appropriate clinician.	-Manage clinics follow up and new patients based on demand with flexibility to swap between either based on waiting times and outcomes -Additional clinics at Boston and Lincoln -Escalated to ELT regarding waiting list -Cardiology meetings monthly with Leicester -Cancellation list in place to ensure clinic is filled and prioritise patients who are overdue and chasing an appointment	-Number of patients awaiting an appointment -Audits -Staff feedback -Next of kin feedback -Incidents -Complaints/PALS	20/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Continuing to support Paediatric Consultant undertaking PEC training to gain Cardiology experience -Ongoing discussions with ELT regarding plan to address clinic backlogs -Review undertaken by East Midlands Congenital Heart Services; awaiting outcome -Source space to facilitate ECHO clinics -Recruited additional Paediatrician at PHB, support being given to upskill to deliver Cardiology clinics	[20/02/2025 14:15:16 Nicola Cornish] Leicester have triaged all patients on the waiting list and identified a priority for each patient. However no additional clinic sessions have been offered to ULHT so only there is only capacity within existing clinic slots to offer appointments to the most urgent patients. The existing Cardiologist is leaving in mid-March so it is likely that the risk will increase following this until recruitment is complete. [29/01/2025 13:09:13 Rachael Turner] Risk discussed at Risk Register Confirm and Challenge as part of the Deep Dive, harm reviews need to be undertaken. Until then the risk to remain at current level. [27/11/2024 13:51:27 Nicola Cornish] Discussed at Risk Register Confirm & Challenge meeting on 27th November. Region-wide issue which executive team are fully sighted on. Approved increase in score to 4x4=16. [07/11/2024 09:51:37 Rachael Turner] Updated risk description due	8	30/06/2024	30/06/2025	20/05/2025

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5002	535	Service disruption	Farquharson, Colin	Edwards, Mrs Jill	Clinical Effectiveness Group, Palliative/End of Life Care Oversight Group	23/08/2022	16	Clinical Support Services	Cancer Services CBU	Specialist Palliative Care	Trust-wide	As a result of the Trust not being consistently compliant with NICE Quality Standards for PEOL and commissioning guidance for specialist palliative care (SPC) due to staffing resource there is a risk of lack of identification of palliative need, delays to assessment, patients not achieving preferred place of care/death across the Trust resulting in serious physical and psychological patient and family harm, with a poor patient experience of care and service. This could lead to Regulatory action.	National Policy - NICE Quality Standard (QS13) End of life care for adults - NICE Guideline (NG142) End of life care for adults: service delivery - NICE - Care of dying adults in the last days of life Quality standard Published: 2 March 2017 - Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026 - 'One Chance to Get it Right: improving people's experience of care in the last few days and hours of life' Leadership Alliance for the Care of Dying People. June 2014. - 'Every Moment Counts' A narrative for person centred co-ordinated care for people near the end of life (VOICES) - Commissioning guidance for Specialist Palliative Care (2016). Local Strategy - Palliative and End of Life Care (PEOL) strategy for Linconshire - PEOL Re-Design for PEOL services LincolnshIre - ULH Strategy for PEOL ULH Governance - SPC Governance/ CSS CBU/ Cancer Services/ SPC - NACEL report Daily caseload review and triage of caseload using	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	25/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business Case to be developed - Sarah Chester-Buckley Ongoing training for PEOL champions. Event planned - Jill Edwards - March 2025 Development of SPC SOP & business continuity plan - Jill Edwards - March 2025	[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	4	30/12/2024		23/05/2025

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5142	65	Physical or psychological harm	Thomson, Cheryl	Lentz, Blanche		12/04/2023	20	Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	Within Lincoln and Pilgrim Emergency Departments there is a risk that, given increases in demand/footfall, the current staffing template for middle grade doctors overnight may not provide assurance to maintain patient safety.	Utilisation of on-call Consultant to support dependant on holistic risk. Specialty support and signposting to other directorates and providers. Full capacity protocol and boarding.	4 hour target/12 hour breaches. Time to first assessment. Decision to admit.	07/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades. New rota templates signed off by finance, to be implemented Q3 2023. Recruitment ongoing.	[07/01/2025 15:08:23 Rachael Turner] No change, however nearly at resolution for tier 2 rota timeline anticipated for the 17th Jan to implement for the 1st April 2025. [03/10/2024 09:15:45 Rachael Turner] Risk reviewed, no change. [02/07/2024 16:05:28 Rachael Turner] Tier 2 programme still ongoing, in the phase of implementation. Workshops in place to work with tier two cohort to proceed to job planning. Timeline to be completed by Q4. [15/04/2024 11:01:21 Rachael Turner] Further delay due to job planning from medical workforce. Now expected Q3/Q4 24/25. CBU Team looking at mitigations including removal of some shifts to improve uptake across 24 hour period. [05/03/2024 15:45:12 Rachael Turner] Consultation has now ended. Expected go live date Q3/Q4, this should have gone live last October. Update to be provided in June. [09/01/2024 15:09:37 Rachael Turner] Risk remains the same.	9	31/08/2023	01/11/2023	07/04/2025

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5267	485	Physical or psychological harm	Mooney, Mrs Katy	Marsh, David		26/09/2023	16	Medicine	Cardiovascular CBU	Cardiology		If there is a continued delay in processing of Cardiac MRIs, which is impacted by workforce limitations and an existing backlog of scans, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcomes. Cardiac MRI backlog was recorded at 125 11th September, this went down to 72 2nd October, this backlog continues to be monitored.	1.Outsourcing some CMR reporting to Medica - they will be reporting ten studies per week for the foreseeable future, which is around one third of our current reporting workload. At cost. 2.Undertaking additional reporting sessions - this will help significantly with the reporting backlog but not solve causal factors. At cost. 3. We now have a Radiographer that can report Cardiac MRI's independently which is approx 8 a week.	Size of reporting backlog (number/time required) Average time for reporting of scans from date of imaging	03/03/2025	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. 4. Currently in early negotiations with a consultant from Nottingham to support with our backlog. 5. There is a possibility of mutual aid from Sherwood Forest, but this is in the early negotiations. 6. We have submitted a paper to the Divisional Managing Director for £35,000 for an external company to clear 200 scans from the backlog.	[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:	3	01/07/2024		03/06/2025

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4779	61	Physical or psychological harm	Landon, Caroline	Marsh, David		16/01/2022	20	Medicine	Cardiovascular CBU	Stroke		Increase in risk of delays to patient care/harm as a result of increasing backlog of planned care activity across stroke arising from service restrictions/ site escalation pressures.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure)	weekly monitoring of RTT and PBWL	09/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Virtual clinics in place for substantive consultants, where long overdue follow ups are giving priority. Overdue was standing at 989 patients, this was reported in October 2023. With industrial action, this will have had an impact. Trajectory of how we continue to reduce to be provided.	[09/01/2025 12:23:04 Rachael Turner] TIA continues to improve and a new pathway is being put in place. For stroke virtual clinics are in place, locum consultant is in place to cover ward discharges returning for the month of Jan. TIA 47 follow ups, but only 1 is over due. For Gen Med (stroke) patients waiting to be seen for clinic is currently just over 400. These patients will be seen through Jan/Feb. Risk score to currently remain. [02/09/2024 11:20:05 Rachael Turner] Follow ups are improving for TIA and stroke. Patients are being reviewed virtually and from Friday we are including validation on Partial Booking Waiting List. 659 patients currently waiting this is split between stroke and TIA. [21/06/2024 13:48:45 Rachael Turner] This remains the same. This has reduced but still a concern. Trying to mitigate through virtual clinics but lack of consultants in post makes this a challenge. [18/03/2024 10:35:28 Rachael	4	31/03/2022	29/12/2023	09/04/2025

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5520	753	Physical or psychological harm	Landon, Caroline	Hunter, Sarah		11/10/2024	16	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of ULHT not having a Thrombectomy centre, we have to transport patients to Nottingham. There is a risk of transfer delays for patients with acute neurological presentation suspected to be a stroke having access to a designated thrombectomy centre for consideration of mechanical Thrombectomy. This could lead to more brain cell death, increase risk to life and ultimately poor functional outcomes/severe disability. On occasions delays have been so long the offer of intervention has been withdrawn.	Attempts to streamline pathway to hold crew bring patient to Lincoln for further transfer to Nottingham however not often successful due to pathway delays. [current acute pathway QI project] Escalating to operation centre as soon as Ambulance requested for transfer if original crew already stood down/handed over. Explored option of increasing category allocated to Stroke transfers [Currently CAT2] so far despite regional engagement Ambulance service unable to re-categorise.	Regional meetings - Integrated Stroke Delivery Network M&M meetings [local & regional] Datix incidents reported.	03/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Continue to work to streamline pathway to avoid transfer delays. Consultant Stroke Practitioner & Stroke ACP lead responsible for streamlined internal pathway – current QI project till December [Code thrombolysis/Stroke] Action 2. Develop internal processes to escalate transfer delays more quickly. Stroke CBU/Acute team to liaise with Operations department for clear escalation process. Action 3. Ongoing communications/meetings with Ambulance service. Consultant stroke Practitioner liaising with ISDN & Ambulance service [Claire] ongoing Action 4. Look to the future to develop local thrombectomy centre to ensure fair access to emergency stroke treatments for the people of Lincolnshire, reducing long-term disability, dependence of health & social services, overall reducing the socio-economic burden of stroke. – Executive responsibility for service allocation?	[03/02/2025 11:05:07 Rachael Turner] Risk reviewed, work remains ongoing with no change to risk scoring. [27/11/2024 13:02:18 Rachael Turner] Risk presented at Risk Register Confirm and Challenge 27/11/24. Risk validated 4x4:16 High Risk. [11/10/2024 12:34:10 Rachael Turner] Risk to be presented for validation at November Risk Register Confirm and Challenge meeting.	8	11/10/2025		03/05/2025
5533	754	Physical or psychological harm	Mooney, Mrs Katy	Hunter, Sarah		07/11/2024	16	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of being unable to provide specialist assessment and investigation to people whom have had a suspected TIA within 24 hours [in line with guidelines] this may result in subsequent stroke due to a delay in intervention/treatment. Stroke may cause lifelong disability or death.	Reviewing patients as soon as we can in clinic and arranging investigations to coincide with clinic appointment [limited to imaging slots allocated per day] We convey ambulance referrals to have patients reviewed in ED by ACP team, if adequate space was provided for rapid TIA review there could be hospital avoidance [better patient experience/reduce cost and better patient flow]	Audit delays from referral to physical review in TIA clinic – Stroke Co-ordinator/service manager Recent data provided by Vascular team reports delays to carotid Doppler scans being performed, creating less benefit from surgical intervention which may result in no intervention being completed Datix review of hospital admissions with stroke symptoms post TIA clinic referral and not yet seen	03/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Allocate appropriate facilities for rapid TIA clinic – recommend similar set up to NOTTINGHAM or alternative – SOP attached. Area to assess patients perform clinic plus access to imaging [carotid dopplers & Head imaging in a timely manner-SDEC approach] Responsible divisional/service managers	[03/02/2025 11:22:54 Rachael Turner] The new TIA Pathway is currently in process, this pathway will streamline the service and will meet the need for patients to be seen within 24 hours. [27/11/2024 13:11:28 Rachael Turner] Risk presented at Risk Confirm and Challenge 27/11/2024. Risk validated as 4x4:16. Risk controls and reduction plan to be strengthened with current position.	8	07/11/2025		03/05/2025

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5488	738	Physical or psychological harm	Rivett, Kate	Flatman, Deborah		12/07/2024	16	Family Health	Children and Young Persons CBU	Children's Community Services	Community	Patient safety risk from inadequate staffing Levels resulting in lack of capacity to safely manage the Children's Community Nursing Caseload. Potential for unrecognised deterioration due to lack of timely visits, increased hospital admissions due to inability to manage effectively in the community, plus increased length of stay due to inability to facilitate timely discharge into community. There is also a risk to staff health and wellbeing as a result of unmanageable workload.	Weekly Senior children's community nurse safety huddles to monitor staffing levels. Weekly CYP Senior Team huddle for escalation of situation Clinical governance reporting. Merged Boston CCN Patient caseload into Lincoln & Grantham CCN teams creating a North and South team due to lack of Boston Team Leader oversight & unsafe staffing > 75% CCN deficit. Approx 50 patients transferred to Grantham & 32 transferred to Lincoln. only 0.8wte Boston CCN available to Grantham. No Boston CCNs available to support Lincoln. Merger was to ensure Caseload oversight & review of Boston BCYP patients.	commenced submission of IR1s	21/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	CCNs from all x3 Teams regularly cross-cover and provide support to managing the county-wide caseload. There is UEC funding within the CCN budgets to recruit more CCNs	[22/01/2025 13:54:28 Nicola Cornish] This still remains an issue. 2 new staff are still completing their induction period and recruitment remains ongoing. There are 2WTE vacancies at Lincoln with 2 shortlisted candidates to be interviewed, 2.2WTE vacancies at Boston with 2 shortlisted candidates to be interviewed, and 1.43WTE vacancies at Grantham currently out to advert. [30/10/2024 14:50:31 Nicola Cornish] Discussed at Risk Register Confirm & Challenge meeting on 30th October 2024. The updated risk description was approved with a score of 16. [28/08/2024 14:35:58 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Not approved - need to update the risk description to include more detail about the impact on patients to justify high risk score. NC to work with KR to update. [16/07/2024 13:57:49 Nicola	6	31/01/2025		21/04/2025

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5306	713	Physical or psychological harm	Cooper, Mrs Anita	Rambani, Reena		28/08/2024	20	Clinical Support Services	Path Links (Pathology)	Microbiology (Pathology)	Trust-wide	As a result of the inadequate resource of Microbiologists provided via the service contracted from NLAG, there is inadequate specialist input to ULH for complex cases or reviews on the correct use of high risk treatments used. This would lead to patient care being unsafe and can result in harm including death. It would also lead to extended hospital stays, readmissions, poor bed flow affecting access to Acute NHS care, increased morbidity and increases risk of antimicrobial resistance as a Public Health threat which harms our patients further. There are severe restrictions to prescribers accessing Microbiologist Specialist advice as it is now limited to Consultant level only that can access. This is resulting in patients being managed without the specialist required input, including for complex cases. Due to lack of Microbiologist capacity there is no pro-active input either in the form of Microbiologists undertaking regular ward rounds in high risk areas, no offer of call-backs	Currently being directed through Consultant Antimicrobial Pharmacist within own working hours and remit. Being flagged at various forums. Regular communication and reminders about availability of Antimicrobial team and guidelines and any resources available	Through antimicrobial consumption and surveillance Audit results Specialist time input from Antimicrobial Team Survey Pending Infection prevention & control surveillance and audits	31/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Trust to consider Antimicrobial Nurses - initiative put forward by ASSG and supported by MQG - as a matter of urgency Trust to review Microbiologist contracting - as a matter of urgency ASSG formally writing to clinical Directors (including ICB Medical Director) with this concern Antimicrobial Guidelines being revised to make them specific to ULHT rather than shared with NLAG as they are now.	[31/01/2025 15:31:36 Gemma Staples] We recently advertised three substantive posts and successfully filled one. The remaining two positions will be re-advertised. So the risk still remains , as it is. [18/10/2024 13:44:29 Reena Rambani] The restriction to calls from "Consultants and GPs only" were lifted end of August when a new locum Consultant Microbiology, Dr Rashmi Dube joined the team as NHS locum for 6 months.The three substantive Consultant Microbiology posts have been advertised and closing date is 31st October.Also another new locum Consultant Microbiology, Dr Milind Khare, has joined the department this week. Having said that, the risk due to staff shortage continues in Microbiology department due to planned leave of multiple colleagues for the next few weeks [28/08/2024 14:11:06 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge	4	30/11/2025	01/06/2025	30/04/2025

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4868	64	Physical or psychological harm	Farquharson, Colin	Martinez, Francisca	Maternity & Neonatal Oversight Group	01/03/2022	16	Clinical Support Services	Pharmacy CBU	Pharmacy		Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors. Breach of Medicines Act: Regulation 3 of the Human Medicines Regulations 2021 permits doctors to prepare medicines for administration. The expectation would be that preparation would be in compliance with current best practice and governance expectations. Regulation 214 permits parenteral administration of medicines by or in accordance with the directions of and appropriate practitioner. This practice would constitute a risk to the patient and falls outside of expected governance arrangements detailed in Advice Note for Chief Pharmacists March 2017 NHS	No current processes in place to minimise risk Policies do not support this practice	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	09/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Use of tamper proof boxes/trays being purchased. 2. The only control to prevent the risk is to prepare the injections prior to administration (within 30 minutes) as per guidance (National and Trust). 3. If the practice is to continue, the prepared products should be labelled to include the recommended information. A procedure should be developed indicating the process to follow to ensure the medicines drawn up are discarded at the end of the day.	[09/01/2025 14:22:58 Lisa Hansford] No update [10/10/2024 10:10:14 Lisa Hansford] No further update [10/07/2024 11:13:39 Lisa Hansford] no further update [04/04/2024 09:02:51 Lisa Hansford] NO FURTHER UPDATE [29/12/2023 13:33:55 Lisa Hansford] No further update [26/09/2023 14:17:01 Rachel Thackray] Meeting to take place to review progress [20/07/2023 10:43:27 Lisa-Marie Moore] narrative updated to reflect conversation between Fran Martinez and Regional QA about breaching medicines act regulation 3 [27/06/2023 09:45:38 Alex Measures] Discussed in risk register review meeting- no further updates [01/06/2023 14:26:57 Lisa-Marie Moore] Risk assessment resent to anaesthetists - to discuss at next MQG. If no further progress to discuss with CQC [04/05/2023 14:26:40 Lisa Hansford] needs to go back to MQG	4	30/09/2022	31/03/2023	09/04/2025

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4935	58	Service disruption	Farquharson, Colin	Sewell, Chris	Workforce Strategy Group	26/05/2022	16	Surgery	Theatres, Anaesthesia and Critical Care CBU	Critical Care		Insufficient medical staffing in Intensive Care Units at Lincoln and Boston. Uncovered shifts may result in Unit being decompressed. Medical staff asked to work extra hours compromising workforce directive. Unsafe cover in Unit when doctors are called to attend patients in A&E. Could result in harm to both patients and staff (in terms of wellbeing/morale).	Locums to recruit. Recruitment adverts out. Staff are being paid in TOIL in order to mitigate the financial risk to staff. Rotas are set and monitored -a Consultant formulates the rota and identifies gaps which cannot be covered in advance. Agency requests. Escalation to Divisional Triumvirate when gaps cannot be filled. Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy. Business Continuity Plans are in place for both sites.	Rotas (gaps). Agency spend - financial risk. Number of Datix incidents recorded.	21/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruit to vacant posts.	[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	4	31/10/2022		21/05/2025
5515	737	Service disruption	Upjohn, Emma	Agarwal, Vandana		25/09/2024	16	Family Health	Women's Health and Breast CBU	Obstetrics		Due to increasing demand for Elective Caesarean Section (El LSCS) exceeding the capacity of the current dedicated El LSCS lists, the maternity service is having to perform El LSCS outside of the planned pathways using both the emergency medical and theatre teams. As a result, there is a risk of severe harm or death to mother and baby should a second emergency arise whilst the second emergency team is performing an elective procedure. Currently there are dedicated El LSCS list on a Tuesday and Thursday morning at the Lincoln site and all day Wednesdays. On average Lincoln performs 2-3 El LSCS every day Monday - Friday. At Boston there are 4 on a Wednesday and 2 on a Friday.	Elective section activity is managed on a daily basis and cancellations made where required. Additional emergency team called in when required.	Any delayed, cancelled LSCS or when the 2nd theatre is opened are reported on Datix	24/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Exploring with theatres the ability to provide further El LSCS lists across both sites.	[24/01/2025 10:29:29 Nicola Cornish] Risk reviewed, no change. [30/10/2024 14:44:18 Nicola Cornish] Discussed at Risk Register Confirm & Challenge meeting on 30th October 2024. Panel approved the score but requested mitigations described are reflected in the Datix record. ULHT is not an outlier in terms of our ElCS rate. [25/09/2024 13:24:51 Nicola Cornish] New risk agreed by Libby Grooby. To be added to agenda for October RRC&C meeting for approval.	2	30/09/2025		24/04/2025

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4843	57	Physical or psychological harm	Landon, Caroline	Landon, Caroline	Medicines Quality Group	19/01/2022	20	Corporate	Operations	Operations		As a result of a lack of Immunologist within the Trust, Screening, management and review mechanisms of patients requiring or in receipt of Intravenous Immunoglobulin (IVIg) is inadequate. The Clinicians prescribing Immunoglobulin are not able to receive advice from an Immunologist and as a result patients could receive incorrect treatment. Patients are receiving Immunoglobulin for longer than they should be.	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) Antimicrobial and High Cost Drugs Management Pharmacist undertaking administrative functions to ensure all referrals are screened and are done so in a timely manner.	Reported incidents involving use of Intravenous Immunoglobulin (IVIg)	15/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Employ an immunologist or have a local agreement with another Trust to have immunologist support - Colin Farquharson - End of December 2024 Shared Care arrangements and prescribing accountabilities to be reviewed - Colin Farquharson - End of December 2024	[15/01/2025 13:41:06 Rachael Turner] Risk reviewed, due to being able to seek advise from other colleagues at Nottingham and it not being a clinical requirement this likelihood score to be reduced. Therefore risk score to be reduced to 2x4:8 Moderate. this risk to be presented at February RRC&C meeting. [02/09/2024 17:26:56 Gemma Staples] Risk agreed to sit under COO - now amended [24/07/2024 11:19:33 Gemma Staples] Sarah Chester-Buckley has spoken with Consultant Haematologist Charlotte Kallmeyer regarding this risk. Haematologists are able to prescribe Immunoglobulins without the input of a Immunologist. Previously the Trust employed an Immunologist for a small number of PAs, this is not required for the Haematology service as patients can be discussed with colleagues at Hull / Nottingham. [22/07/2024 12:54:39 the reporter] 22/07/2024 - Risk reviewed ad	4	01/10/2021	31/07/2023	15/04/2025

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4746	121	Physical or psychological harm	Lacey, Mark	Knapp, Chris	Clinical Effectiveness Group, Outpatient Improvement Group	14/01/2022	20	Surgery	Urology, Trauma and Orthopaedics, and Ophthalmology CBU	Ophthalmology		Overdue patients on the Trust-wide Ophthalmology Partial Booking Waiting List who wait for longer than the expected wait time specified by clinician. This may result in deterioration of eye condition.	Ophthalmology / Surgery Division clinical governance arrangements Outpatient / PBWL management processes The e-Outcomes Out-Patient clinic system has had an additional field added to record these required appointments which will be greater than 6 weeks.	Monitoring Ophthalmology PBWL Clinical harm reviews / reported incidents due to appointment delays	14/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to ensure future sustainability once recovered.	[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	4	31/07/2021	30/06/2022	15/05/2025

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5614	825	Service disruption	Fulloway, Mr Ian	Woods, Mr Michael		04/03/2025	16	Clinical Support Services	Diagnostics CBU	Audiology	Trust-wide	As a result of Increasing demand on referrals to the service, the Paediatric Audiology Service not meeting the Paediatrics Quality Standards and the consequence of the requirement to attain UKAS IQIPS accreditation, due to insufficient staffing, capacity and lack of soundproofing rooms (the room at Boston has recently been condemned after IQUIPS benchmarking visit which has reduced capacity further) there is a risk of 1) an increase in waiting times which is a causing a delay in patients being seen and a delay in treatment which could lead to long term patient harm and risk of litigation and 2) the risk of the Trust not attaining accreditation which could lead to Audiology losing the contract for Paediatric Services in Lincolnshire.	Audiology team are undertaking work to bring the service up to this standard by updating or developing new policies, operating procedures and work instructions to meet the new Paediatric Quality Standard requirements. This is causing capacity pressures as staff are having to be taken out of clinical time due to the work involved in revising the required documents. Team is working to review IQUIPS standards and match requirements to policies and procedures currently in place within the department and to develop the new working practices and quality monitoring processes required. Work will then be undertaken to produce an action plan to put into place any policies, procedures or processes that are not currently embedded in service. Once action plan is complete and revised systems suitably embedded then an application will be placed to UKAS for initial assessment for department's compliance with IQUIPS standards. Clinics are pausing during testing while noise levels abate. Clinic dates have been amended to quieter clinic days. Insert earphones used for greater attenuation of	Standards met Waiting times report Action plan review and UKAS initial assessment report. (This is relating to IQUIPS) Environmental sound levels measured between patients and at times of testing. Recent training identified reverberation risks which cannot be measured Facility will not meet stage C calibration standard for freefield testing hence test stopped. Monitor numbers of patients being transferred and action plan for impact as data is recorded.	26/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Audiologists to take time out of clinical work to review, revise and complete the required documentation. Locum Audiologist in place to reduce backlogs of clinics - Michael Woods - December 2028 Development of Case of Need / Business Case to increase staffing and improve facilities to Gold Standard at all sites - Michael Woods - April / May 2025 Action planning from the UKAS Benchmarking visit is underway - Michael Woods - April 25 Review of waiting list currently underway - Michael Woods + Victoria Biddulph - March 25 Reviewing with Procurement options around temporary booth hire as an interim resolve for the CoN for refurbishment - Michael Woods + Clare Wright - February 25	[26/03/2025 13:38:10 Gemma Staples] Risk approved as a Service Disruption risk scoring a 4x4(16) at RRCoC meeting on 26/03/2025 and agreed for this to supersede 5236 / 5287 / 5317 / 5318 & 5235. [04/03/2025 17:28:57 Gemma Staples] Risk is to be presented at March RRCoC for approval and will supersede 5236 / 5287 / 5317 / 5318 & 5235.	4	31/03/2026		26/06/2025

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5095	59	Physical or psychological harm	Capon, Mrs Catherine	Chamberlain, Liz (Elizabeth)		24/02/2023	16	Surgery	Surgery CBU	Vascular Surgery	Pilgrim Hospital, Boston	Due to increased demand for PICC services there is a risk that within the current establishment there is a significant delay to patients. This can delay treatment, hinder flow and cause poorer outcomes for patients. 8 years ago, venous access within the Trust was classed as central lines (internal jugular insertion) and cannulas. Peripheral central catheters (PICC) were undertaken occasionally for oncology patients and portacaths and Hickman lines were done in theatre, as they still are. The vascular ACPs started to learn how to insert picc PICC lines starting from one morning clinic on a Tuesday (supported by the Consultants). The needs for PICC increased and we went to two full day clinics in a week. They were only inserting in pilgrim at that time. It was then determined that Total Parental Nutrition (TPN) needed to be given centrally and not peripherally, and the work load increased two fold. A business case was successful for a 1.0 WTE band 6	At present there is one 1.0 WTE VAIN (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	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	24/03/2025	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	[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	1	01/06/2023		24/06/2025

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4646	66	Physical or psychological harm	Dunderdale, Karen	Gibbins, Donna	Clinical Effectiveness Group	14/12/2021	20	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	If the Trust is not consistently compliant with with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - not being met at LCH or PHB as of Dec 21 - Start time for NIV <60mins from Arterial Blood Gas (ABG) - not being met at LCH or PHB as of Dec 21 - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours - not being met at LCH as of Dec 21 update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings	04/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	[04/02/2025 14:39:07 Rachael Turner] We have made no more progression with engagement through ED, however we are re-reviewing KPIs against national standards for NIV. Also reviewing dashboard to identify gaps in knowledge in ED. [27/11/2024 12:16:28 Rachael Turner] NIV provision being reviewed with the implementation of a study day for staff in ED at band 6 and 7, this will be followed by a competence pack whereby staff will be required to set up 5 NIV and be signed off by staff on respiratory. The NIV in a non itu setting SOP is being reviewed to consider options for commencement of NIV in ED. There continues to be significant issues with failure to recognise type 2 respiratory failure in ED and refer patients. Education continues as part of the study day and relationship with ED. A daily communications in place with escalations whereby the ringfenced bed is not available for immediate action which is successful	4	30/09/2022	31/12/2024	04/05/2025

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5491	701	Physical or psychological harm	Parkhill, Michael	Davies, Chris	Clinical Effectiveness Group, Infection Prevention and Control Group	18/07/2024	16	Corporate	Estates and Facilities	Estates	Trust-wide	As a result of wards and departments not following the Change of Use Policy this has resulted in rooms being used for clinical treatments in which ventilation requirements are inadequate. This could lead to patients harm and patients contracting Hospital acquired infections.	Change of Use Policy Space Management Policy-this was approved by H&S Committee IPC Action Plan to review all current areas that are being used inappropriately.	IPC Action Plan. Datix incidents raised.	03/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	IPC Action Plan has been developed and carried out identifying all areas where treatment rooms are being used with inadequate ventilation. Estates Actions: •Estates to progress a ventilation compliance review upon Trust approved Capital Funding. •If mechanical ventilation is present – discuss / request Estates feasibility to increase air changes for treatment rooms found to have less than 10 air changes. •Estates to progress environmental infrastructure remedial work upon Trust approved funding. Clinical Division Actions •Where treatments rooms are not up to standard, the relevant Clinicians to be informed by the Divisions so that they can perform their own assessment of risk / responsibility. IPC will support risk assessments. •Red rated treatment rooms to be a priority for relocation to a safer	[04/03/2025 10:56:23 Rachael Turner] Work remains ongoing. Ventilation Safety Group is now set up and regular audits and actions are produced and monitored to support and find solutions for ventilation issues. [19/11/2024 12:16:52 Rachael Turner] Risk action plan remains ongoing. Estates and capital are working towards replacement. A meeting is booked on the 9th December to discuss capital funding. A new ventilation safety group has been put together, chaired by head of estates. Audits and actions are being produced to find solutions for all ventilation issues. Validation reports are available for all critical plants. [31/07/2024 13:53:50 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated at 4x4:16 High Risk. [22/07/2024 15:33:13 Rachael Turner] Treatment room action plan updated version uploaded with feedback from CSS.	8	18/07/2025		03/06/2025
5564	783	Physical or psychological harm	Landon, Caroline	Anderton, Kerry		19/12/2024	16	Medicine	Urgent and Emergency Care CBU	Hospital at night	Trust-wide	As a result of staffing not being uplifted for Hospital Out of Hours along with gaining more wards this has resulted in an increase in patients along with an increase in acuity. This has led to patients waiting for longer than they should do to be reviewed and for essential medications and fluids to be prescribed. This could result into an increase in patient mortality leading to increase length of stay, a reduction in bed flow and a negative effect of patient experience. This risk also has an effect on staff with reduced morale and increased levels of stress due to pressures.	-All clinical task requests are triaged by Hospital Out of Hours clinical coordinator who can advise the nurses on interim measures while they are waiting for their patient to be reviewed and give safety netting advice. -Tasks are then triaged again by the clinician receiving them. -Any tasks left at the end of shift are handed back to day staff. - Staffing levels currently have at both Lincoln & Boston: 1 ACP, 1 Clinical Coordinator and 1 Clinical Support Worker. -Medical staffing at Lincoln: 1 dedicated Hospital Out Of Hours F1 Doctor -Medical staffing Boston: 1 Trauma and Ortho Doctor, 1 Surgical Doctor, 1 Medical Doctor-these are not however dedicated to Out Of Hours so may not be readily available-these also clerk on Admissions Units and A&E.	-Datix Incidents -Audit Nerve Centre -Regional Hospital Out of Hours Network KPI's	29/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To increase the number of clinicians in the Team by 1 extra member of staff per night-a Doctor or ACP-unfortunately there is no current source of funding for a Business Case. Currently looking into this but this is reliant on buy in from Medicine. This is an ongoing piece of work.	[29/01/2025 13:41:22 Rachael Turner] Risk presented at RRC&C meeting 29/01/2025. Risk score validated at 4x4:16 High Risk.	8	19/12/2025		29/04/2025

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5519	739	Physical or psychological harm	Fradgley, Daren	Evans, Thomas		08/10/2024	16	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	As a result of the lack of an established Digital Clinical Risk Management system (Health IT system), processes and resource resulting in non-compliance with the Digital Clinical Safety Standards DCB0129 and DCB0160 (the Standards mandated by NHSE to ensure the safe manufacture, development, deployment, and use of Health IT Systems) this could lead to patient safety incidents involving digital systems, resulting in or contributing to patient harm or death. An informal 'best endeavours' approach has previously been taken and digital clinical systems have been deployed that have not fully met the Standards. The Standards also mandate an approach to Clinical Risk Management which continues for the entire lifecycle of the Health IT system, not just prior to initial deployment. Under the standards, the CRMS must have proactive and reactive elements to effectively	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	26/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Develop and strengthen Digital Clinical Safety Function - will require funding for permanent staff including administrative resource to administer / manage the CRMS. Action 2. Continue to work towards meeting the National standards, all new projects will have the Digital Clinical Safety Standards applied. Action 3. Further development of the new CRMS, embedding of associated processes and improved digital clinical safety literacy among digital, clinical, and operational teams. Action 4. Review of previous projects and live systems, deployed under previous arrangements to ensure a clinical safety review is applied under the new standards. Action 5. Ensure effective application of Digital Clinical Risk Management activities through regular audits	[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	12	08/10/2025		26/05/2025

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5227	439	Regulatory compliance	Lynch, Diane	Hughes, Robert	Clinical Effectiveness Group	02/08/2023	12	Clinical Support Services	Path Links (Pathology)	Mortuary (Pathology)	Trust-wide	As a result of the limited security measures in place, there is significant risk of unauthorised entry into the Trust's mortuary departments and/or temporary body stores. The risk is based on the following security gaps: Lincoln: Temporary body store: No Swipecard access but locked with key In the event of a break in, not only would the dignity of patients be compromised but there is a high probability that damage could be inflicted on patients either deliberately or as a consequence of a failure in the control of the environment. The scenario is reportable to both CQC and HTA as regulators. In addition, criminal investigations would be initiated. As regulators, CQC and HTA can issues fines, sanctions or even revoke the licence to operate mortuaries. It would be highly likely that complaints and claims from families of the deceased would ensue having lasting reputational damage to the	24 hour site security: Walkarounds in place, with security tags fitted to exterior of mortuary buildings; additional security patrols at night CCTV: On entrance to Mortuary departments and the temporary body stores (inside also) Access Control: Swipecard access to main mortuary departments (governed by SOPs). No swipecard access to Temporary body stores, this is key operated locks only. Single key set only accessible by mortuary staff held in the mortuary which is access controlled. Alarm system: All 3 sites main mortuaries have intruder alarm that is connected to the Switchboard. The Titan temporary body store also now has an intruder alarm. Boston: Temporary Body store: Not currently in use, following completion of refurbishment at Boston. Access is via a locked gated yard.	The frequency and extended use of the temporary body store at Lincoln has increased the risk.	19/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Assess security vulnerability (on the back of recent incident at NLAG/DPoW) with NLAG/ULHT/Police review of security (Meeting held during July to understand findings and discuss next steps. Actions in response need to be agreed, to be tabled at HTA Governance meeting) - Robert Hughes - December 2025	[19/02/2025 14:50:31 Gemma Staples] This is being monitored by the HTA Governance group. Recommendations have been received from Lincs Police and we are seeking engagement. Further review will also be required on completion of the Lincoln refurbishment, which has been raised by the HTA to ensure that the CCTV and access is reviewed to ensure suitability for the new environment. [25/11/2024 16:11:34 Gemma Staples] Boston Temporary Body store is not currently in use, following completion of refurbishment at Boston. Access is via a locked gated yard. Meeting held in July with NLAG/ULHT/Police review of security to understand findings and discuss next steps. Actions in response have been discussed at the HTA Governance Meeting and the recommendations made in the report have been ratified by the	6	02/08/2024	31/12/2025	19/05/2025

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5403	712	Regulatory compliance	Cooper, Mrs Anita	Cragg, James		28/08/2024	15	Clinical Support Services	Path Links (Pathology)	Microbiology (Pathology)	Pilgrim Hospital, Boston	As a result of the breakdown of the Microbiology Class A Waste Autoclave (since 11 December 2023) the Trust does not meet HSE Regulatory Compliance (this stipulates that Category A and B wastes are inactivated on-site before final disposal because they may contain high concentrations of biological agents and pose an increased risk of exposure) which could lead to financial penalties to the Trust. As a result, the current failure has led to business continuity plan enactment which necessitates diversion of this work to Scunthorpe which causes a direct impact on patient care. This is affecting ULHT / NLAG and 81 ICB Surgeries and patient flow as patients are waiting longer for a diagnosis which could have a negative impact on their outcome In addition; without the ability to inactivate Category B waste onsite via the autoclave at Boston, waste is going out in a higher category stream	Ceased processing of respiratory samples as the Trust have no method of making waste from these tests safe prior to disposal. Business Continuity Plan diversion of this work to Scunthorpe Using Taxis but this is incurring a cost to ULHT Staff working additional hours at Scunthorpe Two units were moved to Boston from Lincoln as part of the transfer of microbiology service in 2009, one of the units failed and has been out of use for 10+ years. The second unit has been supported by E&F onsite at Boston with LTE servicing and repairing when required.	Audit KPI's Datix Incidents Complaints / PALS	17/03/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Specification to be completed and sent to E&F – James Cragg/Michael Jewsbury to submit by 30/07/2024 BCP to be reviewed – James Cragg/Michael Jewsbury reviewed 30/07/2024 LEBBS – Lincolnshire Charity Bikes to be contacted regarding Monday to Friday support - James Cragg - Pending response 02/08/24-06/08/24 Apply for derogation once specification / plan is in place – James Cragg and Michael Jewsbury - 16/08/2024 Purchase and installation of new Autoclave Unit - Chris Davies - 30/01/2025	[17/03/2025 12:14:24 Alison Gresty] Derogation of waste has progress however the ULTH licenced contractor Stericycle had insisted on only taking the waste as Cat A rather than the usually accepted enhanced Cat B for this waste stream. This is a decision for ULTH and was escalated for resolution within ULTH via the Pathology Chief of Service. Following a further meeting, Stericycle have now agreed that they are able to remove waste as Cat B when there are no actual HG3 cultures present in the waste. ND indicated that the likelihood of HG3 culture generation is low in the time interval remaining, and that any arising would be able to be stored securely within the CL3 containment room at Boston. A response to HSE with the further information required for derogation has been drafted, with confirmation that the load incineration certificates would be made available to UHTH. It is hoped that this should resolve the	6	13/03/2025		17/06/2025

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5535	784	Physical or psychological harm	Mooney, Mrs Katy	Hunter, Sarah		07/11/2024	15	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	Acute Stroke patients have no access to clinical psychology services in line with the National Clinical Guideline for Stroke 2023 which stipulates psychological care should be provided by stroke services across acute and community settings. Services for people with stroke should have a comprehensive approach to delivering psychological care that includes specialist clinical psychology/neuropsychology input within the multidisciplinary team and should include specialist clinical psychology/neuropsychology provision for severe or persistent symptoms of emotional disturbance, mood or cognition. This could result in patients not being able to engage fully with therapy leading to longer rehabilitation periods, increasing lengths of stay. It could also affect staff due to adverse behaviour by patients due to cognitive impairment.	There is currently no commissioned post for this service within the acute service there is limited provision in the community.	SSNAP data & Datix	29/01/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Commission post and recruit to post, currently lies with CBU Proposal for additional ward space	[29/01/2025 13:45:12 Rachael Turner] Risk presented at RRC&C meeting 29/01/2025.Risk validated 5x3:15 High Risk. [05/12/2024 16:28:00 Rachael Turner] Risk description updated to reflect guidelines and negative impact to patients and staff. This risk to be agreed at Stroke and Cardiovascular CBU Governance, once agreed this will be presented at Risk Confirm and Challenge in January. [27/11/2024 13:21:18 Rachael Turner] Risk presented at Risk Confirm and Challenge 27/11/2024, risk requested to be re-worded with details of what that guidelines, once updated this will be returned.	6	07/11/2025		29/04/2025

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5196	309	Regulatory compliance	Costello, Mr Colin	Hansford, Lisa		20/06/2023	15	Clinical Support Services	Pharmacy CBU	Pharmacy		As a result of regular audits not being completed, the standards for medicines storage are likely to fall below the required standards. Medicines storage and temperature monitoring was raised by CQC during the last inspection, as 'must do' actions. Some of these audits have legal implications such as the controlled drugs audits and safe and secure medicines storage. As we have had the same 'must do' action since 2018 with no improvement, there is possibility without full assurance they could impose improvement notices. Due to a shortage in staffing, Pharmacy department are unable to complete the annual medicines management and temperature monitoring audits for all clinical areas that store medication. The organisation is required to be compliant with both the RPS Guidance for the safe and secure handling of medicines and the Health Building Note (HBN 14-02)	The matrons and quality matrons complete ward assurance audits that include some medicines management questions.	Review of incomplete audits, highlights that there are ongoing issues with timely completion of medicines management audits due to the lack available staff to complete these. Datix incidents reported indicate ongoing issues with medicines management.	20/03/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Business Case to be completed to improve Pharmacy staffing - Ahtisham Saddick - September 2025	[25/03/2025 11:05:03 Gemma Staples] Risk level reviewed and request for the risk to be reduced to moderate score 3x3(9) from 5x3(15). This will be presented at April RRC&C meeting for approval in reduction of scoring. [20/03/2025 10:15:41 Lisa Hansford] Audit schedule currently under review to make this more manageable and will be utilising the newly qualified pharmacy technicians to get the audits completed. Risk level reviewed and reduced to moderate score 9 [10/03/2025 09:52:41 Lisa Hansford] Risk review meeting arranged for 20.3.25 to update all risks relating to staffing. Risk remains the same at this time [06/12/2024 17:41:52 Lisa Hansford] No further update [04/09/2024 14:09:01 Gemma Staples] Lisa Hansford reviewed the risk and updated details and felt the risk should stay as a 5x3. [21/08/2024 16:34:29 Gemma Staples] A request for a decrease to	4	20/06/2024		20/06/2025

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5169	60	Physical or psychological harm	Mooney, Mrs Katy	Hunter, Sarah		09/05/2023	15	Clinical Support Services	Therapies and Rehabilitation CBU		Lincoln County Hospital	Approx 15-20 Stroke outliers at any time on the LCH site. Therefore not on the stroke unit and not receiving specialist stroke therapy at the frequency and duration required by SSNAP. Outlier patients are not cohorted on site and can be on any ward therefore Stroke staff cannot go and review and advise. Stroke patient on other non stroke ward will not be assessed as a priority as they are not medically optimised and ready for discharge. Current staffing levels are for the 28 bedded Stroke unit only. If a stroke patient is seen on a non stroke ward this is to the detriment of another patient on that ward. Increased staff stress. General wards do not have the treatment facilities that Stroke patients need.	Stroke Therapy Team review all outliers at the cost of not seeing the Stroke ward patients as much. Stroke team will advise general ward based therapy team. Minimal basic Stroke assessment and treatment skills for general ward therapy staff. Proposal to implement Trusted Assessor Stroke Assessment.	Datixes M&H injury to staff and patient	05/02/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Moving of Stroke specialist therapy staff from PHB to LCH Robust stroke training plan for general ward staff Attendance at Stroke Board to influence change and need for cohorting of outliers Review of Stroke staffing in line with latest staffing levels needed 16/10/23 funding transferred to LCH budget to help support staffing and recruitment has started	[05/02/2025 10:03:18 Gemma Staples] This risk is ongoing, work continues to expand the stroke bed base and the workforce proposal will be in line with the additional beds and national guidelines for therapy staffing levels, unfortunately due to the need for a ward refurbishment and business case approval the predicted completion date is December 2026 [and this may be optimistic.] [04/11/2024 13:21:24 Gemma Staples] We have been working with finance to look at the uplift of staffing against the current staffing guidelines as part of a wider business case linked to the Stroke Estates. [05/08/2024 11:15:56 Gemma Staples] We are currently involved in a review of Estates. Meeting to take regarding plans. Trying to get a Consultant / AHP job description matched to try and support the staffing issues on the Stroke Unit. We have a joint band 6 OT post with LCHS focussing on flow and discharge. Ongoing work with LCHS	8	13/05/2024		05/05/2025
Strategic Objective		**1b. Improve patient experience**																							

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5495	725	Physical or psychological harm	Upjohn, Emma	Bond, Rachel	Estates Infrastructure and Environment Group, Patient Experience Group	07/08/2024	16	Family Health	Women's Health and Breast CBU	Obstetrics	Lincoln County Hospital	Lack of adequate provision for appropriate clinical care of bereaved families within Obstetrics at Lincoln County Hospital. There is a risk of psychological harm due to hearing labouring women and crying babies, and having to share facilities with mothers and their new-borns.	Have allocated a room on labour ward to care for the women, which is not within the centre of the labour ward and has its own en-suite facilities. Women not to be moved to Nettleham ward at any point during their admission.	Incident reports PMRT reviews Patient complaints	24/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Specific bereavement facilities to be included as part of proposed redevelopment of labour ward - unknown timeframe.	[24/01/2025 10:32:31 Nicola Cornish] Discussions are still ongoing with Facilities on how the room can be sound-proofed. [09/12/2024 14:36:27 Nicola Cornish] There are plans to move forward with changing one of the labour ward rooms into a designated area for bereaved families. Talks currently underway with specialist bereavement Midwife, inpatient Matron and HOM of how to move forward with this plan. [25/09/2024 13:22:59 Nicola Cornish] Discussed at RR Confirm & Challenge meeting on 25th September 2024. Panel queried scoring of 16 - Gemma Rayner explained that this issue is a common finding in every PRMT review at Lincoln whereas it is not found at Boston. Significant patient complaints regarding psychological harm - one patient described it as torture. Scoring of 16 approved. [07/08/2024 10:27:39 Nicola Cornish] Plan to enhance facilities in a designated room on labour ward to	4	07/08/2025		24/04/2025

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5234	510	Service disruption	Lynch, Diane	Biddulph, Victoria		25/08/2023	15	Clinical Support Services	Diagnostics CBU	Neurophysiology	Pilgrim Hospital, Boston	As result of the Emergency Department new build project, Pilgrim (PHB) H block was demolished and therefore clinical space was taken from Neurophysiology. No EEG or EMG service is provided at PHB currently. No Inpatient provision for testing at PHB. Inpatients requiring tests have to be transferred by hospital transport to Lincoln County for testing therefore there is a delay in treatment which would lead to patient harm and additional stress caused to patients having to travel to another location.	Adhoc bookings of space available within Outpatients at PHB. Booked where and when possible. Inpatient being transferred to Lincoln (although this is taking staff off wards in Pilgrim)	Waiting times Travel times Patient Feedback Datix Incident	25/02/2025	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	[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.	4	26/08/2024		23/05/2025

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4701	85	Reputation	Upjohn, Emma	Upjohn, Emma	Patient Experience Group	13/01/2022	15	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	If the quality and condition of the hospital environment and facilities used within Maternity services are poor then it may have a negative impact on patient experience and staff morale resulting in loss of confidence in the Trust and damage to reputation; there is also an increased infection risk	- Trust procedures for capital investment and Estates project management - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	24/01/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	[24/01/2025 12:32:05 Nicola Cornish] no change, will remain ongoing until refurb programme is complete. [24/10/2024 15:12:06 Nicola Cornish] Risk reviewed, no change. [25/09/2024 13:13:56 Nicola Cornish] Discussed at RR Confirm & Challenge meeting on 25th September 2024. Risk severity was scored as 5 when initially added but ward has since relocated and some issues addressed so consideration to be given to reducing this to 4. Bring back to next meeting for approval. [09/07/2024 16:06:45 Nicola Cornish] This is ongoing, business cases have been developed for both sites and it is anticipated that work will commence on the Lincoln site before the end of this year. [04/04/2024 10:32:18 Nicola Cornish] No change, awaiting trust board decision regarding the architect plans. [23/01/2024 16:04:20 Nicola Cornish] The team are continuing to work with architects to develop	6	31/03/2025	31/03/2025	24/04/2025

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4724	86	Physical or psychological harm	Lynch, Diane	Taylor, Ruth	Patient Experience Group	13/01/2022	20	Clinical Support Services	Therapies and Rehabilitation CBU	Rehabilitation	Trust-wide	As a result of the inability to provide a 7 day service due to insufficient staffing for Therapies and Rehabilitation Medicine Teams. The service is currently unable to provide a 7 day 8-8 service provision to match organisational demand. There is a risk that weekend cover is inadequate which has an impact on delayed patient flow, delayed discharges and timely outpatient clinic appointments offered which could lead to poor patient outcomes.	ULH policy: - Service planning & budget setting processes - Business case decision making processes ULH governance: - Capital & Revenue Investment Group (CRIG) management of business case process - CSS Division, CBU / speciality governance arrangements	Daily review of staffing levels Front door therapy KPIs Outpatient KPIs Dietetic KPIs Rehabilitation Medicine KPIs Datix incidents Outpatient Capacity & Demand reporting - fortnightly meetings	04/02/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Review current provision and identify gaps in service to feed into the business case - Ruth Taylor - September 2025 Business Cases to be submitted where required - Ruth Taylor - December 2025	[26/03/2025 14:17:30 Gemma Staples] It was agreed at RRCoC 26/03/2025 that the score reduction would be pre-approved, so once staffing in post at the end of April so the scoring can be reduced and doesn't need to come back to RRCoC. [18/03/2025 13:48:53 Gemma Staples] The Therapies Deep Dive is taking place on 26th March 2025 for all of Therapies risks of which a request for the risk to be reduced to a 4x3(12) as the scrutiny and management of the rosters has shown better results, reducing the likelihood. [04/02/2025 11:41:42 Gemma Staples] Remains the same until we have completed the current work around right sizing with budgets and staff. Closer scrutiny and management of rosters since December 24 has shown better results leading to the use of bank staff at weekends to boost services. [04/11/2024 11:04:16 Gemma Staples] We have been working with	3	05/01/2024	31/03/2023	02/05/2025
Strategic Objective		**1c. Improve clinical outcomes**																							

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4828	31	Physical or psychological harm	Farquharson, Colin	Costello, Mr Colin	Digital Hospital Group, Patient Safety Group	17/01/2022	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of Maternity, Paediatrics, Outpatients and ICU using manual prescribing processes which are inefficient and restrict the timely availability of patient information when required by Pharmacists this could lead to delays or errors in prescribing and administration, resulting in a widespread impact on quality of care, potentially reducing the likelihood of a positive clinical outcome and/or causing serious patient harm. EPMA rolled out across the Trust - Outpatients, ICU, Paediatrics and Maternity were removed from scope. • Outpatients module installed as part of ePMA, due to the COVID19 delays, reconfiguration of services and complexities with the nature of outpatient prescribing, it was agreed by the ePMA Steering group to defer this to either EPR or a later optimisation piece of work. • EMIS solution does not support the British National Formulary (BNF) for paediatrics. • Maternity was removed from scope	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG)	Medication incident analysis Audit / review of medicines management processes	21/03/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Maternity : Pursuing new digital system which would have own prescribing feature - Badgernet? - Lorraine Brooks - May 2025 ICU : Suitable software for very complex infusions being sought - Lead? - May 2025 Outpatients : Outpatients module installed as part of EPMA, due to COVID delays, reconfiguration of services and complexities with nature of outpatient prescribing agreed by EPMA Steering Group to defer to either the EPR or later optimisation piece of work - Lead to be confirmed once in post - May 2025	[21/03/2025 13:06:14 Lisa Hansford] Badger net roll out is still imminent, until this is completed the issues with out patients/ICU and Paeds will not considered therefor this risk will remain the same [24/02/2025 11:56:00 Lisa Hansford] Roll out of Badgernet for maternity is imminent. Outpatients/ Paediatrics and ICU are still under review for suitable electronic prescribing and administration systems. [24/01/2025 08:53:20 Lisa Hansford] No further update [24/12/2024 08:25:27 Lisa Hansford] No further update [25/11/2024 10:46:08 Sarah Davy] Outpatients - Product Manager JD is undergoing review for banding and will be appointed once completed. Funds for post have been agreed. [25/11/2024 10:41:10 Sarah Davy] Kate Rivett confirmed that there are mitigations in place where they would accept the minimal risk to Paediatrics. No plans to employ full time Paediatrician for EPMA [29/10/2024 10:20:16 Lisa Hansford]	4	31/12/2023	30/06/2025	24/04/2025

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4731	33	Physical or psychological harm	Landon, Caroline	Landon, Caroline , , , , , , ,	Safety Group	13/01/2022	20	Corporate	Operations	Operations	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review December 2023) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Clinical Records Group - Now led by Deputy Medical Director.	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	06/03/2025	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.	[06/03/2025 09:58:09 Rachael Turner] Risk reviewed, no change until EPR in place [17/02/2025 11:24:13 Rachael Turner] Risk reviewed, no change from January, risk remains at same level until EPR in place. [15/01/2025 13:34:44 Rachael Turner] Risk reviewed, until electronic patient records is in place this risk will remain at the current level with no current change to risk scoring. [28/10/2024 11:14:13 Rachael Turner] Risk reviewed, no change to current scoring. [12/09/2024 20:14:05 Rachael Turner] Risk reviewed, remains unchanged, no change to risk score. [20/08/2024 16:20:51 Rachael Turner] Risk reviewed, risk score remains accurate until EDMS is in place. [16/07/2024 12:40:46 Rachael Turner] Risk reviewed, no further updates. Risk score to remain. [26/06/2024 09:09:01 Rachael Turner] Until EDMS in in place and	4	30/06/2018	31/03/2025	06/04/2025

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4855	207	Physical or psychological harm	Hallion, Simon	Chantry, Chris		10/02/2022	16	Family Health	Women's Health and Breast CBU	Breast Services		As a result of insufficient staffing and clinic capacity within the Breast service, Pathology and Oncology, there is a risk of delays in diagnosis of breast cancer and increased waits for treatment of confirmed cancers, which may lead to patient harm. There is also a risk of staff fatigue through the provision of additional clinics to reduce delays and a reputational risk to trust due to poor performance.	Service level agreement with Path Links Cancer MDT Weekly Breast capacity meetings New Cancer Remote Monitoring Administrator and tracking spreadsheet in place Escalation process for converting unused oncology appointments allocated to other specialties into Breast oncology appointments where possible.	Volume of referrals and clinic capacity. 2ww performance / average wait time for first appointments. 62 day performance. MDT staffing levels / absence rates.	29/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Additional capacity and exploration of creating capacity through redesign of clinic facilities, etc.	[29/01/2025 13:57:28 Gemma Staples] Risk presented at Risk Register Confirm & Challenge Meeting held on 29/01/2025 and the request for an increase of the scoring was agreed and approved. Risk amended from 3x4(12) to 4x4(16) [10/01/2025 11:51:41 Nicola Cornish] Wait times for diagnosis remain acceptable due to staff undertaking increased weekend working currently to maintain current position, however this risks staff burnout. There is an increase wait for treatment due to Oncology input and commencement of radiotherapy/chemotherapy treatment. There are also some delays in receiving histology results and Radiology appointments for pre-operative work up requirements identified at MDT discussion (Magseed insertion). A rightsizing case has been written to add c.1000 slots to the service to meet current and predicted demand.	4	31/12/2021	29/12/2023	29/04/2025

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4928	89	Service disruption	Mooney, Mrs Katy	Marsh, David		28/04/2022	16	Medicine	Cardiovascular CBU	Cardiology		As a result of a current backlog of Cardiology services this could result in a risk of delays to patient care/harm, service restrictions, delays in discharge and site escalation pressures. Cardiology outpatients are delayed due to catching up on backlog post Covid 19 and demand exceeding capacity. This is also exacerbated if patients need cardiology tests and results reporting on prior to their initial outpatient appointment e.g. Holter Monitor/24 Tape. The current longest wait is between 52 & 65 weeks, although the backlog this is a priority for the Division and the waits are reducing.	additional clinics/lists (cost pressure) additional staffing where feasible to increase capacity (cost pressure) Job planning exercises are completed. Consistent choice and access staff allocated to Cardiology bookings which has made a significant impact/improvement.	weekly monitoring of RTT and PBWL Datix incidents weekly meetings with planned care managers Reported to NHSE	06/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Weekly waiting list meeting -Weekly RTT meeting For both of these we make plans for all patients that are 45 weeks and over. This will be ongoing. -The weekly RTT meeting has changed focus and each medical secretary reviews their consultants patients to give more ownership to the pathways. Although there are still delays we are now appointing at 30 weeks.	[06/02/2025 11:46:54 Rachael Turner] Risk reviewed, description and controls updated to reflect current position. A year ago we were appointing at 42 weeks, we are now at 33, after this first appointment the diagnostic pathway begins but this can have delays. We are improving our percentage slowly and work remains ongoing in the reduction plan. [09/01/2025 12:26:47 Rachael Turner] Risk reviewed, no current change. Risk score to remain. [30/09/2024 11:11:54 Rachael Turner] Delays occur due to waiting for diagnostic tests for ECG monitors to come through. Currently 17 waiting for 52 weeks and above. This continues to be monitored. [21/06/2024 13:54:54 Rachael Turner] We have reduced the backlog. The Cardiology waiting list is in a much better position and we are monitoring ourselves against P Codes. We are utilising our capacity as best as we can by booking 6 weeks ahead. RTT continues to	8	15/01/2025	01/03/2024	06/05/2025

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5154	88	Regulatory compliance	Simpson, Mr Andrew	Hansford, Lisa		17/04/2023	16	Corporate			Trust-wide	The Trust currently does not have a Medicines Management or Intravenous Drug Training package on ESR. Previous Medicines management training was removed when the ESR software was changed. Usually all new nurses will be required to complete the medicines management training as part of the mandatory training. This is to support them to be able to administer medicines to patients. Without a robust Medicines management training package staff will not have access to the r Medicines Management training that has previously been available, which is not in line with Trust standards. This could potentially lead to harm to our patients from medication incidents, we will not be adhering to CG174, NG29, SG1 and QAPPS minimising injectables risk. Risk of breaching CQC regulation 12: Safe care and treatment also	All staff will have had undertaken some level of medicines management as part of their professional qualification, however standards are inconsistent and not aligned to trust standards. National (CG174, NG29,SG1) and Local policies and guidance indicate that training should be available to staff to support in administration and safe medicines management. Additionally won't be compliant with QAPPS in relation to minimising injectable medicines risks. CQC regulation 12: Safe care and treatment all indicated training should be available. None currently in place in the Trust. There are new staff that have comenced employment with the organisation that cannot access the trust medicines management training and ward and department leads require a decision to be made as to whether or not these staff can administer medication.	Reported incidents, Staff feedback on training and support available in staff surveys. Inspection feedback	09/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The Medication Safety Team have written the Medicines Management, Controlled drugs training and the Drug Administration Programme. These training documents are also to be supported by the nationally recognised eLearning for health IV therapy passport. These training packages are under review by MOpS group before they can go through the governance process. The governance process is likely to take a number of months. There is then the added task of getting the training packages put onto ESR and mapped to the correct staff. ESR team is severly understaffed which may delay the process further. As an interim measure to reduce this risk level, once the training packages have been through the relevant governance processess, there could be the option to add the training power points to the Trust intranet. This would not be mapped to staff members, however we could signpost staff to this and local training completion records could be kept by the ward/department leads.	[09/01/2025 14:34:06 Lisa Hansford] Awaiting Medicines management and controlled drug training packages to be added to ESR. The IV therapy passport is now on ESR. [10/10/2024 10:14:02 Lisa Hansford] Awaiting packages to be uploaded to ESR [10/07/2024 11:11:57 Lisa Hansford] no further update [04/04/2024 09:01:18 Lisa Hansford] Still awaiting this package to be uploaded to ESR [29/12/2023 12:57:50 Lisa Hansford] Awaiting education and training team to upload to ESR [06/12/2023 14:55:35 Gemma] Training packs signed off through governance process Awaiting update from Education and Training team when these will be uploaded to ESR. Delay in this due to vacancy in their team [07/09/2023 14:09:00 Lisa Hansford] 7.9.23 Signed off by APPG and will go to NMAFF on 8.9.23 for final ratification	8	31/03/2025		09/04/2025

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4866	87	Service disruption	Costello, Mr Colin	Saddick, Ahtisham	Medicines Quality Group	01/03/2022	15	Clinical Support Services	Pharmacy CBU	Pharmacy		Recruitment of ULHT pharmacy technicians to ward-based clinical pharmacy roles affects the balance of the pharmacy workforce and impacts on the core pharmacy service provided	Pharmacy should be fully involved in the development and implementation of these roles. The Chief Pharmacist is accountable for the professional management of these roles, however there is not a clear understanding of the supervision and development framework for the new roles.	Monitoring of Pharmacy Technician performance	20/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To develop a robust supervision, training and development framework for the new pharmacy technicians roles. 1. To undertake a quality impact assessment to evaluate the potential impact on pharmacy services. 2. To develop a robust NVQ apprenticeship training scheme to train band 2/3 staff to band 4/5 roles both on the wards and in pharmacy services to achieve a sustainable pharmacy technician workforce in order to support all pharmacy technician roles.	[25/03/2025 10:55:25 Gemma Staples] Risk to be presented at April RRC&C for approval of closure. [20/03/2025 11:32:39 Lisa Hansford] Risk reviewed by Lisa Hansford and Lisa - Marie Moore and it was agreed to combine the risk with risk 4834. Therefore this risk will now be closed. [09/01/2025 14:20:31 Lisa Hansford] No update. [10/10/2024 10:09:29 Lisa Hansford] No further update [10/07/2024 11:22:38 Lisa Hansford] no further update [04/04/2024 09:06:25 Lisa Hansford] No further update [29/12/2023 13:54:44 Lisa Hansford] No further update [07/11/2023 14:12:59 Lisa Hansford] Update- Variable ward based technician support is being provided for clinical pharmacy cover for admission areas. Risk is ongoing as there is still the possibility of staff movement to WBT roles therefore leaving gaps in core services [26/09/2023 14:15:54 Rachel	16	30/11/2021	28/04/2023	09/04/2025

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4778	94	Physical or psychological harm	Mooney, Mrs Katy	Marsh, David	Patient Safety Group	16/01/2022	15	Medicine	Cardiovascular CBU	Stroke		Risk of failure to meet best practice standards for stroke patients due to lack of timely access to community rehabilitation services. Length of stay for patients is set at 10 working days. Currently all processes for moving patients on from stroke unit for rehab is going over which is having an effect on patients rehab causing potential patient harm, service delays and burn out for staff. This is having an effect of staff morale and performance where they feel they are not delivering the service that they would like to.	LCHS provides Lincolnshire Community Stroke Services with a broadened access criteria post 100 day challenge. This is offering some increased access to stroke rehab in the community. One year seconded band 6 OT is currently covering Lincoln Stroke Unit 2 days. Her remit is to identify and facilitate timely discharge from acute to community. This service has KPI's to measure this. -Teams Groups with LCH to facilitate handover. -Joint email to narrow where referrals are directed and sent. -Reviewing prioritise lists everyday to decide appropriate pathways for patients. This is carried out every morning at 08:30. -Joint assessment with OT and PT to increase effectiveness and reduce time to decide which pathway is best for the patient. -Pathways currently in place are HomeFirst, ABI referral pathway --Working with CHC to create meeting of discussion for patients to trust each other within our assessments	SNNAP data scores . Service provision not in top quartile	26/02/2025	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	[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	6	31/03/2025	28/02/2023	26/05/2025

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4840	329	Physical or psychological harm	Costello, Mr Colin	Baines, Andrew		19/01/2022	15	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of National shortages of medications there is a risk that there will be a potential impact on patient treatment unless we can source suitable alternatives which may include unlicensed imports (this is licensed in the country of origin but not UK licensed). The shortages can impact multiple wards / divisions. Use of unlicensed products is associated with an increased administrative burden for Pharmacy and Clinicians. There is a risk within unlicensed products where not labelled in English so Pharmacy manage an over labelling process.	National policy: - NICE Guideline NG5: Medicines optimisation, etc. ULHT policy: - Policy for Medicines Management: Sections 1-8 (various approval / review dates) ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) - Purchasing for Safety - Unlicensed Medicines Policy Medicines Shortage Notification (MSN) tracker completed regularly assessing each medication - (This goes to the MQG and is attached to the risk)	Monitoring medication stock levels / reported shortages Shortage tracker	28/02/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Continue to monitor and assess medication shortages and alternatives – Andrew Baines - Ongoing	[28/02/2025 09:15:28 Lisa Hansford] National supply shortages out of pharmacy control. The situation is monitored closely by the team and where medications shortages arise there is a risk assessment process in place. [29/11/2024 10:11:09 Lisa Hansford] No further update [28/08/2024 13:58:20 Rachael Turner] Risk presented at RRC&C meeting August 2024. There are no concerns of the quality and safety of the drugs. Due to the complexity of this risk it has been requested to develop an Overarching Medication risk for the Trust and then Pharmacy to provide individual risk assessments for each drug. Governance to support. Following this we can agree the risk score. Risk to remain open at current score until this risk is developed. [09/08/2024 12:32:47 Gemma Staples] Following discussion at PSG it was asked that Pharmacy review the scoring due to the risk of serious harm to patients due to some of the	6	01/12/2021	31/05/2023	28/05/2025
Strategic Objective		**2a. Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise**																							

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5447	691	Service disruption	Capon, Mrs Catherine	Rojas, Mrs Wendy	Workforce Strategy Group	05/06/2024	16	Surgery	Theatres, Anaesthesia and Critical Care CBU	Theatres		Nurse staffing in theatres does not support current activity, resulting in patient cancellations and delays. There is a risk of elective lists being cancelled due to lack of theatre staff. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill.	AFPP guidelines for staffing in perioperative setting Daily review of staffing/lists Daily prioritisation of patients Use of agency staff	Incident reporting Review of staffing/cancellations	13/03/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Establishment review Business case for funding in process to apply for funding with staffing workshop planned for September. Project group commenced at Lincoln to introduce activity manager to try to support planning and management of deficits.	[13/03/2025 15:42:21 Nicola Cornish] Staffing template reviewed and amended to support 9 theatres at Lincoln - roster templates will reflect this change from July 2025. Waiting for confirmation of theatre floor plans from BU. Review of Pilgrim theatres to start in April. [21/02/2025 12:57:19 Nicola Cornish] Risk reviewed, no change. [07/01/2025 10:42:07 Nicola Cornish] Risk reviewed by Wendy Rojas - no further progress. [28/11/2024 10:06:10 Nicola Cornish] Task and finish group now established to look at theatre workforce. [21/10/2024 13:06:13 Nicola Cornish] Business Case is ongoing and risk of cancellation remains very high. Long line agency was agreed but with limited fill. Sourced International nurses and CV's received - awaiting completion of interviews. [11/09/2024 14:23:33 Nicola	8	30/06/2025		13/04/2025

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4996	39	Physical or psychological harm	Lynch, Diane	Chester-Buckley, Sarah	Outpatient Improvement Group	22/08/2022	16	Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	As a result of lack of investment for Haematology workforce historically there is insufficient workforce and to meet increasing demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave and the service to collapse which would also lead to significant patient harm. Patients would need to be referred to other neighbouring Trusts which in turn would cause other Trusts to collapse. Particular areas of concern are Clinical Governance Lead and Head of Service for Haematology.	CG lead duties shared between consultants but no one wishes to take on role (Clinical Governance Lead to commence post in April 2025) Introduction of nurse-led clinics to manage demand. Fixed term Locum Consultants / High cost agency above budget to support service. Ad-hoc additional clinics outside of consultant job plan Workforce review completed Refresher of Fragile Services Paper completed (NB there is a National shortage of Haematology consultants) Additional unfunded ST3+ for Haematologist started in August 2022	New referrals and PBWL show ongoing capacity issues. RTT and cancer performance below target. Increased PA's for substantive consultants. Outcome from Staff Survey results Financial constraints of group Monitoring of outpatient appointments Datix incidents / Clinical Harm reviews / Complaints / PALS	18/03/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Recruitment of further substantive consultants - Sarah Chester-Buckley April 2025 Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - February 2025	[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	8	30/09/2023	01/04/2025	18/04/2025

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4948	50	Physical or psychological harm	Cooper, Mrs Anita	Walker, Helen	Health and Safety Group, Medicines Quality Group, Patient Safety Group	17/06/2022	20	Clinical Support Services	Pharmacy CBU			Workload demands within Pharmacy persistently exceed current staffing capacity which leads to longer working hours (inc weekends), work related stress resulting in serious and potentially long-term effects on staff health and wellbeing. Adding to this with additional workload demands with insufficient staffing, or required level of experience and skill, the risk is patients will not be reviewed by a pharmacist leading to poorer clinical outcomes, reduced flow on acute wards, delayed discharges and increased risk of omitted medicines. For staff the risk is long term absence. This may result in the failure to meet the national and local targets for KPIs	Business Continuity Plans on ward coverage when staffing low	Sickness rates/vacancy rates and staff turnover - highlight that retention is problematic at current. Staff survey highlights issues low staff morale within the department. Medicines reconciliation, datix incidents and omitted doses highlight that the trust is underperforming and not meeting targets at current	20/03/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Review current provision and identify gaps in service to inform business cases for change to support 7 day working (working with Surgery and Medicine Divisions as appropriate). Skill mix requires review due to complexity of patients.. Pragmatic management of workload & provision of management support. On-going exploration of recruitment options. Wellbeing team supporting staff - regular visits organised	[25/03/2025 10:35:20 Gemma Staples] Risk will be presented at April RRC&C for approval of closure explaining that this has now been combined with risk 4844 [20/03/2025 11:14:20 Lisa Hansford] Risk was reviewed by Lisa Hansford and Lisa -Marie Moore and it was agreed to combine this risk with risk 4844 therefore this risk will now be closed. [04/03/2025 10:46:24 Lisa Hansford] Business case submitted in Nov 24 for 7 day working for core supply service. The pharmacy department have been advised to submit a further one page document by end of Feb 25 to outline regulatory and safety risks with each business case. Currently, overtime is being utilised to extend opening hours but uptake between sites is variable. [30/01/2025 16:08:30 Lisa Hansford] no further update [30/12/2024 08:35:51 Lisa Hansford] No further update [29/11/2024 10:18:44 Lisa Hansford] No further update	8	30/06/2023	30/10/2023	04/04/2025

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4997	41	Service disruption	Lynch, Diane	Chester-Buckley, Sarah	Patient Safety Group	22/08/2022	16	Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	As a result of current Consultant staffing and on-call arrangements there is a single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites which could lead to potential patient harm, delays in care/discharge.	Middle Grade cover in Oncology & Haematology over and above budget therefore using high cost agency. VC ward rounds are taking place if face to face ward rounds are not possible. Workforce review completed Refresher of Fragile Services Paper completed (NB there is a National shortage of Haematology consultants) Additional unfunded ST3+ for Haematologist started in August 2022	Datix incidents Complaints and PALS Outcome from Staff Survey results Financial constraints of group	18/03/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - February 2025 Recruitment of further substantive consultants - Sarah Chester-Buckley - April 2025	[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	8	01/04/2023	01/04/2023	18/04/2025

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4844	38	Service disruption	Lynch, Diane	Costello, Mr Colin	Medicines Quality Group	19/01/2022	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of insufficient staffing establishment there is an inability to provide a safe and effective 7 day pharmacy dispensing service at ULTH. Current funding allows for the dispensaries to open Monday to Friday 9-5 and weekends mornings only. The dispensary workloads exceed the staffing capacity. As a result of this under staffing there is a risk that patients may require critical medication and/or specialist pharmacy advice over the weekend when pharmacy is closed, there is a risk that pharmacy staff working long hours without a break could make errors, pharmacy staff could become unwell due to working conditions, patients could be discharged from hospital without vital medication and pharmacy advice. All of these risks have multiple implications such as harm to patients from omitted medicines, delayed discharge from hospital effecting the efficiency of the hospital, readmission to hospital, long term effects on pharmacy staff health and wellbeing and the	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	20/03/2025	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	[20/03/2025 11:11:25 Lisa Hansford] Case was submitted to CRIG 29th Nov 2024 and a one page summary was submitted 25th Feb 2025 as requested by CRIG, currently awaiting further instruction. [04/03/2025 10:43:34 Lisa Hansford] Pharmacy are currently providing a limited 7 day pharmacy service which is being funded by winter pressures money. This relies on staff ding overtime and is therefore not sustainable long term. [30/01/2025 16:02:34 Lisa Hansford] No further update. [30/12/2024 08:32:18 Lisa Hansford] No further update December CRIG meeting was stood down. [29/11/2024 10:17:21 Lisa Hansford] No further update [29/10/2024 10:16:49 Lisa Hansford] Weekend supply business case going to CRIG November. Case of need for ED pharmacy cover also going to November CRIG. Full business case still in development. [30/09/2024 13:37:45 Gemma Staples] Risk reviewed and remains	4	29/10/2021	28/04/2023	21/04/2025

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4862	44	Service disruption	Mooney, Mrs Katy	Smith, Charles	WORK	22/02/2022	16	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 3 Substantive consultants in place at LCH and 2 at PHB. We have a vacancy of 5 across the three sites. Various gaps are covered with Adhoc Locum. The main current risk is to the inpatient cover at Pilgrim Hospital. With only x2 Consultants over there, when we have 1 on annual leave, the risk that the other could be either sick or covid contact is extremely high. We have supported this with clinicians going over from LCH, however due to a further resignation at LCH, this is proving more difficult This combined risk on Medical staffing has now impacted the Secretarial team at LCH. There is currently 0 secretaries at work at LCH due to sickness in the team. This is mitigated through support from Agency / Other specialties supporting.	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)	04/03/2025	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.	[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.	4	30/12/2022	03/06/2024	04/06/2025

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5469	697	Service disruption	Rinaldi, Dr Ciro	Chablani, Manish		21/06/2024	16	Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of Pharmacy struggling to budget and recruit into the role whilst there are budgetary provisions on the medical education side there is a risk that without adequate educators we would fail to deliver the curriculum across the entire clinical years for years 3,4 & 5 which would lead failure of our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	We are currently liasing with the Pharmacy department around the appointment of a part time prescribing skills lead. This would be a 50/50 appointment shared with the pharmacy team	Meeting reviews.	18/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[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	8	21/06/2025		18/05/2025

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4741	42	Service disruption	Lynch, Diane	Chester-Buckley, Sarah		13/01/2022	20	Clinical Support Services	Cancer Services CBU	Oncology	Trust-wide	As a result of lack of investment for Oncology workforce historically there is insufficient workforce to meet demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave. We are heavily reliant on high cost agency covering vacant posts due to the national shortage of Oncologists. If the service was to stop for specific tumour sites this would lead to significant patient harm whereby patients would have to travel following referral to neighbouring Trusts for radiotherapy and chemotherapy treatment, which in turn would put further pressure on other Trusts who could potentially collapse. Oncology is considered to be a fragile service due to consultant oncologist gaps. Demand vastly exceeds the capacity, requiring an increase in establishment. Oncology Consultants do not have capacity to review patients as required for their treatment which has a knock on effect on Pharmacy services.	Medical staff recruitment processes Agency / locum arrangements Extra clinics offered Unable to cover sarcoma due to no capacity/specialisation so this is now picked up by NUH Job plans continuing to be reviewed Recruited at risk over and above budget to support service Support offered through on-call consultant, this is not adequate due to their workload.	Monitoring tumour site performance data Datix incidents Complaints and PALS Outcome from Staff Survey results Financial constraints of group	20/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a fragile service review (Sarah Chester-Buckley - December 2024)	[20/01/2025 10:33:02 Gemma Staples] Business case now not going to CRIG, needs to be taken through Divisional PRM for funding, awaiting next meeting. [18/10/2024 10:37:20 Gemma Staples] CoN written to be submitted on 31st October 2024 to ensure this is included in the planning round 2025/26. [23/09/2024 09:58:14 Gemma Staples] Following the CSS Confirm & Challenge meeting it was agreed to combine this risk with 5180. [24/07/2024 11:38:27 Gemma Staples] Clinical Lead appointed due to start August 2024. SACT Lead appointed to, HR checks in progress, therefore no start date as yet. [23/04/2024 13:04:41 Gemma Staples] Risk reviewed and no further update [05/04/2024 10:41:51 Gemma Staples] Risk reviewed. No further update [05/04/2024 10:38:06 Gemma Staples] Consultant Oncologist workforce capacity	4	31/03/2023	31/03/2023	18/04/2025

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5563	782	Physical or psychological harm	Mooney, Mrs Katy	Smith, Charles		19/12/2024	16	Medicine	Specialty Medicine CBU	Neurology	Trust-wide	As a result of impending retirement of 50% of the substantive workforce in Apr 2025 and a challenging national recruitment environment; there is a risk that the trust's Neurology service will cease to function sustainably. This would lead to a risk of harm to patients via delayed outpatient appointments, delayed inpatient reviews and an inability of the service to meet it's demands. Prior to the impending retirement, the Neurology service is already in a situation whereby substantive capacity does not meet recurrent demands on the service At present Neurology has 5485 overdue patients on its PBWL, 44% of which (2415) are overdue by more than 1 year. At this time there is no clinical capacity (for all the reasons highlighted in this report) for any clinical validation of this backlog and no available administrative resource for a data cleanse. It may be some of	Agency workforce already in place to supplement establishment that is not right-sized to service demands JDs being sent to Royal college for recruitment of substantive vacancies (with interim 6mo locum) One of retiring consultants has agreed to do x2 monthly weekend clinics for 6mo to support Botox FUs who have no alternative treatment provider.	-Substantive workforce against establishment -Size of PBWL -NEW backlog/Booking timeframes	04/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Working group convened to discuss plans for service as current model not appropriate. Have met twice as of 19/12. Action 2. Discussions to take place with contracting team/ICB re: discussion of service model for Lincolnshire. Action 3. Meetings taken place with NUH to discuss interim measures for balancing workload/pt cohorts.	[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		04/06/2025

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5422	684	Service disruption	Costello, Mr Colin	Martinez, Francisca	Medicines Quality Group	28/08/2024	16	Clinical Support Services	Pharmacy CBU	Pharmacy		As a result of Chemotherapy prescriptions not being prescribed in a timely manner this impacts on staff health and wellbeing due to additional stress to staff. There have been a significant number of near miss incidents. This causes an ineffective service leading to a reduction of capacity to make chemotherapy and significant time is wasted by pharmacy staff ensuring correct processes have been followed. Products have to be wasted regularly and remade, causing a loss to the Trust of approximately £100k per month.	Pharmacy staff working increased hours to complete late chemotherapy orders. Chemotherapy Prescribing Policy Cancer Services CBU has discussed the timely prescribing of chemotherapy with their Oncology and Haematology consultants. All consultants aim to prescribe 48 hours ahead of dosing with chemo.	Near misses/incidents Staff health and wellbeing Staff concerns Delays on chemotherapy appointments Chemotherapy waste	04/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To monitor and review prescribing to ensure Prescribers are adhering to the 48 hours required time. (Fran to provide SCB with any names of staff not adhering to this) - Sarah Chester-Buckley - July 2025	[04/03/2025 11:35:14 Lisa Hansford] Aseptic team report that chemo is still not being prescribed 48 hours in advance of required treatment. This is being escalated through the chemotherapy group. [18/12/2024 16:46:51 Gemma Staples] Risk is being monitored to see if Consultants are prescribing with the 48 hours notice and escalate if not. [18/12/2024 15:43:01 Gemma Staples] Cancer Services CBU has discussed the timely prescribing of chemotherapy with their Oncology and Haematology consultants. All consultants aim to prescribe 48 hours ahead of dosing with chemo. [29/11/2024 10:13:46 Lisa Hansford] No further update [28/08/2024 14:25:03 Nicola Cornish] Risk discussed at Risk Register Confirm & Challenge meeting on 28th August. Revised risk description relating to service description was approved. [01/08/2024 08:53:01 Gemma Staples] Risk updated by Fran and	4	09/04/2025		04/06/2025

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5093	40	Service disruption	Costello, Mr Colin	Baines, Andrew	Workforce Strategy Group	16/02/2023	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of a long term sickness absence within the invoicing team and a capability issue within the purchasing team (therefore both teams are a staff member reduced) there is a risk that any further absence due to sickness or leave will mean the remaining staff member doesn't have the capacity to do the work of all 3 sites which would impact staff wellbeing and also impact drug ordering and invoice payment and there is a Trust target to pay invoices within 30 days with any further absence, we would not be able to meet this.	Band 7 covering the Band 3 gap when needed We have two members of staff who are trained and substantive part time staff but also able to provide bank support (though their availability to work is not guaranteed)	Staff Survey Staff Feedback Staff sickness Finance performance on invoice payment Workload	26/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	A further case of need will be prepared to identify workforce requirements to better support the day to day management of the team and also shortages and stock management across the Trust - Andrew Baines - July 2025	[26/03/2025 09:21:33 Lisa Hansford] B2 sickness ongoing and we anticipate 0.6 WTE B2 invoice clerk leaving in July to commence pre-registration pharmacist training. 0.6xB3 purchase clerk leaving in April (bringing vacancy up to 1.6 WTE), 1.0 WTE B2 storekeeper vacancy at Lincoln and 1.0xB2 storekeeper leaving Pilgrim in April. Recruitment underway to cover the existing B2 and B3 vacancy at Lincoln but subject to a delayed start date currently (aim to appeal this) Vacancy request submitted at risk in anticipation of significant invoicing gap by August. Vacancy request to be submitted for B2 storekeeper at Pilgrim. [03/01/2025 10:35:48 Lisa Hansford] Capability process complete. 1xB3 vacancy and long term sickness in invoicing team is ongoing. Awaiting outcome of banding exercise on new post associated with biosimilars with the hope of creating B4 role. In the interim reliant on B7 covering any B3 gaps. Office capacity	4	16/02/2024	16/02/2024	26/06/2025

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5467	695	Service disruption	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	18/02/2025	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	[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		18/05/2025
5466	698	Service disruption	Babu, Suresh	Chablani, Manish		21/06/2024	16	Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of the current Paediatrics teaching fellow leaving in September at the end of this academic year, there is a need for a departmental plan to ensure training is in place for a new teaching fellow ready for the students starting in March 2025. Without this the Trust would be unable to deliver the required teaching in Paediatrics. This could lead to the Trust failing on our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	No controls in place at the moment. This risk has been flagged up to the head of Paediatric service by the modules leads, Dr Broodbank and Dr Herath.	Workforce	18/02/2025	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	[18/02/2025 15:21:05 Rachael Turner] New Teaching Fellow has been appointed. Risk to be presented at RRC&C in March to validate closure. [26/11/2024 15:06:27 Rachael Turner] Interviews are taking place in the next couple of weeks. This is still a risk until an appointment is made. [31/07/2024 13:25:41 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		18/05/2025

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5468	696	Service disruption	Babu, Suresh	Chablani, Manish		21/06/2024	16	Corporate	Medical Director's Office	Medical Education	Trust-wide	As a result of failing to provide the curriculum requirements for clinic based specialties across the board but especially Dermatology, ENT Ophthalmology and Rheumatology. This has resulted in clinics being overbooked and the patient numbers not being reduced to allow for teaching the medical students. Which could lead to failing on our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	None at the moment. Dr Chablani has written to the Clinical Leads asking them to support with reduced patient numbers in teaching clinics and for the clinical and attachment leads to work closely together to ensure a balance between service provision and teaching but is yet to get reassurance or a formal response.	Work around appropriate remuneration with Business Units and recognising the need to release clinicians to deliver teaching. Reduce patients in clinics - balancing waiting lists alongside teaching opportunities	18/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[18/02/2025 15:24:41 Rachael Turner] Work has been carried out around remuneration and this has been actioned. Risk to be presented at RRC&C in March to validate closure. [26/11/2024 15:08:57 Rachael Turner] A meeting with Dermatology has taken place and this is no longer a risk in Dermatology. Further meetings are planned over the next few weeks with ENT and Ophthalmology [31/07/2024 13:22:46 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk.	8	21/06/2025		18/05/2025
4780	74	Service disruption	Mooney, Mrs Katy	Hunter, Sarah		16/01/2022	20	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of a significant deficit in stroke consultants levels due to staff leaving/ retiring and stroke service struggling to recruit substantive consultants there is a risk of not being able to maintain effective stroke provision across ULTH. From April 2025 the stroke service will have only one Substantive Consultant, upcoming retirement could result in no substantive Consultant Stroke Physicians in 2028-2029 if continue to not recruit. Reliance on Locum consultants is costly and causes instability in the rota. Locum/Agency/Bank reliance results in limited medical training & supervision for resident doctors, Registrars, ACPs and students – limiting staffing pool for the future & reduces staff experience/satisfaction.	•Utilising a regular pool of locum consultants •Consultant advert out •Attended recruitment drive at medical conference November 2024 •Consultant ACP post •Liaising with Integrated stroke delivery network [ISDN] for possible regional solutions	Datix/incidents/SJR/SI Rota Gaps Budget/costing	09/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Convert locum contacts to Bank where possible Action 2. Continue to advertise for consultant stroke physicians Action 3. Continue to liaise with Integrated stroke delivery network [ISDN] for possible regional solutions ?regional rota Action 4. Further consultant stroke practitioner post & support Stroke registrars to become stroke consultants. Action 5. Redesigned stroke pathway.	[29/01/2025 13:49:21 Rachael Turner] Risk presented at RRC&C meeting 29/01/25. Risk validated for increase i score 4x4:16 High Risk. [09/01/2025 12:18:33 Rachael Turner] Risk being presented for increase in score at RRC&C this month. [18/12/2024 12:42:46 Rachael Turner] Risk reviewed-substantive consultant leaving early next year, we are struggling to recruit substantive consultants. Our substantive/clinical lead may retire soon. There is a future risk of no consultant physician substantive workforce. There is a risk of not being able to maintain effective stroke provision across ULTH due to the significant deficit in stroke consultant staffing and nurse staffing. 1 in 4 consultant on-call rota is unsustainable with current staffing levels. Risk score to be reviewed for increase in score of 4x4:16 High Risk, risk to be presented at Risk Confirm and Challenge in January.	8	31/03/2022	01/07/2024	09/04/2025

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5427	699	Service disruption	Babu, Suresh	Chablani, Manish		30/04/2024	16	Corporate	Medical Director's Office	Medical Education		Student report discrepancy in teaching between Lincoln and Boston site especially in HCOL and stroke where there is only one educator. To mitigate this , we plan to employ Teaching Fellows so they can offer similar amount of teaching on both sides.	We have appointed Teaching Fellow in Stroke and shortly will do so in HCOL.	Workforce	26/11/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[26/11/2024 15:13:38 Rachael Turner] There are barriers within the Business Unit in terms of the JD/funding for the Specialty Teaching Fellow, which is delaying the appointment to this post. This should be a joint risk which sits with the Business Unit as we are unable to move forwards with this from an undergraduate perspective. [31/07/2024 13:26:57 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk. [10/06/2024 15:43:27 Gemma Staples] Request for the handler to be amended from Catherine Wormington to Dr Maish Chablani. [29/05/2024 13:48:30 Gemma Staples] No attendance to present so deferred to June RRC&C meeting	4	30/04/2025	30/04/2025	26/02/2025
5381	560	Service disruption	Landon, Caroline	Hodgkins, Mr James		09/02/2024	15	Corporate	Operations	Operations		Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands. Significant RN and HCSW WTE shortfall. No B7 manager in place. B6 jnr sister post is unfunded secondment. No ward clerk. Insufficient housekeeping hours. This means that DL cannot staff each shift witihin budget and relys on temporary workforce and inpatient ward support. RNs and HCSWs act as ward clerk and Housekeeper. The risks are:- service is not well led on every shift contributing to delays, failed discharges, reduced patient capacity and turnover, reduced patient flow impacting on front door, omissions in care, omissions in documentation, errors, patient safety incidents, poor staff wellbeing, Poor patient notes and careflow management, poor patient experience. Improvement to practice very challenged to implement due to temporary staffing. Unable to function within current budget. Reputational damage. Inability to	Each shift has substantive, bank or ward swap nurse in charge. Staffing issues on the day managed by ops matron. Shifts go to bank and then to agency. Dynamic risk assessment; capping capacity or refusing complex patients. Strategic on call sign off required to close discharge lounge due to staffing. Orientation of temporary staff; Induction materials. limited support and advice from operations centre. RNs and HCSWs complete meal and refreshment service. RNs and HCSWs complete cleaning required outside of 2hrs allocated Housekeeper time. RNs and HCSWs complete ward clerk duties.	Healthroster, Workforce safeguard spreadsheet, 8a lead audit, flo audit, datix, PALS feedback and complaints, e-mail feedback, monthly budget, CQC assurance summary, DL patient flow dashboard, daily delays escalation, complaints, PALS feedback, TSSG, Confirm and challenge process. Sickness rates.	24/01/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1)Recruiting RNs against potential agency savings as part of TSSG. 2)Case of need in progress to fund appropriate establishment to meet demand.	[24/01/2025 14:12:16 Rachael Turner] Risk reviewed, no change risk score remains at current position. [25/06/2024 17:05:43 Rachael Turner] Risk reviewed, no change, risk score remains. [28/02/2024 11:51:43 Rachael Turner] Risk presented at RRC&C meeting 28/02/2024. Risk validated at 5x3: 15 High Risk.	4	09/02/2025		24/04/2025

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Reportable to	Opened	Rating (initial)	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
4905	48	Physical or psychological harm	Cooper, Mrs Anita	Taylor, Ruth		22/04/2022	12	Clinical Support Services	Therapies and Rehabilitation CBU		Trust-wide	As a result of having insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on Ashby and the acute wards, delayed discharges, delayed referral to response times. Increase in avoidable harm i.e. deconditioning. Patient reviews delayed. Lack of specialist service area resource impacting on long term social value outcomes. Lack of consistency of provision across Lincolnshire footprint. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff.	Recruitment and retention strategies being work through. Therapies and rehab right sizing and service review. Improved joint working with LCHS and system colleagues. Clear therapies and rehab strategy to include CIPP and CON. Working with finance on establishment and nominal role review. Plan in place for sustainable medical workforce rehab medicine. Development team established for therapies. Neuro psych posts recruited too, therapies at front door service substantive funding in place.	Patient complaints. Monitoring of flow at front and back door. Site escalation. Vacancy rate monitoring. Roster fill rates. Waiting list numbers of frequency of follow ups. Staff absence. Staff survey and feedback.	04/02/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Good use of relocation and workforce development resources. Actively managing and reviewing the waiting lists to include RAG rating, use of TC/VC, PIFU and discharge . Case of need strategy in place linked to wider system work. Development team in place. Competency frameworks and preceptorship processes being developed. Joint working with LCHS including new joint system posts. Clear strategy in place to include capacity and demand management, workforce management and development - Ruth Taylor Lead to all above with completion dates as March 2025	[04/02/2025 11:33:00 Gemma Staples] Risk remains the same with a deteriorating picture currently on Ashby therapy and OT at PHB. [04/11/2024 11:14:51 Gemma Staples] Risk reviewed and remains the same [20/08/2024 09:21:14 Gemma Staples] Risk reviewed and will be reviewing progress monthly as is part of our workstream plan. [07/05/2024 11:37:33 Gemma Staples] The position remains the same however we are looking at capacity and demand reviews. We have also looked at were there is a known risk and been able to recruit to those areas against the matched establishment. Potential challenges to putting forward cases of need in the current financial restrictions and processes. [05/02/2024 11:25:33 Gemma] We are in the process of working on Therapy Strategy document and models of care document which will review current position against future planning. There is a safer	9	30/09/2023	18/12/2023	02/05/2025

ID	4762
DCIQ ID	47
Risk Type	Service disruption
Executive lead	Capon, Mrs Catherine
Risk lead	Rojas, Mrs Wendy
Reportable to	Nursing, Midwifery and AHP Forum, WORK
Opened	14/01/2022
Rating (initial)	15
Division	Surgery
Clinical Business Unit	Theatres, Anaesthesia and Critical Care CBU
Specialty	Critical Care
Hospital	Lincoln County Hospital
What is the risk?	Issues with maintaining nurse staffing levels/skill to establishment in ICU at Lincoln.
Controls in place	Nursing workforce planning arrangements. Nurse recruitment / retention processes. Clinical Governance arrangements in Critical Care / Surgery Division.
How is the risk measured?	Staffing vacancy rate within ICU nursing
Date of latest risk review	21/02/2025
Likelihood (current)	Extremely likely (5) >90% chance
Severity (currently)	Moderate (3)
Risk level (current)	High risk (15-16)
Rating (current)	15
Risk reduction plan	Review of current recruitment strategy. Advertisement for vacant posts.
Progress update	[21/02/2025 12:59:05 Nicola Cornish] Risk reviewed, no change. [11/09/2024 14:26:31 Nicola Cornish] Risk reviewed, no change. [14/06/2024 13:15:32 Nicola Cornish] All substantive posts have now been recruited to but the staff are not yet not fully skilled yet. Additional funding for the clinical educator continues in order to support staff development. [09/05/2024 12:15:19 Nicola Cornish] Risk reviewed as felt needed to stay at 15 due to increased capacity in ICU, increased vacancy and poor skill mix. As of 8th May we currently have 8.91 wte vacancy at Lincoln and 0 vacancy at PHB. We are interviewing this month and hope to fill all vacancies. Skill mix will remain an issue but we have recruited some nurses with critical care experience. It will be several months before skill issues improve. We continue to have an additional clinical educator funded by the network. [26/03/2024 13:42:01 Gemma
Risk level (acceptable)	6
Initial expected completion date	30/06/2021
Expected completion date	30/09/2022
Review date	21/05/2025

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Reportable to	Opened	Rating (initial)	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
5480	683	Service disruption	Spendlove, Mrs Clare	Bursey, Sarah		05/07/2024	12	Medicine	Cardiovascular CBU	Endocrinology/Diabetes	Trust-wide	As a result of a depleting workforce in diabetes this is leading to withdrawal of ward work which is impacting on the quality of care that patients are receiving. Currently pan Trust Trust there should be eleven DSN nurses WTE and there is currently only two in post. Out of these two in post one is due to retire. There is currently three members of staff on maternity leave. Care is having to be withdrawn from ICU, DSN reviews and referrals. For Navenby Ward they are having to rely on junior medic workforce. Active in reach for ED is now limited due to lack of resources. This leads to the potential of missing patients. Staff education has stopped, if its not on ESR or online but no face to face is not currently possible due to work pressures.There is an impact of outpatient referrals, unless it is life threatening these are delayed till further notice which would lead to an increase in waiting lists. Unless patients are pregnant PUMP cannot be offered, there is currently a	-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.	26/02/2025	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.	[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	2	05/07/2025		26/05/2025

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5439	714	Service disruption	Costello, Mr Colin	Saddick, Ahtisham		14/05/2024	20	Clinical Support Services	Pharmacy CBU	Pharmacy	Trust-wide	As a result of weekend workload (dispensing and checking of medication) exceeds staffing capacity on all sites, which leads to colleagues staying late and workplace stress. This results in serious and long-term effects on staff health and wellbeing. The Working Time Regulations (1998) state that breaks are mandatory but under current working structures, the weekend team are staying late to complete the workload. Therefore the Trusts is failing to comply with the legal requirements of rest periods as the weekend team feel undertaking breaks will compound on late finishes. A key improvement theme from the pharmacy staff survey identifies service resilience and quality- It is felt that weekend understaffing and negativity is leading to stress, burnout, dissatisfaction and low morale.	Staff working voluntary overtime to complete workload Case of need and Business case developed and approved at CSS Business meeting	Late finishes (data from healthroaster and time sheets) Items dispensed on a weekend - workload Near misses/error recording systems Staff surveys discussing welling Staff concerns regarding lack of breaks / late finishes Staff sickness	20/03/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Case of need and Business Case to seek approval from CRIG - Ahtisham Saddick - November 2024 A proposal is being developed which will review workforce allocation and suggest a new way of working on the weekends. This will discuss an increase in staffing resource and will form the basis of the CoN/BC – Ahtisham Saddick – End of July 2025	[25/03/2025 10:58:46 Gemma Staples] Risk to be presented at RRC&C meeting in April for approval of closure. [20/03/2025 11:36:07 Lisa Hansford] Risk reviewed by Lisa Hansford and Lisa -Marie Moore. I was agreed that this risk should be combined with risk 4844 and this risk can be closed. [28/02/2025 09:00:05 Lisa Hansford] Business case submitted in Nov 24 for 7 day working for core supply service. The pharmacy department have been advised to submit a further one page document by end of Feb 25 to outline regulatory and safety risks with each business case. Currently, overtime is being utilised to extend opening hours but uptake between sites is variable and long term overtime is not sustainable. [29/11/2024 10:09:34 Lisa Hansford] Case of need and Business Case to seek approval from CRIG - Ahtisham Saddick - November 2024 A proposal is being developed which will review workforce allocation and	3	14/05/2025	31/07/2025	28/05/2025
Strategic Objective		**3a. Deliver financially sustainable healthcare, making best use of resources**																							

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4657	7	Reputation	Warner, Jayne	Hobday, Fiona	Digital Hospital Group	10/01/2022	12	Corporate	Trust Headquarters	Information Governance	Trust-wide	If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, then it could lead to complaints to the Trust and Information Commissioner's Office (ICO). This could result in regulatory action and possibly financial penalties. Inconsistent levels of expertise outside IG team regarding SAR requirements. Lack of technical tools to carry out a search of emails / systems to identify personal information held. Implementation of digital systems which don't include a disclosure process. Potential financial implications.	ULHT policy in place. Monitoring through IGG and at exec level. Temporary additional resource has been put in place to oversee. Proposal made to ELT and IGG regarding process which has removed reliance on clinical staff to review all cases. Increased training provided to team. 18/11/24- Procured new solution to better manage requests.	Monthly reporting completed. Compliance rate is monitored by the Supervisor and reports taken to IGG in our KPI report. Volume of ICO complaints and Trust complaints received.	10/03/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Current active communications with ICO- regulator. Changes to processes are being constantly discussed and implemented. Resource needs being discussed and temporarily increased to support. Monitored through the IGG in DP KPI report. Head of IG leading on work to review and improve. Working in a more digital way where feasible. Workforce change is required which will be a much longer process. Early identifications of chasers and urgent requests to reduce the likelihood of complaints.	[10/03/2025 10:02:35 Fiona Hobday] Weekly compliance monitoring being carried out- reporting to SIRO/ Dir of Corp Affairs. Compliance for newer requests is doing well with resource available but won't meet national targets. Central IG resource continues to be reallocated to support team. Ongoing discussion with LCHS as to any possible support they can provide. Number of current cases of lost personnel files for staff SARs- adds to risk of legal action/ complaints/ etc... HR advise to add to corporate risk register. No short term fix. [29/01/2025 12:39:05 Rachael Turner] Risk discussed as part of the Deep Dive at Risk Confirm and Challenge meeting. Given that we are subject to ICO working with us, risk to remain at current level. [09/01/2025 15:39:47 Fiona Hobday] Trust have been issued with a reprimand by ICO- published Dec 24.	6	29/12/2023	30/04/2025	10/04/2025

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4665	14	Finances	Young, Jonathan	Sargeant, Paula		11/01/2022	20	Corporate	Finance and Digital	Finance	Trust-wide	The Trust has a £40.1m Financial improvement target for 24/25. If the Trust fails to deliver the CIP Plan, this will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to deliver its breakeven financial plan for the year. This represents a 5% target which is greater than any financial improvement the trust has delivered in previous years. In addition to this target, invest to save investments required to deliver the savings plan will need to be funded via more CIP identification/ delivery. Failure to deliver the CIP plan will have an adverse impact on the trusts ability to decrease its underlying deficit and build towards a sustainable pipeline of cost improvement for the future.	National policy: - NHS annual budget setting and monitoring processes ULHT policy: - Detailed Financial plan inclusive of the establishments and embedding of the 3 T's; Transactional, Targeted and Transformational. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial recovery plan aligned to CIP. - Development of Divisional Schemes assured through FPAMS (Transactional) - Establishment of future looking programme to develop schemes for a sustainable cost improvement programme for the future. (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Trust Improvement Strategy. (Targeted) - Divisional CIP targets allocated as part of the budget setting process. ULHT governance: - Detailed CIP reporting via the CIP tracker supported by QIA process at Improvement Steering Group (ISG) - Programme Management Office (PMO) monitors full programme & dedicated Head of Financial Improvement. - Introduction of the Trust wide Improvement	against the Trust CIP target through the monthly finance return to NHSE/I. For 2024/25 the Trust continues to be monitored twice a month on the FRP by the ICB and system Improvement Director. To exit NOF3, into NOF2, the system must deliver against the FRP plan for 2 consecutive quarters and ULHT is held to account to deliver their element of this £40.1m FYE. The Trust monitors internally against its CIP targets inclusive of specific Divisional and targeted scheme targets through the Improvement Steering group and Finance, Performance and Activity meetings. (FPAM's). Scrutiny & oversight will be increased as the Improvement Steering Group meets as a Group across LCHG. Confirm & Challenge across organisations will develop.	19/03/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Training & Support offered to all Divisions and stakeholders through CIP planning workshops. - Increased CIP governance & monitoring arrangements introduced. - Alignment with the Trust Strategy and System objectives - CIP is embedded as part of the Trust Improvement Strategy not seen as a separate annual work stream. - Development of future programme of cost improvement. - Continual exploration of new opportunities.	[19/03/2025 09:05:08 Rachael Turner] Risk reviewed, no change this month from previous. [19/02/2025 11:25:07 Rachael Turner] The current CIP forecast is £40.1m which represents full achievement of the plan for 2024-25. This has been identified through non recurrent mitigations forecast to deliver in the last 2 months of the year. [20/01/2025 09:33:25 Rachael Turner] The current forecast for 2024-25 is £36.7m; inclusive of executive led mitigations, set to deliver in quarter 4. Divisions have submitted a list of measures which will reduce the run rate of spend in the last quarter of the year for consideration. These measures are considered higher risk, and some may impact other performance metrics, therefore, consideration is required by the Group Leadership team and QIA's will be required. [20/12/2024 15:49:56 Rachael Turner] Executive colleagues have	4	31/03/2023	31/03/2024	19/04/2025

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4664	5	Finances	Young, Jonathan	Picken, David		11/01/2022	20	Corporate	Finance and Digital	Finance	Trust-wide	The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services.	ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Financial plan for agency expenditure is based upon developed savings plans in relation to agency staffing; acknowledges the progress made in 2023/24 in relation to real reductions in actual agency expenditure - Monthly financial management & FRP monitoring arrangements are in place to identify variation; agency expenditure reduction is a major part of the FRP and as such is heavily monitored. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes - Board assurance through Finance, Performance and	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Finance, People & Activity Meeting (FPAM)	19/03/2025	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	[19/03/2025 09:08:10 Rachael Turner] In 2024/25, the Trust's financial plan requires the Trust to make a similar level of reduction to agency expenditure as made in 2023/24, but the focus is to reduce expenditure in relation to medical and dental (M&D) staffing, whereas in 2023/24 it was on reducing expenditure in relation to registered nursing and midwifery. The 2024/25 financial plan includes a total agency plan of £14.9m and the expenditure profile in the plan requires agency expenditure to reduce quarter by quarter. Agency expenditure YTD of £21.3m is £7.0m higher than planned agency expenditure of £14.4m (driven by M&D agency expenditure); expenditure YTD of £21.3m, though, is £8.7m lower than expenditure of £30.0m in the same period last financial year. The adverse agency pay position is	8	31/03/2023	31/03/2024	19/04/2025

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5020	6	Finances	Hamer, Fiona	Lentz, Blanche	WORK	02/09/2022	20	Medicine	Urgent and Emergency Care CBU			If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget	Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	03/04/2025	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[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	10	02/09/2023		03/05/2025

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4641	18	Service disruption	Fradgley, Daren	Gay, Nigel	Emergency Planning Group	23/11/2021	16	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs	National policy: - NHS Digital Data Security Protection Toolkit (DSPT) and Guidance ULHT policy: - Telecoms infrastructure maintenance arrangements - ICT hardware & software upgrade programme - Corporate and local business continuity plans for loss of access to ICT systems & system recovery ULHT governance: - Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC) - 5 year capital plan -	- Network performance monitoring - Digital Services reported issues / incidents - Monitoring delivery of digital capital programme - Horizon scanning across the global digital market / supply chain to identify availability issues	03/04/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Prioritisation of available capital and revenue resources to essential projects through the business case approval process. - Working with suppliers and application vendors to understand upgrade and support roadmaps. - Assurance mechanisms in place with key suppliers for business continuity purposes - Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks. - Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates.	[03/04/2025 11:30:21 Rachael Turner] Work is continuing to commission the two new locations at Lincoln and on the building of the new data centre at Pilgrim Hospital. Work is also planned this coming year 25/26 to develop new second rooms at Louth and Grantham as well as refresh the current spaces. A contract has been awarded to replace fibre cabling on Trust sites, new fibre has between the new data centre has been run and fibre work has started at Lincoln to run new fibre out to end cabinets around the site, work will follow on other sites, as the new locations come on line.[27/01/2025 09:42:07 Rachael Turner] Work is continuing to commission the two new locations at Lincoln and a suitable location has now been confirmed and work has started on build of the new data centre at Pilgrim Hospital. Work is also planned next year 25/26 to develop new second rooms at Louth and Grantham as well as refresh the current spaces. A contract has been	4	31/03/2023	31/03/2023	03/07/2025

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4658	17	Reputation	Warner, Jayne	Willey, Karen	Digital Hospital Group	10/01/2022	20	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	If the Trust does not have a defined records management framework/ strategy it runs the risk of not meeting national best practice and not making informed decisions in relation to Digital programmes of work. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.	The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management. Reports of unmanaged records found in Trust locations.	29/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments. Needs to link into 365, ePR and EDMS Programme. 365 cannot be delivered with dedicated Records SME resource.	[29/01/2025 12:42:38 Rachael Turner] Risk discussed as part of the Deep Dive at Risk Confirm and Challenge meeting. This has started to escalated as its an area where we do not have a dedicated resources. Do to changes as a Trust there have been issues raises where records management issues have been identified. We are looking at how we can provide this resource, EPR being one of these resources. Currently score to remain at current level. [16/01/2025 10:50:39 Rachael Turner] Risk reviewed, consideration of Records Management resource taking place through development of Executive structures. [22/10/2024 09:20:44 Fiona Hobday] Still awaiting answer from Digital re money for resource. Move to national tenant has began- no SME to support. Project to procure scanning provider has started- no SME to support. EMDS project reaching contract award- no SME for any implementation.	4	28/06/2024	31/03/2025	29/04/2025

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5245	19	Service disruption	Fradgley, Daren	Humber, Michael		30/08/2023	20	Corporate	Finance and Digital	Digital Services (ICT)	Trust-wide	The Trusts disaster recovery capabilities are limited. In the event of a major incident affecting the primary data centre/site the ability to restore services elsewhere is limited. This would affect the availability and data integrity of tier 1 clinical and corporate systems, leading to extended unavailability and reliance on Business Continuity Plans. In addition there is a risk of significant data loss in the event that recent backups are unavailable or compromised.	-Business Continuity Plans which the Trust is planning to exercise of a regular basis via Emergency Response. -Annual SIRO approved incident response exercise. -Protections that reduce the likelihood of various disasters, including environmental and technical controls: A number of improvements have been made in this area. We now have a dedicated ""stretched"" Metro cluster between Lincoln and Boston. We also have Standard clusters at each site which have increased capacity. -Immutable Backup system introduced to ensure organisational data is held securely and available for recovery, this includes off site cloud storage for critical data	-Annual SIRO approved incident response exercise. -Incidents reported via Datix these are backed up via an RCA and lessons learned.	20/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Whilst some systems still need to transition fully with VLAN/IP changes we do have new systems and system upgrades migrating to the new solution. Enabling Tech programme in place to improve the Trust Foundations from which the Digital Services will run. This requires completion prior to remobilisation of EPR. Trajectory for this is 2025/26.	[27/01/2025 09:44:28 Rachael Turner] In addition to the implementation of Rubrik, the Trust uses resilience direct to store important procedural documentation, BCP and contact lists such that in the event of system loss, recovery and build documentation can be pulled from this cloud resource. Development of the overall Digital Services BIA and BCP has progressed significantly and will be presented to the relevant Trust committees/groups in reasonable time. [19/09/2024 16:39:50 Rachael Turner] This risk is linked to risk 575. In that we have commissioned the Rubrik product that manages our backup processes and also keeps an immutable copy in the cloud which allows restoration to anywhere. This system is being refined with Operations to prioritise systems into P1, P2,etc for DR instances and provide a plan for recovery if a	10	30/08/2024		20/04/2025
5389	559	Finances	Landon, Caroline	Hodgkins, Mr James		19/02/2024	20	Corporate		Hospital at night		Risk of overspend due to current service provision being unfunded. Also overspend due to increased sickness leading to a higher requirement for bank, agency and Overtime. Increased insurance due to increased litigation. Due to patient complaints and safety aspects.	Monthly budget reviews, and recognised overspend.	Datix, through finance reviews.	19/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Case of Need to be heard by CRIG on the 26th March 2024, following which a business case to be submitted.	[19/12/2024 13:05:31 Rachael Turner] There is currently no source of funding so Business Case cannot be heard. Finances are being looked currently looking at the overspend. Money is still left in staffing budget but this due to current staff not being yet at the top of their band. [17/09/2024 10:24:21 Rachael Turner] Risk remains with no change at present. [14/06/2024 11:12:21 Rachael Turner] Risk reviewed, no change at present. Risk score remains the same. [28/02/2024 11:50:14 Rachael Turner] Risk presented at RRC&C meeting 28/02/2024. Risk validated as a 4x4:16 High risk.	6	19/02/2025		19/03/2025
Strategic Objective		**3c. A modern, clean and fit for purpose environment across the Group**																							

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Reportable to	Opened	Rating (initial)	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
4725	466	Physical or psychological harm	Taylor, Ruth	Taylor, Ruth	Health and Safety Group	13/01/2022	20	Clinical Support Services	Therapies and Rehabilitation CBU	Rehabilitation	Lincoln County Hospital	As a result of the poor Estates requiring essential repairs and maintenance requirements at Lincoln County Hospital Therapy & Rehabilitation Medicine Department there is a risk that staff, patient and visitors may experience harm as result of inadequate temperature control and ventilation, poor quality flooring, poor quality furnishings, inadequate toilet facilities and poor infrastructure. There is a security risk to the building.	Legislation: - Health & Safety at Work Act 1974 -Management of Health & Safety at Work Regulations 1992 associated guidance. ULH policy: - Health & Safety Policy & related guidance - Health & safety training (Induction, Core Learning, Core Plus Learning and CPD) - Estates Planned Preventative Maintenance (PPM) / testing - Occupational Health services ULH governance: - Health & Safety Committee / site-based H&S Forums; accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) Frequent escalations to Estates Team for repairs Increased use of flexible working policy Site visits by senior Exec Team members Frequent escalations through Governance processes	IPC flo scores Datix incidents Staff surveys Complaints / PALS	04/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Work with Estates to identify better facilities – Ruth Taylor – December 2025	[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.	4	31/03/2022	31/03/2023	02/05/2025

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5136	10	Physical or psychological harm	Parkhill, Michael	Davies, Chris	Health and Safety Group	28/03/2023	20	Corporate	Estates and Facilities	Estates	Trust-wide	Following monitoring for Nitrous Oxide levels in Pilgrim and Lincoln (Theatre and Maternity Units), it was identified that in a number of locations, staff were exposed to higher levels of nitrous oxide where levels exceed the Workplace Exposure Limit (WEL) OF 100 ppm (8hr time weighted average (TWA)).	Following notification the following actions were undertaken: Pilgrim Hospital – Labour Ward: Estates staff checked the supply ventilation from the Air Handling Unit (AHU) to the Supply Grilles within the labour rooms. At the time of inspection, the Estates staff identified the dampers restricting airflow were not adjusted correctly. This was addressed and airflow checks were undertaken. Typical air change rates were around 6 air changes per hour (ACH) – current guidance is a minimum of 10 ACH, however the ventilation systems are circa. 1960 and the guidance is not retrospective. Following the actions undertaken, resampling commenced 15th March (15 sample tubes), 13 were within WEL limits, but 2 sample results were recorded at 255 and 407 ppm (8 h TWA) in Rooms 2/2a and Room 3, respectively and exceeded WEL limits. Estates are reviewing the current system to look at increasing air changes by upgrading the supply fans / changing pulleys / upgrading filter media or a combination of factors. Further works to increase ventilation has been completed and whilst not HTM03 compliant by design - supply ventilation has been increased to reduce the risk of WEL exceedance. Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	21/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have	[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.	10	28/03/2024		21/04/2025

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4648	2	Physical or psychological harm	Landon, Caroline	Davey, Keiron	Emergency Planning Group, Health and Safety Group	15/12/2021	20	Corporate	Estates and Facilities	Fire and Security	Trust-wide	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services. Low level of attendance/completion of fire safety training also contributes to this risk as there there may be significant non-adherence to fire safety policy and procedures which could lead to potential of a major fire.	National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) ULH policy: - Fire Policy (approved by FEG / FSG Sept 2022 - awaiting final approval / signature to be HTM compliant): # Personal Emergency Evacuation Plans (PEEPs), approved April 2017 - Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - review / protocol in draft, TNA in draft for Fire Safety Team review - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme ULH governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPEC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - All areas within the Trust estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems at all 3 sites (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (all 3 sites) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates. Internal audit review of fire safety training provision	18/12/2024	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Capital investment programme for Fire Safety being implemented on the basis of risk - costed budget plan for FEG submission Sept 2022. - Trust-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	[18/12/2024 11:16:34 Rachael Turner] Risk presented at Risk Confirm and Challenge 18/12/2024, risk validated for reduction in score of 4x4:16 High Risk. [05/12/2024 12:49:00 Rachael Turner] Risk mitigation currently in place includes fire door mapping work is now complete. 22 new fire doors are currently being installed across the Trust. An additional 21 have been ordered and a further 74 doors are being sent out for costings with the intention to be installed within this financial year. We have a fire safety trainer to competently inspect all fire doors. An additional 6 estate joiners have also been allocated a course for fire door inspection. Capital works for compartmentation remedials and replacement across all three sites continues to make good progress with work being targeted on the basis of risk. Fire Warden numbers across the Trust continue to rise. Due to these mitigations risk proposed for a reduction in score to 4x4:16.	10	31/03/2022	31/03/2025	18/03/2025

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4858	12	Service disruption	Parkhill, Michael	Whitehead, Mr Stuart	Emergency Planning Group, Estates Infrastructure and Environment Group	10/02/2022	25	Corporate	Estates and Facilities	Estates	Trust-wide	If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Emergency Planning Group / Major Incident Plan and departmental business continuity plans.	Surveys of water supply infrastructure - Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	18/03/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Regular inspection, automatic meter reading and telemetry for the incoming water main at all sites. Keeping components on site and regular contractors on stand by. Regular stock levels for emergency fixes. Recently undertaken a survey that looks at the condition of infrastructure. 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.	[18/03/2025 09:19:55 Rachael Turner] Confirmation of estimated time for survey to be carried out is 15 weeks[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.	5	30/10/2020	31/03/2023	18/06/2025
Strategic Objective		**1d. Deliver clinically led integrated services**																							

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5104	8	Regulatory compliance	Farquharson, Colin	Rinaldi, Dr Ciro	Estates Infrastructure and Environment Group	16/03/2023	10	Clinical Support Services	Path Links (Pathology)	Mortuary (Pathology)	Trust-wide	As a result of the HTA's concerns relating to the fabric and capacity of the Trusts mortuary service and the delay in timescales by which the Trust is able to refurbish these following the HTA inspection in May 2022. There is a risk that The HTA as the regulator could impose conditions on our licence to store the body of a deceased person within the Trusts mortuary facilities.	- HTA undertook an unannounced inspection during October/November 2024. This visit centred on the Lincoln site which was mid-refurbishment. No significant concerns were identified from HTA inspectors. -HTA oversight group has been established-meeting to manage the action plan. -Papers have been to CRIG for initial funding to establish planning and building work. This has been approved. -Draft business case has been developed and approved. -Initial concerns have been addressed from Lincoln site. -The Trust currently has two Titan units (temporary additional mortuary capacity) which provides additional capacity in the event of winter pressure peaks in demand and also in the event of equipment failure, although the Boston refurbishment has enabled the Titan unit at Boston to be no longer needed. -The Trust has a memorandum of understanding with Hull University Teaching Hospitals to support with the storage of bariatric bodies that require longer storage (freezer capacity). - Escalation of concerns to designated individual with respect to the Lincoln refurbishment process and security disparities in terms of alarm, CCTV and swipe	ULHT Improvement action plan HTA Governance Group	19/02/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	DI to escalate to ULTH security team the HTA governance group approval of the recommendations made following the Police Led review. Ciro Rinaldi – February 2024 Refurbishment completion at Lincoln – Andy Clay – March 2025	[21/02/2025 11:30:56 Gemma Staples] HTA have confirmed their acceptance of the Trust's plans to mitigate and have closed down their inspection process as complete. HTA unannounced on site inspection during October and November did not identify any significant concerns. [19/02/2025 14:46:24 Gemma Staples] The Mortuary refurbishment work at Lincoln is still ongoing, whilst the Refrigeration is near completion we are still using the temporary store at this time so the risk still stands. [25/11/2024 16:16:31 Gemma Staples] HTA undertook an unannounced inspection during October/November 2024. This visit centred on the Lincoln site which was mid-refurbishment. No significant concerns were identified from HTA inspectors. [22/08/2024 08:04:09 Gemma Staples] The HTA have recently confirmed to all Trusts about the greater powers of enforcement now granted which includes the ability to	4	31/03/2024	01/01/2025	19/05/2025

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Reportable to	Opened	Rating (initial)	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
5334	533	Physical or psychological harm	Grooby, Mrs Libby	Carr, Katy		26/01/2024	15	Family Health	Women's Health and Breast CBU	Obstetrics	Pilgrim Hospital, Boston	There is no second theatre within the confines of the labour ward within which to undertake any theatre based procedures when Theatre 8 is already in use. In time critical scenarios the increased time taken to transfer to Theatre 1 on ground floor and commence surgical management may impact on the health and/or wellbeing outcomes for mother and/or baby. There is a patient experience risk due to a lack of privacy and dignity for women when transferring to ground floor theatres through public corridors. There is also a potential for an increase in Caesarean Section rate as clinicians attempt to avoid late labour transfers.	Multi-professional discussions in relation to plans of care. Out of hours – on call maternity manager available for support. Dedicated theatre available in ground floor theatre. Close monitoring of labour ward activity. Publication of Standard Operating Procedure (SoP) Labour Ward Manager / Matron / Labour Ward Obstetric Lead to have an awareness of all theatre cases. Visible management and Leadership/active on call support to teams PMA support	Closely monitor all cases where woman transferred to theatre before or following birth – daily Medway report for scrutiny. Regular review of Incident reporting system.	24/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To inform teams of the risk controls in place. Coordinate Estates to undertake the works on Theatre 8a to minimise disruption as soon as practicably possible.	[24/01/2025 10:34:50 Nicola Cornish] This issue is ongoing and will remain the same until the refurbishment programme has been completed. Continue to receive patient feedback about poor experience of being moved through corridors. [09/12/2024 10:11:00 Nicola Cornish] Risk reviewed by Emma Upjohn - no further progress, still awaiting trust board decision regarding refurbishment plans for the whole maternity unit at Pilgrim. [25/09/2024 13:09:11 Nicola Cornish] Discussed at RR Confirm & Challenge meeting on 25th September. Acknowledged the mitigations in place and requested that data on incident numbers/harm occurring is included in progress updates. [09/07/2024 16:09:21 Nicola Cornish] This is ongoing, it is being be picked up as part of overall refurb at Pilgrim. [04/04/2024 10:33:53 Nicola Cornish] Risk reviewed, no change.	6	01/01/2025		24/04/2025

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Reportable to	Opened	Rating (initial)	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
5272	455	Physical or psychological harm	Mooney, Mrs Katy	Miller, Mrs Sally		06/10/2023	12	Medicine	Cardiovascular CBU	Cardiology	Lincoln County Hospital	Lincoln cardiac catheter lab is not connected to the emergency power supply at Lincoln County Hospital. There is currently emergency power to safely abort procedures, however without being connected to an uninterrupted power supply we could potentially be unable to offer a PPCI service (primary percutaneous cardiac intervention). There is a risk if any patient undergoing a procedure at a time of a power cut that loss of power could result in serious harm or death or possible implications around infection.	Temporary electrical fix via Estates-UPS-however there have been mechanical failures which has required Estates to manually to change it over. Estates had a third party assess the UPS switch-this needs to be re-wired but are currently awaiting a date for this to be carried out. Both of the Cath Labs will need re-wiring. Estates have stated they cannot provide power in the event of national grid power outage. Business Continuity Plan Cath Lab-short term power cut would look at utilising Thrombolysis. Prolonged power outage we would need to request mutual aid from those that offer PPI in neighbouring organisations.	Monthly audit internally (Cath Lab) Incidents of power outage raised on Datix.	12/03/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Job has been raised with Estates-this may be tied in with Lab replacement. Request to Estates to provide sufficient power to Cath Lab during a power outage has been made. Estates are currently working on solutions for this.	[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	1			12/06/2025

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Reportable to	Opened	Rating (initial)	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
4830	11	Service disruption	Cooper, Mrs Anita	Myers, Joseph	Estates Infrastructure and Environment Group, Medicines Quality Group	17/01/2022	15	Clinical Support Services	Pharmacy CBU	Pharmacy	Pilgrim Hospital, Boston	The area above Pharmacy at Pilgrim Hospital contains estates plant and pipes that are prone to blockage and overflow, which could cause extensive damage to medicines; computer equipment and aseptic facilities that disrupts service continuity.	ULHT policy: - Estates maintenance / repair arrangements - Business continuity plans ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) / Pharmacy CBU / CSS Division	Reported incidents of service disruption	21/03/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Discussions with Estates to identify potential solutions to the blockage / overflow issues. Contingency plan - medicines and equipment are moved to a temporary location in the event of overflow into Pharmacy. 7.9.23 there are no ongoing conversations with estates. JM will open up discussions again with estates and facilities	[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.	6	30/09/2021	31/03/2022	21/06/2025

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Reportable to	Opened	Rating (initial)	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
5383	615	Regulatory compliance	Cooper, Mrs Anita	Rigby, Lauren	Estates Strategy Group, Health and Safety Group	13/02/2024	15	Clinical Support Services	Cancer Services CBU	Haematology (Cancer Services)	Pilgrim Hospital, Boston	As a result of the treatment room not being compliant with HBN 00-03 procedures are being performed in an area that is not compliant, Adhoc and urgent bone marrow biopsies and intrathecal chemotherapy will still be performed in this room which would lead to an infection risk to patients.	Room is being decluttered Estates have reviewed, still awaiting if they can increase the air exchanges and how much this would cost. Larger organisation piece of work being undertaken Regular bone marrow biopsy clinics have been moved to outpatient department Venesections have been confirmed by the lead Estates Nurse can continue Risk assessment and precautions have been circulated to staff to adhere to for adhoc and urgent bone marrow biopsies and intrathecal chemo.	Datix incidents Complaints / PALS Assessment against regulations	13/04/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Estates job logged to see if can increase air exchange to 10 - Stuart Whitehead - December 2024 Wider organisational piece of work - Karen Bailey - December 2024	[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	3	13/02/2025	13/02/2025	13/07/2025

NHS
Lincolnshire Community and Hospitals NHS Group

Board Assurance Framework 2024/25

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6 May 2025*
Item Number	*12.2*

Lincolnshire Community and Hospitals Group Board Assurance Framework 2024/25

Accountable Director	*Professor Karen Dunderdale, Group Chief Executive*
Presented by	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations/ Decision Required	*The Board is asked to:-* • *Close the Board Assurance Framework for 2024-25 noting the introduction of the 2025-26 framework*

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

4d Enhanced data and digital capability	*X*
5a Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	*X*
5b Co-create a personalised care approach to integrate services for our population that are accessible and responsive	*X*
5c Tackle system priorities and service transformation in partnership with our population and communities	*X*
5d Transform key clinical pathways across the group resulting in improved clinical outcomes	*X*

Executive Summary

The Board Assurance Framework (BAF) enables the Board to maintain effective oversight of its strategic objectives with assurance being provided by the relevant Committees. The development of the Lincolnshire Community and Hospitals Group (LCHG) BAF is being completed alongside the development of the 2024/25 Strategy for the Group.

The 2024/25 framework has been received throughout the 2024/25 year by the relevant Committees on a monthly basis and updated accordingly. The Audit Committee has received the BAF to each of the meetings held to confirm that the format was relevant and effective.

The Board is asked to note the closing position for the 2024/25 year.

Lincolnshire Community and Hospitals Group
Board Assurance Framework (BAF) 2024/25

Strategic Aims	Board Committee
Patients - To deliver high, quality, safe and responsive patient services	Quality Committee
People - To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	People Committee
Services - To ensure services are sustainable, supported by technology and delivered from an improved estate	Finance Committee / Integration Committee
Partners - To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	Integration Committee
Population Health - To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	Integration Committee

Assurance Rating Key:	
Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

Objective alignment
Lincolnshire Community Health Services NHS Trust objectives
United Lincolnshire Teaching Hospitals NHS Trust objective

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating									
SA1 To deliver high, quality, safe and responsive patient services																								
1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Group Chief Nurse/Group Chief Medical Officer	1. Improve medical devices and use of in practice	1.1. Develop in house maintenance programme 1.2. Review contracts for medical supplies and medical device management 1.3. Support implementation of Point of Care (POC) testing at Urgent Treatment Centres 1.4. Modernising and innovating use of technology to improve quality of patient care 1.5. Virtual Ward Programme Support	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. National releases on best practice	395 495 681 403 714 695 715			Skin Integrity Group (SIG) established as a sub group of the Patient Safety Group to provide oversight, monitoring and accountability of the ongoing improvement work around prevention of pressure ulcers and the wider skin integrity programme of work. Skin Integrity management policies, procedures and pathways in place.	Following National changes in pressure ulcer categorisation in April 2024, all ulcers previously categorised as Unstageable will now be classified as a minimum of Category 3 ulcers, and therefore an increase in Category 3 and 4 incidents is expected and has been observed.	Weekly Pressure Ulcer Assurance meetings with the community nursing teams with safeguarding support. Thematic review of all Category 3 and 4 incidents completed monthly and presented into QSG and SIG.	Skin Integrity care is reviewed in the weekly ward/service leader's assurance and monthly Matrons audits for CoHo and CoNu. The monthly Quality Metrics review meeting monitors ward and services performance relating to skin integrity. Skin Integrity Group (SIG) provides oversight and receives Divisional performance reports, which provide assurance of the improvement actions being taken in areas reporting increased number of incidents. Skin Integrity incidents are analysed to identify themes and trends which are reported through SIG and improvement actions identified. Overarching action plan for incidents, themes and improvement actions is in place and monitored through Skin Integrity Group	Work progressing on live data stream identifying all current pressure ulcer in the community. Requirement to triangulate oversight for complex wound with increase specialist support and confirm and challenge process.	Continued Observation of Section 42 incidents across community services. Safeguarding referrals monitored monthly by safeguarding team and via SVOG. Quarterly update reports to PSIRF	Quality Committee			G	G	G	G	G	G	G	G	G
			2. Wound care and improvement management	2.1. Implement the National wound care strategy for pressure damage 2.2. Implement the National wound care strategy for leg ulcers 2.3. Introduction of a digital application																				
			3. Improve medicines related safety	3.1. Develop the pharmacy strategy, including gases and workforce																				

			4. Strengthen LCHS Patient Safety Culture	4.1. Embed the Just Culture principals and a full programme of training as part of the PSIRF response. 4.2. Strengthen a learning culture across LCHS through the introduction of the Patient Safety Incident Response Framework. 4.3. Recruitment of Patient Safety Partners										
			5. Strengthen Effective Practice	5.1. Develop clear nursing competencies, from band 2-6, aligned to clinical pathways and best practice within community nursing and community hospitals 5.3. Aim to be top recruiter in GP trials in East Midlands in 2023 5.4. Start participating in commercial trials 5.5. Work with the Medicine Management Team on medicines related research 5.6. Modernising and innovating use of technology to improve quality of patient care 5.7. Develop workforce plans for clinical services across the organisation 5.8. Support the delivery the clinical and professional workforce models in line with the Lincolnshire ACP strategy with regards to job plan implementation, workforce modelling and 3-5 year workforce training plans										
								Primary: 1. Clinical Strategy 2023-28 and linked reporting of delivery 2. Integrated Care System (ICS) Strategy 3. Integrated Care Board 5-year joint forward plan 4. Trust Leadership Team (TLT) reports 5. LCHS Operational Plan reports 6. Lincolnshire Long Term Plan 7. Quality Team/ Patient Experience and Involvement leads. Funding identified for new B7 Patient Experience Manager for LCHS. This is the sole establishment and Patient Experience now a Group managed model. 8. Complaints, Patient Advice and Liaison (PALS), and Claims Team. Data now included within SUPERB dashboard. 9. System Communications and Engagement Team 10. Volunteering Services Team. Voluntary Services now a Group managed model.	1. System Engagement Team not currently in place and timeline not confirmed. 2. Data - not connected Datix/ Business Intelligence/ System 1 Head of Patient Experience & Patient Experience Data Insight Manager need LCHS systems access. Group approach to Patient Panel explored & agreed separate ULHT & LCHS Patient Panels that come together 1/4rly. Draft ToR and plan prepared with aim to commence recruitment in Jan 25 and launch April 25. Current Head of Patient experience retiring in April 2025 - Interviewed for replacement and appointed to - start date July 2025 (GROUP Head of Patient Expereince nd Volunteer Services) - team covering gaps in the interim with planned handover once new person is in post.	1. System CEOs meeting to progress decisions. 2. FBI developed rollout plan for datix being pulled into the data warehouse. 3. FBI developed rollout plan for Systemone data linkage to datix incidents/ complaints/ claims. PEIG Task & Finish Group established to lead Group modelling, planning and working.	1.1 Recruitment and delivery of System Statutory Engagement Team resource and plan 2.1 LCHS involvement plan, feedback, improvement and delivery of plan (including national patient surveys) 3.1 LCHS experience plan, feedback, improvement and delivery of plan 3.2 Improved service design, access and experience 3.3 LCHG plan in development that will include ULHT priorities, LCHS priorities and collaborative priorities. Self assessment completed by PEIG Task & Finish Group. Timetable is for this to be approved at Feb 24 PEIG and QGC for		New template for divisional assurance reports developed and scheduled reports received at PEIG. SUPERB now includes LCHS data, monthly reports and infographics received at PEIG and circulated. To identify service level champions / leads to work in partnership with Patient Experience Team.	Quality Committee

1b	Improve patient experience	Group Chief Nurse	1. Grow People Engagement	1.1. Co-produce an LCHS statutory engagement plan and trajectory for informing decision-making and service delivery collaboratively across the group	1. Lack of System Engagement and Comms Team/ recruitment to team/ External partnerships and ways of working 2. Inadequate resources to deliver against objective/ programmes 3. Mindset, ownership and behaviour of leaders 4. Quality improvement approach and toolkit 5. System working interdependencies 6. Patients and public behaviours 7. Lack of capacity, capability and/or skills 8. Staff health and wellbeing	468 - Complaints		a Group managed model. 11. Triumvirate weekly complaints, incidents and claims reviews 12. Divisional monthly operational plan reporting. Divisions have now commenced Patient Experience Group meetings. 13. Quality Assurance Groups Secondary: 1. LCHG Patient Experience & Involvement Group (PEIG) 2. Clinical Safety and Effectiveness Group (CSEG) 3. Strategy and Planning Group (SPG) 4. Quality and Risk Committee (QRC) 5. Audit Committee 6. Trust Leadership Team (TLT) 7. Performance Management Reviews (PMRs) Tertiary: 1. Care Quality Commission Engagement and Assessment 2. Healthwatch monthly reports 3. Patient-Led Assessments of Care Environment (PLACE) Report 4. NHS Resolution reporting 5. Audit - internal/ external 6. Patient and Public feedback/ surveys/ NHS Choices Aiming to promote Care Opinion as a source. Data now included within SUPERB dashboard 7. Volunteering placement evaluations/ take up of opportunities 8. Complaints and Claims benchmarking data 9. Friends and Family Test data. New tender exercise across LCHS, ULTH, LPFT commenced. Current contract extended by 6 months	Voluntary Services Manager post being interviewed for - 11.03.2025		PEIG and QSC for launch April 25.									G	A	A	A	A	A	A	A
1c	Improve clinical outcomes	Group Chief Nurse/Group Chief Medical Officer	1. Quality Assurance and Accreditation Programme	1.1 Develop and implement a Programme of Quality Assurance and Accreditation				Weekly assurance within Community hospitals with monthly overnight. Monthly oversight commenced in community nursing	Monthly senior review in CoHo with developing weekly review in CoNu. Defined therapy assurance and assurance for specialist services.	Quality team support and leadership in building programme	Monthly assurance meetings overseeing divisional performance and quality improvement plans	Increased senior assurance in Coho and other services where model not yet built	Bi monthly quality assurance oversight aiding continued development of the model and harm free care certification building accreditation process	Quality Committee			G	G	G	G	G	G	G	G	G
			2. In collaboration develop a quality dashboard and infrastructure to provide best evidence to demonstrate quality of care	2.1. Develop an overarching infrastructure to ensure quality improvement and performance can be continually monitored, evidenced and understood from ward to Board ensuring that evidence can easily be collated for CQC assessments																			
			3. Improve People Involvement	3.1. Develop a programme of assurance with effectiveness of clinical procedural documents																			
			1. Review and transformation of Intermediate Pathways of Care Review	1.1. Working with system partners to review priority pathways for looked after children in Lincolnshire 1.2. Links to system Intermediate Care Review. This is currently paused so will be picked up again once this has been reinstated.																			

1d	Deliver clinically led integrated services	Group Chief Nurse/Group Chief Medical Officer	2. Frailty Pathways	2.1. Community Hospitals being recognised as Frailty specialists within our Lincolnshire system 2.2. Adult Community Therapy Frailty Rebranding 2.3. Delivering a population health needs based service that maximises the potential of our estate from Archer Assessment Unit										Integration Committee											
			3. Childrens Services Transformation	3.1. Child to adult transition of services - Business Cases and Case for Change being prepared nationally - where do these children go - for example Asthma - there is no adult service for this																					
			4. Palliative Pathways	4.1. Review the palliative pathways across LCHS to meet the needs of all palliative patients and their families.																					
SA2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG																									
2a	Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	Group Chief People Officer	1. Workforce Planning	1. Work Planning Solution - Implement the KPMG strategic workforce planner	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity/capability 4. External partnerships and ways of working 5. Mindset of leaders and staff 6. Staff health and wellbeing 7. Further Industrial Relations 8. National/Region directives	442 Recruitment 470 Staffing levels		Primary: 1 Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. LCHS People Strategy 2023-28 4. Clinical Strategy 2023-28 5. People Strategy Group 6. LCHS Operational Plans 7. Divisional delivery plans 8. Action Plans (eg Workforce Race Equality Scheme/Workforce Disability Equality Scheme) 9. Equality Diversity and Inclusion Lead/ Freedom to speak up guardian (FTSUG) /Staff Networks/ Health and Wellbeing Lead and Champions 10. Mental Health First Aid Champions 11. Swartz Rounds 12. Staff Networks 13. NHSE EDI Improvement Plan/6 High Impact Actions Secondary: 1. People Executive Group (PEG) 2. Finance, People, Performance and Investment Committee (FFPIC) 3. Lincolnshire People Board 4. Audit Committee 5. Equality, Diversity and Inclusion Group 6. Trust Well-Being Guardian 7. Lincolnshire People Plan 2024/25 8. Executive Leadership Team 9. Transformation Delivery Group (TDG) 10. Stakeholder Engagement and Involvement Group (SEIG) 11. Performance Management Reviews (PMRs) 12. Transformation Delivery Group (TDG) 13. Trust Leadership Team (TLT) 14. Quality and Risk Committee (Q&RC) 15. Lincolnshire People Hub 16. Lincolnshire Integrated Care Board 17. Lincolnshire Health and Care Collaborative Delivery Board 18. Strategic Delivery Plan (SDP) Programme Board Tertiary: 1. Audit 2. NHS National Staff Survey 3. Regional People Board 4. NHSE EDI Improvement	1. 10 Year NHSE Workforce Plan	1. 10 Year NHSE Workforce Plan	1. Delivery of the LCHS People Strategy 2024/25 Action Plan 2. Standard People Metrics (Sickness/Turnover/MT /Vacancy/agency spend etc) better than LCHS targets and benchmarking 3. NHS National Staff Survey results above average in all People Promise areas 4. Delivery of the Lincs People Plan 23/24 and improved system people metrics (sickness, staff survey, turnover, agency spend etc) 5. Efficient use of Apprentice Levy funds 6. Improved NHS Freedom to Speak Up Guardian (FTSUG) Index score 7. National Quarterly Pulse Survey (Quarter 1, Quarter 2 and Quarter 4) above benchmarking 8. Improved Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) Data 9. Corporate Benchmarking in the lowest quartile for People Functions 10. Delivery of NHSE EDI Improvement Action Plan 11. Sub Groups now in place across the Group (LCHG) which will include oversight of workforce planning as required. These commenced in Q3 of 2024/25 and include: Workforce Strategy Group (WSG), Education Oversight Group (EOG), Culture & Leadership (CLG) and Equality, Diversity & Inclusion Group (EDIG). Each will be attended by key stakeholders and consider workforce planning and other key workforce aspects as relevant to the meeting and will report into the	None identified	None identified	People Committee			G	G	G	G	G	G	G	G	G	
			2. Inclusion	2.1 Reduce total pay gaps - race, disability, gender 2.2 Inclusive Recruitment Processes																					
			3. Pipeline	3.1 Group Bank 3.2 Apprenticeships 3.3 Wider Workforce																					
			4. Flexibility	4.1. Enabling a flexibility by default approach																					
			5. Retention	5.1 Support better retention																					
			6. Civility and respect	6.1 Allyship 6.2 Reduce bullying and harassment																					

			7. Health and Wellbeing	7.1 Research into staff self-care/role of leadership				4. NHSE EDI Improvement Plan/6 High Impact Actions 5. CQC 6. System Improvement Director 7. NHS People Plan 8. National/Regional Benchmarking			and will report into the People Committee on a monthly basis. 12. People Quality & Governance Manager attends the monthly Strategic Workforce Planning meetings to represent LCHS, and the Head of Workforce Plannign & reporting to represent ULTH as part of the wider Group Model. 13. As part of the LCHG Workforce Strategy Group meeting there is regular inclusion of benchmarking data for workforce included - this commenced within the meeting in January 2025.														
			8. Leadership and Talent	8.1 Leadership Development 8.2 Inclusive Talent Development																					
			9. Workforce Transformation	9.1 New ways of working 9.2 Develop New Roles and Skills																					
2b	To be the employer of choice	Group Chief People Officer	1-9 highlighted above in 2a	1-9 highlighted above in 2a	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity/capability 4. External partnerships and ways of working 5. Mindset of leaders and staff 6. Staff health and wellbeing 7. Further Industrial Relations 8. National/Region directives	442 Recruitment 470 Staffing levels		Primary: 1 Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. LCHS People Strategy 2023-28 4. Clinical Strategy 2023-28 5. People Strategy Group 6. LCHS Operational Plans 7. Divisional delivery plans 8. Action Plans (eg Workforce Race Equality Scheme/Workforce Disability Equality Scheme) 9. Equality Diversity and Inclusion Lead/ Freedom to speak up guardian (FTSUG) /Staff Networks/ Health and Wellbeing Lead and Champions 10. Mental Health First Aid Champions 11. Swartz Rounds 12. Staff Networks 13. NHSE EDI Improvement Plan/6 High Impact Actions Secondary: 1. People Executive Group (PEG) 2. Finance, People, Performance and Investment Committee (FPPIC) 3. Lincolnshire People Board 4. Audit Committee 5. Equality, Diversity and Inclusion Group 6. Trust Well-Being Guardian 7. Lincolnshire People Plan 24/25 8. Executive Leadership Team (ELT) 9. Stakeholder Engagement and Involvement Group (SEIG) 10. Performance Management Reviews (PMRs) 11. Transformation Delivery Group (TDG) 12. Trust Leadership Team (TLT) 13. Quality and Risk Committee (Q&RC) 14. Lincolnshire People Hub 15. Lincolnshire Integrated Care Board 16. Lincolnshire Health and Care Collaborative Delivery Board 17. Strategic Delivery Plan (SDP) Programme Board Tertiary: 1. Audit 2. NHS National Staff Survey	1. 10 Year NHSE Workforce Plan	1. 10 Year NHSE Workforce Plan				People Committee			G	G	G	G	A	A	A	A	A	

								2. NHS National Staff Survey 3. Regional People Board 4. NHSE EDI Improvement Plan/6 HIAs 5. CQC 6. System Improvement Director 7. NHS People Plan 8. National/Regional Benchmarking						
SA3 To ensure services are sustainable, supported by technology and delivered from an improved estate														
			1. Develop foundational insight	1.1. Develop regular integrated portfolio analysis 1.2 Develop and embed a multi-level performance management framework and conditions for a performance and improvement culture	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests	528 Breakeven Duty - Cost Control 529 Efficiency Requirement 530 System Risk and Gain Share - Financial Risk 532 Non attainment of capital plan		Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. Transformation Delivery Group (TDG) 5. Data Quality Group 6. Capital Investment Group 7. LCHS private board 8. Performance Management Reviews (PMR) 9. Lincolnshire Integrated Care Board 10. Lincolnshire Health and Care Collaborative Delivery Board 11. Strategic Delivery Plan (SDP) Programme Board 12. System Financial Assurance Group 13. System Financial Leaders Group (FLG) 14. System Digital, Data and Technology (DDAT) Tertiary: 1. Internal audit – Standard Financial Controls Annual Audit 2. External audit – Annual Independent Audit and Opinion on Financial Statements 3. Benchmarking data 4. National Oversight Framework rating 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter	Skills and capability to use tools and frameworks	Programme of knowledge and skills development for FBI and stakeholder partners. Formal finance training sessions re-established.	1. Delivery of the financial plan measured through reporting and variances to planned performance 2. Deliver the required operating budget alongside leaders feeling engaged, informed and empowered to drive their service efficiency agenda 3. Delivery of the FBI Strategy plan 2023-24 4. National Oversight Framework (NOF) rating (annual and quarterly)		Variation from financial plan agreed with system and regulator (system control total allocated). CIP plan fully identified, although through significant NR action and in year mitigations.	

3a	Deliver financially sustainable healthcare, making best use of resources	Group Chief Finance Officer	2. Produce a multi-year financial plan including the key service transformation priorities	2.1 Develop frameworks to identify, scope and prioritise tactical, operational and transformational efficiency opportunities	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests	528 Breakeven Duty - Cost Control 529 Efficiency Requirement 530 System Risk and Gain Share - Financial Risk 532 Non attainment of capital plan		Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. Transformation Delivery Group (TDG) 5. Data Quality Group 6. Capital Investment Group 7. LCHS private board 8. Performance Management Reviews (PMR) 9. Lincolnshire Integrated Care Board 10. Lincolnshire Health and Care Collaborative Delivery Board 11. Strategic Delivery Plan (SDP) Programme Board 12. System Financial Assurance Group 13. System Financial Leaders Group (FLG) 14. System Digital, Data and Technology (DDAT) Tertiary: 1. Internal audit – Standard Financial Controls Annual Audit 2. External audit – Annual Independent Audit and Opinion on Financial Statements 3. Benchmarking data 4. National Oversight Framework rating 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter	Skills and capability to use tools and frameworks	Programme of knowledge and skills development for FBI and stakeholder partners	1. Delivery of the financial plan measured through reporting and variances to planned performance 2. Deliver the required operating budget alongside leaders feeling engaged, informed and empowered to drive their service efficiency agenda 3. Delivery of the FBI Strategy plan 2023-24 4. National Oversight Framework (NOF) rating (annual and quarterly)			Finance Committee			A	G	G	G	G	G	G	G
								Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-	Strategic business partnering approach well-established	Embedding FBI structure and new ways of working. Agreed to implement post investment evaluations into 25/26 FPC agenda.	1. Partner satisfaction ratings with FBI (internal) 2. Delivery of the Finance and Business Intelligence (FBI) Strategy plan 2023-24 3. National Oversight												

			3. Deliver a multi-year financial plan including the key service transformation priorities	3.1 Support to deliver the operational efficiency initiatives and the strategic transformation/new operating models	1. Mindset and behaviour of leaders 2. Lack of capacity 3. Lack of skills and capability 4. Leadership capacity and capability 5. A poor internal reputation	529 Efficiency requirement 530 System Risk and Gain Share - Financial Risk		28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. LCHS Strategy and Planning Group (SDP) 5. Transformation Delivery Group (TDG) 6. Performance Management Reviews (PMR) 7. Lincolnshire Integrated Care Board 8. Lincolnshire Health and Care Collaborative Delivery Board 9. Strategic Delivery Plan (SDP) Programme Board 10. System Financial Leaders Group (FLG) Tertiary: 1. Internal audit 2. External audit 3. Benchmarking data 4. Partnership satisfaction ratings 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter			3. National Oversight Framework (NOF) rating (annual and quarterly)															
				1.1 Use integrated portfolio analysis to inform strategic				Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Finance reporting to Finance Performance, People and Innovation Committee (FPPIC) 6. Trust Leadership Team (TLT) reports 7. LCHS Operational Plan reports 8. Clinical Strategy 2023-28 9. Chief Clinical Digital Information Officer (CCDIO) 10. Lincolnshire Long Term Plan 11. Strategic Delivery Plan as part of the Recovery Support Programme 12. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance,	Strategic business partnering approach well-established	Embedding FBI structure and new ways of working	1. Partner satisfaction ratings with FBI (internal) 2. Delivery of the Finance and Business Intelligence (FBI) Strategy plan 2023-24 3. National Oversight Framework (NOF) rating (annual and quarterly)															

3b	Drive better decisions and impactful action through insight		1. Drive change, insight and direction	and tactical decision making and prioritise opportunities 1.2 Drive change, insight and direction through a business partnering approach and culture 1.3 Use performance management framework to identify key areas to maximise performance, and swiftly address areas of underperformance to ensure tangible better outcomes for patients	1. Mindset and behaviour of leaders 2. Lack of capacity 3. Lack of skills and capability 4. Leadership capacity and capability 5. A poor internal reputation	529 Efficiency requirement 530 System Risk and Gain Share - Financial Risk		1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. LCHS Strategy and Planning Group (SDP) 5. Transformation Delivery Group (TDG) 6. Performance Management Reviews (PMR) 7. Lincolnshire Integrated Care Board 8. Lincolnshire Health and Care Collaborative Delivery Board 9. Strategic Delivery Plan (SDP) Programme Board 10. System Financial Leaders Group (FLG) 11. System Digital and Data Team (DDAT) Tertiary: 1. Internal audit 2. External audit 3. Benchmarking data 4. Partnership satisfaction ratings 5. Clinical audit reports 6. National best practice data and reports 7. CQC rating 8. National Oversight Framework (NOF) rating quarterly letter						Finance Committee			G	G	G	G	G	G	G	G	G								
3c	A modern, clean and fit for purpose environment across the Group	Group Chief Estates and Facilities Officer	1. Safe and Sustainable Foundations (Estates and Transformation)	1.1. Driving the efficiency of our estate 1.2. Transparency in our Estates Utilisation	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	454 NHSPS Water Supply 460 Cost of estate 461 NHSPS Maintenance of LCHS estate 483 JCH Theatre Ventilation 473 NHSPS property ventilation 551 JCH Water Purity 552 Skegness Hospital Water Purity		Primary: 1. Estates and Transformation Strategy 2. Clinical Strategy 3. Lincolnshire Long Term Plan 4. LCHS Operational Plan 5. Integrated Care System (ICS) Strategy 6. Integrated Care Board 5-year joint forward plan 7. Strategic Delivery Plan as part of the Recovery Support Programme 8. LCHS Green Plan 9. NHS Lincolnshire Green Plan Secondary: 2. Estates Delivery Group 4. Health and Safety Committee 5. Finance, Performance, People and Investment Committee (FPPIC) 6. Audit Committee 7. Estates Shared Service Programme Group (ESSPG) 9. Lincolnshire Strategic Infrastructure and Investment Group 10. Transformation Delivery Group (TDG) 11. Trust Leadership Team (TLT) 12. Performance Management Reviews (PMRs) 13. Quality and Risk Committee (Q&RC) 14. Capital Investment Group 15. Lincolnshire System Operational Estates Group 16. Lincolnshire Greener NHS Group Tertiary: 1. Estates Returns Information Collection (ERIC) Return 2. Patient-Led Assessments of Care Environment (PLACE) Report 5. Internal Audit 6. Health and Safety Executive Standards 7. CQC rating 8. Benchmarking data 9. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Fully developed Estates dashboard 2. Fully developed 3rd party compliance dashboard 3. No Authorising Engineers reports handed over from ESS ro ULTH E&F Team	1. Programme of AE audits being planned & additional resources being scoped to support the audit process & actions arising from said audits.	1. Delivery of the Estates and Transformation Improvement Plan 24/25 2. Delivery of the LCHS Green Plan action plan 24/25 3. Increased compliance and safety 5. Delivery of LCHS Capital Plan 24/25 6. Greater utilisation of Estate	Lack of assurance relating to statutory compliance of the estate. No Authorising Engineer audits being undertaken. Former LPFT Shared Service handed over very little in terms of assuarnce.	LCHS Estates now being managed by ULHT Estates & Facilities Services following termination of shared service agreement. Group Chief Estates & Facilities Officer. ULHT Safety Groups being reviewed to include LCHS Estate. Performance meetings being held with NHSPS. Group Estates & Facilities structure being developed to provide capacity to effectively manage the estate and maximise potential going forward. Further Authorising Engineers audit on fire safety being undertaken in November 2024 to ascertain what level of improvement has been made since the last audit and actions taken by ULTH Fire safety Team. Safety Groups established across the Group to commence January 2025 which have oversight of all risks, e.g. fire safety, electrical safety, water safety, medical gas management etc. Health & Safety Committee in Common to launched in April 2025, Terms of Reference currently being finalised. Premises Assurance Model completed and tabled at FPPIC which shows significant areas in improvement required - action plans being developed. integration & improvements plans monitored through E&F SMT. AE audits currently being commissioned due to histroic lack of AE audits and lack of assurance.	Finance Committee / Integration Committee			R	R	R	R	R	R	R	R	R								

3d	Reduce waits for patients who require urgent care and diagnostics to constitutional standards	Group Chief Operating Officer												Finance Committee			A	A	A	A	A	A	A	A	A							
3g	Reducing unwarranted variation in community service delivery and ensure we meet all constitutional standards	Group Chief Operating Officer				ID681 Children in care, ID403childrens SLT, ID397 Lymphoedema staff workspace, ID409 lymphoedema service capacity	referral to treatment(18 week wait)	1. Planned care group oversight, 2. Weekly community SLT 3. GLT/PRM 4. ELT 5. FPEC 6. CWL system meeting (external), 7. regional CWL group	Live community waiting list available on power BI with agreed waiting list policy supporting completion of records	Programme of specilaity deep dives with audit programme initiated	Audit against waiting list policy adherence			Finance Committee			R	R	R	R	R	R	A	A	A							
SA4 To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation																																
4a	Establish collaborative models of care with all our partners including Primary Care network Alliance (PCNA), GPs, health and social care and voluntary sector	Group Chief Integration Officer	1. Community Primary Partnerships	1.1 Neighbourhood Working 1.2 Tobacco Dependence Team move 1.3 First Costal Development									Integration Committee			R	G	G	G	G	G	G	G	G							
			2. Support and provider leadership to the ICS operating framework and governance	2.1 Paly an active role in the governance structures of the ICS	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.Commissioning practices 6.A poor external reputation"	444, 481, 504, 526, 530 - TO BE CHECKED AGAINST DATIX		1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Lincolnshire Long Term Plan 4. LCHS IIP 5. Clinical Strategy 2023-28 6. NHS England Planning Guidance 7.Performance Management Reviews (PMR) 8.Lincolnshire Leaders Board 9.Better Lives Lincolnshire Leadership Team 10.System joint committees 11.System Financial Leaders Group (FLG) 12.Quarterly System Review Meeting (QSRM) 13.National Oversight Framework (NOF) rating (annual and quarterly 14.Internal audit 15.External audit	No up to date survey of partner views	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.	1.Delivery of the FBI Strategy plan 2024-25 2.National Oversight Framework (NOF) rating (currently out to consultation) 3.LCHS representation on system boards, committees and groups 4.Compliance with system mechanisms e.g. Risk/Gain Share 5.LCHS delivery of its elements of system projects	Partner satisfaction ratings	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.																			
			3. Play an active role in collaborations that make a difference	3.1 Play and active role as a key partner in the Lincolnshire Health and Care Collaborative 3.2 Work in partnership to identify and deliver initiatives that can only succeed in collaboration	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.Commissioning practices 6.A poor external reputation"	444, 481, 504, 526, 530 - TO BE CHECKED AGAINST DATIX		1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Lincolnshire Long Term Plan 4. LCHS IIP 5. Clinical Strategy 2023-28 6. NHS England Planning Guidance 7.Performance Management Reviews (PMR) 8.Lincolnshire Leaders Board 9.Better Lives Lincolnshire Leadership Team 10.System joint committees 11.System Financial Leaders Group (FLG) 12.Quarterly System Review Meeting (QSRM) 13.National Oversight Framework (NOF) rating (annual and quarterly 14.Internal audit 15.External audit	No up to date survey of partner views	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.	1.Delivery of the FBI Strategy plan 2024-25 2.National Oversight Framework (NOF) rating (currently out to consultation) 3.LCHS representation on system boards, committees and groups 4.Compliance with system mechanisms e.g. Risk/Gain Share 5.LCHS delivery of its elements of system projects	Partner satisfaction ratings	CIO once in post to take a view on whether (and when) to conduct a survey of partner views.																			
4b	Successful delivery of the Acute Services Review	Group Chief Integration Officer												Integration Committee			A	A	A	A	A	A	A	A	A							

4c	Grow our research and innovation through education, learning and training	Group Chief Integration Officer												People Committee (To move to: Transformation and Integration Committee)												
4d	Enhanced data and digital capability	Group Chief Integration Officer	1. Care Closer to Home (Digital)	1.1. Technology Enabled Transformation	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	430 Cyber Security 553 Migration from network drives to SharePoint		Primary: 1. Digital Health Strategy Secondary: 1. Digital Strategy Group (DSG) 2. Digital Executive Group (DEG) 3. Finance, Performance, People and Investment Committee (FPPIC) 4. System Digital, Data and Technology Board (DDaT) 5. Transformation Delivery Group (TDG) 6. Trust Leadership Team (TLT) 7. Performance Management Reviews (PMRs) 8. Capital Investment Group Tertiary: 1. Annual Network and Security Penetration Test (DSPT) 2. Data Security and Protection Toolkit 3. Internal Audit 4. Benchmarking data 5. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Patient Digital Literacy Information 2. Workforce Digital Literacy Information 3. Fully developed Estates dashboard	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis 3. Programme of work around information into the dashboard and further training for staff	1. Delivery of the Digital Health Strategy 23/24 Action Plan 2. Improved use of digital technologies 3. Delivery of LCHS Capital Plan 23/24 4. Greater uptake of digital services from the public			Finance Committee / Integration Committee			G	G	G	G	G	G	G	G	G	
			2. Safe and Sustainable Foundations (Digital)	2.1. Safe Practice 2.2. Technology Optimisation					1. Fully developed 3rd party compliance dashboard	1. Programme of work to share compliance data across organisations into a dashboard																
			1. Change Ready Workforce (Digital)	1.1. Digital Ready Workforce 1.2. Digital Leadership					1. Patient Digital Literacy Information 2. Workforce Digital Literacy Information	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis																
SA5 To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population																										
5a	Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	Group Chief Nurse/Group Chief Medical Officer	1. Develop foundational insight	1.1 Develop the Population Health Management (PHM) and Health Inequalities (HI) approach	1.Mindset and behaviour of leaders 2.Lack of capacity 3.Lack of skills and capability 4.Leadership capacity and capability 5.A poor internal reputation 6.National guidance changes 7.System finance/data requests			Primary: 1. Integrated Care System (ICS) Strategy 2. Integrated Care Board 5-year joint forward plan 3. Finance and Business Intelligence (FBI) Strategy 2023-28 4. FBI Strategy update on current year plan 5. Trust Leadership Team (TLT) reports 6. LCHS Operational Plan reports 7. Clinical Strategy 2023-28 8. Chief Clinical Digital Information Officer (CCDIO) 9. Lincolnshire Long Term Plan 10. Strategic Delivery Plan as part of the Recovery Support Programme 11. NHSE Planning Guidance Secondary: 1. LCHS Finance Performance, People and Investment Committee (FPPIC) 2. Quality and Risk Committee (Q&RC) 3. LCHS Trust Leadership Team (TLT) 4. Transformation Delivery Group (TDG) 5. Data Quality Group 6. Performance Management Reviews (PMR) 7. Lincolnshire Integrated Care Board 8. Lincolnshire Health and Care Collaborative Delivery Board 9. System Digital, Data and Technology (DDAT) Tertiary: 1. Benchmarking data 2. Clinical audit reports 3. National best practice data and reports 4. CQC rating	Skills and capability to use tools and frameworks	Programme of knowledge and skills development for FBI and stakeholder partners				Integration Committee			R	G	G	G	G	G	G	G	G	

5b	Co-create a personalised care approach to integrate services for our population that are accessible and responsive	Group Chief Nurse/Group Chief Medical Officer												Integration Committee												
5c	Tackle system priorities and service transformation in partnership with our population and communities	Group Chief Integration Officer												Integration Committee		R	R	R	R	R	R	R	R	R		
			1.1. Care Closer to Home (Estates and Transformation)	1.1. Supporting Models of Care 1.2. Driving Integrated Working	1. Lack of resources 2. Lack of skills and capability 3. Leadership capacity 4. External partnerships and ways of working 5. Patients and public behaviours 6. Mindset of leaders 7. Staff health and wellbeing 8. Patient and public engagement	430 Cyber Security 454 NHSPS Water Supply 460 Cost of estate 461 NHSPS Maintenance of LCHS estate 483 JCH Theatre Ventilation 473 NHSPS property ventilation 551 JCH Water Purity 552 Skegness Hospital Water Purity 553 Migration from network drives to SharePoint		Primary: 1. Digital Health Strategy 2. Estates and Transformation Strategy 3. Clinical Strategy 4. Lincolnshire Long Term Plan 5. LCHS Operational Plan 6. Integrated Care System (ICS) Strategy 7. Integrated Care Board 5-year joint forward plan 8. Strategic Delivery Plan as part of the Recovery Support Programme 9. LCHS Green Plan 10. NHS Lincolnshire Green Plan Secondary: 1. Digital Strategy Group (DSG) 2. Estates Delivery Group 3. Digital Executive Group (DEG) 4. Health and Safety Committee 5. Finance, Performance, People and Investment Committee 6. Audit Committee (FPPIC) 7. Estates Shared Service Programme Group (ESSPG) 8. System Digital, Data and Technology Board (DDaT) 9. Lincolnshire Strategic Infrastructure and Investment Group 10. Transformation Delivery Group (TDG) 11. Trust Leadership Team (TLT) 12. Performance Management Reviews (PMRs) 13. Quality and Risk Committee (Q&RC) 14. Capital Investment Group 15. Lincolnshire System Operational Estates Group 16. Lincolnshire Greener NHS Group Tertiary: 1. Estates Returns Information Collection (ERIC) Return 2. Patient-Led Assessments of Care Environment (PLACE) Report 3. Annual Network and Security Penetration Test (DSPT) 4. Data Security and Protection Toolkit 5. Internal Audit 6. Health and Safety Executive Standards 7. CQC rating 8. Benchmarking data 9. Healthcare Information and Management Systems Society Assessment (HIMSS)	1. Patient Digital Literacy Information 2. Workforce Digital Literacy Information 3. Fully developed Estates dashboard	1. Creation of a patient co-design group 2. Trust wide Digital skills training needs analysis 3. Programme of work around information into the dashboard and further training for staff	1. Digital Health Strategy 23/24 Action Plan 2. Estates and Transformation Strategy 23/24 Action Plan 3. Delivery of the LCHS Green Plan action plan 23/24 4. Improved use of digital technologies 5. Improved Cyber security reporting and oversight 6. Increased compliance and safety 7. Robust signed off Service Level Agreements (SLAs) for the Estates Shared Service 8. Delivery of LCHS Capital Plan 23/24 9. Greater uptake of digital services from the public												

5d	Transform key clinical pathways across the group resulting in improved clinical outcomes	Group Chief Integration Officer/Group Chief Medical Director	2. Transforming Nursing in the Community	2.1. Reviewing existing and ensuring the right longer term Skin Integrity (incl. Lymphoedema) services for Lincolnshire 2.2. Reviewing the Community Nursing offer- what does "good Community Nursing look like" (the catalogue) Specialist Service criteria, including but not limited to: - Proactive care provisions - Catheters - IV Therapy, INR - Skin Integrity, Lymphoedema - Community Nursing Safer Staffing 2.3 Voice Before You Visit Service Evaluation										Integration Committee
			3. Transforming Community Hospitals	3.1. Rebranding / Standardisation of Community Hospital offer - Discharge hub - Proactive care provisions - Correct bed distribution										
			4. Children's Services Transformation	4.1. Childrens hub in Lincolnshire 4.2. Children's services reviews - ALL LCHS Children's services 4.2.1. Children In Care 4.3. Children's services reviews - ALL LCHS Children's services 4.3.1. Childrens Therapy - SALT										
			5. Development of Community Neurology Services	5.1. One community Neuro team with the scope of maximising the capability of existing Community Neuro Nursing and Therapy Services - currently at ULHT and LCHS - Community Outreach and Parkinson's										
			6. Transforming Operations Centre	6.1. Transformation of One Front Door including Ops Centre, CAS, Home Visiting and UCR including triage and dispatch										
			7. IUEC Pathways	7.1. Initial unplanned pathways, response project 7.2. UTC Review - outcomes and recommendations 7.3. Virtual Wards										
			8. Seasonal Planning Reviews - Winter Schemes	8..1. Seasonal Planning Reviews - Development										
			9. Agile Workstream	9.1. Continence Re-model of service										

Lincolnshire Community and Hospitals Group
Board Assurance Framework (BAF) 2024/25

Strategic Aims	Board Committee
Patients - To deliver high, quality, safe and responsive patient services	Quality Committee
People - To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG	People Committee
Services - To ensure services are sustainable, supported by technology and delivered from an improved estate	Finance Committee / Integration Committee
Partners - To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation	Integration Committee
Population Health - To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population	Integration Committee

Assurance Rating Key:	
Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

Objective alignment
Lincolnshire Community Health Services NHS Trust objectives
United Lincolnshire Teaching Hospitals NHS Trust objective

Ref	Objective	Executive Lead	Linked programmes in Integrated Improvement Plan/Operational Plan	Linked projects in Integrated Improvement Plan/Operational Plan	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SA1 To deliver high, quality, safe and responsive patient services															
								Medicines Quality Group in place with a focus on improving medication safety / appropriate prescribing / appropriate management of drugs and controlled drugs Robust medicines management policies and procedures in place Improving the safety of medicines management / review of Pharmacy model and service are key projects within the IIP. Improvement actions reflect the challenges identified from a number of sources e.g. CQC, internal audit. MQG will retain oversight of the relevant IIP programme of work through divisional upward reports Electronic prescribing has been rolled out to areas where this was planned, although some challenges are being identified post-rollout	Gaps identified within internal audits undertaken by Grant Thornton Lack of adherence to Medicines management policy and procedures (i.e. Controlled Drugs processes as evidenced by regular audit work programmes) Lack of 7 day clinical pharmacy service and specific specialty specific gaps in service (i.e. Emergency Departments, Childrens and young persons, as identified by Neonatal ODN Network visit in June 2024) Some medicines management policies are overdue / past their review dates Medicines reconciliation compliance is poor and has remained an outlier during 2023/2024	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes. Divisional Upward Report template to be developed to ensure divisional assurances are provided against actions/improvement work linked to Grant Thornton and CQC now that Medicines Management Action Task and Finish Group has closed	Upward Report from the Medicines Quality Group to PSG Routine analysis and reporting of medication incidents and outcomes from medicines audits in to Medicines Quality Group Omitted doses audit Controlled Drugs Audit Prescribing Quality reports Robust Divisional reporting and attendance into MQG monthly Internal Audit report Upward reporting from other groups	Lack of upward reporting from the Medical Gases, Sedation Group Pharmacy audits only occurring in areas they are providing a clinical service to. Some gaps in other groups not reporting to MQG / or concerns in respect of effectiveness (i.e. Drugs and Therapeutics Group, Patient Group Directive (PGD))	Divisional representation at Medicines Quality Group reinforced by Medical Director and Director of Nursing and template for divisional reporting of BAU medication safety activities in to Medicines Quality Group developed and in place		
								Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering AKI; sepsis (Ensuring early detection and treatment of deteriorating patients) (PSG)	Maturity of some of the sub-groups of DPG not yet realised. This will be considered as part of the review of DPG.	Observation policy ready to go to next NMAAF Fluid management policy approved by DPG/PSG and awaiting approval at NMAAF Work taking place across the Group to support Deteriorating Patient agenda. Development of DPG across Group Chair now appointed as the Deputy Medical Director. First meeting undertaken in November to review terms of reference / workplan and subgroups. First upward report submitted to QC in January 2025	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas Number of incidents occurring regarding lack of recognition of the deteriorating patient Robust upward reports received monthly into PSG	Fluid Management group has not been meeting and therefore concerns through PSG have been raised. Reporting not being received by PSG from DPG due to vacancy	First upward report to QC in Janaury 2025- group TOR require review and workplan to be agreed.		

1a	Deliver high quality care which is safe, responsive and able to meet the needs of the population	Group Chief Nurse/Group Chief Medical Officer			Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to respond to patient safety alerts appropriately	5101 4947 5016 5100 4879 5143 5450 5002 5142 5267 4779 5488 5306 4868 4935 5515 4843 5423 4746 5095 4646 5491 5227 5403 5196 5169		Implementation and oversight of national patient safety strategy (culture and systems) Human Factors Faculty	Development of Safety Culture review process in conjunction with People and OD	Working group established to review and propose framework to be utilised	Patient Safety Board Development session held - June 2024 6 monthly gap analysis against National Patient Safety Strategy reporting in to PSG and upwardly to Quality Committee Safety Culture review process From Q2 Group Patient Safety report triangulating across multiple key stakeholders to consider patient safety culture and future plans of work, to report to PSG and QC quarterly	Working group outputs not yet available due to group in infancy	Initial meeting held in October, verbal updated expected at November PSG. Clarification on project lead required. Commenced recruitment process for TTT for Human Factors cohort for Jan/Feb 2025.	Quality Committee			G	G	G	G	G	G	G	G	G
									Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. One central monitoring process now in place. Monthly Group Oversight Meeting for CAS and FSN alerts Strengthen oversight of designated Executive and Patient Safety Specialist on recovering CAS alerts and final sign off (PSG)	CAS and FSN Group policy	Development of CAS and FSN Group Policy commenced, expected completion December 2024	Quarterly report to PSG with escalation to QC as necessary and monthly exception report to PSG. Compliance included in the integrated governance report for Divisions.	None identified	None identified									
									Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices). Includes regular meetings with divisions, CQC action plan which goes to relevant committees, TLT, etc. Regular executive challenge meetings on delivery. Escalation routes into PRM and TLT. (CG)	No gaps identified.	Not applicable.	Monthly reporting to sub-committees with the relevant extract of the action plan. CYC and TLT receive monthly reports. QGC receive quarterly update on the entire plan. Quarterly updates Trust Board. Feedback to CQC on achievements at monthly engagement meeting. CQC assurance data.	CQC assurance data not yet complete. CQC assurance data not yet shared with committees. Output from PRM is not clear. Escalations not always acted upon promptly.	Use of exec led meeting to pick up escalations which may not occur via other routes. Additional resource identified for compliance team to support with sourcing levels of assurance.									
									Skin Integrity Group (SIG) established as a sub group of the Patient Safety Group to provide oversight, monitoring and accountability of the ongoing improvement work around prevention of pressure ulcers and the wider skin integrity programme of work. Skin Integrity management policies, procedures and pathways in place.	Following National changes in pressure ulcer categorisation in April 2024, all ulcers previously categorised as Unstageable will now be classified as a minimum of Category 3 ulcers, and therefore an increase in Category 3 and 4 incidents is expected and has been observed.	Weekly Pressure Ulcer Support and Supervision panel with Quality, Tissue Viability and Safeguarding team representation reviews all Category 3 and 4 pressure ulcers against the safeguarding adults protocol for all pressure ulcers and raising a safeguarding concern guidance.	Skin Integrity care is reviewed in the weekly ward/dept. leader's assurance and monthly Matrons audits. The monthly Quality Metrics review meeting monitors ward and departments' performance relating to skin integrity. Skin Integrity Group (SIG) provides oversight and receives Divisional performance reports, which provide assurance of the improvement actions being taken in areas reporting increased number of incidents. Skin Integrity incidents are analysed to identify themes and trends which are reported through SIG and	No gaps identified.	Not applicable.									

												through SIRS and improvement actions identified. Overarching action plan for incidents, themes and improvement actions is in place and monitored through Skin Integrity Group																		
1b	Improve patient experience	Group Chief Nurse				5495 5234 4701 4724		Patient and Carer Experience (PACE) plan 2022 - 2025 The PACE Delivery Plan is actioned and embedded over the life of the delivery plan. (PEIG)	PACE plan due for review in 2025. Patient Experience Team capacity to support both ULHT & LCHS imperatives.	LCHG plan in development that will include ULHT priorities, LCHS priorities and collaborative priorities. Self assessment completed by PEIG Task & Finish Group. Timetable is for this to be approved at Feb 24 PEIG and QGC for launch April 25. Funding identified for LCHS Patient Experience Manager - aiming for recruitment in January 2025	Patient Experience & Carer Plan progress report to Patient Experience & Involvement Group (PEIG) as per schedule. PEIG Task & Finish Group upward reports provided to PEIG re: progress and actions.	There are no assurance gaps identified.	Not applicable	Quality Committee			G	A	A	A	A	A	A	A	A
								Enhance patient experience by learning from patient feedback and demonstrating our values and behaviours in the delivery of care with a specific focus on discharge of patients. (PEIG)	National surveys evidence overall poor experiences in relation to discharge and UEC with a number of questions being benchmarked as worse than others Trusts. Patient Experience Team working with divisions to support improvements including a deep dive triangulation across data sources and real time surveying.	Amalgamated national survey action plan in place to identify Trust wide improvement focus; the current plan is cumbersome for divisional engagement so will be managed by Patient Experience Team and collective focus across all divisions to be linked to targets within each benchmarked quartile: 'upper' - cleanliness and food, 'about the same' - individual needs met and information, 'bottom' - moving wards at night and sleep. Rolling out of new suite of communication and patient experience training including Hearing it Your Way and at induction. Patient Experience Team working with Discharge and UEC teams staff facilitating real time surveying to enable improvements and developments	New template for divisional assurance reports developed and scheduled reports received at PEIG. SUPERB now includes LCHS data, monthly reports and infographics received at PEIG and circulated.	Engagement capacity within discharge and UEC teams to lead patient experience improvement initiatives and developments.	To identify service level champions / leads to work in partnership with Patient Experience Team.											
								Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. Thematic review of SIs and complaints undertaken - recommendations being progressed as part of the Maternity & Neonatal Improvement Plan. External independent input in to SI process. MNOG will retain oversight of the implementation of the relevant IIP programme of work. (MNOG)	Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG. Validation of the implementation & embedding of the Ockenden IEAs has been provided by the regional maternity team. There is a process in place for ongoing testing through supported site visits. Training compliance data.	None Identified	Not applicable.											

								Ensure we provide clinically safe services, through an increased number of Diamond Award Accredited Wards / Departments (PEIG)	there are no identified Control gaps	Not applicable	monthly Quality metrics dashboard meeting with all clinical areas. Diamond award applications received and supported by corporate nursing team. Diamond Award Panel chaired by DoN/DepDoN. Award presented by Trust Chair. Metric included with the IIP, and measured Quarterly.	None Identified	Not applicable												
								Getting it Right First Time Programme in place with upward reports to CEG and onward reporting to QGC. (CEG)	Reports currently tend to focus on the process of GIRFT. Further work needed to demonstrate changes in practice as a result of GIRFT work.	Quarterly reports to Clinical Effectiveness Group with a request to focus on specific areas each quarter to see improvements GIRFT team in place to support divisions and ensure that appropriate activity takes place.	Upward reports to CEG and onward reporting to QC KPIs in the integrated governance report Process in place for feedback to divisions Reporting through IIP to QC	Reporting has begun to focus on outcomes but this is not yet well embedded.	Request from CEG for future reports to show improved outcomes as a result of GIRFT activity.												
1c	Improve clinical outcomes	Group Chief Nurse/Group Chief Medical Officer				4828 4731 4928 5154 4866 4778 4840		Clinical Effectiveness Group in place as a sub group of QC and meets monthly CEG works to an annual work programme and standard agenda to ensure that all business is covered appropriately. Upward reports are received from reporting groups inc: Human Tissue Authority Group Transfusion Committee Organ Donation Group Adjustment to policy and procedures Group Mortality Groups VTE Group Radiation Protection Committee NATSSIP/LOCSIP Group Research Groups Role of CEG is to Improve clinical effectiveness through increased compliance with national and local standards. Quality of reporting into CEG has improved and is increasingly robust. (CEG)	Acknowledged that there is good engagement from nursing and AHPs, however work continues to encourage engagement from medics. Leads of the reporting groups attend CEG on a quarterly basis to present upward report	Invites to speakers to come direct from Mr Simpson as Chair of the Group in future. Mr Simpson to continue as Chair of the Group whilst appointment of Deputy Medical Director concluded and will commence in role of CEG chair Increasing engagement with leads of reporting groups	Effective upward reporting to QGC from reporting groups. Regular reports received from Divisions providing assurance that they understand their position with respect to clinical effectiveness	No gaps identified.	Not applicable.	Quality Committee			G	G	G	G	G	G	G	G	G
								Clinical Audit Group in place and meets monthly (CAG) with monthly upward reports to CEG Refocus of CAG to focus on the learning from audit. (CEG)	There are outstanding actions from local audits ULHT and LCHS Groups being considered as a single meeting to strengthen learning and assurance	ToR currently being reviewed as new Chair in place for CAG	Upward report to CEG confirming status of clinical and associated actions and shared learning	No gaps identified.	Not applicable.												
								National and Local Audit programme in place and agreed which is signed off by QC. Improved reporting to CEG regarding outcomes from clinical audit. Reports and process in place for any areas where the Trust is identified as an outlier. (CEG)	None identified.	Not applicable	All National Audits presented to CEG with associated action plan Internal Audits undertake review of Clinical Audit Programme on a scheduled basis	None identified	Not applicable												
								Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QC (CEG)	There are sometimes delays in the completion of the gap analysis for the Clinical Guidelines.	Process in place for escalation if required within the Clinical Divisions.	Reports on compliance with NICE / TAs demonstrating improved compliance.	None identified	Not applicable												
								Process in place for taking part in the Patient Related Outcome Measures (PROMs) project. (CEG)	None identified.	Not applicable	Quarterly reports to CEG and upwardly reported to QGC Outcome measures report published annually and shared with CEG														

								Specialised services quality dashboards (SSQD) Process in place for identifying outliers through Model Hospital. Clinical leads for outlying areas present updates to CEG quarterly. (CEG)	No gaps identified.	Not applicable.	Quarterly reports to CEG and upwardly reported to QGC. Action plans developed for all required areas.	No gaps identified.	Not applicable.	
								Process in place for monitoring of and implementation of NCEPOD requirements. (CEG)	None identified.	Not applicable	Quarterly reports to CEG on progress.	Some outstanding baseline assessments. Some overdue actions identified.	Work taking place with divisional leads to address.	
								Monthly MorALS meeting chaired by the Deputy Medical Director and attended by a representative of the Triumvirate for each division. Monthly reporting to CEG (CEG)	Timeliness of completion of SJRs	Process being developed for M&M meetings.	Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback Compliance with SJR completion reported through PRMs Divisional updates art MORaLs by the Triumvirates	None Identified	Not applicable	
1d	Deliver clinically led integrated services	Group Chief Nurse/Group Chief Medical Officer												Integration Committee
SA2 To enable our people to lead, work differently, be inclusive, motivated and proud to work within LCHG														
			Medical Workforce Programme (Medical Staffing Project)	Medical Workforce Programme - Medical Staffing Project with focus on: a) Plan for Every Post b) NHSE Workforce Productivity Tool c) Reporting				Workforce planning and workforce plans. Recruitment to agreed roles - plan for every post, for Agenda for Change, Medical and Dental Workforce People Planning & Transformation Team are in post, with Senior Lead (Director of People & OD) overseeing functions. Strong working relationships to utilise Divisional Heads of HR, Finance and Improvement Team to monitor compliance against KPIs set out within the IIP. This is established and regular reviews are now in place. Reported through to the Workforce Strategy Group and then included within the highlight report for People & OD Committee highlight report to Board.	None identified	None identified	Workforce plans submitted for 2024/25 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division working with each of the SHRBP's and are reporting through to FPAM in terms of pipeline linked to reducing agency spend. Medical Workforce Programme reports into ISG on a monthly basis following monthly Steering Group chaired by SRO. Comprehensive review of project plan has been undertaken to ensure the Plan for Every Post' progress is fully reflective and able to provide upward level of assurance on deliverables within 2024/25.	Currently Medical & Dental vacancies are not managed by Position Number	Continued progress with refreshed approach to 'Plan for Every Post' being developed as part of the Medical Staffing Project within the Medical workforce Programme. Reported at Medical Workforce Steering Group and ISG on a monthly basis. It is expected that this will be a key enabler to supporting the Trust in reducing temporary staffing spend within this staff group. Divisional roll out of the refreshed Plan for Every Post process has commenced, with the largest Divisions being the priority. This has now been rolled out across all four clinical Divisions for Medical & Dental staff. People Quality & Governance Manager attends the monthly Strategic Workforce Planning meetings to represent LCHS, and the Head of Workforce Plannign & reporting to represent ULTH as part of the wider Group Model.	

								Focus on retention of staff - creating positive working environment and integration of People Promise 'themes' System retention role established and in place for 2023/24. People Promise Y1 work complete with funding for Y2 agreed, this has now ended and is incorporated into the BAU for the Education, Learning & OD Team. Education and Learning Team in place and actively working to improve compliance with Statutory and Mandatory Training. Organisational Development Team in place and actively working to improve completion rates for Appraisals. Maintain a link between the Education, Learning & OD Team and their work that supports the approach to Just Culture & Leadership through the Culture & Leadership Group (CLG). Maintain a 'golden thread' of Civility& Respect, Compassionate Leadership and Just Culture throughout all interactions and developments.	Reward, Recognition & Engagement Officer is now in place and will take on some of the ongoing work with regards to the People Promise now that the Fixed Term Contract for the People Promise Manager has come to an end as at October 2024. Consideration to the concept of group appraisals and appraisal lite to form part of the review of people policies and procedures.	Turnover (retention):Turnover has continued to improve over the last 12 months and is on track to deliver against the 2024/25 KPI set out within the IIP. To further support this, work has begun to understand how we develop exit data to gather insights for 'reasons for leaving' and support our staff to remain working Statutory & Mandatory Training: Reported into LCHG Education Oversight Group (monthly) and within Divisional FPAM (monthly) with areas<50% compliance highlighted. Support offered to Divisional Teams by Head of HR and Education, Learning & OD (ELOD) Team to improve in these areas to ensure that staff are compliant with mandatory training, and where issues identified are supported as required. All staff are now being contacted with regards to their compliance rates where thy are <90% and not just those who are <50% compliance so as to ensure we can sustain our improved position. Appraisals**:** Workforce Strategy Group to discuss group appraisal and appraisal lite Ongoing discussions are in place with agenda items on Workforce Strategy Group as required. Focus on those areas where there are <50% compliance to encourage improved compliance rates, ensuring that where support to record is required this is offered.	Workforce Strategy Group upward report to People Committee including scorecard analytics i.e. appraisal, statutory and mandatory training.	Mandatory Training compliance has improved and continue to be on target for full year effect. Appraisal compliance levels have improved and continue to be on target for full year effect.	To be monitored through the Workforce Strategy Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 2024/25 KPIs as featured in the Integrated Improvement Plan. As of Quarter 3 within 2024/25 there will be a new: 1) LCHG Education Oversight Group commenced which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis. 2) LCHG Culture & Leadership Group (CLG) commenced which will oversee key aspects of culture and leadership with key stakeholders across the Group. This will report into People Committee on a monthly basis. As part of the LCHG Workforce Strategy Group meeting there is regular inclusion of benchmarking data for workforce included - this commenced within the meeting in January 2025.													
								Reducing sickness absence - Absence Management System	Manager call back compliance and return to work interview	Compliance with use of AMS being addressed through People Management Essential Training and AMS training from HRBPs Early Occupational Health led interventions are being explored for top two reasons for sickness absence. Absence reported at Divisional FPAMs with areas of concern highlighted (eg: CBU and Staff Group information) to support targeted action if required.	Sickness/absence data with detailed report available for Head of HR use to support targeted actions with Divisions. Deep dive by Workforce Strategy and OD Group into absence data Internal Audit Report Actions Report via FPAM (monthly), Workforce & OD Group (monthly) and into PODC via Scorecard.	Various reports through Heads of HR to Divisions. Output from Workforce Strategy Group deep dive into absence data.	Work continues with the completion of the audit actions and work/training with the departmental managers and HR. To be monitored through the Workforce Strategy Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 24/25 KPI's as featured in the Integrated Improvement Plan. A deep dive is being undertaken of the full utilisation of the AMS management system as early indications show improvement is needed aligned to Health and Wellbeing initiatives. As part of the LCHG Workforce Strategy Group meeting there is regular inclusion of benchmarking data for workforce included - this commenced within the meeting in January 2025.													

Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation Establish ULHT Education and Learning service Promote benefits and opportunities of Apprenticeships	None identified	None identified	Workforce Strategy Group Finance, People & Activity Meeting and People Committee data Workforce Strategy Group upward report to People Committee including scorecard analytics i.e. appraisal, statutory and mandatory training Sub Groups now in place across the Group (LCHG) which will include oversight of workforce planning as required. These commenced in Q3 of 2024/25 and include: Workforce Strategy Group (WSG), Education Oversight Group (EOG), Culture & Leadership (CLG) and Equality, Diversity & Inclusion Group (EDIG). Each will be attended by key stakeholders and consider workforce planning and other key workforce aspects as relevant to the meeting and will report into the People Committee on a monthly basis. Mandatory Training compliance have improved and continue to be on target for full year effect, and this is reported via FPAM each month. Appraisal compliance levels have improved and continue to be on target for full year effect, and this is reported via FPAM each month.	None identified	None identified
Improve the consistency and quality of leadership through:- a) Reset leadership development offer and support (Leadership SkillsLab and PME) b) Improved mandatory training compliance c) Improved appraisals rates using the WorkPal system d) Developing clear communication mechanisms within teams and departments. Better Together Programme for multi disciplinary senior leaders across the Organisation is in place across LCHG. Maintain a link between the Education, Learning & OD Team and their work that supports the approach to Just Culture & Leadership through the Culture & Leadership Group (CLG). Maintain a 'golden thread' of Civility& Respect, Compassionate Leadership and Just Culture throughout all interactions and developments.	Education, Learning & OD Team in place with ELOD certified experts with a mission to "engage and develop our people, champion differences and nurturing relationships to embrace a culture of civility and respect. Becoming the employer of choice"	Dedicated capacity and project leadership identified for Culture and Leadership Programme.	Workforce Strategy Group Finance, People & Activity Meeting and People Committee data Sub Groups now in place across the Group (LCHG) which will include oversight of workforce planning as required. These commenced in Q3 of 2024/25 and include: Workforce Strategy Group (WSG), Education Oversight Group (EOG), Culture & Leadership (CLG) and Equality, Diversity & Inclusion Group (EDIG). Each will be attended by key stakeholders and consider workforce planning and other key workforce aspects as relevant to the meeting and will report into the People Committee on a monthly basis.	None identified	None identified

2a	Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise	Group Chief People Officer				4844 4996 4997 5447		Proactively support staff to remain well and at work, however should the need arise, supporting them through illness and their return to work Staff Vaccination Programme Health and wellbeing Programme for staff.	2024/25 5.5% sickness absence target Continue to fill vacancies within the HR department to support Divisions with sickness management.	Continue to fill vacancies within the HR department to support Divisions with sickness management. Now at a fully recruited position within HR. Standardised absence reporting via FPAM, with Divisional HR Teams also having access to Division/CBU/Specialty level specific data to support the active management and monitoring of absence with Divisional colleagues. Staff are signposted to Health & Wellbeing services as a matter of routine through regular communications and in response to specific incidents/needs across the Trust (eg: Employee Assistance Programme).	Health and wellbeing Manager and Health and Wellbeing Group/Wellbeing Champions Upward reporting to WSODG from H&WB Group Board level HWB Guardian change enacted Vaccination Programme updates through Workforce Strategy Group Compliance rates continue to be monitored via the People Committee Scorecard for the below: 1) Rolling 12mths Sickness Absence rate 2) Return to Work compliance 3) Flu vaccination rate 4) Occupational Health referral data	None Identified	None Identified	People Committee			G	G	G	G	G	G	G	G	G
								Vacancy levels below 4.5% across the Trust by 31st March 2025. Aligned to the plan for every post, recruitment plans for each division and aligned to the workforce submission plan for 24/25.	Changes in budgeted establishment as a result of approved (System and Interval) investments which increase establishment, thus widening the vacancy gap.	Regular monitoring of monthly reports and tracking of changes with clear rationale.	Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Operational and Strategy Group. Pastoral care award received for recruitment and on-boarding of international nurses Compliance rates continue to be monitored via the People Committee Scorecard for the below: 1) Vacancy rate (Trust wide and by specific staff groups) 2) Recruitment KPIs	None Identified	None Identified											
								Reduce our staff turnover rate to 9.00% across the Trust by 31st March 2025	9.00% turnover rate yet to be embedded as BAU in all staff groups	Aligned to the continued work under the People Promise Manager role and plans for 24/25 to continue to improve work life balance, flexible working requests, flexible retirement/retire and return options. People Promise Mgr funding identified for Yr2. To be embedded as business as usual at the end of Year Two funding for the Group.	Key Performance indicators have been identified as part of the IIP and will be monitored through the scorecard at Workforce Strategy Group Pastoral care award received for recruitment and on-boarding of international nurses Compliance rates continue to be monitored via the People Committee Scorecard for the below: 1) Turnover rate 2) Flexible Working agreement rates	None Identified	None Identified											

								Reset ULH Culture and Leadership through delivery and implementation of Culture and Leadership Programme and Restorative and Just Culture Programme. Cultural deep dives, specific / ad hoc pieces of OD work with individual areas, as identified that requires support / help and associated action plans agreed and owned by Clinical/Management teams. Working in conjunction with HRBP's and OD Business Partners for a joined up approach to tackle culture challenges. The OD, Education and Development Directorate was restructured as part of the redesign piece of work within People & OD Directorate and investment made to increase the workforce. Maintain a 'golden thread' of Civility& Respect, Compassionate Leadership and Just Culture throughout all interactions and developments.	Culture shift takes time to be embedded however improvements continue to be recognised in engagement scores in the National Staff Survey results. Very strong performing staff networks now in place and being recognised nationally for awards. Investment in wellbeing manager leading the wellbeing work across the Trust under Occupational Health offering direct support for staff who may require it in addition to the Employee Assistance Programme available. Increase in the number of staff reaching out to FTSU guardian is a positive reflection of the effectiveness of the FTSU processes.	Leading Together Forum - regular bi-monthly leadership event Delivery Plan and actions to be confirmed further to results of Leadership Survey LTF Forward Plan Leadership SkillsLAB - essentials in management and leadership for existing managers. Comprehensive follow up and prioritisation of NSS results - key areas of concern identified for action 7 point action plan presented and agreed by ELT and shared with Group Leadership Team. Restorative Just and Learning Culture project team has been formed with a full roll out now being undertaken.	Culture and Leadership Group and System People Board Culture and Leadership Programme Group upward report NSS results (Feb 2023/Feb 2024) Themes from cultural deep dives presented to People Committee. Patient complaints and compliments data. staff complaints data. FTSU data. External stakeholders feedback. Just and Learning Steering Group offer a highlight report to People Committee. Culture and Leadership Group offer a highlight report to People Committee. Staff Networks and their effectiveness is measured through the EDI action plan.	None identified	None identified
								Support Divisions to achieve and maintain 90.00% of our people having completed all relevant statutory and mandatory training by 31st March 2025. Trust aligned to National Core Skills Training Framework Mandatory Training Governance Group in place. Manager reports re: training compliance MTTG used as Gateway to core learning Mapping of core training on more individual basis.	Dedicated Education Department now in place as part of the restructure. Aligned to the People Promise continued work for 24/25. Updates to ESR system to allow better monitoring and reporting. Consideration of appraisal lite and group appraisal now embedded. Further work required aligned to the Quarterly Pulse survey and promotion of this. 90.00% compliance yet to be embedded as BAU.	HRBP support in each Division and Directorate supporting the promotion of mandatory training and appraisals, using reported data to show progress. New Appraisal paperwork embedded. Recommendations captured through the National Staff Survey.	Workforce Operational Group training report Upward reporting to People and OD Committee CQC Monthly reporting Individual core training matrix on ESR. Additional monthly assurance offered to CQC through governance team regular meetings Education Oversight Group (EOG) is now in place and meets monthly with upward report to People Committee. Monitored through the Workforce Strategy Group and FPAM meetings and will feature in the highlight report to PODC. Phased targeted approach in 24/25 KPI's as featured in the Integrated Improvement Plan has been implemented	None identified	None identified
								Support our Divisions to provide all staff with an appraisal and clear objectives by 90.00% of our staff having an 'in-date' appraisal within 2024/25.	90.00% compliance yet to be embedded as BAU.	HRBP support in each Division and Directorate supporting the promotion of mandatory training and appraisals, using reported data to show progress. New Appraisal paperwork embedded. Recommendations captured through the National Staff Survey.	Workforce Operational Group reports Upward reporting to People and OD Committee CQC Monthly reporting Education Oversight Group (EOG) is now in place and meets monthly with upward report to People Committee.	None identified	None identified

								55% of our staff recommending ULHT as a place to work.	NSS results show a requirement to improve this recommendation	Annual NSS. Pulse surveys staff feedback through Facebook, exit interviews, Attractive recruitment campaigns and packages; Retention strategy being developed. Attrition rates monitored	Workforce Operational Group reports Upward reporting to People and OD Committee CQC Monthly reporting National Awards e.g. Pastoral Care Award received for IEN recruitment.	Sub-Group meetings within the People Directorate are not yet in place	As of Quarter 3 within 2024/25 there will be a new LCHG Education Oversight Group (EOG) commence which will oversee key aspects of education and learning with key stakeholders across the Group. This will report into People Committee on a monthly basis.												
								53% of our staff recommending ULHT as a place to receive care	NSS results show a requirement to improve this recommendation	Further work required aligned to the Quarterly Pulse survey and promotion of this. Annual NSS. Patient feedback. National recognition for improvements in service delivery and care Eg. Maternity Service Improvements.	Workforce Operational Group Reports Upward reporting to People and OD Committee CQC Monthly reporting Recognition certificate and letter received for the 2022 National Staff Survey Patient Experience Group Staff satisfaction reports Education Oversight Group (EOG) and Culture & Leadership Group (CLG) are now in place and meets monthly with upward report to People Committee.	None identified	None identified												
			Education, Training & Development	Aligns to Integrated Improvement Plan at Trust Level and Divisional Level where there are in year plans within the People Objective with regards to developing staff and teams.	Capacity to release staff due to operational pressures to attend relevant training and development sessions.			Embedding continuous learning and personal development culture across the Trust	Dedicated Talent Academy Team who support wider access to apprenticeship programmes which support the ongoing development of current staff, and the attraction of new staff to the Trust. Education, Learning & Organisational Development Team who support the Trust to meet the regulatory areas of compliance, such as Mandatory Training, and also support ongoing learning which is bespoke to the needs of the Trust. For Medical Workforce, Clinicians are able to access the training provided by the Talent Academy. There is a gap in how this is reviewed and monitored within the Chief Medical Officer portfolio. This is an area of focus for 2024/25 to ensure that there is a robust mechanism for oversight and assurance.	Reported via People & OD Committee for regulatory needs/compliance. Updates provided within FPAM at Divisional Level with regards to attendance and engagement with: 1) People Management Essentials Training, 2) Just Culture Briefings and 3) 50% or less compliance for Mandatory Training Close working between Education, Learning & OD Team with regards to the co-ordination of the METIP and TNA so that this is aligned to the wider needs of Workforce Planning.	People & OD Committee Workforce Strategy & OD Group Nursing & AHP Transformation Group Education Oversight Group (EOG) and Culture & Leadership Group (CLG) are now in place and meets monthly with upward report to People Committee.	None Identified, although regularly reviewed to consider platforms which are best placed to provide further insights and levels of assurance for Education, Training & Development.	Working closely with key roles and groups to better understand the needs of the organisation and staff. Collaborative working by ensuring that key functions are included as part of ad hoc or standing agendas for the regular review and discussion about kept areas within education, training and development. For example: Education is now a key area of focus with a regular slot on the Workforce, Strategy Group. On a monthly basis.												
2b	To be the employer of choice	Group Chief People Officer				4948		Embed continuous improvement methodology across the Trust	Embedding and sustaining cultural improvement change when the ability of the ULHT teams to engage is limited or constrained when we are operationally challenged. Ability to demonstrate quick impact on the cultural change due to various interventions will be limited (as these are multi year/multi factorial projects).	Improvement Academy now report all training & associated activity to embed continuous improvement through Improvement Steering Group for oversight and escalations. Working with each improvement programme and Divisions to develop identify and align improvement plans.	Internal training reports produced by Improvement academy. Improvement programmes identifying personalised training needs for ULHT staff. Divisions training plan (aligned to the IIP) presented at FPAM.	Information is reported to ISG - Low uptake of our various training offers despite general and targeted comms through various platforms. Services are struggling to release staff for QI training due to pressures. Plan for a QI relaunch in the new financial year. Use of virtual training option via MS Teams. Sub-Group meetings within the People Directorate are not yet in place	Weekly meetings with Improvement Academy to increase offer with more agile training methods to meet the needs of the varied staff. Developing communications & engagement strategy for on-going awareness of Improvement Academy to enable improvement culture change (not just limited to sending email updates but being creative and being on site on wards to talk about quality improvement) As of Quarter 3 within 2024/25 there will be a new LCHG Equality, Diversity & Inclusion Group (EDIG) commence which will oversee key aspects of equality, diversity and inclusion with key stakeholders across the Group. This will report into People Committee on a bi-monthly basis.	People Committee			G	G	G	A	A	A	A	A	A

			Medical Workforce Programme (Medical Staffing Project)					Compliance with National agency utilisation target of 3.7% agency and locum workforce	None identified		FRP and ISG	None identified	None identified												
								Lincs Belonging Strategy EDI Delivery Plan 2022-25	None identified		Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NSS EDI/EDS objectives	None identified	None identified												
SA3 To ensure services are sustainable, supported by technology and delivered from an improved estate																									
					ERF - Failure to deliver the ERF target of 113% of 19/20 planned activity will result in a potential clawback of an element of the ERF allocation made to Lincolnshire and non delivery against the ERF gain share CIP scheme for ULHT.			1.1 ERF clawback - Collective ownership across the Lincolnshire ICS of the planned care pathways leading to improved activity delivery. 1.2 Trust focus to deliver 113% of activity	1.1 Maximisation of the Trust Resources - Theatre and Outpatient productivity. 1.2 Ability to recruit and retain staff to deliver the capacity. 1.2 Production of an activity delivery plan.	1.1 Improved counting and coding, focus in this area including data capture and missing outcome reductions. 1.1 Shared risk and gain share agreements for the Lincolnshire ICS. 1.2 Divisional ownership and reporting 1.2 Reporting by POD and Specialty against the delivery plan	1.1 & 1.2 Delivery of the 113% target - phased trajectory.	1.1 & 1.2 The operational pressures, specifically; sickness, excess beds open, rising acuity of patients and continuing rising demand at the front door of the acute Trust is putting at risk in year delivery of the 113% ERF activity target.	1.1 The Lincolnshire ICS is monitored externally against the system activity target through the monthly activity returns 1.2 The Trust is monitored externally against the Trust activity target through the monthly activity returns 1.2 The Trust monitors internally against its activity targets inclusive of specific Divisional and Specialty plans and targets												
3a	Deliver financially sustainable healthcare, making best use of resources	Group Chief Finance Officer			Capital - Capital investment levels are significant and require delivery in 'live' environments. Robust planning is required to ensure that delivery of the agreed schemes takes place within the financial year to avoid any under-investment in our services.	5020 4664	CQC Well Led CQC Use of Resources	2.1 Three key capital groups; MDCG, DHG and Estates, are in existence to understand the issues and provide mitigations, alongside escalation where required. Escalation should be via Capital Delivery Group (CDG) and CRIG which links in the risk impacts of the requirement. Upward reporting from CDG/CRIG to GLT, FPEC and Trust Board is in place. 2.2 From a clinical divisional perspective, investment priorities continue to be identified and these are being reviewed and prioritised based on risk. 2.3 Lincolnshire does have an agreed Capital SOP that will be utilised if/where required in terms of risk management across all provider organisations. 2.4 ULHT has a rolling 5 year capital programme analysis that details the level of investment required across the organisation with financial estimates included. Financial assessments include; Medical Device equipment replacement cost, 6-Facet Survey within Estates and CIR calculations. 2.5 Business cases are produced for future investment that include capital requirements.	2.1 & 2.2 Difficult to compare Estate, Digital and Medical Equipment risks when allocating capital resources. 2.1 & 2.2 & 2.5 Robust timeframes for operational delivery of schemes required. Financial consequences (Capital & Revenue) if operational delivery is outside of agreed plans. 2.5 Capacity to produce business cases to access external funds. 2.1 - 2.5 Impact of IFRS16 (Right of Use Assets) agreements. 2.1 & 2.5 Contractor 'contracts' and transfer of risk away from ULHT.	2.1 & 2.2 & 2.3 & 2.5 Open and transparent discussion around proposed scheme deliverability to manage risks identified with Estates, Digital and Medical Devices. Presentations to FPEC and Trust Board to engage senior leaders in the proposed capital programme together with the risks that remain. Further discussion with Lincolnshire partners to ensure all opportunities are understood and awareness of shared risks. 2.5 Robust business case process with all key stakeholders involved in the support and approval of cases. Business Case (Green book & Local requirements) training roll out across the Trust and partners. 2.1 & 2.2 & 2.4 & 2.5 Risk rating pre & post investment required in all investment requests. 2.1 & 2.5 Key stakeholders involved in agreement of leases (IFRS16) aware that Finance need to be involved in all discussions to assess the implications of agreements proposed.	2.3 & 2.4 & 2.5 Capital Programme approval process ahead of the financial year - FPEC / Trust Board development session / Trust Board. 2.1 Capital Delivery Group (CDG) fortnightly monitoring of scheme delivery. Upwardly reported on a monthly basis to FPEC and Trust Board. 2.5 CRIG approval process for business cases. Upward reporting into GLT for final agreement. 2.5 Benefits realisation group review and upward reporting into CRIG, GLT and FPEC. 2.4 Development of a 5 year capital programme cross referenced to risk register.	2.5 Benefits identified in business cases not being fully delivered. Need to ensure greater accountability of delivery and learning lessons if ambitions were not achieved. 2.1 Control process for timeline changes for scheme delivery needs to be implemented.	2.4 Multi-year capital requirements prioritised to assess 'need' versus 'affordability'. Mitigations discussed and agreed at the key capital groups and escalation where required. Capital programme to be 'managed' within Lincolnshire therefore ability to 'pause' schemes if impact of 'new' scheme is greater is possible. 2.4 6-Facet survey completed and details being assessed to feed into a revised and more robustly prioritised multi-year capital planning requirement. 2.3 & 2.4 & 2.5 Discussions continue with NHSE regarding the level of capital limits (CDEL) applied to Lincolnshire and the need for this to be reviewed and increased as part of national calculations. As it stands, the national limits are lower than the level that would be investable based on 'local' available resources.	Finance Committee			A	A	A	A	A	R	R	R	R

					Cash - Deficits in the last 3 years have depleted cash reserves. Factoring in the 2024/25 deficit plan with additional delivery risks alongside a large capital programme means that the availability of cash to meet Pay and Non pay obligations is at substantially increased risk unless carefully managed.			3.1 Cashflow Monthly Projection to 30 June 2025 3.2 Daily cashflow projected 3 months ahead 3.3 Monthly reporting to FPEC 3.4 Access to cash support via NHSE subject to formal Board approval and application process 3.5 Facility to move cash around Lincolnshire System utilising NHSE cash support process	3.1, 3.2 & 3.3 Cash forecasting dependent upon accurate capital, CIP and I&E projections and certainty of delivery. 3.4 Cash support above the level of the I&E deficit is subject to more rigorous challenge through the business case process. May not be approved. 3.5 Transfer of cash between Lincolnshire bodies requires formal agreement by both parties. 3.5 Process to enable cash transfer between NHS bodies requires the repayment of PDC by the donor and issuing of PDC to the recipient (ULHT). LCHS has very limited PDC that can be repaid which in turn restricts the ability to transfer cash within LCHG.	3.1, 3.2 & 3.3 Capital, CIP & I&E risks are separately identified with mitigations. 3.5 System discussions to facilitate moving of cash.	3.1 - 3.5 Cash and working capital reporting to FPEC	3.1 - 3.5 Underlying Capital, I&E projections / timelines are best assessments at a point in time.	3.1 - 3.5 Ongoing review												
					CIP - Not delivering the identified required £40.1m of CIP schemes			4.1 Delivery of CIP Schemes 4.2 Medical Recruitment improvement 4.3 Medical job planning 4.4 Agency price reduction 4.5 Workforce alignment 4.6 Service Reviews process and transformational programmes of work 4.7 Budget compliance	4.1 & 4.6 Maximisation of resources to deliver CIP 4.2 Reliance on temporary staff to maintain services, at premium cost 4.3 Management within staff departments and groups to funded levels. 4.4 Maximisation of below cap framework rates 4.5 Rapid ability to on-board temporary staff to substantive contracts 4.7 Manage divisions to contain costs within budgetary envelope.	4.4 Embedding of centralised agency & bank team. 4.1 , 4.2 , 4.3 & 4.4 Workforce Groups / Delivery programmes to provide grip 4.1 & 4.6 Improvement Steering Group to provide oversight across the group 4.5 Overseas & local recruitment support fragile services and substantive staff aligned to fragile areas 4.1 & 4.7Continuous Non-Clinical Agency sign off process & Vacancy control process	4.1 - 4.6 Delivery of the planned agency reduction target, supported by substantive recruitment to vacancies 4.7 Budget compliance reported to FPAM's	4.3 Granular detailed plan for every post plans 4.2 & 4.7 Rota and job plan sign off in a timely manner	4.1 -4.5 The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group 4.1 & 4.6 The Trust CIP workstreams are reported to the Improvement Steering Group 4.1 & 4.7 The Divisional cut of the workstreams are reported to the relevant FPAM 4.7 The staff areas of key focus - Medical and Nursing are reported through their Workforce Groups 4.1 Fortnightly FRP Board assurance with Lincolnshire ICB CIP plan now fully identified and overall financial poisition for 24/25 agreed with ICB and regulator.												
3b	Drive better decisions and impactful action through insight							Provide our people with real-time data to support high quality care delivery to all clinical staff			Agreed to implement post investment evaluations into 25/26 FPC agenda.			Finance Committee									
								Continual improvement towards meeting PLACE assessment outcomes	None	N/A	PLACE Light Assessments PLACE Full assessments completed annually PLACE Steering Group monitors action plans following audits												
								Review and improve the quality and value for money of Facility services including catering and housekeeping	Review of catering services currently being undertaken		MiC4C cleaning inspections Staff and user surveys Catering project plan Cleanliness is reported through IPC Group to QGC. Water Safety and Fire Safety Fire Safety, confined spaces, working at heights, electrical safety, security management, lift safety and medical gases report to the Health & safety Committee via an upwards report.												

3c	A modern, clean and fit for purpose environment across the Group	Group Chief Estates and Facilities Officer			Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	4648 4647 5415	CQC Safe	Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes. External Specialist Advisor working jointly NHSE & ULHT providing external guidance and validation. Use of the premises assurance model PAM will help identify gaps and subsequent actions or schemes of improvements.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy. PAM Quarterly internal review and annual submission. Up to date 6 facet survey completed in 2024, high & significant being identified now on the risk register.	Funding gap when considering the full £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year	Statutory compliance and actions from AE (Authorised Engineers) reports monitored through safety groups which report into the Health & Safety Committee. Progress against Estates Strategy/Delivery Plan and IIP via sub groups upward reports. Delivery of 2024/25 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response.	Finance Committee / Integration Committee			A	A	A	A	A	A	A	A	A
								Continued progress on improving infrastructure to meet statutory Health and Safety compliance		Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Group Chief Estates and Facilities officer. Upward reporting to Finance, Performance and Estates Committee Medical gas, ventilation, Water safety group, electrical safety group, confined spaces group, Lift Safety group and Asbestos Working Group have all been established and include the relevant authorising engineers in attendance. These groups monitor and manage risks and report upwards any exceptions or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Action tracker managed by Fire Safety group which monitors progress against fire safety actions previously held under prohibition notices Health and Safety Committee upward report British Safety Council External Review 2023 -	Improvement needed in closing AE audit actions. Review of infrastructure risks currently being undertaken which will result in additional risks being placed on the Trust Risk Register which accurately reflects the quality and risks being carried by the current estate.	AE actions audits reviewed at safety groups amd weekly Estates Managers Meetings. Upwards reports now include more detail relating to progress being made to close AE audit actions. Site Estates Managers present performance data to SMT on a monthly basis. Progress relating to high risk AE actions reported through to Finance & Performance Committee. External review to be commissioned to review PPM (Planned Preventative Maintenance) to identify any gaps in statutory requirements, resource gaps and potential efficiencies in estates workforce.											
								Estates Strategy currently being refreshed	Funding gaps between overall plan of replacement vs available funding. Availability of Suppliers and Changes in market forces. Availability of raw materials and specialist components to replace/repair etc.	Business Case Development and preparation pre-empting available capital to maximise available. Use of procurement framework and liaison with NHSE to coordinate bids and larger schemes	Estates Group Upward Report											
								Refurbishment of 8 theatres, across our sites	Funding stream			Theatre strategy Group											
								Support capacity maximisation ensuring modernisation and utilisation of space, including that leased off the main acute sites			Revised Space Management Policy developed.	Revised Space Management Policy needs embedding.											
								Reduce our net carbon footprint		Trust Green Plan. CEF business case to bring investment in energy related improvements at Pilgrim			Weekly CEF Project board established to manage PSDS4 application for grant funding, grant letter issued to to Trust confirming grant application successful. Grant letter signed off by Board/CEO. Detailed designs being worked up to RIBA stage 4 by preferred partner (FP Hurley). Heat Decarbonisation Plans being developed - to be signed off and submitted to SALIX by 20th March 2025.											
								Develop Health Master Plans to better algin wards															

3d	Reduce waits for patients who require urgent care and diagnostics to constitutional standards	Group Chief Operating Officer						3x daily internal capacity meetings to improve discharge and flow and trouble shoot operational issues at the front door Weekly performance meetings within division System Urgent Care Partnership Board. Daily 4 hour performance scrutiny with divisional clinical lead. Group UEC Board established reflecting 5 Pillars of Improvement	Internal professional standards not embedded Medical and Nursing WFP not reflective of 24/7 UEC service requirements Lack of understanding at ward level re SAFER leading to poor implementation Assessment areas not substantively funded	5 Pillars / Workstreams reflecting key cross system programs of work. Progress of the above measured through the Group UEC Board Monitoring of performance at Tiering Meetings with NHSE, although these have now been stepped back to fortnightly as UEC has moved from Tier 2 to Tier 3 Rapid transfer in place across all wards to force through pace and time of day of discharge improvement 2 hourly 'huddles' with SDEC, ED and UTC to identify and ensure an active 'push pull model'. Lift and shift model across both sites for early movement from ED to SDEC Utilisaiton of CDU and Chairs embedded to decrease los in ED and shift risk load from solely ed but wider organisation response.	Improvement against 3 key metrics as agreed with NHSE and monitored via Tier 2 meetings : % of patients in Emergency Department >12 hrs (Total Time) 4 hour Type 1 performance Cat 2 Mean EMAS performance Updates full suite of metrics to ELT, TLT and Board. Updates provided to Group UEC Board and UEC System Partnership Board	Pathway 0 patients discharge is being effectively planned from the point of admission All PW1-3 capacity is used on a daily basis Escalation policy is not fit for purpose and not used to define triggers and actions form divisions and support services. Process and deployment of Full Capacity Protocol not clear and not used effectively as not aligned to Escalation Policy. Specialist teams are attending ED within 30 mins of request in line with IP standards	Monthly Group UEC Board from August 2024 through which x 5 pillars of cross LCHS/ULHT work are monitored Daily EMAS performance meetings with division and EMAS Daily feedback to division regarding delays in TTFA and plans using the 2:1:1: methodology with CL having specific discussions with EPICs re performance. NIC education and support Increased oversight of daily, weekly , monthly and ytd performance compared to previous year. Comprehensive daily rerrot is circulated with key meterics including time of day of discharge and all UEC meterics. Revised capacity meetings implemented with Solomon lead and consitency across the meetings.. Full capacity protocol is in process of being updated with increased focus on wider trust and system responses to surges in demand and activity in UEC. Opel triggers will be the national opel triggers.	Finance Committee								A	A	A	A	A
								Maximisation of capacity and efficiencies to reduce waiting times in ED Support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy and increased flow			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT New board has a suite of metrics to measure improvements and focus divisional leadership teams on discharge target actions to ensure patients are bale to return to their usual place of residence or most fitting place of care sooner		Further rollout of SAFER will be supported by 4 B6 nurses to support discharge and flow out of wards and improve "pull" from ED. New Group Discharge Board set up to pull together workstreams that focus on discharge and flow, including SAFER principles, criteria led discharge and divisional flow targets												
								Development of plans for seven day working, across all of our services			Requires scoping and costing for all support and direct care services												
3e	Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional	Group Chief Operating Officer					Cancer Standards 62 day, 14 day and 28 Day	Daily reporting of all three metrics (62 day backlog, FDS and 62 day performance) Weekly Intensive Support meetings to review all 3 metrics and position of patients on the cancer PTL Monthly cancer recovery meeting System Cancer Improvement Board Weekly ICB/Group oversight through Planned Care and Cancer catch up	Capacity v demand across all tumour site pathways not completed Insufficient oversight of system partners contribution (e.g. primary care testing and workups)	Cancer Leadership Group Deep Dive Workshops (e.g. Colorectal) Intensive Support Meetings (Trust and ICS)	Cancer board assurance and performance reports Routine Performance and pathway data provided by Sommerset system Cancer Intensive Support Meetings Cancer Intensive Support Meetings Monthly Trust Board reporting for planned care and cancer	Process information below the cancer stages are not always captured Some digital systems are not linked and not all wait information is recorded e.g. MIME system	Trajectories in place agreed with all tumour sites, to achieve a reduction in number patients >62 days, achievement FDS 75% March and reduction in patients >104 days. Tool developed to identify optimum ptl sizes for FDS/62 days for each tumour site. This allows us to identify key pressure areas and focus support	Finance Committee								A	A	A	A	A
								Achievement of FDS, 104 and 62 week performance trajectory	Capacity to deliver Faster Diagnosis (FDs) for all services		Weekly system elective and cancer recovery meetings 3x weekly cancer meetings for all T Sites led by Deputy COO, Urgent Care and Cancer and ICB Cancer lead		Due to sustained improvement, NHSE de-escalated cancer from Tiering in December 2023.												

	meet all constitutional standards						and 28 Day FDS	Maximisation of capacity and efficiencies to reduce waiting times and support discharge processes, ensuring services are provided within timeframes which are safe and responsive, enabling a reduction in length of stay/bed occupancy			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT RAPs at Tumour Site level available from March through which performance will be monitored		Focused piece of work in place to review Navigator role in terms of WF capacity and capability has been undertaken with a training program in place and supported PTLs as a result. Additional support from external ICB funded cancer specialist to further refine the PTL process and provide on the job coaching and training of the cancer team. Breast are developing a sustainability plan to be taken through CRIG in Q4 that will provide a backdrop for continuous achievement of all 3 cancer targets. Number of capacity increasing BCs have been agreed by CRIG and others dependent upon slippage. Each tumour site has worked through mitigations and impact.																
3f	Reducing unwarranted variation in planned service delivery and ensure we meet all constitutional standards	Group Chief Operating Officer		Outpatient Recovery and Improvement Group (ORIG) Productive Theatres Group (PTOG) Medical Workforce Programme	Hybrid Mail		Referral to Treatment (18week wait) Standards Diagnostic 6week (DM01)	Internal assurance process through ISG and corporate into ELT, GLT and FPEC Planned Care & Diagnostic Board	Inconsistent approach to validation Clinic slot utilisation driven by DNAs and last minute cancellations Theatre utilisation, including; 1. Preop 2. Estate utilisation 3. Late starts/early finishes 4. Day case rates 5. On the day cancellations Gaps in Job planned and delivered activity for Admitted & Non-Admitted Workforce gaps, particularly in theatres	Improvement programmes driving workstreams to address control measures. These include; 1. Outpatient letter project to reduce variation of clinic template letters, ensuring patients receive timely and accurate information 2. Hybrid mail project to digitalise and streamline Outpatient correspondence 3. Use of PIFU to reduce unnecessary follow up 4. Preop focused workstream to increase access to preop and build a prospective service 5. GIRFT workstreams focused on compliance with BADS identified day case procedures and unexpected conversion to Inpatients 6. 6-4-2 Processes in Outpatients and Theatres to ensure clinics/lists fully utilised 7. Look Back Wednesday to address unexpected changes to theatre lists impacting utilisation 8. Ongoing work to match job plans with clinic session	Performance Data Planned Care Improvement and Performance Reporting Integrated Improvement Plan Highlight and Status Reports GIRFT Reports and Model Hospital Regional Performance Packs	Escalations & issues through ISG when required Limited Diagnostic reporting/assurance	Reporting through Improvement Steering Group & FC Diagnostic reporting tools and process currently being developed	Finance Committee							A	A	A	A	A
								HVLC/GIRFT Programme - Theatre productivity and efficiency	Ability of the ULHT teams to engage in the programme Emergency pressures resulting in elective cancellations Culture mindset change takes time.	Full robust Theatre programme with focus on KPIs now meeting weekly to oversee and drive changes	Theatre dashboard has been created and reviewed by operational teams for booking & scheduling - aim for 90% 6-4-2/scheduling now in place and now has a Senior Leader attendance rota. Weekly Capacity meetings held to ensure theatre utilisation	Increased in NEL demand may impact staffing levels, elective bed capacity, and therefore could impact on elective activity. KPIs potentially impacted: OTD cancellations and actual utilisation against planned levels	Reporting through Improvement Steering Group/FPEC/HVLC												
								Maximisation of capacity and efficiencies to reduce and eliminate 78 week, 65 week waits across all specialties and moves to ambition of reducing 52 week to 700 by end of Q4 2023/2024			Trajectories for all specialties in place, weekly position statements offered to ELT and TLT Weekly planned care update meeting												

SA4 To collaborate with our primary care, ICS and external partners to implement new models of care, transform services and grow our culture of research and innovation

4a	Establish collaborative models of care with all our partners including Primary Care network Alliance (PCNA), GPs, health and social care and voluntary sector	Group Chief Integration Officer						Lead the Lincolnshire ICS and Provider Collaborative as an Anchor Institution and play an increasing leadership role within the East Midlands Acute Services Collaborative	Governance arrangements for Provider Collaborative, Integrated Care Board still in development Clarity on accountability of partners in integration/risk and gain Lincolnshire ICS anchor organisation plan not yet in place Wider regional governance to provide East Midlands oversight of population need and outcomes not yet finalised (via East Midlands Acute Provider Collaborative (EMAP)) ULHT have not embedded a culture of contributing towards population health across the whole organisation and a further understanding of health inequalities and mitigating actions.	Map key stakeholders and priorities for a partnership strategy focussing on addressing health inequalities and prevention Board and senior leadership team sessions on understanding the new ICS landscape and ULHT role within this Lincolnshire System Anchor Workshops underway to align areas of focus and develop system Anchor Plan - looking to agree priorities and exploring opportunities associated with Greater Lincolnshire devolution EMAP Governance structure now agreed, EMAP Managing Director in post and will be hosted by ULHT. ULHT engagement in 3 EMAP work programmes. EMAP MOU approved by board. Scope what a good effective partnership look like. Stakeholder mapping & engagement plan. Develop appropriate comms for the Lincolnshire ICS and our provider collaborative Agreements to support the development of the Provider Collaborative have been designed and shared. The Provider Collaborative is undertaking a stock take of services.	ULHT Green Plan Risk and Gain share (provider collaborative) Early Warning Discharge Indicators/development a common set of agreed metrics for flow and discharge across the system ICB delegation agreement ULHT Partnership Strategy EMAP governance structures/MOU	Green Pan under-delivery A better understanding of effective partnerships and what good looks like Clarity around role/accountability of partners within the Provider Collaborative Clarity around system improvement plan and provider collaborative plan and what outcomes each seeks to achieve Shared understanding and implications of the early warning discharge indicators, risk and gain share agreement within ULHT	Green Plan assurance - governance and PMO plan Part of the refreshed IIP Reporting processes Regular updates to ELT/TLT/TB on Provider Collaborative, Health Inequalities, EMAP and our ICS Evidence and intelligence gathered from Service Reviews, Business Planning, Population Health and all other aspects of work will be pulled into this strategy to support the wider considerations of partnership working and future opportunities (commercial and non-commercial) Group Clinical Franework to be included within new LCHG Organisational Strategy.	Integration Committee												
								A Joint Forward Plan (JFP) by June 2023 and continued utilisation of Joint Strategic Needs Assessment (JSNA), population health data from Optum and the health and wellbeing strategy, to influence our collective approach	JFP completed February 2024 and shared with Board	JFP triangulation with IIP Year 5	JFP completed and considered in Chief Executives Group and formally to the Board	JFP triangulation within new Group Strategy	Year 5 IIP will include JFP triangulation for Boards prior to sign to off, April 2024 New group Strategy includes triangulation to JFP.													
								Joint working with system partners, maximising care homes, virtual wards and admission avoidance schemes, such as the frailty programme	Investment Business Cases not yet in place (SDEC frailty assessment, ED Paed Hub, Community Child Nurse, Rapid Assessment and Triage (RAT), Hospital at Night, SAFER)	Business Cases being presented to CRIG in July	Business Cases Shared Performance Dashboard - frequent attenders	Business Cases in development Dashboard in development	Business Cases being presented to CRIG in July Joint work with Optum to create dashboard													
								Play an increasing leadership role within the East Midlands Acute Provider Collaborative to develop key partnerships	EMAP work programmes establishing - outcomes/deliverables not yet agreed	Programme Boards in place with monthly meetings underway Highlight reports being overseen by monthly EMAP executive meetings EMAP updates to ELT/TLT	EMAP executive meeting minutes EMAP Quarterly reports	Impact of EMAP programmes	Verbal updates at EMAP exec meetings and ULHT representation at EMAP programme groups, quarterly EMAP updates via IIP													
4b	Successful delivery of the Acute Services Review	Group Chief Integration Officer						Develop a ULHT clinical service strategy with focus on fragile services in order to provide sustainable and safe services for the future Identify the key services to focus on for Clinical Service Review (taking into account CIP, benchmarking, GIRFT and other core data)	Divisional IIPs need to be completed to ensure links into fragile services/clinical service strategy Identify resources to implement ASR outcomes	First and second cohort of specialty reviews underway and on track Programme management support being identified via Provider Collaborative to help deliver ASR phase 1 Individual work streams to be established Clinical Strategy engagement period has successfully concluded - 1st draft document has been socialised for feedback from key stakeholders. Group Strategy (to include clincial framework) with new strategic aims and objectives in final draft and will be shared with ELT on 27th February and Trust Board on 3rd March 2025	Health inequalities and core25 PLUS indicators Early Warning Discharge Indicators Rigorous engagement, both for feedback from the ASR review and further implementation	Evidence available but working on a process to bring together the information for services to aid the identification of the Top 5 areas for focus in 2022/23.	Part of the refreshed IIP Reporting processes Group Clincial framework to be incorporated into new Group Strategy from April 2025. ASR- Work continues to improve the Single Lincolnshire Stroke Service supported by the Stroke Model of Care and appropriate staffing to meet the needs of the service and the estates development at Lincoln County Hospital. The consolidated stroke service is in place at Lincoln hospital, work continues to reduce the current 18-day average length of stay (LOS) of patients to the required 10 days workign with the national CLEAR project team	Integration Committee												

4c	Grow our research and innovation through education, learning and training	Group Chief Integration Officer						Shared understanding and implications of the UHA guidance and identify relationship management of key stakeholders nationally (DH, UHA) Agree contract with UOL, R&I team to Increase the number of Clinical Academic posts	Funding for Clinical Academic posts and split with UOL to be agreed although current proposal to target substantive vacancies with high agency/bank spend has provisionally been agreed by GCMO and CFO. Short list currenlty being agreed via TSSG for discussion with UoL.	Monthly meetings with ULHT and Uni of Lincoln to discuss funding position and agree MOU. Clinical Academic Oversight Group to oversee recruitment of clinical academic model, recruitment and delivery. Group meetings being held to support discussion on performance and any adjustments to job plans Meetings with ULHT and UOL finance/contracting teams to finalise financial model and MOU based on principles of the Selby report produced early 2024. Current proposal to target substantive vacancies with high agency/bank spend has provisionally been agreed by GCMO and CFO. Short list currenlty being agreed via TSSG for discussion with UoL	Contract agreed with UOL for Clinical academic posts. UoL and ULHT have draft contracts and offer letters ready for use. Increase in numbers of Clinical Academic posts - agreed to prioritise on clinical specialities where there are workforce gaps/high agency spend to mitigate ULHT cost pressure RD&I Strategy and implementation plan agreed by Trust Board Upward reporting and approval sought through TLT/ELT/PODC	Unknown financial commitment for the Trust in relation to the clinical academic roles until the financial model is completed and recruitment commences.	Monthly meetings with ULHT and Uni of Lincoln Financial best case, most likely and worst case models reviewed by ELT and shared with Board in March 2024 to agree risk appetite Proposed model to target substantive vacancies with high agency/bank spend will mitigate costs to ULTH Exploring all opportunities across ULHT and UoL to mitigate the financial risk through additional income generation, wider socio-economic impact	People Committee (To move to: Integration Committee)			R	R	R	R	R	R	R	R	R
								The training and support environment for students and clinical academics will be in place. ULHT Library and training facilities improvements are now complete.	Lack of a model for research training and support for new clinical academics as they start to be employed No current agreement between ULHT/UoL in relation to clinical academic accommodation and resources model	Clinical Academic Model financial model and contract will include facilities and resource provision. Exploratory work underway to understand package of support e.g. via clinical rails unit, UoL and Joint Research Office	Clinical academic financial model once complete GMC training survey Stock check against checklist Internal Audit - Education Funding	Clinical Academic financial model not yet agreed	A new R&I group has been set up being led by Director of R&I/Deputy Medical Director, this will provide more oversight and rigor in developing an R&I agenda with representation from key stakeholders and clear milestones for delivery												
								Develop a joint research strategy with the UoL by September 2023, which identified shared research focus areas which is needed to meet UHA requirements	A joint MOU is in place at a Lincolnshire System level as agreed in April 2022, and the Steering Group and ELT has agreed that this should be used as the overarching MOU A draft ULHT/UOL MOU has been prepared but this has not been signed off as ideally it will need be combined with the final clinical academic model into a shared contract. Draft priorities based on initial dialogue with vice dean of the medical school has been created, further work to develop UOL strategy is being undertaken.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy. There is an existing ULHT R&I Strategy in place and a new version will be developed for 24/25 as the current one is it its final year. The Lincolnshire ICS have commenced work on a system wide R&I strategy - UHLT Director of R&I is engaged with this process. As ULHT are not currently in a position to apply for UHA status due to the lack of clinical academics employed, the shared Strategy is not required currently. However it will need to be in place ahead of a UHA application.	RD&I Strategy and implementation plan agreed by Trust Board	Clinical Academic Model is required to support shared Strategy development UoL have refreshed their Research Strategy and as at end Oct 2022 ULHT are awaiting a copy of this to then align to joint strategy between the two organisations.	Monthly meetings with ULHT and Uni of Lincoln and through ULHT Steering Group Shared Strategy is a requirement for UHA application and not Teaching Hospital Status												
								Develop a strong professional relationship with the University of Lincoln and the Medical School and jointly create a strategy with a focus on developing rural healthcare, medical/nursing/AHPs/Clinical Scientists/R&I staff education and other healthcare roles	Evidence bound by UHA requirements Clear plan/strategy on development of medical/nursing/SHPs/Clinical scientists/R&I staff education roles	A new R&I group has been set up, being led by Director of R&I/Deputy Medical Director. We continue active stakeholder management with Medical Director of ICS and UOL VC.	ULHT healthcare roles plan Increased recruitment/academic posts (across ICS)	The change to the UHA Guidance (20xClinical Academics) is a challenge. Received further feedback from UHA and need to have at least 20 clinical academics remain unchanged.	Working closely with University of Lincoln to develop plans for recruitment of Clinical Academic posts with a view to maximising existing research relationships where possible. Two potential candidates have been identified for the Clinical Academic recruitment.												
								Successfully recruit 6 Clinical Academics within the first year of agreement of the UoL/ULHT model	Agreed clinical academic financial model	A financial model for the appointment of clinical academics is in development that describes a timeline to achieve the required 6% of medical workforce for UHA status	Working group Meetings, ULHT/UOL Exec meetings and R&I meetings	The financial model is not yet agreed which is delaying appointment of clinical academic roles Identified early adopter Clinical Academic roles once model agreed	Ongoing meetings between ULHT and UoL, commissioned working group developing final proposal which will be used to inform the financial model and MOU. Update to Trust Board shared in March 2024 to agree risk appetite and next steps.												

4d	Enhanced data and digital capability	Group Chief Integration Officer				4657		EPR - Contract Award and implementation started	Contract Finalised Regional and National approval of FBC Affordability of FBC Contract Awarded Implementation Started	Digital Oversight Group EPR Programme Steering Group Capital, Revenue and Investment Group Integration Committee Engagement with regional colleagues	Delivery of FBC Agreement of funding	Regional feedback on FBC		Finance Committee / Integration Committee
								Upgrade of our technological infrastructure to support technology advancements	Insufficient cap/rev to replace aging technology Insufficient capacity to deliver purchased equipment	Technical Design Authority Digital Oversight Group Information Governance Group (for cyber / info security)	Digital Maturity Assessment		Looking to procure a Technical / Implementation Partner to provide capacity as and when required Enabling infrastructure funded via FD (EPR) rollout going to plan.	
								Enhance our organisational digital capability and skills through training	Insufficient capacity to create and deliver training materials	Digital Oversight Group			Looking to procure a Technical / Implementation Partner to provide capacity as and when required As part of EMAP DDC looking to purchase same training system as other Trusts to enable sharing of resources, reduce costs, etc.	
SA5 To embed a population health approach to improve physical and mental health outcomes, promote well-being, and reduce health inequalities across an entire population														
5a	Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS	Group Chief Nurse/Group Chief Medical Officer						Gain a greater understanding of the Lincolnshire population and support a reduction in health inequalities using our Core20PLUS dashboard			Core20PLUS dashboard		Dashboard in place for A&E and 18 weeks, plans for further expansion being overseen by Health Inequalities Working Group.	Integration Committee
5b	Co-create a personalised care approach to integrate services for our population that are accessible and responsive	Group Chief Nurse/Group Chief Medical Officer						Embed personalisation and Population Health Management across our improvement and transformation programmes Increase the number of personalisation Champions acroos the group PEG Patient Panels			Health Ineqaulities working group PEG/Patient Panels			Integration Committee

5c	Tackle system priorities and service transformation in partnership with our population and communities	Group Chief Integration Officer						Build a Partnership strategy to support improvements in safe and sustainable care, and harness benefits for the population of Lincolnshire	Partnership Strategy needs to be updated in line with new LCHG Strategy			Partnership Plan completed - will be reviewed and updated in line with new Group Strategy	Work is underway to align the plan with the new Group Strtagey and emerging work around the Alliance	Integration Committee											
5d	Transform key clinical pathways across the group resulting in improved clinical outcomes	Group Chief Integration Officer/Group Chief Medical Director	OP and UEC Improvement Programmes Speciality Support programme EMAP clinical programmes		Readiness of Primary Care to support pathway transformation			ISG EMAP Executive Meetings/Upward reports	Alliance Steering Group tba	Executive Meeting 10th February 2025 to map Steering group and Corporate support for transformation programmes	IC upward reports EMAP Executive Meeting upward reports to ELT			Integration Committee											

NHS
Lincolnshire Community and Hospitals NHS Group

Group Board Assurance Framework (BAF)

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6 May 2025*
Item Number	*12.2*

Group Board Assurance Framework (BAF)

Accountable Director	*Jayne Warner, Group Director of Corporate Affairs*
Presented by	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Wendy Booth, Interim Governance Advisor* *Karen Willey, Deputy Trust Secretary*
Recommendations/ Decision Required	*The Group Board is asked to:* • *note progress with the development of the new group BAF;* • *note plans to further refine the group BAF over the coming months with continued input from lead executives and review and challenge from the relevant board committees;* • *agree the need for any additional action or assurance at this stage*

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

Executive Summary

Background & Introduction

An effective BAF should guide the agenda setting for a board and its committees and, in turn, should be used as the framework for the board committees to report assurance and / or escalate gaps in assurance to the board in respect of delivery of the group's strategic aims & objectives.

In order to reflect the move to group and to provide a more high-level and concise view of the risks to the achievement of the group's strategic aims & objectives and, in turn, the controls, sources of assurance and any gaps, the LCHG Board had agreed in January 2025 to the introduction of a revised BAF format. It was also agreed that the BAF would be populated with a view to submission to the board committees in April 2025 and the Group Board in May 2025.

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 first iteration of the BAF in the agreed new format.

BAF entries have been populated with reference to the previous LCHG BAF and with input from relevant executive directors. Some entries are more developed than others recognising the early stage of the process and some but not all entries have been reviewed by the relevant board committees, as follows:

- The initial BAF entry for Strategic Objective *1a: Improve patient safety, patient experience and deliver clinically effective care* was reviewed by the Quality Committee during April 2025. From that discussion, it became clear that there was a need to have separate entries, risk scores and assurance ratings for the three elements – *Improve patient safety, Improve patient experience and Deliver clinically effective care* – covered within Strategic Objective 1a, not least to ensure sufficient detail and, in turn assurance, is captured within the BAF. Separate entries have now been drafted for review and challenge by the Quality Committee at its next meeting.

- The following BAF entries were reviewed by the Finance & Performance Committee during April 2025:

    - *Strategic Objective 1b: 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*

- *Strategic Objective 1c: 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*

- *Strategic Objective 1d: 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*

Whilst no significant changes were highlighted by the Finance & Performance Committee, it was agreed that details of relevant internal audits should be added to the assurances sections of the BAF. Where available, this information has been added. Further detail will be added to future iterations of the BAF.

- Whilst the BAF entries in respect of the strategic objectives under the 'People' aim have not yet been formally discussed at the People Committee, the BAF entries have been shared with the NED chair and NED members of the committee in advance of the Group Board meeting.

- The BAF entries in respect of the strategic objectives under the 'Population' aim have yet to be shared with the NED chair and NED members and discussed by the Integration Committee. It should also be noted that a risk score and assurance rating for Strategic Objective 3c: Enhance our digital, research and innovation capability has yet to be agreed*.

- The BAF, in development form, was shared with the Audit & Risk Committee during April 2025. The Audit & Risk Committee was satisfied with progress to date and it was agreed that the BAF would continue to be reviewed at the committee's quarterly meetings. The BAF has also been shared with the Internal & External Auditors.

Group Board Action Required

The Group Board is asked to:

- note progress with the development of the new group BAF;

- note plans to further refine the BAF over the coming months (including the addition of clear timescales and leads for all agreed actions) with continued input from lead executives and review and challenge from the relevant board committees;

- agree the need for any additional actions or assurances at this stage.

Lincolnshire Community & Hospitals NHS Group (LCHG)

Group Board Assurance Framework (BAF)

As at April 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** **Very low**	**2** **Low**	**3** **Medium**	**4** **High**	**5** **Very high**
Harm (physical or psychological)	Low level of harm affecting one or more patients, staff or visitors within a single location	Low level of harm affecting one or more patients, staff or visitors within a single business unit	Significant long-term or permanent harm affecting one or more patients, staff or visitors within a single business unit	Significant long-term or permanent harm affecting multiple patients, staff or visitors within one or more business units	Significant long-term or permanent harm affecting a large number of patients, staff or visitors
Service disruption	Manageable, temporary disruption to peripheral aspects of service provision affecting one or more services	Noticeable, temporary disruption to essential aspects of service provision reducing the efficiency & effectiveness of one or more services	Temporary, unplanned service closure affecting one or more services or significant disruption to efficiency & effectiveness across multiple services	Extended, unplanned service closure affecting one or more services; prolonged disruption to services across multiple business units / sites	Indefinite, unplanned general hospital or site closure
Compliance & reputation	Limited impact on public, commissioner or regulator confidence e.g.: Small number of individual complaints / concerns received	Noticeable, short term reduction in public, commissioner and / or regulator confidence e.g.: Recommendations for improvement for one or more services; concerns expressed in local / social media; multiple complaints received	Significant, short term reduction in public, commissioner and / or regulator confidence e.g.: Improvement / warning notice for one or more services; independent review; adverse local / social media coverage; multiple serious complaints received	Significant, long-term reduction in public, commissioner and / or regulator confidence. e.g.: Special Measures; prohibition notice for one or more services; prosecution; sustained adverse national / social media coverage	Fundamental loss of public, commissioner and / or regulator confidence. e.g.: Suspension of CQC Registration; Parliamentary intervention; vitriolic national / social media coverage
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 core & descriptor (with examples)				
1 Extremely Unlikely	2 Quite Unlikely	3 Reasonably Likely	4 Quite Likely	5 Extremely Likely
Unlikely to happen except in very rare circumstances Less than 1 chance in 1,000 (<0.1% probability) No gaps in control. Well managed	Unlikely to happen except in specific circumstances Between 1 chance in 1,000 & 1 in 100 (o.1 – 1% probability) Some gaps in control; no substantial threats identified	Likely to happen in a relatively small number of circumstances Between 1 chance in 100 & 1 in 10 (1 – 10% probability) Evidence of potential threats with some gaps in control	Likely to happen in many but not the majority of circumstances Between 1 chance in 10 &1 in 2 (10 – 50% probability) Evidence of substantial threats with some gaps in control	More likely to happen than not Greater than 1 chance in 2 (>50% probability) Evidence of substantial threats with significant gaps in control

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 – 10)	High (12 – 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 1 April 2025

Strategic Aim	Strategic Objective	Strategic Risk	Executive Lead(s)	Board Committee Oversight	Current Risk Score (as at April 2025)	Target Risk Score (March 2026)	Assurance Rating (as at April 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	**12 (High)**	**8 (Moderate)**	**Amber**	**Green**
	1b (ii): Reduce waiting times for our patients **(Planned Care)**				**12 (High)**	**8 (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 (High)**	**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)**	**12 (High)**	**Red**	**Amber**

People: Better Opportunities – Develop, empower and retain great people	2a: Enable our people to fulfil their potential through training, development and education	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable harm, less efficient services and the inability to attract and retain staff	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Amber**	**Green**
	2b: Empower our people to continuously improve and innovate	If we do not **empower our people to continuously improve and innovate** they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Amber**	**Green**
	2c: Nurture compassionate and diverse leadership	If we do no **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Amber**	**Green**
	2d: Recognising our people through thanks and celebration	If we do not continue to **recognise our people through thanks and celebration** then we will be unable to attract and retain staff of the required caliber and experience resulting in services becoming unsustainable / fragile	Group Chief People Officer	People Committee	**6 (Low)**	**3 (Very Low)**	**Amber**	**Green**
Population: Better Health – Improve population health	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience	Group Chief Integration Officer	Integration Committee	**12 (High)**	**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	**TBC**	**TBC**	**TBC**	**TBC**
	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 (High)**	**8 (Moderate)**	**Amber**	**Green**

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (i): **Improve patient safety**, patient experience and deliver clinically effective care
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

8 (Moderate)

⇔

Last Review Date:	March 2025
Lead Executive:	Group Chief Nurse / Group Chief Medical Officer
Committee Oversight:	Quality Committee
Risk Appetite:	Minimal

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	2	8 (Moderate)	Amber
Target	Mar-26	3	1	3 (Very Low)	Green

Assurance Rating & Movement since last review:

Amber

⇔

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate											

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											

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
6	Improvement plans in place to address identified risks e.g. management & use of medical devices, medicines safety, wound care management, effective practice & harm free care
7	Ward / service accreditation process in place
8	IPC team and governance framework in place across the group
9	Safeguarding team and governance framework in place across the group

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Quality & safety priorities and KPIs being refreshed
2	Safety culture not yet fully embedded across all areas of the group
3	Inconsistency of some policies, procedures & guidelines across the group
4	'Just Culture principles not yet fully embedded across all areas of the group
5	Children & Young People Oversight Group to revert to reporting to Quality Committee for continued oversight of improvements within paediatric services
6	• Medicines safety across the group remains a risk although oversight is improving • There has been an increase in category 3 & 4 pressure ulcers in community services
7	Ward / service accreditation programme not fully embedded in community
8	NHSE and other external reviews of the group's IPC arrangements have identified gaps
9	Low uptake of mandatory safeguarding training by operational teams

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of quality & safety agenda and key risks by the Quality Committee and reporting sub-groups (e.g. Patient Safety Group, Maternity & Neonatal Oversight Group, Safeguarding & Vulnerabilities Group), with escalation to the Group Board as required
2	Reporting on quality & safety KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	QIAs reviewed by care groups and executives with Quality Committee oversight
4	Learning from incidents reported to the Patient Safety Group and disseminated across the group
5	Incident themes & trends monitored through the Patient Safety Group
6	Delivery of quality & safety KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
7	Local level and Group Board Maternity & Neonatal Safety Champions in place with reporting to the Group Board
8	Internal & external audit, external reviews and visits provide independent assurance of the robustness of the group's quality governance arrangements
9	Internal audit review of ULTH's management of medical devices undertaken during 2024 / 25 has provided 'reasonable assurance'

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	QIAs not universally used across the group
4	The occurrence of repeated or same type incidents suggested processes for learning lessons are not yet fully embedded across the group
5	None identified
6	None identified
7	None identified
8	None identified
9	Group level Medical Devices Group being established

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Engagement Plan for further embedding the safety culture to be agreed	Group Chief Clinical Governance Officer	Deputy Chief Clinical Governance Officer	30 September 2025	Not yet started
2	Just Culture action plan covering engagement, training and new processes in place and ongoing	Group Chief Clinical Governance Officer / Group Chief People Officer	TBC	TBC	Underway
3	Aligned policy agreed on the development of policies, procedures & guidelines. Improvement trajectories to be agreed for bringing all out of date documents into compliance	Group Director of Corporate Affairs	Deputy Trust Secretary	TBC	TBC
4	Weekly pressure ulcer assurance meetings being held with the community nursing teams with safeguarding support. Improvement Trajectory agreed (10% reduction by the end of December 2025)	Group Chief Nurse	Deputy Chief Nurse	31 December 2025	Underway
5	Full review of pharmacy and medicines management to be undertaken across the group / system (key priority for incoming Chief Pharmacist)	Group Chief Medical Officer	Chief Pharmacist	30 September 2025	Not yet started
6	Ward / service accreditation programme to be fully established in community	Group Chief Nurse	Deputy Chief Nurse	31 March 2026	Underway
7	Response to findings from NHSE inspection and other reviews of the group's infection control arrangements to be developed and implemented.	Group Chief Nurse	Deputy Chief Nurse	31 March 2026	Underway

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Underway
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Underway – some slippage in finalising and approval of the PMAF and IPR but aligned PRMs in place
3	Group level Medical Devices Group to be established reporting to the Patient Safety Group	Group Chief Medical Officer	TBC	TBC	Underway
4	Review of learning lessons mechanisms to be undertaken and a plan developed for a programme of learning lessons mechanisms across the group	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	31 December 2025 (plan)	Not yet started
5	Group QIA process to be embedded across the group underpinned by a training plan	Group Clinical Governance Officer	Head of PMO	30 September 2025	Underway

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

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 (ii): **Improve** patient safety, **patient experience** and deliver clinically effective care
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

9 (Moderate)

Last Review Date:	March 2025
Lead Executive:	Group Chief Nurse / Group Chief Medical Officer
Committee Oversight:	Quality Committee
Risk Appetite:	Minimal

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	3	3	9 (Moderate)	Amber
Target	Mar-26	2	2	4 (Low)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26

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

Identified Controls *(What are we already doing to manage the risk?)*	
1	Quality & safety and patient experience priorities and KPIs agreed
2	Patient Experience & Involvement Team in place
3	Established complaints & PALS teams
4	Group Complaints & PALS Policy agreed
5	Improvement Plans developed in response to national patient experience surveys
6	PLACE reviews completed and improvement plans developed

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Quality & safety and patient experience priorities and KPIs being refreshed
2	• Group approach to Patient Panels agreed and being implemented • There are currently workforce gaps in the Patient Experience Team
3	None identified
4	None identified
5	Lack of staff engagement has the potential to lead to a lack of timely implementation of improvement plans
6	PLACE improvement plan not yet delivered

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of patient experience and key risks by the Quality Committee and its reporting sub-group: the Patient Experience & Involvement Group, with escalation to the Group Board as required
2	Reporting on quality & safety and patient experience KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	Patient Stores are heard at the Group Board
4	Patient Experience data is gathered and improvements tracked through the Patient Experience & Involvement Group
5	Delivery of patient experience KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
6	Internal & external audit, patient surveys, PLACE reviews etc. provide independent assurance on the quality of the patient experience

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	None identified
4	Triangulation of patient experience data with other sources of information e.g. complaints, PALS etc. requires strengthening
5	None identified
6	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Agree patient experience metrics / KPIs that reflect the group priorities with oversight through the Patient Experience & Involvement Group to periodically assess that agreed actions are achieving the intended benefits and priorities	Group Chief Nurse	Head of Patient Experience	30 September 2025	Underway
2	Group approach to Patient Panels to be implemented from April 2025	Group Chief Nurse	Head of Patient Experience	1 April 2025	In Place
3	Ensure action plans from national patient experience surveys are SMART and translated to local action and establish a robust process / protocols for disseminating data to frontline teams	Group Chief Nurse	Head of Patient Experience	31 December 2025	Underway
4	Define and enforce timeframes for implementation of improvements identified during PLACE assessments	Group Chief Nurse	Head of Patient Experience	31 March 2026	Underway

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Underway – on track
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Underway – some slippage in finalising and approval of the PMAF and IPR but aligned PRMs in place

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (iii): Improve patient safety, patient experience and **deliver clinically effective care**
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

8 (Moderate)

Last Review Date:	March 2025
Lead Executive:	Group Chief Nurse / Group Chief Medical Officer
Committee Oversight:	Quality Committee
Risk Appetite:	Minimal

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	2	8 (Moderate)	Amber
Target	Mar-26	3	1	3 (Very Low)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26

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

Identified Controls *(What are we already doing to manage the risk?)*	
1	Quality & safety and clinical effectiveness priorities and KPIs agreed
2	Established clinical audit team in place and clinical audit plan agreed
3	NICE Policy and process in place
4	Medical Examiner in post and learning from deaths process well established
5	Mortality review process in place and well established

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Quality & safety and clinical effectiveness KPIs being refreshed
2	Some specialty clinical audit / governance groups require strengthening
3	None identified
4	None identified
5	None identified

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of clinical effectiveness and key risks by the Quality Committee and its reporting sub-group: the Clinical Effectiveness Group, with escalation to the Group Board as required
2	Reporting on quality & safety and clinical effectiveness KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	Learning from deaths reported to the Clinical Effectiveness Group and disseminated across the group
4	There is oversight of delivery of the clinical audit programme through the Clinical Effectiveness Group with reporting to the Quality Committee as required
5	There is oversight of compliance with NICE guidance through the Clinical Effectiveness Group with escalation to the Quality Committee as required
6	Delivery of clinical effectiveness KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
7	Internal & external audit, external reviews and visits provide independent assurance

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	None identified
4	'Outlier' status has been received for some of the National audit projects
5	None identified
6	None identified
7	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	TBC				
2					
3					
4					

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Underway – on track
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Underway – some slippage in finalising and approval of the PMAF and IPR but aligned PRMs in place

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

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:

12 (High)

Last Review Date:	March 2025
Lead Executive:	Group Chief Operating Officer / Group Chief Integration Officer
Committee Oversight:	Finance & Performance Committee
Risk Appetite:	Open / Cautious

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	3	12 (High)	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
	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											

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 in place
8	45 Ambulance handover protocol agreed and enacted

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 requires improvement
3	Redesigned EPIC/NIC roles need support and embedding
4	Assessment area capacity not substantially funded
5	SDEC on both sites not large enough
6	Confusion regarding 'send' to assessment areas still exists
7	Not all specialty teams attend ED within 30 minutes of request in line with IP standards
8	None identified

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	OPEL triggers regularly used and activated
2	ED activity, flow and LoS regularly reviewed by site teams and issues escalated through the daily capacity meetings
3	Improvement trajectories in respect of ED performance and expectations agreed for all specialties
4	Suite of metrics in place to measure improvements and focus Care Group leadership teams on discharge target
5	ED performance monitored through the Unplanned Care Group and System Unplanned Care Partnership Board
6	Delivery of ED performance and improvements reviewed through the Care Group PRMs
7	Reporting on ED performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board as required
8	Sustained improvements seen across the UEC pathway: standard currently being delivered

Gaps in Assurance	
1	None identified
2	
3	
4	
5	
6	
7	
8	

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Work is ongoing internally to increase SDEC / assessment centres utilisation	Group Chief Operating Officer	Group Deputy Chief Operating Officer	TBC	Underway
2	Work is ongoing to address 'send' and IPR	Group Chief Operating Officer	Group Deputy Medical Director	TBC	Underway
3	Discharge task force being refreshed	Group Chief Operating Officer	Group Deputy Chief Nurse	TBC	Underway
4	Escalation Policy & Full Capacity Protocol to be reviewed and aligned	Group Chief Operating Officer	Group Deputy Chief Operating Officer	TBC	TBC

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:

12 (High)

Last Review Date:	March 2025
Lead Executive:	Group Chief Operating Officer / Group Chief Integration Officer
Committee Oversight:	Finance & Performance Committee
Risk Appetite:	Open / Cautious

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	3	12 (High)	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
	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											

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 utilisation
4	Booking Centre 'protocol' being developed
5	Planned Care Group established to driver delivery of agreed planned care performance & improvements
6	Forecast performance in place and used to monitor delivery
7	List brokering commenced
8	

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Lack of standardised and centralised scheduling and booking
2	Inconsistent approach to validation
3	Opportunities exist to maximise theatre productivity & utilisation - theatre timetable not refreshed
4	Gaps in job planned and delivered activity for admitted and non-admitted
5	Workforce gaps
6	Time to first appointment delivery is high risk for 2025 / 26
7	Delivery of cancer 62 day performance remains a risk
8	There is no shadow booking process in place

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	RTT and cancer improvement trajectories agreed for all specialties
2	Theatre dashboard in place and monitored through the Planned Care Group
3	RTT & cancer performance monitored through the Planned Care Group
4	Delivery of RTT and cancer performance and improvements reviewed through the Care Group PRMs
5	Reporting on RTT and cancer performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board, as required
6	Improved performance: sustained backlog reduction
7	Internal audit review of RTT pathways within ULTH during 2025 / 26 provided 'reasonable assurance)
8	

Gaps in Assurance	
1	IPR is not comprehensive
2	Reports to committee and ELT require improvement
3	
4	
5	
6	
7	
8	

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Maximise theatres & out-patient improvements (scheduling / booking / cancellations) including introduction of Booking Centre	Group Chief Operating Officer	TBC	TBC	Underway

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Diagnostic reporting tools in development	Group Chief Operating Officer	TBC	TBC	TBC
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Underway – some slippage in finalising and approval of the PMAF and IPR but aligned PRMs in place

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	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 (High)

Last Review Date:	March 2025
Lead Executive:	Group Chief Financial Officer
Committee Oversight:	Finance & Performance Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	3	12 (High)	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
	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											

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
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
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

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Current financial policies are up to date but some have yet to be aligned across the group
2	Financial literacy of the organization not fully developed
3	Finance Strategy for the group to be agreed
4	Forward assurance on efficiency delivery and activity position being developed
5	The delivery of workforce / headcount reduction, adherence to workforce controls (e.g. bank and agency spend) and activity levels are key risks.
6	Business Case development, review and approval process not yet fully harmonised
7	
8	

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of finance and key risks by the Finance & Performance Committee and reporting sub-groups with escalation to the Group Board as required
2	Reporting on finance KPIs to the Finance & Performance Committee and Group Board through the Integrated Performance Report (IPR)
3	Internal & external audit arrangements in place
4	Internal audit review of performance management and data quality within ULTH during 2025 / 26 provided 'reasonable assurance'
5	Assessment of 'grip and control' undertaken by external parties including through ICB and regulator challenge

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	Internal audit arrangements have been aligned across the group but work remains ongoing to develop a single report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability
4	Internal audit review of overseas and contracts within ULTH provided 'limited assurance'
5	

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Harmonise the remaining financial policies across the group	Group Chief Financial Officer	TBC	31 December 2025	Underway – on track
2	Review, harmonise and strengthen the financial training offer and culture	Group Chief Financial Officer	TBC	30 June 2025	Underway – on track. First Finance roadshow training event held in February 2025. Budget holder refresher training held in February & March 2025
3	Agree the Group Finance Strategy	Group Chief Financial Officer	TBC	30 June 2025	Underway – on track
4	Approve & implement the Group Performance Management & Accountability Framework (PMAF)	Group Chief Integration Officer	TBC	30 June 2025	Underway – PMAF drafted
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		31 July 2025	Underway

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Underway – on track
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance &	30 June 2025	Underway – some slippage in finalising and

			Information		approval of the PMAF and IPR but aligned PRMs in place
3	Complete the work to develop a single internal audit report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability	Group Chief Financial Officer	Head of Internal Audit	31 August 2025	Underway – on track

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1d: Provide modern, clean and fit for purpose care settings
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

20 (Very High)

⇔

Last Review Date:	March 2025
Lead Executive:	Group Director of Estates & Facilities
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	4	3	12 (High)	Amber

Assurance Rating & Movement since last review:

Red

⇔

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Very High											

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											

	Identified Controls *(What are we already doing to manage the risk?)*
1	Estates & Facilities Management (EFM) leadership & professional structures in place (including Authorising Engineers (AEs), Authorised Persons (APs) and Competent Persons (CPs). The Director of Estates & Facilities is the 'Designated Person' for EFM for the group and this is now a board role
2	EFM governance structure and safety groups in place reflecting Health Technical Memorandums (HTMs), Health & Safety legislation and other statutory requirements
3	Estates Strategy, Green Plans and EFM Transformation & Improvement Plans in place
4	EFM policies, processes, work plans and risk assessments in place covering HTMs, Health & Safety legislation and other statutory requirements
5	Six-facet survey completed for ULTH in 2024: good level of understanding of the estates statutory compliance and critical infrastructure risks with clear ELT, Finance & Performance Committee and Group Board 'line of sight'
6	Decisions on EFM investment from the group's capital allocation are risk-based and prioritised based on the results from the six-facet survey and affordability
7	Alternative sources of capital continue to be explored wherever possible

	Gaps in Controls *(What are the gaps in control that are required to manage the risk)*
1	There is currently a lack of EFM capacity due to the limited EFM resource within LCHS (and termination of the shared service agreement with LPFT and support from NHSPS) and some senior leadership and professional roles currently remain unfilled including AEs for LCHS. Work remains ongoing to bring together the Fire Safety, Health & Safety and Emergency Planning & Business Continuity Teams
2	A review of the EFM governance structure is underway to ensure alignment with the wider group governance arrangements. Safety groups are being expanded to cover the LCHS estate
3	Estates Strategy and Green Plans not yet aligned for group
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 £180m remains a significant risk. The lack of space and the need to decompress the acute site also remains a key area of focus
7	Inability to address critical infrastructure risks with limited capital

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Increased levels of compliance with EFM statutory compliance requirements as demonstrated through internal audits, external condition surveys, AE audits etc.
2	External / independent review processes in place including AE annual audits and quarterly reviews across all HTMs (ULTH) with monitoring of improvement actions through the EFM Cabinet and reporting to the Finance & Performance Committee in the monthly EFM report
3	Premises Assurance Model (PAM) utilised annually to evaluate the effectiveness of premises performance against a set of common domains / SAQs with assurance and / or key risks reported to the Finance & Performance Committee and the Group Board. Comparison of the 2023/23 & 2023/24 PAM evaluation submissions for ULTH show a year on year on year improvement in compliance across most domains
4	Benchmarking of EFM performance is undertaken against local & national indicators and reported through the governance structure
5	Patient Led Assessment of the Care Environment (PLACE) assessments are undertaken with good levels of compliance in the areas assessed: privacy & dignity, cleanliness, food and general building maintenance and reporting to the Patient Experience & Involvement Group and Quality Committee
6	Oversight of EFM statutory compliance and key risks by the Finance & Performance Committee and relevant sub-groups (e.g. Health & Safety Committee, Infection Prevention & Control Committee, Water Safety Group) with escalation to the Group Board as required
7	Internal audit review of EFM areas provides independent assurance and / or escalation of risks. Internal audit review of the business continuity and emergency planning arrangements within ULTH during 2024 / 2025 provided 'reasonable assurance'

Gaps in Assurance	
1	EFM compliance dashboards not yet fully aligned
2	LCHS: AE audit programme for relevant HTMs not yet in place for LCHS premises ULTH: Further AE audit on fire planned at ULTH to ascertain the level of improvement since the previous audit and the delivery of the improvement actions by the Fire Safety Team
3	• Comparison of the 2022/23 & 2023/24 PAM evaluation submissions for LCHS show a deterioration in compliance across the majority of domains although with good levels of compliance in the patient experience domain. The requirement for risk assessed, costed action plans for SAQs rated 'inadequate' or requiring 'moderate or minor improvements' was rated 'Inadequate' across all domains • Areas for focus from the PAM evaluation for both trusts, albeit to differing degrees, include policies, procedures & availability of documentation, risk assessment, maintenance, training & development and resilience, emergency & business continuity • The PAM evaluation process is not yet fully aligned across the group • There is no clear process for monitoring PAM improvement actions through the year
4	Reliability of LCHS Estates Returns Information Collection (ERIC) scores to be evaluated
5	Shortfalls in housekeeping staffing levels, due to difficulties in recruiting, have the potential to impact on PLACE scores
6	There is a need for further clarity on the elements of the EFM agenda to be reported to the Integration Committee
7	Internal audit review of planned and preventative estates maintenance within ULTH during 2024 /25 provided 'limited assurance'

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Appoint to directorate critical / professional roles as a priority and in line with vacancy controls process	Group Director of Estates & Facilities	TBC	Ongoing	Underway
2	Recruit to the AE roles for LCHS during Q1 2025/26	Group Director of Estates & Facilities	TBC	30 June 2025	Underway
3	Transfer preventative and reactive maintenance for LCHS from NHSPS to the ULTH EFM team from 1 April 2025	Group Director of Estates & Facilities	TBC	1 April 2025	Complete
4	Undertake a planned preventative maintenance (PPM) and asset register review across the group – to include the findings and response to the 2024 / 25 internal audit	Group Director of Estates & Facilities	TBC	1 April 2026	Brief & scope work currently being developed (Estimated cost: c£150k)
5	Complete the work to bring together the Fire Safety, Health & Safety and Emergency Planning & Business Continuity Teams	Group Director of Estates & Facilities	TBC	TBC	TBC

6	Complete the review of EFM governance structure and associated assurance processes	Group Director of Estates & Facilities	TBC	30 September 2025	Underway
7	Once the EFM risks in respect of LCHS are clear following the AE audits, service mapping exercise, PAM, review of leases and licences etc, complete the work to align the Estates Strategy & Green Plans. Transformation & Improvement Plans for 2025/26 already in development	Group Director of Estates & Facilities	TBC	2 September 2025	Underway
8	Complete the work to align the EFM policies & procedures across the group	Group Director of Estates & Facilities	TBC	31 December 2025	Underway
9	Undertake an estates rationlisation review with a focus on decompressing the acute site and agile working	Group Director of Estates & Facilities	TBC	30 June 2025	External support to undertake the review being sourced at an estimated cost of £22.5k. Work to be progressed during 2025/26
10	Align and update the group business continuity plans to reflect the group infrastructure risks and challenges	Group Director of Estates & Facilities	TBC	TBC	TBC
11	Continue to explore alternative sources of capital funding	Group Director of Estates & Facilities	TBC	Ongoing	Ongoing

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		**Executive Lead**	**Operational Lead**	**Due Date**	**Progress**
1	Align the EFM compliance dashboards across the group as part of the review and strengthening of the EFM governance arrangements	Group Director of Estates & Facilities	TBC	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 Director of Estates & Facilities	TBC	TBC	TBC
3	Undertake AE fire audit at ULTH	Group Director of Estates & Facilities	TBC	TBC	TBC
4	Align the process for the completion and submission of the PAM and strengthen the process for the delivery and oversight of agreed improvement actions	Group Director of Estates & Facilities	TBC	31 July 2025	Underway
5	As part of the review of the board committee terms of reference and work plans, ensure there is greater clarity on the elements of the EFM agenda for which the Finance & Performance Committee has oversight and which come under the remit of the Integration Committee	Group Director of Estates & Facilities	Group Director of Corporate Affairs	6 May 2025	Board Committee Work Plans & Assurance Plan provide clarity

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2a: Enable our people to fulfil their potential through training, development and education
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable harm, less efficient services and the inability to attract and retain staff

Current Risk Score & Movement since last review:

Moderate (9)

Last Review Date:	March 2025
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	3	3	Moderate (9)	Amber
Target	Mar-26	3	2	Low (6)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate											

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											

Identified Controls *(What are we already doing to manage the risk?)*	
1	Education, Learning & Organisational Development Team working with Care Groups to improve statutory and mandatory training compliance to 90% by 31 March 2026, with a focus on areas where compliance is <50%
2	Education, Learning & Organisational Development Team working with Care Groups to ensure that staff have the correct training and support available to fulfil their roles as leaders through upskilling, strengthening and awareness of responsibilities through active engagement with leadership and development training
3	Further opportunities being developed for improving productivity and integration through a 'grow our own' approach and use of apprenticeship levy being maximised
4	Education Oversight Group in place
5	Processes in place for holding Care Groups/Corporate Directors to account for the delivery of people KPIs and improvements to support ownership at local level
6	Lincolnshire (system) People Plan in place. Continued focus on ensuring that the People Promise themes are embedded across the group in line with the wider Lincolnshire System People Plan objectives

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Divisional/Clinical Care Group Leadership Teams awareness of areas of non-compliance to support local improvement interventions
2	Divisional/Clinical Care Group uptake of leadership and development training
3	Limited oversight of apprenticeship levy use at Clinical Care Group level
4	There is no Education Oversight Group KPI dashboard in place and assurance that Education Oversight Group agenda is in line with assurance required within People Committee, and that KPI Dashboard is in place to monitor progress against key deliverables
5	FPAM monthly reports are not aligned to the refreshed PRM packs. Divisional Leadership Teams not able to / unclear on how to access the standard reports to support oversight
6	None identified

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of the people agenda and key risks by the People Committee and reporting sub-groups with escalation to the group board as required
2	Reporting on People KPIs to the People Committee and Group Board through the Integrated Performance Report (IPR). Mandatory training compliance continues to improve
3	Reporting on medical and non-medical education and medical revalidation to the People Committee
4	Reporting on safer staffing (including training and knowledge gaps) to the People Committee
5	Monthly FPAM and PRM meetings take place which review KPIs against targets, and this is reported at overall Trust level at People Committee within the scorecard
6	Internal audit review of the people agenda provides independent assurance and / or escalation of risks. Internal audit review of mandatory training within ULTH undertaken during 2024 / 25 provided 'reasonable assurance'
7	National and regional benchmarking data considered through the People Committee and reporting sub-groups
8	External oversight and assurance in respect of people performance is undertaken through the Lincolnshire People Board/Workforce Committee

Gaps in Assurance	
1	Sub-Groups ensuring that agenda items and upward reports are in line with People Committee annual plan
2	IPR metrics currently being confirmed – have been reviewed within People Directorate and shared, with alignment across LCHS and ULTH in line with Workforce Plans for 2025/26.
3	TBC
4	TBC
5	Alignment to PRM Packs required to ensure consistency of data and reporting by exception
6	Limited oversight of group-wide audit schedule where there is an impact on people. Audit of LCHS areas unclear
7	Oversight of benchmarking data needs to be considered and consistent across all sub-groups – currently in place in line with agenda items and discussion points within Workforce Strategy Group
8	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	People Systems Team are undertaking a review of ESR hierarchy structures to ensure reporting lines are validated / accurate to support leaders to access statutory / mandatory training and appraisal compliance, and support accurate recording of appraisals. Additionally, monitoring of workforce metrics / compliance rates through monthly performance meetings such as FPAM and PRM	Group Chief People Officer	Head of Workforce Planning & Reporting / People Systems Manager	30 June 2025	Underway – on track
2	Monitoring uptake of leadership and development training through monthly performance meetings such as FPAM, with a focus on further supporting the areas with the least uptake to release staff to be able to attend and the identification of trends and any correlation between HR / ER cases, sickness and turnover	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track
3	Development of Education Oversight Group KPI Dashboard which reports monthly into the Education Oversight Group and upwardly into People Committee to ensure that there is oversight of apprenticeship levy use across the Group and our position against the public sector target	Group Chief People Officer	Education & Learning Managers	May 2025	Underway – on track
4	Standardised upward report from Education Oversight Group into People Committee in place, and the current development of Education Oversight Group KPI Dashboard is ongoing	Group Chief People Officer	Education & Learning Managers	31 May 2025	Underway – on track
5	Review of FPAM Packs within the acute Trust (People Section) underway to bring in line with PRM format and report by exception. This will include updated training for Divisional Head of HR and Leadership Teams on how to access core People KPI Reports to maintain regular oversight	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	Underway – on track
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

	Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*	Executive Lead	Operational Lead	Due Date	Progress
1	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee workplan and ensuring that each sub-group is aware of its reporting objectives in year.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	Underway – on track
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025/26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief People Officer	Group Deputy Director of People / Head of Workforce Planning & Reporting	30 June 2025	Underway – on track
3	Regular report into Workforce Strategy Group and upward report into People Committee – to be reviewed and refreshed in line with 2025/26 objectives (as required)	Group Chief Medical Officer / Group Chief People Officer	Business Manager to the Group Chief Medical Officer / Head of Workforce Planning & Reporting	30 September 2025	Not yet started
4	Regular report into Workforce Strategy Group and upward report into People Committee – to be reviewed and refreshed in line with 2025/26 objectives (as required)	Group Chief Nurse / Group Chief People Officer	Assistant Director of Nursing / Head of Workforce Planning & Reporting	30 September 2025	Not yet started
5	Review of standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms	Group Chief People Officer	Group Deputy Director of People / Head of Workforce Planning & Reporting	30 September 2025	Not yet started
6	Audit schedule to be requested and shared with key plan in place to manage audit cycles which impact People (close working between Corporate Governance and People Directorate required to deliver)	Group Chief People Officer	Head of Workforce Planning & Reporting	31 May 2025	Not yet started
7	All sub-groups to incorporate benchmarking (using as a minimum Model Hospital data) as regular agenda items in 2025/26	Group Chief People Officer	Group Deputy Director of People	30 June 2025	Not yet started
8	Develop and embed standard reporting mechanisms into Lincolnshire People Board / Workforce Committee	Group Chief People Officer	Deputy Group Chief People Officer	30 September 2025	TBC

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:	2b: Empower our people to continuously improve and innovate
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **empower our people to continuously improve and innovate** they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience

Current Risk Score & Movement since last review:

Moderate (9)

Last Review Date:	March 2025
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	3	3	Moderate (9)	Amber
Target	Mar-26	3	2	Low (6)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate											

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											

Identified Controls *(What are we already doing to manage the risk?)*	
1	Education, learning and development programmes and KPIs in place
2	Engagement 'Tube Map' – 'Better Together' Programme in place and ongoing including OD support
3	Improved job planning compliance rate to 95% with supporting evidence in place, and a move towards a prospective cycle.
4	Improved Medical & Dental middle tier vacancy rate with a focus on stabilisation and succession planning through fully embedding a revised 'Plan for Every Post' process
5	Quality Improvement (QI) strategy/Quality Management System (QMS) being developed as a key enabler to support innovation/delivery of the group improvement/transformation agenda
6	Creating a culture of research and innovation recognised as a group priority

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Delivery of action plans and improvements at operational level needs to be incorporated into the Performance Management & Accountability and PRM process
2	Staff awareness at all levels of group strategy, values and approach to innovation and continuous improvement remains ongoing
3	2023 / 24 and 2024 / 25 job plans are still being finalised although significant improvements have been made
4	Division/Clinical Care Groups not yet fully owning the 'Plan for Every Post' process
5	Capacity of staff to engage with improvement agenda to be determined
6	Culture of research and innovation not yet embedded

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Upward Reporting: Pulse Survey and NHS Staff Survey results are reported to the Executive Leadership Team, People Committee and Group Board and action plans are monitored through the People Committee with escalation to the Group Board as required.
2	
3	Oversight of the people agenda and key risks by the People Committee and reporting sub-groups with escalation to the group board as required. Reporting on people KPIs to the People Committee and Group Board through the Integrated Performance Report (IPR)
4	
5	TBC
6	Oversight of research & innovation has transferred to the Integration Committee

Gaps in Assurance	
1	Monitoring of action plan progress not fully embedded within sub-groups and relevant upward reporting, with priority focus being on the Divisional Clinical Care Groups monitored via PRM/FPAMs so that leaders are accountable and undertaking their actions
2	
3	Sub-Groups ensuring that agenda items and upward reports are in line with People Committee annual plan. IPR metrics currently being refreshed
4	
5	TBC
6	Regular reporting to be established

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review the way in which Staff Survey action plans are monitored and reported through standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms	Group Chief People Officer	Education & Learning Manager / Head of Workforce Planning & Reporting	30 September 2025	Not yet started
2	Staff awareness at all levels of group strategy, values, behaviours and approach to innovation and continuous improvement remains ongoing and will form part of a rolling programme of regular communications and engagement in 2025 / 26	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track
3 4	IPR metrics have been reviewed within People Directorate and shared, with alignment across LCHS and ULTH in line with Workforce Plans for 2025/26. People Committee Scorecard to be refreshed to ensure inclusion of current job planning and Medical & Dental middle tier rates for assurance purposes.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	31 May 2025	Underway – on track
5	TBC	TBC	TBC	TBC	TBC
6	TBC	TBC	TBC	TBC	TBC

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee workplan and ensuring that each sub-group is aware of its reporting objectives in year.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 Jun2 2025	Underway – on track
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025/26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce	30 June 2025	Underway – on track

			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	Underway – on track
5	TBC	TBC	TBC	TBC	TBC
6	Reporting requirements to be agreed as part of the refresh of the board committee terms of reference and work plans	Group Director of Corporate Affairs	Deputy Trust Secretary	30 June 2025	Underway – on track

Related risks on Risk Register – ULTH

Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS

Trust	Datix ID	Score	Summary Risk description

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2c: Nurture compassionate and diverse leadership
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then out staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement

Current Risk Score & Movement since last review:

Moderate (9)

Last Review Date:	March 2025
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	3	3	Moderate (9)	Amber
Target	Mar-26	3	2	Low (6)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate											

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											

Identified Controls *(What are we already doing to manage the risk?)*	
1	Group values agreed by the Group Board – Compassionate, Collaborative & Innovative
2	HR policies and T&Cs are being harmonised across the group supported by staff side
3	Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) submissions are completed and signed off by the Group Board
4	Results from Pulse surveys and NHS staff survey are systematically reviewed and action plans developed in response to findings
5	Culture and Leadership Programmes are in place across the group: Equality, Diversity & Inclusion (EDI), Civility & Respect, Compassionate Leadership and Just Culture
6	There are clear processes for raising concerns with Freedom to Speak Up Guardians in place across the group
7	Staff networks are in place with executive sponsorship
8	A comprehensive staff well-being offer is in place including a board level well-being guardian, a health and well-being operational lead and champions with further developments planned

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Behaviours that underpin each value – 'Our Values in Action' – being developed through staff engagement exercises
2	The review of HR policies and T&Cs will take time to complete due to capacity issues
3	HR reporting and analysis (e.g.: Employee Relations) needs to be strengthened to support WRES / WDES work streams
4	Delivery of pulse surveys and NHS staff survey action plans at operational level needs to be incorporated into the Performance Management & Accountability and PRM process
5	None identified
6	None identified
7	None identified
8	There is currently insufficient funding for the development of the menopause service

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Feedback on the adherence to the group values and expected standards of behaviours is gathered through a variety of sources including engagement roadshows, surveys, exit interviews, staff networks, and union engagement
2	There is monitoring of progress with the review and alignment of HR policies and T&Cs through engagement with staff side colleagues and through JCNC/JNF
3	WRES and WDES results and actions plans are monitored through the People Committee with escalation to the Group Board as required
4	Pulse Survey and NHS Staff Survey results are reported to the Executive Leadership Team, People Committee and Group Board and action plans are monitored through the People Committee with escalation to the Group Board as required. NHS Staff Survey results are currently above average in the 'People Promise' areas. Pulse Surveys are above benchmark
5	People KPIs / metrics are reported through the IPR to the People Committee
6	There is routine reporting on employee relations activity and themes to the People Committee and Group Board
7	There is routine reporting on FTSU concerns to the People Committee and Group Board
8	Staff networks meet regularly and there is reporting from the network chairs to the People Committee
9	Staff well-being offer is monitored through discussion with staff side and through the People Committee
10	Internal audit review of the people agenda provides independent assurance and / or escalation of risks. Internal audit review of equality, diversity and inclusion undertaken within ULTH during 2024 / 2025 provided 'reasonable assurance'

Gaps in Assurance	
1	Triangulation of data sources and feedback with other relevant sources of information and where this is reported needs to be reviewed and strengthened
2	There is currently no shared platform for oversight of when when policies are due for review
3	None identified
4	Monitoring of action plan progress is not fully embedded within sub-groups and relevant upward reporting
5	IPR metrics are currently being refreshed to reflect the group strategic aims & objectives and workforce plans for 2025 / 26
6	Ability to support triangulation of HR/ER data with other key performance metrics to support wider oversight and ability to identify trends and develop action plans
7	
8	None identified
9	None identified
10	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Education, Learning & Organisational Development Team are actively developing ways of communicating across LCHG, including the 'Better Together Forum' relating specifically to values, and this will include how we embed as part of our business as usual cycles.	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track
2	LCHG Policy Group has commenced and is working collaboratively to review policies at pace. Policies have been prioritised to focus on contractual policies as the priority	Group Chief People Officer	Group Deputy Chief People Officer	31 March 2026	Underway – on track
3	People Directorate Teams are working collaboratively to develop improved reporting mechanisms to support the inclusion of relevant WRES / WDES data to enhance ability to support annual reporting and identify trends with a view to creating improved inclusion data in standard reporting	Claire Low	Group Deputy Chief People Officer	31 March 2026	Underway – on track
4	People Directorate Teams (Education, Learning & OD and People, Planning & Transformation) are working together to identify improved reporting within FPAMs / PRMS	Claire Low	Education & Learning / OD & People & Transformation Teams	30 September 2025	Underway – on track
5	Review of menopause service and review of funding options to be undertaken	Claire Low	Education & Learning Manager	31 March 2026	Not yet started

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Develop a KPI dashboard to enable triangulation and highlighting of cultural trends and issues with reporting into the Culture and Leadership sub-group on a monthly basis with onward upward reporting to People Committee	Group Chief People Officer	Education & Learning Managers	30 June 2025	Underway – on track
2	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the Policy report and due dates and create a dashboard which provides oversight	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 September 2025	Underway – on track
3	Review the way in which Staff Survey action plans are monitored and reported through standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms.	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track
4	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee workplan and ensuring that each sub-group is aware of its reporting objectives in year	Group Chief People Officer / Group Director of Corporate Affairs	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	Underway – on track

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2d: Recognising our people through thanks and celebration
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not continue to **recognise our people through thanks and celebration** then we will be unable to attract and retain staff of the required caliber and experience resulting in services becoming unsustainable / fragile

Current Risk Score & Movement since last review:

Low (6)

Last Review Date:	March 2025
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	3	2	Low (6)	Amber
Target	Mar-26	3	1	Very Low (3)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Low											

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											

Identified Controls *(What are we already doing to manage the risk?)*	
1	Reward and Recognition arrangements harmonised across the group including the development of a group Reward and Recognition Policy
2	Reward, Recognition and Engagement Manager in post to support ongoing workstreams from 'People Promise' themes
3	ELT visibility and recognition of staff and teams through established communication and engagement channels
4	Annual staff awards ceremony held to recognise the contribution of individuals and teams
5	Robust review processes in place including appraisal, 1:1 meetings and feedback

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Policy approved but needs embedding
2	Role is in place within ULTH workforce but needs expanding to work across the group with an ability to utilise insights from this role to support wider reporting and identification of trends and development of action plans
3	None identified
4	None identified
5	Concept of group appraisals and appraisal lite process to be considered as part of review and alignment of HR policies

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Reporting through relevant sub-groups and People Committee on compliance rates for key workforce performance indicators (e.g. Turnover, Vacancies, Sickness, HR Cases, Appraisals)
2	Pulse Survey and NHS Staff Survey results are reported to the Executive Leadership Team, People Committee and Group Board and action plans are monitored through the People Committee with escalation to the Group Board as required. NHS Staff Survey results are currently above average in the 'People Promise' areas. Pulse Surveys are above benchmark
3	Pastoral care award received for recruitment and on-boarding of international nurses
4	Internal audit of people agenda provides independent assurance

Gaps in Assurance	
1	Regular reporting in place for key performance indicators via People Committee Scorecard and Workforce Strategy Group, but there is limited triangulation of wider data sources such as datix, complaints and Freedom to Speak Up Concerns which would highlight cultural trends / issues
2	Monitoring of action plan progress not fully embedded within sub-groups and relevant upward reporting
3	None identified
4	None identified in respect of reward and recognition

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Embed Group reward & Recognition Policy	Group Chief People Officer	Group Deputy Chief People Officer	31 March 2026	Ongoing
2	Review how the Reward, Recognition and Engagement Manager role aligns to wider LCHG workstreams and how the role can bring insights to wider workstreams, including reporting into FPAM and other key assurance meetings	Group Chief People Officer	Group Deputy Chief People Officer	31 March 2026	Not yet started
3	Launch refreshed appraisal cycle as part of further harmonisation across the group	Group Chief People Officer	Education & Learning Managers	30 June 2025	Underway – on track

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Develop a KPI dashboard to enable triangulation and highlighting of cultural trends and issues with reporting into the Culture and Leadership sub-group on a monthly basis with onward upward reporting to People Committee	Group Chief People Officer	Group Head of Workforce Planning & Reporting	31 March 2026	Not yet started
2	Review the way in which Staff Survey action plans are monitored and reported through standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms.	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **transform key clinical pathways,** rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience

Current Risk Score & Movement since last review:

12 (High)

Last Review Date:	March 2025
Lead Executive:	Group Chief Integration Office
Committee Oversight:	Integration Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	3	12 (High)	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

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

Identified Controls *(What are we already doing to manage the risk?)*	
1	Left Shift Transformation Plan with oversight of delivery by the Alliance Steering Group
2	Transformation of planned and unplanned pathways to be managed through a sub-group of the Alliance Steering Group
3	Governance structures and QIA processes in support of the transformation programme in place
4	Programme / project interdependencies to be managed through the Productivity, Improvement & Transformation Forum (PITOF)
5	Partnership Strategy in place to support transformation
6	Dedicated work stream to support collaboration at scale in place with key sub-work streams
7	Health Inequalities Working Group established to identify and address health inequalities, focusing on the use of the Health Inequalities Maturity Matrix to drive improvement
8	Estates strategy being developed, Space Group set up to support rationalization and specific service transformation request

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Alliance Steering Group currently being set up with first meeting planned for May 2025
2	Alliance Steering Group sub-groups on planned / unplanned care group transformation, left shift re-design programmer and integrated neighborhood teams not yet commenced
3	Governance and reporting being refined in support of transformation programme
4	PITOF currently being set up with first meeting planned for May 2025
5	Partnership Strategy needs to be refreshed in line with the Group Strategy and Alliance Model
6	Spectrum of integration options to be formalised for all partners based on Partnership Strategy
7	
8	

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of transformation work streams by the Integration Committee with escalation to the Group Board as required
2	External assurance will be provided through the Alliance Steering Group updates to Lincolnshire Leaders Group and partner provider boards
3	PITOF upward reports including reporting on delivery of key KPIs and milestones to the Integration Committee
4	IPR to support demonstration of a positive shift in key metrics such as improved LOS, improved staff and patient satisfaction, improved access to services
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Gaps in Assurance	
1	Integration Committee in place but work plan and reporting sub-groups not yet fully established
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4	Work streams, KPIs and timelines still being worked up
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Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Alliance Steering Group first meeting to be arranged for May 2025 with terms of reference and subgroups to be agreed with members	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	31 May 2025	Underway
2	Alliance Steering Group sub-groups to be established and work streams being set up with a clear 12 month delivery plan	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	31 May 2025	Underway
3	First PITOF meeting diarised for 12 May 2025 and to take place monthly	Group Chief Integration Officer	Director of Improvement and Integration	12 May 2025	Complete
3	Partnership Strategy to be refreshed with sign off by the Integration Committee	Group Chief Integration Officer	Associate Director of Partnership	30 June 2025	Underway
4	Work with EFM to contribute to developing the Estates Strategy	Group Chief Integration Officer	Chief Estates Officer	31 August 2025	Underway

	Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*	Executive Lead	Operational Lead	Due Date	Progress
1	Integration Committee work plan and reporting sub-groups to be established	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	31 May 2025	Underway
2	Left shift specialties being identified, relevant population health management data collated to produce evidence packs to commence service redesign with relevant partners from acute, community and wider system	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	31 May 2025	First meeting held with population health mgmt. team and wider system
3	Strategy, improvement and redesign team working on pulling together programme plans for all the work streams to report through a central reporting mechanisms	Group Chief Integration Officer	Director of Improvement and Integration	31 May 2025	Underway
4	Integration brochure to provide options for collaborative working being developed.	Group Chief Integration Officer	Director of Improvement and Integration	31 May 2025	Underway

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3b: Move from prescription to prevention, through a population health management & health inequalities approach
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes

Current Risk Score & Movement since last review:

9 (Moderate)

Last Review Date:	March 2025
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	3	3	9 (Moderate)	Amber
Target	Mar-26	4	3	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

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

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	
7	

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	None identified
2	Alliance Steering Group not yet in place
3	Health inequalities action plan in development
4	None identified
5	Data packs in development for key left shift transformation priorities and a progrmme to address skills / knowledge gaps
6	
7	

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Health Inequalities Working Group upward report into the new Alliance Steering Group and Integration Committee and Group Board
2	Development of a LCHG Co-production Strategy to support the health inequalities and personalisation agenda and reduce health inequalities
3	PHM and HI are golden threads through the LCHG Strategy and delivery will be monitored through upward reporting to the Integration Committee and Group Board
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Gaps in Assurance	
1	Health inequalities action plan in development / Alliance Steering Group being established with the first meeting planned for May 2025
2	Co-production Strategy in development working with ICB Health Inequalities and Personalisation Teams
3	Strategy to be launched across the group from April 2025
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Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Alliance Steering Group date to be confirmed for May 2025	Group Chief Integration Officer	Director of Integration and Improvement / Deputy Chief Integration Officer	31 May 2025	Underway
2	Health Inequalities action plan in development and will be shared with Alliance Steering Group and Integration Committee in May 2025	Group Chief Integration Officer	Associate Director of Partnership	31 May 2025	Underway
3	Population Health data packs/intelligence being produced for all of the first tranche of left shift specialties, supported via ICB team and LCHG Data Analysts. PHM approach embedded in BAU Transformation Framework. Confirming any resource issue internally to support the data workstream.	Group Chief Integration Officer	Director of Integration and Improvement / Deputy Chief Integration Officer	31 May 2025	Underway - date being arranged for first meeting

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Alliance Steering Group meeting to be held in May 2025 – narrative reports being provided directly to Integration Committee in the interim Health inequalities action plan to be developed and approved	Group Chief Integration Officer	Associate Director of Partnership	31 May 2025	Underway
2	Health Inequalities Action Plan in development from the four work stream leads and will be provided to the Alliance Steering group/Integration Committee in May 2025	Group Chief Integration Officer	Associate Director of Partnership	31 May 2025	Underway
3	Communications cascade to be developed (as one of the four Health Inequalities work streams) to increase awareness of the role of the Exec Lead for Health Inequalities and Personalization	Group Chief Integration Officer	Associate Director of Partnership	31 May 2025	Planned
4	New LCHG Strategy to be signed off by Board in May 2025 and deployed via Roadshow and in communications cascade	Group Chief Integration	Director of Integration and	30 June 2025	Underway

		Officer	Improvement		

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:

Last Review Date:	March 2025
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	TBC	TBC	TBC	TBC
Target	Mar-26	TBC	TBC	TBC	TBC

Assurance Rating & Movement since last review:

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

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

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	Single Microsoft 365 teams platform in place
4	Director of Digital in post and digital team to be aligned with a single identity
5	Disaster Recovery Plans in place. Cyber security & malware processes in place and tested
6	Digital Oversight Group in place to driver delivery of digital agenda
7	Key group focus on research and innovation
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	Processes require embedding
4	Capacity within the digital team to deliver the digital transformation
5	
6	None identified
7	LCHG Research & Innovation Strategy not yet developed
8	Application in development. Resource allocated to support application

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of digital strategy, digital transformation and key risks by the Integration Committee
2	Digital Maturity Assessment completed
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Gaps in Assurance	
1	TBC
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Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Technical / Implementation Partner to be procured to provide capacity as and when required	TBC	TBC	TBC	TBC
2	LCHG Research & Innovation Strategy to be developed	Chief Medical Officer	Head of Research & Innovation	TBC	First meeting with stakeholders to be held early June 2025
3	Meeting to be arranged with DHSC to confirm the position on the LCHS teaching status application and timescales	Group Chief Integration Officer	Associate Director of Partnerships	1 April 2026	Scoping due to commence April 2025

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	TBC				
2					
3					
4					

Related risks On Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable

Current Risk Score & Movement since last review:

12 (High)

Last Review Date:	March 2025
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	3	12 (High)	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

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

Identified Controls *(What are we already doing to manage the risk?)*	
1	Productivity & Transformation Framework developed – outline programme for 2025 / 26 agreed
2	Common PMO approach developed to monitor and drive oversight of our CIP
3	Productivity, Improvement & Transformation Group being set up reporting to GLT
4	ULTH and LCHS Sustainability & Green Plans reviewed – phase 1 actions complete: improvement workshops complete and areas of opportunity and risk identified
5	Network of Green Champions formed
6	Green Group meetings scheduled
7	Sustainability agenda embedded in new Group Strategy
8	The Director of Estates & Facilities is the SRO for the sustainability agenda

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Care group transformation and improvement programmes not yet fully worked up – support being provided from strategy, improvement and re-design teams
2	PMO not yet embedded and programmes still being developed
3	Green Plan areas of oversight to be agreed by GLT
4	Refreshed Sustainability & Green Plan being drafted for board approval
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Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of productivity, improvement & transformation by the Integration Committee
2	Sustainability report to the Alliance Steering Group for oversight and assurance. Upward reporting to the Integration Committee and Group Board
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Gaps in Assurance	
1	Clarity is needed on oversight responsibilities of Integration Committee v Finance & Performance Committee
2	Sustainability sub-group (Green Group) not yet established
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Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Care Group transformation programme being finalized as part of planning submission / CIP / annual plans and will be complete by the end of April 2025	Group Chief Integration Officer	Director of Improvement and Integration	30 April 2025	Underway
2	PMO being embedded and establishing all programmes onto Aspyre – working with finance to ensure full capture of all programmes	Group Chief Integration Officer	Director of Improvement and Integration	30 April 2025	Underway
3	New Green Plan in development with key work stream leafs, for socialization via ELT, GLT and approval by Group Board	Group Director of Estates & Facilities	Group Head of Sustainability	31 July 2025	Underway

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Sustainability sub-group (Green Group) terms of reference agreed by Integration Committee in April 2025 – first meeting to be scheduled for May 2025	Group Director of Estates & Facilities	Group Head of Sustainability	31 May 2025	Underway

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

NHS
Lincolnshire Community and Hospitals NHS Group

Group Audit Committee Upward Report

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

Meeting	*Lincolnshire Community and Hospitals Group Board Meeting*
Date of Meeting	*6 May 2025*
Item Number	

Group Audit Committee Upward Report of the meeting held on 25th April 2025

Accountable Director	*Neil Herbert, Audit Committee Chair*
Presented by	*Neil Herbert, Audit Committee Chair*
Author(s)	*Jayne Warner, Director of Corporate Affairs*
Recommendations/ Decision Required	*The Board is asked to:-* • *Note the upward report*

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

This assurance Committee meets quarterly and takes scheduled reports according to an established work programme, for both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH). The Committee worked to the 2025/26 objectives for the Lincolnshire Community and Hospitals NHS Group (LCHG).

External Audit

The Committee received the Audit Strategy Memorandum, the formal external audit plan for the 31st March 2025 year end for both organisations. The Committee were advised of those areas where process differed from in previous years and updated on how the audit process was going so far in respect of both organisations. The Auditors highlighted that for LCHS an additional significant risk relating to valuation of land and buildings had been been identified. This was as a result of the Trust commissioning the services of an external valuer. The Auditors confirmed that a draft set of accounts had been submitted for both organisations by the due dates. The Committee considered the previously identified significant weakness in the ULTH 2023/24 process relating to financial sustainability. It was recognised that the detailed planning which had been produced for the two organisations for 2025/26 was significant, however the year remained a significant challenge. The Auditors confirmed that these areas were still under review as part of the preliminary work.

The Committee challenged the increase in the audit fees for LCHS as these had increased disproportionately compared to the ULTH audit fees. These would be reviewed.

The Committee received reports assuring on the lessons which had been learnt from the interim audit and the actions which were being taken to deliver the year end process internally. The Auditors confirmed that the process was all running smoothly and to plan at this stage. The Committee sought assurance that the appropriate capacity was available in the team to deliver and this was confirmed.

The Committee received the accounting policies and the going concern assessment and approved these.

The Committee received the draft annual reports for both organisation and noted progress against deadlines for submission to audit.

Internal Audit

The Committee received the Internal Audit Progress Report for both organisations noting that six audit reports had been finalised for LCHS five reports offering reasonable assurance and one with limited assurance and eight reports for ULTH. There were a number of other reports at final stages of completion awaiting issue.

The Committee noted that the internal audit review of NHS Provider licence. It was recognised that the evidence could not be offered to demonstrate the completion of a self-assessment in the previous financial year for LCHS, however management responses had been offered to the audit findings and one of the papers being offered to the Committee addressed one of the outstanding actions. It was acknowledged that this issue was believed to relate to the retention of the supporting evidence rather than the level of compliance and would be resolved by the aligning of the two organisational processes in year. The Committee asked for assurance to be delivered in the form of a follow up review during the 2025/26 plan.

The Committee noted that reasonable assurance had been offered in both the reviews of Policies and Procedures and BAF and Risk Management reviews for LCHS.

The Committee noted that the reports for ULTH relating to Planned and Preventative Estates Management (PPEM) and Overseas and Contracts had been issued with limited assurance ratings. The Committee chair noted that the reviews had been considered by the Finance Committee and it was agreed that a further meeting would be held with the Chair of the Finance Committee and relevant executive as agreement had not been reached between internal audit and management in respect of the audit findings and actions for PPEM.

The Audit Committee were advised of progress against the rest of the Audit Programme for the year for both Trusts. The Committee recognised that there had been significant movement with the plan since its last meeting. The Committee were

assured that the work required to allow the internal auditors to deliver the head of internal audit opinion was in place.

The Committee highlighted that two audit reports relating to absence management and vacancy controls for ULTH had been out in draft with the organisation for a number of months. The Committee chair agreed to escalate this through the upward report.

The position with audit recommendations and the audit plan were noted. Internal Audit recommendations continued to be closely monitored recognising that a number had fallen due during April. Monitoring to ensure these did not build was in place.

The Committee agreed the Internal Audit Annual Plans for 2025/26. The Committee discussed how some efficiencies in the plans across the two organisations could be achieved where audits in each organisations would duplicate in terms of evidence and controls for example the Risk and BAF review and the Fit and Proper Person Review. The Committee also requested consideration be given to including audits on Bank/Agency; Provider Licence; Medical Devices Management; and Well-Led using the time freed from the above and removing the Site Audits.

Local Counter Fraud Specialist Progress Reports

The Committee noted the progress report which had been aligned for both organisations.

The Committee approved the Group Countering Fraud, Bribery and Corruption Policy and Response Plan and the Operational Work Plan. The Committee were assured that the plan was comprehensive and covered the four areas of contracted activity.

Compliance Report

The Committee received the quarterly compliance report which was being developed to reflect compliance across both organisations.

It was noted that the levels of waivers remained stable after an increase had been seen earlier in the year.

NHS Provider Licence Self Certification

The Committee received and agreed the self-certification ahead of submission to Trust Board.

Policies Update

The Committee received the quarterly update on the policy position. It was noted that the position remained poor. The Committee noted the actions being taken by the Executive to address the areas of concern and that traction could be seen but this was yet to deliver the overall improvement in numbers. It was noted that

compliance was now being monitored through all Committees, not just Audit Committee.

Executives continued to receive monthly updates, and performance data was being challenged through Performance Review Meetings (PRMs). Committee Chairs shared their experiences and challenges with policy management, risk ratings had now been applied to a number of overdue policies but this was not yet completed.

The Committee would continue to make this an area of focus.

Board Assurance Framework and Risk Register

The Committee received the revised BAF format for 2025/26 recognising that this was still in development and had been considered for the first time at each of the assurance committees during April. The Committee recognised the real step change in how this was presented and would offer increased clarity around assurance levels. The Committee also received the Risk Register confirming that each remain fit for purpose.

NHS
Lincolnshire Community and Hospitals NHS Group

NHS Provider Licence Self Certification

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

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of Meeting	*6 May2025*
Item Number	*12.4*

NHS Provider Licence Self Certification

Accountable Director	*Jayne Warner, Group Director of Corporate Affairs*
Presented by	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Jayne Warner, Group Director of Corporate Affairs*
Recommendations/ Decision Required	*The Board is asked to:* • *note the self certification for both organisations*

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

Executive Summary

This report provides assurance to the Audit Committee and Board that the Trust is compliant with the conditions of its NHS provider licence. Whilst the Trust is not required to submit self-certifications to NHS England (NHSE), it may be required to provide evidence of its compliance with licence conditions, specifically that the Trust has:

- effective systems in place to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G5 formerly G6);
- complied with governance arrangements (condition NHS2, formerly FT4)

Condition G5
The condition requires NHS providers to have processes and systems that:
- identify risks to compliance with the licence, NHS acts and the NHS Constitution
- guard against those risks occurring.

Providers must assess whether their processes and systems were implemented in the previous financial year and were effective. A self-certification has been completed using the recommended template which confirms that processes and systems were implemented in the previous financial year and were effective. On the basis that ULTH and LCHS are not subject to any imposed requirements under the NHS Acts, has regard to the NHS Constitution in delivering NHS services and has received positive assurance on its processes and systems from internal auditors, it is reasonable for the Trust to confirm it is compliance with Condition G5 in its self-certification this year.

Condition NHS2
This condition requires NHS providers to apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. The relevant template has been compiled in line with the Annual Governance Statement for 2024-25, which will be subject to review by the Trust's External Auditors.

Evidence of Compliance

In making the above declarations, the following assurances can be provided to the Board for both organisations;

- The Trusts have Standing Orders, Standing Financial Instructions, a Scheme of Delegation and an Accountability Framework, which together describe how the Trust Boards discharge their duties through the Trust's governance structure.
- The Organisations have well established Joint Assurance Committees chaired by Non Executive Directors. Committees complete annual self assessments and have been subject to additional review and oversight as part of the Group working arrangements by the Independent Governance Advisor.
- A risk management strategy which sets the standards for staff regarding the management and responsibility for risk for both Trusts, describes the risk appetite and defines the framework and structure for risk management.

- There is a Risk Register in place for both organisations**.** The Audit and Risk Committee, and assurance committes provide assurance regarding the management of risk to the Trust Board via the monthly risk reports.

- A risk based Internal Audit programme has been delivered that includes audits of risk management, key financial systems and governance arrangements.

- An Annual Governance Statement is produced which reflects the each Trust's governance structures and internal control arrangements.

- An Integrated Performance Report is received by the Board at each meeting which details performance against operational, quality and financial targets and offers opportunity for challenge.

The Board is asked to:

- note the self certification

Worksheet "NHS2 declaration" | **Financial Year to which self-certification relates** | **2024/25** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust has well developed systesm of corporate governance which have been reviewed in year as part of the move to a Group Model. This is evidenced by Annual Governance Statement, Head of Internal Audit Opinion, internal and external reports and regular review of risk by Board and Committees.
2	The Board has regard to such guidance on good corporate governance	Confirmed	The Board reviews and takes account of all guidance issued by NHS E
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board has conducted a review of its committee structures and terms of reference and ensured that committee responsibilities are aligned to a revised BAF. The Board has engaged external support in a review of management structures and is implementing a new Operating Model. Responsibilities are clearly defined in a Trust Governance Manual.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Trust has sound systems of governance in place which are underpinned by programmes of internal, external and clinical audit. All statutory audits and reporting requirements are fulfilled. B. A monthly performance report is produced, and is scruinised by the Quality Commitee and the Finance & Performance Commitee and the Trust Board. C. Board approved financial plans are in place and Internal Audit has provided assurance that the organisation is delivering a sound system of financial control. The Standing Financial Instructions govern financial decision making and financial performance is scrutinised by the Finance & Performance Committee. The 2024/25 accounts have been prepared on an on-going concern basis. D. The Board and its committees work to pre-agreed work plans and are serviced by the Corporate Affairs Team which assists with agenda setting, paper circulation, minute taking, and action follow-up. Directors take responsibility for enuring that accurate, comprehensive and up-to-date information is presented for consideration. E. An established embedded Risk Register identifies key strategic risks. It is presented to each Board meeting ; risks are also subject to detailed review and scrutiny by the commitees. F. The Trust's Strategic plan is refreshed each year G. The Trust's regularly seeks advice on legal compliance and a compliance report ios considered quarterly at Audit Committee.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Robust appraisal and performance review arrangements are in place at Board level (and throughout the organisation) and portfolios have been reviewed and refreshed in the recruitment to teh Group Board. B. The Quality Committee, on behalf of the Group Board , receives assurance on issues of patient safety and quality of care, patient experience and patient outcomes, and promotes the involvement of service users, carers and the public. In addition focussed reviews of any indicators or areas of concern are commissioned by and shared with the QualityCommittee as they arise. C. The Quality Committee receives information on the quality of care, and relevant information and metrics relating to quality performance . D/E. A patient story or service overview is presented at the start of each Board Meeting. Board members undertake service visits. The Board receives a range of quality related reports, including reports on Serious Incidents, CQC regulatory compliance . F. There is clear accountability for quality of care throughout the Trust and systems of governance allow for appropriate escalation to Board .
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Recruitment has now been made to all Group Board positions. The Trust has an Interim Chief Estates and Facilities Officer and has agreed a secondment arrangement for its Chief Nurse.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name [ ] **Name** [ ]

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Worksheet G5"

Financial Year to which self-certification relates 2024/25 Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	**Signature**
Name	**Name**
Capacity	**Capacity**
Date	**Date**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

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 Horizon Scan	Group Chief Executive	Executive Business Manager	N/A	X	X	X	X	X	X	X	To brief the boards on local and national topical matters, risk issues & mitigations and good news & communication updates	
Group Workstreams Report	Group Chief Executive		N/A	X	X	X	X	X	X	X	To receive regular updates on the delivery of the expected benefits of moving to a Group model and the integration of clinical and corporate services	
Celebrating Group Success	Group Director of Corporate Affairs	Deputy Trust Secretary	N/A	X	X	X	X	X	X	X	To hear from Clinical Teams and give clinical teams access to the Board	
Patient/staff Story	Group Chief Nurse	Associate Director of Communications and Engagement	N/A	X	X	X	X	X	X	X	To receive direct feedback on the experience of both patients and staff	
Patients												
Strategic Aim 1 - High quality, timely care in the right place												
Assurance and Risk Report from the Quality Committee	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Quality Committee Annual Report	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Quality Committee ToR and Work Programme	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee		X						To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Safeguarding Annual Report	Group Chief Nurse	Group Director of Safeguarding and Patient Experience	Quality Committee			X					To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Infection Prevention and Control Annual Report	Group Chief Nurse	Deputy Director of Infection Prevention and Control	Quality Committee			X					To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Complaints Annual Report	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	Quality Committee			X					To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Patient Experience Annual Report	Group Chief Nurse	Group Director of Safeguarding and Patient Experience	Quality Committee			X					To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Assurance and Risk Report from the Finance Committee	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Finance Committee Annual Report	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Finance Committee ToR and Work Programme	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee					X			To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Financial Plan	Group Chief Finance Officer		Finance Committee								To approve the Financial Plan	Approval
Capital Plan	Group Chief Finance Officer		Finance Committee								To approve the Capital Plan	Approval
Contract Award Reports	Group Chief Finance Officer	Deputy Director of Procurement	Finance Committee	X	X	X	X	X	X	X	To approve relevant Contract Awards in accordance with the Trusts' Schemes of Delegation	Approval
Emergency Preparedness Annual Report and EPRR Core Standards	Group Chief Estates and Facilities Officer	Emergency Planning and Business Continuity Manager	Finance Committee			X					To receive and approve the Trusts' annual submission to NHSE on EPRR including any required improvement actions	Assurance
People												
Strategic Aim 2 - Attract and retain talent, build a strong culture												
Assurance and Risk Report from the People Committee	Chair of People Committee	Deputy Trust Secretary	People Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
People Committee Annual Report	Chair of People Committee	Deputy Trust Secretary	People Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
People Committee ToR and Work Programme	Chair of People Committee	Deputy Trust Secretary	People Committee					X			To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Gender Pay Gap Report	Group Chief People Officer	Director of People	People Committee	X						X	To receive the Gender Pay Gap Report	Assurance
Ward Establishment Review	Group Chief Nurse	Deputy Director of Nursing and Midwifery	People Committee				X (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		

		2025												2026		
Item	Lead	Jan	Feb Day	Mar	April	May	Jun Day	July	Aug Day	Sep	Oct Day	Nov Day	Dec	Jan	Feb Day	Mar
Strategic Objectives/ Board Assurance Framework	DF/JW	x														x
Board Roles and Responsibilities/ Assurance/ Effective Meetings	NHS Providers		x													
Strategic Risk, Risk Tolerance and Risk Appetite	KH/ NHS Providers			x												
Group Strategy	DF/SRM				X											
EDI	CLo									x						
R&I – Building capability and capacity and Uni Hospital ambition	Ciro R										x					
NHS Providers Workshop 3	NHS Providers						x									
NHS Providers Workshop 4	NHS Providers								x							
NHS Providers Workshop 5	NHS Providers											x				
NHS Providers Workshop 6	NHS Providers														x	
Cultural Intelligence	CLo										x					

Care Groups	DF/CLa							x					x			
PCNA – To be arranged	DF															
Future Group Developments	JW/KH/DF					x										