# Bundle LCHG Board Meeting in Public Session 6 January 2026

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

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

2 Public Questions
*Chair*

2.1 Ward Accreditation - Scampton Ward
*Group Chief Nurse*

2.2 Staff/Patient Story - St Francis School Nursing Team
*Group Chief Nurse*

3 Apologies for Absence
*Chair*

4 Declarations of Interest
*Chair*

5 Minutes of the meeting held on 4th November 2025
*Chair*
- Item 5 DRAFT Public Board Minutes Nov 25

5.1 Matters arising from the previous meeting/action log
*Chair*
- Item 5.1 Public Board Action log Nov 2025

6 Group Chief Executive Report to the Board
*Group Chief Executive*
- Item 6 Group CEO update Public Board - January 2026 - Final

6.1 Group Model Workstream Progress Briefing
*Group Chief Executive*
- Item 6.1 Group Model Front Sheet
- Item 6.1 Appendix Work Programme as at 311225 v1

6.2 Winter Plan/Operational update
*Group Chief Operating Officer*
- Item 6.2 Winter Plan and Operational Update to Trust Board
- Item 6.2. Appendix One - IA December 2025

7.2 BREAK

8 Strategic Aim 1 - Patients

8.1 Assurance and Risk Report from Quality Committee
*Chair, Quality Committee*
- Item 8.1 Quality Committee Assurance Upward Report November 2025v1
- Item 8.1 Appendix 1 Qual Cmtt upward report Nov - MODERN SLAVERY Annual Statement 2025
- Item 8.1 Quality Committee Assurance Upward Report December 2025v1
- Item 8.1 Qual Cmtt upward report Dec Appendix 1.0 - Perinatal Assurance Report V1
- Item 8.1 Qual Cmtt upward report Dec Appendix 1.6 - PMRT Q2 July - Sep '25 (non-identifiable data)
- Item 8.1 Qual Cmtt upward report Dec Appendix 1.7 - Claims Scorecard Q2 '25
- Item 8.1 Qual Cmtt upward report Dec Appendix 1.8 - Bi-annual staffing report Nov 25 FINAL

8.2 Finance Briefing
*Group Chief Finance Officer*

Item 8.2 Trust Board - Finance Briefing M8

8.3 Assurance and Risk Report from Finance and Performance Committee
*Chair, Finance and Performance Committee*

Item 8.3 Finance Committee Assurance Upward Report November 2025v1
Item 8.3 Appendix 1 Fin Cmtt upward rpeort Nov Health & Safety Annual Report 202425
Item 8.3 Finance Committee Assurance Upward Report December 2025v1

8.4 2026/27 Draft Plan Submission
*Group Chief Integration Officer*

Item 8.4 TB_Jan 26_PlanningUpdate_171225

9 Strategic Aim 2 - People

9.1 Assurance and Risk Report from People Committee
*Chair, People Committee*

Item 9.1 People Committee Assurance Upward Report November 2025
Item 9.1 Appendix 1 Ppl Cmttt upward report Nov - Sexual Safety Charter - 11.11.25
Item 9.1 Appendix 1.1 Ppl Cmtt upward rerpot Nov - Self Assessment Framework Sexual Safety Charter October 2025
Item 9.1 People Committee Assurance Upward Report December 2025v1
Item 9.1 Resident Doctors 10 Point Plan Update for January 2026 Group Board meeting
Item 9.1 RDrs Appendix A - Measuring the Impact of the Improving Doctors' Working Lives Programme - 10 Point Plan submission 10122025
Item 9.1 RDrs Appendix B - Resident Doctors 10 Point Plan - Status report on ULTH Survey responses 10 Dec 2025
Item 9.1 RDrs Appendix C -UNITED LINCOLNSHIRE TEACHING HOSPITALS NHS Trust 10 Point Plan Survey Midlands _Follow-up Survey December 2025

10 Strategic Aim 3 - Population

10.1 Assurance and Risk Report from Integration Committee
*Chair, Integration Committee*

Item 10.1 Integration Committee Assurance Upward Report November 2025
Item 10.1 Integration Committee Assurance Upward Report December 2025v1

10.2 Partnership Plan
*Group Chief Integration Officer*

Item 10.2 LCHG Refreshed Partnership Plan and Delivery Plan Update Integration Committee December 2025

11 Integrated Performance Report
*Group Chief Officers*

Item 11 IPR Front Sheet
Item 11 IPR Group Board M8 v2

11.1 Strategy Delivery Q2 Assurance Report
*Group Chief Integration Officer*

Item 11.1 Q2 Strategy delivery update report_FINAL for TB

12 Risk and Assurance

12.1 Group Risk Management Report
*Group Chief Clinical Governance Officer*

Item 12.1 Group Board - LCHG Risk Report January 2026 v1.1
Item 12.1 Appendix A- LCHS Group Board High or Very High - December 2025.
Item 12.1 Appendix B-ULTH-Group Board-Active Very High & High Risks
Item 12.1 Appendix C - Risk Appetite
Item 12.1 Appendix D

12.2 Board Assurance Framework
*Group Director of Corporate Affairs*

Item 12.2 BAF Group Board Front Sheet Jan 2026

Item 12.2 LCHG Group BAF as at December 2025

12.3 Board Forward Planner
*Group Director of Corporate Affairs*

Item 12.3 Board Forward Planner

13 Any Other Notified Items of Urgent Business

14 The next meeting will be held on Tuesday 3rd March 2026

*EXCLUSION OF THE PUBLIC*

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

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

# Minutes of the Joint Public Board Meeting

Held on 3rd November 2025

Via MS Teams Live Stream

## Present

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

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

**In attendance:**
Mrs Karen Willey, Deputy Trust Board Secretary, ULTH
Mrs Rachel Lane, Board Administration, LCHS (minutes)
Imogen De Benedictis, Matron Witham Ward (Item 3.1)
Sarah Foster, Ward Sister Witham Ward (Item 3.1)
Paul Cartwright, Volunteer (Item 3.2)
Connor Broughton, Programme Manager, ULTH (Item 3.3)
Kirstie Cartledge, Lead Specialist Screening Practitioner, ULTH (Item 3.3)
Ellie Sadler, Macmillan Living with Cancer Community Development Programme Manager, ICB (Item 3.3)
Emma Townend, Interim Health Inequalities Programme Lead, ICB(Item 3.3)

**Apologies:**
Mr Neil Herbert, Non-Executive Director

*Some agenda items were taken out of sequence and have therefore been recorded in the order that they were received*

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| 634/25 | **Item 1 Introduction**<br><br>The Group Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream. |
| 635/25 | **Item 3 Apologies for Absence**<br><br>Apologies for absence were received from Mr Neil Herbert, Non-Executive Director. |
| 636/25 | **Item 3 Public Questions**<br><br>**Q1 Received from Vi King**<br><br>Please can I ask why it is still the same regarding my question that I raised to the board re fracture clinic at Grantham hospital on 2nd September 2025. I was informed that now they had gone from 3 consultants to 2. |
| 637/25 | They have been able to fill it so hopefully things will be resolved so there should be a full service at Grantham fracture clinic. I am getting people tell me it's still the same. Also, some patients when they are asking for Grantham follow up appointments for fractures they are being told that as their appointments have been at Lincoln or Boston that's where they have to go. |
| 638/25 | Please can I ask why this is still happening after lots of reassurance that it shouldn't be. |
| 639/25 | The Group Chief Operating Officer apologised that a second question had been submitted relating to this subject. She explained that the reduced capacity at Grantham was due to sickness absence within the clinical team which had recently reduced, with one Consultant returning to full duties and a further Consultant now on a phased return. The Group Chief Operating Officer offered that this was not expected to be a long term issue now that those staff members had returned. |
| 640/25 | The Group Chief Operating Officer further explained that whilst appointments were accommodated at the site patient's requested where clinically suitable, where a specific surgeon was required patients sometimes had to travel to alternative sites. |
| 641/25 | The Group Chief Operating Officer offered to investigate any direct examples Mrs King could provide to give a more meaningful response, alternatively Mrs King was invited to contact the Group Chief Operating Officer directly for a conversation outside of the Board arena where assurances could be provided as to the organisation's commitment to delivering services at Grantham. |

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| 642/25 | **Item 3.1 Ward Accreditation**<br><br>The Group Chair was pleased to be able to commence the Board meeting with the celebration of achievement of the provision of high quality, safe care through the awarding of ward accreditation.<br><br>Matron De Benedictis and Sister Foster from Witham Ward, Lincoln County Hospital were welcomed to the meeting to celebrate their achievements. |
| 643/25 | The Group Chief Nurse introduced the team who had successfully achieved the Bronze Diamond 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. |
| 644/25 | Sister Foster shared some examples with Board members of what had been achieved on Witham Ward as the staff focussed on quality improvement, specifically in relation to patient falls which had been increasing over recent months. It was explained that new notes trolleys had been purchased allowing staff members to complete notes within each of the three bays on the Ward to increase visibility for patients, as a result of this patient buzzers had reduced as they had not needed to call for assistance as the nursing staff were always visible. |
| 645/25 | Bay inspections had also been introduced which included clearing any unnecessary items, introducing yellow wristbands and socks and all staff were able to complete a falls assessment, which had seen further improvement in the numbers of falls reducing. Yellow lanyards had also been introduced for patients who had enhanced care requirements and nurses remained in that bay to focus on the patient, thus providing staff members with a good sense of responsibility. Patient education and deconditioning had also been reviewed, and information books were available at the bedside containing exercises patients could complete. Portable pedal exercisers had also recently been utilised, and it was the intention to purchase more of these to offer to patients in the future. There was also a falls Stanley box on the ward which contained any equipment that would be required in the event of a fall. |
| 646/25 | The Ward Sister informed those present that as a result of the steps taken, the Ward had, for the month of October, achieved 30 days harm free for falls. |
| 647/25 | The Group Chief Executive thanked the Ward Matron and Ward Sister for attending the meeting and providing some excellent examples of good working and was proud of the team for making the necessary changes; adding that the multiple actions taken by the team had multiple benefits in other ways for patients. The Group Chief Executive commented that 30 days harm free was an excellent achievement and no falls had been experienced due to the impact of the actions taken. The Group Chief Executive asked if the team had thought about adopting the work they had done and rolling the initiatives out to other areas. The Ward Matron explained that the Medicine Division had quality days where initiatives and best practice were shared, and this work would be shared with colleagues at the next meeting. |

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| 648/25 | The Group Chief Finance Officer commented that this demonstrated a good collective team effort and suggested this be shared through the new Shared Governance Council and then more widely than the Care Group. The Group Chief Nurse added that this excellent work could be shared across the entire Group, including the Community Hospitals and building into the prevention work across the county. The Group Chief Nurse was very proud of the team's achievements. |
| 649/25 | The Group Chair thanked the Matron and Ward Sister for attending the meeting and for their continued leadership. The service was a credit to the organisation and the Group Chair commented that the team should be proud of their achievements. |
| 650/25 | **Item 3.2 Patient/Staff Story**<br><br>The Group Chief Nurse welcomed Mr Cartwright, Volunteer to the meeting and explained that the story would focus on volunteering and the support provided by volunteers to the Group. The Group Chief Nurse explained that there were currently 342 volunteers across the Group who provided 45,000 hours per year to support and look after patients and colleagues and they made an incredible difference each day. |
| 651/25 | The Group Chief Nurse offered that colleagues would see through a video that Mr Cartwright had incredible passion and drive and had helped the organisation in many ways to ensure patients received the right care. |
| 652/25 | A recording was then shared with the Board which demonstrated Mr Cartwright's enthusiasm for volunteering and his dedication in relation to ensuring palliative syringe pumps were available for patients, which included tracking the equipment in and out of the Hospital, into the community and at times into other Counties and ensuring that the syringe pumps were cleaned and serviced regularly. Mr Cartwright was also a fire warden for two areas within the Hospital and a Volunteer Chaplin on the Wards, where he talked to patients and undertook printing for the Hospital Chaplains. |
| 653/25 | The Group Chair commented that this was an excellent story and without Mr Cartwright's support the Group would not be in a position to provide the levels of care it aspired to for patients. |
| 654/25 | Mrs Brown offered that this was an excellent story, and thanked Mr Cartwright for both his and all the volunteers support who made such a difference to patients and staff. |
| 655/25 | Mrs Wells echoed Mrs Brown's comments and asked Mr Cartwright what message he would give to anyone interested in becoming a volunteer. Mr Cartwright responded offering that volunteers were very useful and could save the nursing teams a lot of time, adding that he believed in the use of volunteers, who helped as many people as possible each day. |
| 656/25 | The Group Chief Executive commented that she and Mr Cartwright had become friends over recent years and took the opportunity to thank him personally for all his time, effort and dedication offered to the Group and added that he often provided some guidance and a steer which was welcomed. The Group Chief Executive |

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| | thanked Mr Cartwright for the excellent work undertaken in championing the syringe drivers and wheelchairs, which was also one of his passions. |
| 657/25 | The Group Chair took the opportunity to thank Mr Cartwright for all that he did, often going over and above the things that were asked of volunteers, for which she was very grateful. Mr Cartwright's feedback was very valuable, and the Group Chair also thanked all volunteer colleagues adding that the Group would not be able to provide great standards of care without the support of volunteers.<br><br>The Board:<br>• **Received the Patient/Staff Story** |
| 658/25 | **Item 3.3 Celebrating Group Success**<br><br>The Group Chair welcomed Group and Integrated Care Board (ICB) colleagues to the meeting who provided the Board with a comprehensive presentation on collaborative working across the system on bowel screening and health inequalities. |
| 659/25 | The bowel screening programme had been running since 2009 and had recently been extended and was now offered to 50 – 74 year olds through a national programme which included test kits being sent out in the post. The process, if a positive test was received, was described and it was highlighted that over 23,000 people had been assessed and over 1,000 bowel cancers had been detected since 2010. |
| 660/25 | The team described a focussed piece of work that looked at four areas of the county where uptake of screening was low, where data and insight, community engagement and co-production had been utilised to develop targeted outreach and tailored campaigns to improve uptake. This hyper-localised approach was the first step to targeting interventions where they were most needed and would make the biggest impact for patients. |
| 661/25 | Other PCNs were now looking to replicate the use of facilities and coproduced templates for letters and posters to promote the importance of bowel screening moving forward, via a community centred coproduction approach and it was believed that this was one of the key ways of tackling health inequalities across the County. |
| 662/25 | The Group Chair thanked colleagues for attending the meeting and for providing such an informative presentation which formed part of the Group's Strategy in respect of prevention and health inequalities. |
| 663/25 | The Group Chief Integration Officer commented that this was a phenomenal piece of work on many levels including the bringing together of population health mapping and the differences in communities recognising the different needs for different people. This also brought together the proactive and reactive agendas, and the view was expressed that lessons could be learned from this on targeted health checks. The Group Chief Integration Officer asked about coproduction and engagement in communities and whether relationship management would be replicable in other programmes of work, as if it was replicable, this could offer many opportunities for local people. The Interim Health Inequalities Programme Lead responded that this |

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| | was completely replicable and what should be being offered. Moving to the new ICB cluster arrangements would provide an opportunity for this area of work to be showcased and expanded upon. |
| 664/25 | The Group Chief People Officer commented that this has personally resonated and took the opportunity to thank the team for all that they did in this area of work and commented that removing the stigmatism and catching early diagnosis was excellent. |
| 665/25 | Mr Orrell offered that this was an excellent presentation; regarding deprivation nationally and within the county and asked if any research had been undertaken in terms of the national position and to see if that was anything being done over and above the work that was being undertaken across the county. The Programme Manager responded that this was a larger problem than just Lincolnshire in terms of deprivation. Noting that it was hard to look at why some areas were deprived and why more were impacted more than others. There was recognition that potentially with the NHS 10 Year Health Plan and left shift, there could be more links with countywide education systems, utilisation of healthcare in the community and reaching out to targeted rural areas more which would be helpful. |
| 666/25 | The Group Chair commented that the Group had a good relationship with system colleagues, noting that the presentation had been a good example of that. The Group Chair expressed a view that the Group's Strategy had been brought to life throughout the presentation with references to health inequalities, prevention and screening and co-production and recognised the learning could be taken from this into other areas, which presented some good opportunities moving forward.<br><br>The Board:<br>• **Received the presentation** |
| 667/25 | **Item 4 Declarations of Interest**<br><br>There were no additional Declarations of Interest made. |
| 668/25 | **Item 5 Minutes of the meetings held on 1 July 2025**<br><br>The minutes of the meeting held on Tuesday 2 September 2025 were approved as an accurate record. |
| 669/25 | **Item 5.1 Matters Arising from the previous meeting/log**<br><br>The Board reviewed the action log and acknowledged that two items were completed, and the remaining open action was due in January 2026.<br><br>The Board:<br>• **Received the action log** |

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| 670/25 | **Item 6 Group Chief Executive's Report to the Board**<br><br>The Group Chief Executive presented the report to the Board and offered that operational colleagues continued to work in busy times, and took the opportunity to thank all staff members for all the work they did. |
| 671/25 | Across the Group a joint Winter Plan 2025-26 had been developed, built on lessons learned from 2024/25 which outlined a proactive approach to managing pressures across the acute and community services. The plan focused on reducing avoidable admissions, enhancing urgent and emergency care pathways and supporting timely discharge through expanded virtual wards and community-based care. |
| 672/25 | The Model Region Blueprint had been published on 11 September 2025 which set out a high-level vision for the future role of NHS regions, as part of the 10 Year Health Plan for England. The blueprint outlined how the seven NHS regions would act as strategic leaders overseeing performance and driving improvements. |
| 673/25 | On 30 September 2025 Lincolnshire ICB, as it was known, changed and from 1 October 2025 the three existing NHS ICBs for Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire, formed a cluster as part of wide-ranging Government reform of the NHS and healthcare landscape. Dr Kathy McLean had been appointed as the Chair designate and Amanda Sullivan as Chief Executive Designate for the clustered ICBs. The first Cluster Quarterly System Review Meeting (QSRM) had also taken place on 1st October, which was chaired by the NHSE Midlands Regional Director. |
| 674/25 | The NHS National Oversight Framework had been published in September and introduced a new approach to measuring the performance of all NHS trusts. The framework assessed providers against 22 metrics across six domains, resulting in a segment rating for each organisation. Under the new framework, ULTH had been placed in Segment 4, while LCHS was placed in Segment 3. |
| 675/25 | The Group Chief Executive informed Board members that in recognition of the continued development of the Group, amendments had been made to some of the executive portfolios to ensure alignment with strategic priorities and operational effectiveness. The Communications and Engagement team would now report directly to the Chief Executive, reinforcing the importance of clear, consistent messaging and stakeholder engagement across the Group. Additionally, the medical staffing and rota coordination teams had been realigned to report directly to the Group Chief Medical Officer, ensuring the responsibility for a more integrated and clinically led approach to medical workforce planning and service delivery. |
| 676/25 | Following the Care Quality Commission (CQC) inspections at Lincoln County Hospital Emergency Department in October 2024, a follow-up visit in July 2025, and an inspection at Pilgrim Hospital, Boston Emergency Department in November 2024, the reports were published on 4 September 2025. The reports acknowledged the significant progress made and commended the departments for their dedication to patient care. While the reports recognised many positive developments, they also noted some areas for improvement. |

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| 677/25 | The new Electronic Patient Record (EPR) programme was officially launched at ULTH in September where there had been good staff engagement through a series of events, with this being a key transformation programme for the organisation which would be a vast improvement in the digital world. |
| 678/25 | As part of the East Midlands Neuro-Oncology Service, which supported patients across the region with brain tumours, ULTH has been awarded the prestigious Tessa Jowell Centre of Excellence status. This recognition highlighted the exceptional standards of treatment, care, and research delivered by the oncology team. The award was granted to a select number of brain tumour centres across the UK, acknowledging the commitment to excellence and continuous improvement in patient outcomes. |
| 679/25 | The Group Chief Executive offered that ULTH had officially launched its Neonatal Home Phototherapy Service which was a significant step forward in the commitment to providing high quality, patient-centred care for newborns and their families. This innovative service enabled clinically stable newborns with mild to moderate jaundice to receive phototherapy treatment in their homes, reducing the need for prolonged hospital stays. |
| 680/25 | From 1 October patient visiting hours at acute and community hospitals across LCHG were extended to 11am – 8pm following feedback from staff and patients, which reflected the Group's commitment to patient centred care by supporting more consistent and accessible visiting opportunities. |
| 681/25 | The Group Chief Executive informed Board members that LCHG digital teams had worked collaboratively with partners across the Lincolnshire system to support the transition of digital support services for Lincolnshire ICB, primary care and LCHS from Arden and GEM Commissioning Support Unit (AGEM CSU) to an internally hosted model. 29 experienced colleagues from Lincolnshire ICB, LCHS and primary care services had been welcomed into the digital team. |
| 682/25 | ULTH had successfully completed its one-year review for the Veteran Aware Accreditation, reaffirming its commitment to delivering personalised, informed, and compassionate care to veterans, serving personnel, reservists, and their families. The Trust continued to meet all eight core standards required for accreditation, demonstrating its sustained dedication to the Armed Forces Covenant. |
| 683/25 | Finally, the Group Chief Executive explained that the LCHG Staff Awards ceremony had taken place on 10th October 2025, celebrating colleagues from across the Group for their outstanding contributions in patient care, innovation, leadership, and teamwork**.** The awards were a key part of the Group's reward and recognition programme, designed to honour and thank staff for their dedication and impact. This year, 1,297 nominations had been received across 13 categories, with 52 individuals and teams being shortlisted which was testament to how highly valued staff members were by both colleagues and patients. |
| 684/25 | The Group Chair thanked the Group Chief Executive for the comprehensive report which demonstrated the vast amount of work currently being undertaken. The Group Chair was looking forward to building good working relationships with Dr Kathy McLean and Amanda Sullivan and the new ICB Cluster moving forward. |

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| 685/25 | The Group Chair requested that the Neuro Oncology Service be received by the Board at a future meeting as a Celebrating Group Success item.<br><br>**Action: Group Director of Corporate Affairs, 6 January 2026**<br><br>The Board:<br>• **Received the report and noted the significant assurance provided** |
| 686/25 | **Item 6.1 Group Model Workstream Progress Briefing**<br><br>The Group Chief Executive presented the report which was taken as read and explained that this was a high-level briefing in respect of progress against Group developments and key milestones. |
| 687/25 | The Group Chief Executive advised of some slippage on timescales, which was being worked through. It was explained that out of date policies remained a risk for the Group, however there was an improvement plan and trajectory to bring that back into compliance and oversight was being given to this directly by the Group Chief Executive. |
| 688/25 | The Group Chair commented on the good progress being made and noted the issue of escalation in respect of policies.<br><br>The Board:<br>• **Received the report and approved the ongoing developments**<br>• **Noted the escalation and mitigations as described** |
| 689/25 | **Item 6.2 Winter Plan**<br><br>The Group Chief Operating Officer presented the report which was taken as read and explained that this was the first joint Winter Plan for the Group which would maximise community pathways and was guided by the expectations of NHS England. |
| 690/25 | The focus of recent work had been in relation to the respiratory response and working with HR colleagues in respect of the offer of care for the workforce to ensure this was robust, recognising that winter was always a demanding time of year. |
| 691/25 | Work had been undertaken with community colleagues and partners across the system to manage demand at the front door and around Medically Fit For Discharge patients to ensure that they were in the right place at the right time. A daily battle rhythm had also been established for winter and there were two Winter Leads, one for ULTH and the other for LCHS who were having daily meetings ensuring flow was being maximised. |
| 692/25 | Work was continuing to be pursued relating to ambulance response times and moving to the 45 minute hard handover mandate which was expected to be delivered prior to the Christmas period. Close working was also underway with mental health colleagues in respect of the ambition to eliminate waits of more than 24 hours in ED. |

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| 693/25 | The Group Chief Operating Officer offered that work was also continued in the system to review performance month by month and additional responses would be put in where necessary, particularly around frailty. The Board was advised that the Full Capacity Plan had been refreshed and approved. |
| 694/25 | Services for children and young people were also being maximised, and the ULTH would be opening the Paediatric Assessment Unit (PAU) in December and today, Ward 7a at Pilgrim Hospital had been opened, which was the frailty assessment unit. The use of additional pharmacists at the front door had also been introduced and the rewards of that initiative were also now being seen. There had been no cancelled patients to date, with the position trying to be maintained for planned care patients to be seen in a timely manner. |
| 695/25 | From a community perspective, the Group Chief Integration Officer explained that work had been undertaken with the Local Authority in respect of transitional care beds which were not being utilised in the best ways possible. Some transitional care capacity had been reduced thus providing a substantial increase in discharge to assess capacity, which had increased from 70 to 175 slots currently and would further increase until January 2026. |
| 696/25 | Mrs Brown commented that this had been discussed at the recent Integration Committee meeting and was an excellent piece of work and offered great strength in terms of winter preparedness. |
| 697/25 | The Group Chief Nurse explained that leadership visibility would be important in the coming months and informed the Board that the winter period was anticipated to be hard for teams, with an increase in influenza cases beginning to be seen, along with more complex patients. |
| 698/25 | The Group Chief Executive commented on the clear direction nationally regarding leadership visibility and asked if the Group Leadership Team were involved in this fundamental piece of work. The Group Chief Nurse responded that quality leadership visibility rounds had recently been launched which were running every three weeks where each leader in the organisation walked around different areas, talking to staff and patients. Feedback was being gathered, and any themes would be fed through to the Quality Committee.<br><br>The Board:<br>• **Received the report and noted the reasonable assurance provided** |
| | **Item 8 Strategic Aim 1 Patients** |
| 699/25 | **Item 8.1 Assurance and Risk Report Quality Committee**<br><br>The Chair of the Quality Committee, Mr Connolly, presented the Committee reports following the meetings held during September and October 2025 and the reports were taken as read with no formal escalations. Mr Connolly drew the Board's attention to changes in respect of internal reporting on mixed sex accommodation, regarding reporting non justified breaches. An increase had started to be seen, and the Committee had requested a deep dive to further understand this. |

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| 700/25 | Mr Connolly also informed the Board in respect of Looked After Children initial health checks where there continued to be some challenges in respect of ongoing capacity and resourcing. Mr Connolly informed the Board of some significant improvements seen in paediatric cardiology waiting lists and as such ULTH had moved from regional to local oversight. Harm reviews were in place and were being consistently reviewed and reported to the Committee. |
| 701/25 | The 2024/25 LCHS Infection Prevention and Control Annual Report had been received and was commended to the Board, and significant improvements had been made in this area. ULTH had been identified as an outlier in antimicrobial usage, however an improvement had been seen with recognition that there was further work to do, specifically on E-Coli infections where actions and mitigations were in place. |
| 702/25 | In respect of maternity the Board was asked to note the continued challenge around the Clinical Negligence Scheme for Trusts (CNST) Maternity Standard Four, neonatal staffing and BAPM standards were there was a plan in place to achieve the nursing establishment however, it was likely that the ULTH would not be fully compliant until January 2027. This remained on the risk register and plans and mitigations were in place. |
| 703/25 | With regards to Standard Five, maternity workforce, as previously reported there was a 12.1WTE shortfall, in relation to being able to deliver the 24/7 triage service. Mr Connolly requested that Board noted that the ICB had declined the additional funding request and further work was ongoing to strengthen the business case. The Committee believed that this presented a material risk to the CNST compliance. |
| 704/25 | Standard Seven, maternity and neonatal voices, the current contractual hours were no longer sufficient to meet the year seven standard. Mitigations were in place, and a full review of the guidance would be undertaken to understand how this was provided and commissioned in the future. |
| 705/25 | Mr Connolly drew attention to the remaining CNST updates which were highlighted as follows and included within the upward report. The remaining reports were available in the iBabs Reading Room for Board members. |
| 706/25 | Standard Three, ATAIN: Note update relating to continuation of the Quality Improvement Project ‘Midwives as second checkers for neonatal IV antibiotics’. |
| 707/25 | Standard Six, Saving Babies Lives Care Bundle: Note progress to achieve compliance with all six elements of SBLCB v3.1 |
| 708/25 | Standard 9- Floor to Board; Progress was continuing with the Staff Experience Group maternity and neonatal culture plan and the Committee received the quarterly Claim, Complaints and incident Scorecard. |
| 709/25 | Standard ten, MNSI; Patient event numbers for CNST MIS Year 7 were received: there had been three cases that qualify for MNSI and one that qualified for Early Notification. There was also 100% compliance with Duty of Candour in both verbal and written formats, including EN and MNCI information in accessible format in the patient’s own language. |

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| 710/25 | The Committee received an update on Martha's Rule, following the recent national announcement and the reporting structure and further rollout had been discussed for Grantham ED. Updates would be provided to the Committee moving forward via the Patient Safety Group upward reports. |
| 711/25 | The Group Chief Nurse referred to the mixed sex accommodation breaches, and provided assurance that work was underway and updates would be provided through the Patient Experience report. The ventilation report had also been received, and work was being undertaken in respect of harm relating to surgical site infections triangulating through the Infection, Prevention and Control Group. |
| 712/25 | The Group Chief Nurse commented that there were a number of items to celebrate in terms of next steps for Matha's Rule and in relation to the CNST Standards the ICB had requested further information on the values framework. The Board would be kept updated on the governance processes. |
| 713/25 | In relation to Paediatric Cardiology, the Group Chief Medical officer explained that teams had now cleared the backlog, and positive work had been undertaken by clinicians to get this back on track. Clinical harm reviews had been completed and were being reported through the oversight group into the Quality Committee and the Group Chief Medical Officer advised that no major harm had been seen at present. |
| 714/25 | The Group Chief Clinical Governance Officer advised that the CQC reports had now been published and whilst there were no specific actions, areas for improvement may still be identified. The reports were currently being finalised and would be formally submitted to the Quality Committee and on to the Board in due course. |
| 715/25 | Mrs Brown held oversight of the CNST work and advised that training was being completed. There were some vulnerabilities relating to the investment in staffing. Mrs Brown commented that implementation of the triage system was a national must do and investment would be required for this, with recognition of the work of the Executive team to rectify this situation. |
| 716/25 | The Group Chair requested a Board Development Session be held on maternity services at an appropriate time.<br><br>**Action: Group Director of Corporate Affairs, 6 January 2026**<br><br>The Board:<br>• **Received the assurance reports, noting there were no formal escalations**<br>• **Received the 2024/25 LCHS Infection, Prevention and Control Annual Report as presented**<br>• **Noted the updates on the CNST Standards as presented** |
| 717/25 | **Item 8.2 Finance Briefing**<br><br>The Group Chief Finance Officer offered a summary of performance at month six and be explained that the Group was on plan for a £14.3m deficit which had been built broadly during quarter one, with the run rate improving during quarter two. The Group |

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| | Chief Finance Officer explained that to achieve a break even position at the end of the year, efficiency programmes needed to be stepped up during the second half of the year; and there were three key areas of focus on the revenue position. |
| 718/25 | The Group Chief Finance Officer explained that variable incomes relating to activity within planned care settings including elective day cases and outcomes; productivity improvements were being seen and for month six were above plan and the position was beginning to recover. |
| 719/25 | In terms of efficiency programmes, the Group Chief Finance Officer offered that these were slightly behind schedule by £0.2m with some schemes not delivering in line with expectations, which was being addressed with the Care Groups. |
| 720/25 | Workforce controls were also being reviewed and whilst the overall WTE position was reducing, this was not at the required pace and was mainly attributed to the temporary workforce. The Group Chief Finance Officer explained that HR and nursing colleagues were working on this along with medical colleagues to develop plans to further reduce the position. There had been some reductions from the Mutually Agreed Resignation Scheme (MARS) in September and October and it was anticipated that more would come through during November, due to notice periods being worked in some cases. |
| 721/25 | External challenges continued to be addressed with system partners and regional colleagues in respect of winter beds. The Group Chief Finance Officer advised that overall, the revenue position had an identified £14m risk, mainly linked to system efficiency schemes. Internal and external mitigations were now being implemented. |
| 722/25 | The Group Chief Finance Officer offered confidence to Board members that a break even position could be achieved at the end of the financial year in terms of capital delivery and reminded colleagues that the Group had the largest capital programme of over £125m to deliver and at month six this was behind trajectory, which was principally due to delays on external approvals, however those had now been received and progress was underway. |
| 723/25 | The Group Chief Finance Officer also informed those present that since the capital plan had been approved, notification had been received of an additional £6m capital investment into the system which had been applied to the Group and was attributed to improvements made on the four hour performance standard and category two response times, which would allow further improvements to services and front line care. |
| 724/25 | The Group Chair took the opportunity to thank the Group Chief Estates and Facilities Officer and his team for the delivery of this large scale transformational estates work to improve environments for patients and staff. The Group Chair had recently heard nationally that if capital funding was not spent by month eight, there was potential for this to be removed. The Group Chief Finance Officer advised Board members that a submission had been made, providing assurance on the capital trajectory for the year end. There was in fact potential for funding to become available from those areas unable to spend allocations. |

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| 725/25 | Mrs Buik commented that further work could be undertaken in respect of helping members of the public to understand the full level of investment being made across the various sites and suggested this formed part of the new Communications strategy. |
| 726/25 | In terms of efficiency delivery, the Group Chair asked what support was being provided to the Care Groups and the plan for managing the shortfall. The Group Chief Finance Officer responded that external delivery partners were assisting with the large productivity projects, and an internal service improvement team were working across Care Groups on specific schemes with forward trajectories, which were being reviewed at Productivity, Improvement and Transformation Oversight Forum (PITOF) and Performance Review Meetings. There was a strong governance framework around this work. The Group Chief Integration Officer commented that one issue relating to this was moving resource to assist with the required work and for that reason, it had been added to the risk register. Consideration was also being given to adding a cohort of PMO focussing on financial efficiency to achieve some consistency. |
| 727/25 | With regards to temporary staffing, the Group Chief Nurse explained that high level approval of temporary staffing was now required, and this was being triangulated from a vacancy control perspective where Trac ID numbers were being added to Health Roster where Bank staff were being utilised. |
| 728/25 | The Group Chief Medical Officer advised the Board that following the changes in portfolios, described by through the Group Chief Executive's report, he was leading the work as the Senior Responsible Officer (SRO) for temporary medical workforce CIP, supported by Medical Staffing and rota co-ordination and also advised that work was underway to enact a new priority access bank rate which was lower than the previous rates used, creating a reduction in spend. Temporary staffing capping would also be enacted which would require approval from either the Group Chief Medical Officer or Deputy Group Chief Medical officer and would provide more enhanced grip and control on job planned activity. The Group Chair asked when a more certain position and trajectory would be available, along with mitigations for any gaps. The Group Chief Medical officer would provide an update on the impact of the actions at the next Board meeting.<br><br>**Action: Group Chief Medical Officer, 6 January 2026** |
| 729/25 | The Group Chief People Officer explained that recovery actions had been undertaken in August and September which were in line with the workforce plan to move the Group back on in line with the plan. Vacancy control processes were in place and there were further gateways for each Care Group to have a screening process in place which was working well, despite an increase in vacancy rates being seen as expected. |
| 730/25 | The Group Chief Executive, in support of the Group Chief Medical Officer as the SRO, advised that weekly updates were being received by the executive team in terms of temporary medical workforce and that a trajectory and any gaps would be received in the next 2 weeks at the meeting. |

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| 731/25 | The Group Chair advised of recent attendance at a regional meeting where cash had been discussed and a comment had been made on requests for cash, which signalled that Boards did not have a grip of the financial position; any requests for cash would not be received favourably by NHS England.<br><br>The Board:<br>• **Received the report noting the reasonable assurance and recommendations** |
| 732/25 | **Item 8.3 Assurance and Risk Report Finance and Performance Committee**<br><br>Ms Cecchini provided the assurances received by the Finance and Performance Committee, at the meetings held during September and October 2025 and the reports were taken as read. |
| 733/25 | Performance Review Meeting upward reports were now being received by the Committee and provided clarity into the work of the Care Groups on actions being taken with the Board noting that one Care Group was in escalation. |
| 734/25 | At the September meeting performance had been behind trajectory however was now showing some positive improvement. Upward reports had been received from the planned care and unplanned care board meetings which provided positive assurance on the actions being taken on performance issues. |
| 735/25 | With regards to estates at the September meeting the Committee agreed a recommendation to move from red to amber on the Board Assurance Framework (BAF) as consistent assurances continued to be received and the Committee was satisfied that all authorised engineers were now in place across the Group. The premises assurance model also showed positive improvement from previous years, which added to overall assurance around the estates. |
| 736/25 | The Committee received the Emergency Planning report which demonstrated partial compliance for both ULTH and LCHS in respect of core standards. |
| 737/25 | From an Information Governance perspective, the Data Security Protection Toolkit (DSPT) submission had been received and offered confirmation for LCHS having declared standards being met. For ULTH the submission made was approaching standards with NHS England accepting the position and associated improvement plan. The Committee noted the continued progress and improvements being made in respect of Subject Access Requests and the significant reduction of the backlog. |
| 738/25 | The Group Chief Finance officer advised at the September meeting a deep dive had been taken on cash and a checklist had been used from the regulator on a good practice assessment. A cash update would be provided to the Committee on a monthly basis moving forward. |
| 739/25 | The Group Chief Finance officer also advised at the October meeting that learning from the post investment evaluation from Skegness CDC had been received to support identification of learning for teams that could be demonstrated from previous schemes. |

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| | The Board:<br>• **Received the assurance report**<br>• **Noted the recommendation on the Board Assurance Framework** |
| | **Item 9 Strategic Aim 2 People** |
| 740/25 | **Item 9.1 Assurance and Risk Report People Committee**<br><br>Mr Connolly provided the assurances received by the People Committee, at the meeting held during September 2025 and the report was taken as read. |
| 741/25 | There were three elements for the Board to note; the recognition of removal of the level 7 apprenticeship funding, some clinical AHP programmes continued however there was awareness of the impact on this moving forward. In terms of medical education, improvement had been seen following two external visits from Health Education England and NHS England. The Committee received the 10 Point Plan for Resident Doctors, and two areas were identified where further work was required. |
| 742/25 | A discussion had taken place on medical staffing and the Committee agreed that further analysis was required to align and triangulate the substantive workforce, temporary staffing and productivity with the Committee also requiring further assurance on the workforce hub, where further work was requested to provide more detailed assurance on delivery of the plan. |
| 743/25 | Mrs Wells provided the assurance received by the People Committee at the meeting held in October 2025 and the report was taken as read. Key points to note included the improvement in statutory and mandatory training for Doctors. |
| 744/25 | LCHG had been successful as the overall winner at the Greater Lincolnshire Apprenticeship Awards as an employer champion. |
| 745/25 | Concerns were raised on non-compliance of induction training and further information would be provided at the next meeting. |
| 746/25 | Some work had commenced on nursing profile updates which were anticipated to be concluded by May 2026 with learning from the recent healthcare support worker process being utilised to support this. Improvements were also being seen on the medical workforce data triangulation and the Committee heard of actions being taken to mitigate any risks in medical staffing in more fragile services. |
| 747/25 | The 2024/25 freedom to speak up annual report was received, and the Committee commended the work of both Freedom to Speak Up Guardians who continued to work well together across the Group. Sickness absence co-ordinators were being recruited who would be able to provide specific support in dedicated areas. |
| 748/25 | The Committee acknowledged the new leadership programme which had a focus on promoting staff to speak up well in their own areas, the formal launch of the sexual safety charter was also received. The Group had also launched the values and behaviours framework on the 1st October 2025. |

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| 749/25 | Work was being undertaken to improve the AAC process and further work would be shared in future meetings with positive progress noted to date. Mrs Wells echoed the Group Chief Executive's previous comments in respect of the excellent staff awards evening that recently been held with an update offered to the People Committee. |
| 750/25 | The Group Chief People Officer provided an update on employer exclusions where the average duration of exclusions had reduced from 19 weeks to 9 as a result of hard work being undertaken in the background. The Group Chief People Officer also advised that there was no exclusions currently from an LCHS perspective and four within ULTH. Close working was continuing with ER casework managers. |
| 751/25 | An update was provided on the wellbeing day reward where a poll had recently been circulated to staff, and a positive impact was being seen on flu vaccination uptake and completion of the national staff survey as a result of the additional health and wellbeing day offer. |
| 752/25 | The Group Director of Corporate Affairs offered that benefits of bringing together the freedom to speak up function were now being seen, and learning was being shared along with the exploration of different approaches. |
| 753/25 | Mr Orrell commented on the increase in statutory and mandatory training compliance for doctors and the increase to 50% and asked if this was good enough. The Group Chief Medical Officer responded that the aim should always be 100% however time was often a factor for doctors to complete mandatory training, however work was underway to ensure improved compliance on this aspect. |
| 754/25 | The Group Chief Clinical Governance Officer advised that the Safe to Say Campaign, which would be launching in the coming weeks, was aimed at encouraging people to speak up without retribution and a communications plan for this would be received at both ELT and GLT in the coming weeks.<br><br>The Board:<br>• **Received the assurance reports**<br>• **Noted the escalations in respect of medical staffing and the workforce hub**<br>• **Received the 2024/25 Freedom to Speak Up Guardian Annual Report** |
| 755/25 | **Item 9.2 Resident Doctors 10 Point Plan**<br><br>The Group Chief Medical Officer informed Board members that following receipt of a letter from NHS England in August 2025 setting out a “10-Point Plan” to improve the working lives of resident doctors, initial actions were required to be taken over the next 12 weeks, with further milestones to be achieved into 2026. |
| 756/25 | In response to the letter, a focused Task and Finish group had been established to ensure that the Group enacted the required actions based on the NHS England request and the baseline and gap analysis for ULTH. The current organisational position was presented to the Board which identified areas of compliance and gaps and those actions that had been undertaken or were proposed to deliver the domains of the 10 Point Plan. |

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| 757/25 | A Resident Doctor Peer Representative had been appointed as per the requirements of the plan, and two further appointments of associate representatives had also been made who would work together on this. The Group Chief Medical officer would also fulfil the role of Senior Medic. The Group Chief Medical Officer and Group Chief Executive Officer had met with the Resident Doctor Peer Representative. |
| 758/25 | The Group Chief Medical Officer advised that a national meeting regarding the 10 Point Plan was taking place this week where it was anticipated that more detail would be made available. Assurance was offered to the Board that the necessary requests for the first six to twelve weeks had been undertaken. |
| 759/25 | Mrs Wells referred to an action regarding dedicated space for Resident Doctors and the risk surrounding this. The Group Chief Medical Officer responded that this was being addressed, and it was hoped that space could be allocated as per the action plan and further detail would be provided to the People Committee. |
| 760/25 | From a Board perspective, the Group Chair expressed a view that NHS England would commence publishing this data as part of the overall NOF data. It was understood that the baseline assessment had been submitted, and the initial response and process was being worked through via the Task and Finish Group. The Group Chief Medical Officer responded that this was the case, however in the absence of any framework currently, which would underpin the next steps, this was difficult. |
| 761/25 | The Group Chair commented that there were several points relating to the Trust addressing rota and scheduling transparency and the opportunity to self-rota however this did not appear to be detailed in the response to provide any assurance to the Board. The Group Chief Medical Officer responded that there was transparency in terms of scheduling, however the lack of detail may be due to the framework not yet being received and it was anticipated that the meeting later this week would offer further information. |
| 762/25 | The Group Chair commented that more was being specified in the documentation than in the action plan, however agreed to discuss the governance aspects of this outside of the meeting, alongside what reports would be received by the People Committee. Currently limited assurance was being received by the Board on all the aspects of the 10 point plan. The Group Chair commented that the reporting of this would need to be reviewed as this moved into the People Committee, which would retain overall oversight and the Board would expect to receive assurance through this route.<br><br>**Action: Group Chief Medical Officer, 6 January 2026**<br><br>The Board:<br>• **Received the Report** |

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| 763/25 | **Item 9.3 Nursing Establishment Review**<br><br>The Group Chief Nurse explained that a nursing establishment review had been undertaken following the education programme for ward managers and the improved data collection in May – June 2025, using the updated NICE-endorsed SNCT tool. |
| 764/25 | Further rounds had taken place in October and would again in January 2026 to align with the wider bed reconfiguration and the changes to the urgent and emergency care pathways. |
| 765/25 | Across ULTH and LCHS, the Group Chief Nurse informed the Board that consistent shift patterns had been implemented, ward leaders had moved to the 80/20 supervisory model to focus on improving skill mix rather than increasing numbers. Most areas only required minor template adjustments, and many changes related to moving to long days, correcting historical templates, or ensuring a band 6 was present per shift where clinically indicated. |
| 766/25 | Further work was required at Pilgrim ED, where a business case was required due to increased activity, estate changes and the future Life & Limb model and chemotherapy services across all three sites, which would also require business cases to support extended hours and activity. |
| 767/25 | Several wards had increasing demand for enhanced care, and rather than uplift each establishment individually, the central Enhanced Therapeutic Observation & Care (ETOC) model was being progressed, which would improve quality and reduce temporary staffing spend. |
| 768/25 | The Group Chief Nurse explained that from a financial perspective the overall impact of the review was a net reduction of 7.31 WTE and £339k, with the Medicine Care Group seeing a small increase, and Surgery, Clinical Support Services and Family Health seeing reductions. This supported the nursing CIP position, particularly the shift to long days which would stabilise rosters and reduce the use of temporary staffing. |
| 769/25 | The Group Chief Nurse offered that this had been a robust, clinically led review that strengthened consistency, supported safety, and would ensure the workforce was matched against the future operating model of the Group.<br><br>The Board:<br>• **Received the report and accepted the recommendations** |
| | **Item 10 Strategic Aim 3 Population** |
| 770/25 | **Item 10.1 Assurance and Risk Report from the Integration Committee**<br><br>Mrs Brown provided the assurances received by the Committee at the meetings held in September and October 2025 noting there were no upward escalations to the Board. A twelve month review of the Committee would be taking place in the coming weeks. |

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| 771/25 | Key areas of transformation relating to lymphoedema, the redesign of MSK services and future opportunities to work together as a system to deliver AI had been discussed that the recent meetings and Mrs Brown advised that the left shift work was also gathering momentum. |
| 772/25 | Good progress was being made on the patient service hub which was an exciting piece of work to focus on moving forward. An update had been provided in respect of the Planning Framework which had been included within the Board paper pack and demonstrated the level of planning and work being undertaken across the footprint and system. Confirmation of approvals of the EPR and Electronic Document Management System (EDMS) programmes had also been included in the Board paper pack for information. |
| 773/25 | In respect of the digital arena, a lessons learned exercise was being undertaken which would help other areas in terms of moving forward on complex pieces of work. From an estates perspective there were many programmes of work currently being undertaken, the new endoscopy area was one area of focus and Mrs Brown also explained that the current Target Operating Model arrangements required further clarity and had been paused, following the new ICB Cluster arrangement, and further information was awaited. |
| 774/25 | From a planning perspective the Group Chief Integration Officer advised that the new guidance had recently been received, and further updates would be provided accordingly. The Board was advised that the first neighbourhood board had recently taken place, and it was noted that more focus needed to be paid to third sector colleagues and Primary Care Network (PCN) Alliances.<br><br>The Board:<br>• **Received the assurance reports noting there were no escalations** |
| 775/25 | **Item 11.1 LCHG Strategy Delivery Q1 Assurance Report**<br><br>The report was presented and the Group Chief Integration Officer provided assurance to the Board that good progress was being made against the Strategy which was evidencable. There were areas to be looked at without exception including the cultural work and engagement between teams. |
| 776/25 | In terms of the scheduling of the next update to the Board, the Group Chief Integration Officer confirmed that this would be provided at the first meeting of quarter four and then at the end of quarter one of 2026/27, to ensure that this would not coincide with the planning window.<br><br>The Board:<br>• **Received the report noting the substantial assurance** |
| 777/25 | **Item 11.2 National Oversight Framework Report**<br><br>The National Oversight Framework (NOF) Report was presented and the Group Chief Integration Officer advised that LCHS had been scored in segment three and ULTH in segment four, however the underlying measures scored the organisations in |

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| | the segments below, segment two for LCHS and segment three for ULTH, as there were some outliers in the scoring profiles. |
| 778/25 | For assurance the Group Chief Integration Officer offered that there was good oversight on this within the relevant Committees and associated work was being undertaken with the measures triangulating back to the new performance reports. |
| 779/25 | The Group Chief Integration Officer explained that the new performance dashboard was now being measured against the same framework as the segmentation. The way in which 12-hour waits had been recorded for ULTH had disproportionately disadvantaged the scoring and similarly the way in which Urgent Community Response data had been collected for LCHS had also disadvantaged the scoring. |
| 780/25 | The new NOF dashboard would provide a monthly view, and nationally this was received on a quarterly basis. All Committees would receive a monthly view of the data that would be updated on the NOF position, and the Board would receive a Board level dashboard at each meeting. |
| 781/25 | The Group Integration Officer advised caution of not focussing on the NOF as the new measures, however these would act as a barometer for progress being made in comparison to other measures. |
| 782/25 | The Group Chair commented on the impressive work had been undertaken to create the new dashboards.<br><br>The Board:<br>• **Received the National Oversight Framework Report which provided reasonable assurance** |
| 783/25 | **Item 11 Integrated Performance Reports**<br><br>The Integrated Performance Reports were taken as read with the Board noting that the reports had been received and reviewed in depth by the Committees and several areas had been discussed throughout the meeting. |
| 784/25 | The graphical presentation final report in the pack demonstrated the at a glance position which would continue to be developed with Committee Chairs and Executive leads, with the Group Chief Integration Officer noting that this was not yet the final version of the report for the Board, with further data to be included.<br><br>The Board:<br>• **Received the Integrated Performance Reports noting the reasonable assurance** |
| | **Item 12 Risk and Assurance** |
| 785/25 | **Item 12.1 Group Risk Management Report**<br><br>The Group Chief Clinical Governance Officer presented the report and highlighted that for LCHS there was one very high risk sitting with the Quality Committee, which was in relation to speech and language therapy, however service re-design was |

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| | taking place which was expected to reduce the risk. For ULTH there were several very high risks; one relating to medicines reconciliation which had been closed, however not entirely and had been merged with another similar risk, where there was further work to be undertaken. |
| 786/25 | A further risk had not been reviewed within relevant timescales relating to delays in cancer pathways, which had subsequently been updated, and a recovery trajectory was now in place to improve 62 day plus breaches by March 2026. |
| 787/25 | New risks for the Integration Committee had been identified recognising the transformational work being undertaking across the system, and the potential impacts of and how these would be navigated.<br><br>The Board:<br>• **Accepted the risks as presented noting the significant assurance** |
| 788/25 | **Item 12.2 Board Assurance Framework**<br><br>The Group Director of Corporate Affairs presented the 2025/26 Board Assurance Framework in its new format as considered by all the Committees during September and October 2025. |
| 789/25 | One recommendation was made to the Board in respect of objective 1d, to move from a red to amber rating in respect of modern, clean and fit for purpose care settings which was based on assurance being received through the Finance and Performance Committee.<br><br>The Board:<br>• **Accepted the 2025/26 Board Assurance Framework**<br>• **Endorsed the recommendation of objective 1d to move to an amber rating** |
| 790/25 | **Item 12.3 Assurance Report from the Audit Committee**<br><br>Mrs Brown provided the key highlights from the Audit Committee meeting held in October 2025. |
| 791/25 | External auditors had undertaken a lessons learned report from the 2024/25 audit of the financial accounts and proposed changes were being implemented as appropriate within the Finance teams. Work was also underway in readiness for the 2025/26 audit of the financial accounts whilst still awaiting the final submission deadline. |
| 792/25 | From an Internal Audit perspective, it was reported that all audits were progressing well, which was a good improvement from last year's position which was positive and there was good alignment from the Group's internal team and the Internal Audit team. |
| 793/25 | A report was received from the Counter Fraud team which provided assurance that all areas were being met; one concern raised was in relation to overdue policies and procedures which remained a key focus for the Committee and the Audit Committee |

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| | Chair had received confirmation that a process was being implemented to address the backlog, and a formal update would be provided at the next meeting. |
| 794/25 | The Committee also received some good feedback on the new BAF framework, where it was agreed that this was working well. |
| 795/25 | The 2024/25 Audit Committee Annual Report was presented for information to the Board.<br><br>The Board:<br>• **Received the Assurance Report and noted the ongoing escalation point in respect of overdue policies**<br>• **Received the 2024/25 Audit Committee Annual Report** |
| 796/25 | **Item 12.4 Board Forward Planner**<br><br>The Forward Planner was presented and received for information.<br><br>The Board:<br>• **Received the Board Forward Planner** |
| 797/25 | **Item 13 Any Other Notified Items of Urgent Business**<br><br>No further items were discussed. |
| 798/25 | The next scheduled meeting will be held on Tuesday 6th January 2026 via MS Teams live stream. |

| **Voting Members** | **6 May 2025** | **1 July 2025** | **2 Sept 2025** | **3 Nov 2025** | | | | | | | | |
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| **ULHT/LCHS** | | | | | | | | | | | | |
| Elaine Baylis | X | X | X | X | | | | | | | | |
| Rebecca Brown | X | X | A | X | | | | | | | | |
| Neil Herbert | X | X | X | A | | | | | | | | |
| Dani Cecchini | X | X | X | X | | | | | | | | |
| Jim Connolly | A | X | X | X | | | | | | | | |
| Karen Dunderdale | X | X | X | X | | | | | | | | |
| Daren Fradgley | X | X | X | X | | | | | | | | |
| Nerea Odongo | X | X | A | X | | | | | | | | |

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

**PUBLIC BOARD IN COMMON ACTION LOG**

Agenda item: 5.1

| Trust Board date | Minute ref | Subject | Explanation | Assigned to | Action due at Board | Completed |
|---|---|---|---|---|---|---|
| 1 July 2025 | 386/25 | Assurance Report from Quality Committee | Stocktake to be undertaken to understand the gap analysis in respect of maternity services | Group Chief Medical Officer | 06.01.26 | |
| 3 Nov 2025 | 685/25 | Group Chief Executive's Report | Neuro Oncology Service to be invited to attend a future Board meeting as a Celebrating Success item. | Group Director of Corporate Affairs | 06.01.26 | Completed – added to the list for future Celebrating Success item |
| 3 Nov 2025 | 716/25 | Assurance and Risk Report from Quality Committee | Board Development Session to be scheduled for maternity services | Group Director of Corporate Affairs | 06.01.25 | |
| 3 Nov 2025 | 728/25 | Finance Briefing | Position and trajectory update to be provided on job planned activity and mitigations for any gaps | Group Chief Medical Officer | 06.01.25 | |
| 3 Nov 2025 | 762/25 | Resident Doctors 10 Point Plan | Group Chief Medical Officer and Chair to discuss governance aspects of the Plan | Group Chief Medical Officer | 06.01.25 | Completed |

NHS
Lincolnshire Community and Hospitals NHS Group

# Group Chief Executive's Report

Caring and building a healthier future for all

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| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6th January 2026* |
| Agenda item number | *6* |
| Report title | *Group Chief Executives Board Report* |
| Report purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | • *Information* |
| Accountable Director | *Karen Dunderdale, Group Chief Executive* |
| Author(s) | *Karen Dunderdale, Group Chief Executive*<br>*Gemma Coupland, Executive Business Manager* |
| Assurance rating:<br>• Substantial assurance<br>• Reasonable assurance<br>• Limited or no assurance | |
| Prior approval process, if applicable | *N/A* |
| Financial implications, if applicable | *N/A* |
| Action / decision required | *The Board is asked to note the update on the key points from November and December 2025* |

*Assurance Rating Key:*

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

| How the report supports the delivery of the LCHG strategic aims & objectives: | |
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| *Patients: Better Care – Timely, affordable, high quality care in the right place:* | *X* |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | |
| 1b: Reduce waiting times for our patients | |
| 1c: Improve productivity and deliver financial sustainability | |

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| 1d: Provide modern, clean and fit for purpose care settings | |
| *People: Better Opportunities – Develop, empower and retain great people:* | *X* |
| 2a: Enable our people to fulfil their potential through training, development and education | |
| 2b: Empower our people to continuously improve and innovate | |
| 2c: Nurture compassionate and diverse leadership | |
| 2d: Recognising our people through thanks and celebration | |
| *Population: Better Health – Improve population health:* | *X* |
| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | |
| 3b: Move from prescription to prevention, through a population health management & health inequalities approach | |
| 3c: Enhance our digital, research & innovation capability | |
| 3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan | |

**System Overview**

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

b) Resident Doctors participated in national industrial action coordinated by the British Medical Association from 14th until 19th November 2025. NHS England issued a detailed letter outlining expectations that trusts should maintain critical services whilst sustaining at least 95% of elective activity, which we did. The professionalism, flexibility and compassion of staff under pressure ensured that our patients continued to receive safe, high-quality care and that teams were supported. A letter of thanks to all colleagues was received from Sir Jim Mackey, NHSE Chief Executive and Rt Hon West Streeting MP, Secretary of States for Health and Social Care.

   A further round of Resident Doctor industrial action took place from 17th to 22nd December where we saw a similar level of resident doctors taking strike action. During this period of strike action, we were able to continue to deliver over 99% of scheduled activity..

c) During October, The Medium Term Planning Framework was published which sets out the priorities and planning assumptions for 2026/27 to 2028/29, focusing on productivity, financial sustainability, and transformation. It marks a shift from short-term cycles to a locally empowered model aligned with the 10-Year Health Plan. Central to this approach are three major strategic shifts: delivering integrated neighbourhood health to bring care closer to communities, embedding digital pathways through the NHS App and Federated Data Platform to improve access and efficiency, and prioritising prevention to reduce long-term demand and improve population health. The first submission of a three-year plan, covering finance, workforce, and performance trajectories, took place in December 2025, with a final five-year narrative plan due by February 2026.

d) During November NHS England published the Strategic Commissioning Framework, which sets out the principles of strategic commissioning, clarifies expectations of ICBs and sets the approach within the NHS operating model and the ambitions of the 10 year health plan. The framework introduced a four stage approach; understanding population needs through linked data and intelligence; developing a long term population health strategy and delivery plan; delivering priorities through resource allocation payor functions; and evaluating impact through rigorous outcome monitoring.

e) I have taken a seat on the ICB Cluster Board as the Lincolnshire provider partner. I attended the first ICB Cluster Board public meeting in November. I also attended a board development session in December where the Strategic Commissioning Framework was discussed and an early development of the long term population health strategy was debated.

f) Sir Jim Mackey, NHS England Chief Executive and Jo Lenaghan, Chief Workforce Officer wrote to all Trusts confirming NHS England were formally

and actively adopting the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism and encouraged all NHS Organisations to adopt and note the associate commitments to free speech in order to reinforce the collective stance against antisemitism. Lincolnshire Community and Hospitals NHS Group (LCHG) is committed to this ask and will continue with the planned local actions and also ensure that the national actions are embedded when new guidance and training is released.

g) NHS England wrote to all NHS Trusts in December with requirements to strengthen processes to promote sexual safety and reduce sexual misconduct in the NHS. A number of new actions were outlined for trusts to undertake including introducing investigation training and specialist investigators. Trusts are also required to review their chaperoning policies to ensure that they reflect the key principles in the improving chaperoning guidance, along with establishing review groups to ensure that sexual misconduct reports are correctly and robustly considered. The Group has reinforced our commitment to creating a safe environment through the launch of the Sexual Safety Charter.

**Group overview**

a) Following an inspection carried out in September 2025 into end of life care at LCHS the CQC published its report on 24th November 2025. During the assessment the CQC visited all locations within LCHS that provide end of life care including The Butterfly Hospice in Boston, John Coupland Hospital in Gainsborough, Louth County Hospital, the Tulip Suite at Johnson Community Hospital in Spalding and Skegness District Hospital. The overall rating of the service remained as 'Good' as a result of the inspection, which demonstrates a continued commitment to providing high quality end of life care to the residents of Lincolnshire.

b) In November, the Group had the privilege of hosting the Public Board meeting of the Health Services Safety Investigations Body (HSSIB), providing a valuable opportunity to observe their proceedings. Following the meeting, Group representatives engaged with HSSIB to showcase the significant patient safety improvements currently being implemented across the Group. Immediate feedback from HSSIB was positive, recognising the depth and quality of our patient safety work and noting the substantial impact these initiatives are expected to deliver once fully embedded.

c) During December, the National Oversight Framework ratings for Quarter 2 were published. For this period, ULTH remains in segment 4, ranking 124th out of 134 acute trusts. LCHS was placed in segment 4, ranking 46th out of a peer group of 61. The data highlights several areas where our services compare well against peers, and the publication of these metrics enables us to focus on opportunities for improvement to benefit our patients. It is important to note that the report reflects performance from three months ago. While there is still more to do, we know that a number of access measures have continued to improve since then.

d) The first Provider Oversight Group Meeting for the Group with the NHSE regional team took place during December, chaired by the Director of System Co-ordination and Oversight. The meetings have been established in line with the oversight arrangements linked to the NHS Oversight Framework. The meeting was positive and there was recognition of our improving position across performance and finance.

e) The Group continues to face significant challenges due to the national rise in cases of flu and other respiratory illnesses. In response to this, NHS England issued guidance for all trusts to increase healthcare worker flu vaccine uptake further. We have agreed to aim to vaccinate at least 58% of acute staff and 55% of community staff this year. In addition, the Group has introduced mandatory mask wearing in all clinical areas providing patient care across the organisation. This reflects our commitment to protecting patients and staff, reducing transmission risk, and maintaining resilience during a period of heightened seasonal pressure.

f) Following a successful pilot of the Pharmacy First initiative at Lincoln Urgent Treatment Centre (UTC), a new referral pathway will be rolled out across all UTCs and Clinical Assessment Services (CAS) in 2026. This pathway enables staff to refer patients with specific conditions directly to a pharmacy of their choice, reducing waiting times at UTCs.

g) The School Aged Immunisation Service (SAIS) for Lincolnshire has been recognised as one of the leading performers in the region, surpassing both Midlands and national averages. Since September, the team has successfully administered over 51,500 flu vaccinations to children aged 4–16 across the county, helping to protect thousands of families and communities. LCHS will continue to host and deliver SAIS in Lincolnshire for a further 3 years.

h) The county's Community Diagnostic Centres (CDC) have had a lot to celebrate in the last few months. The joint building project for the Lincoln and Skegness CDCs was honoured at the Building Better Healthcare Awards 2025, winning Gold in the CDC of the Year category. These prestigious awards celebrate the most innovative projects driving the future of healthcare design, technology, and delivery across the UK. The award was collected by ULTH's building partners, MTX Contracts, in recognition of their outstanding contribution to the project. In addition, our CDCs reached an important milestone in December, completing more than a quarter of a million diagnostic tests overall since the programme was launched in Lincolnshire in 2022.

i) Carol Jackson, Healthcare Support Worker at Lincoln County Hospital, has been honoured with the prestigious Chief Nursing Officer for England Award. Carol plays a vital role in supporting patients undergoing cancer treatment, providing emotional care and compassion during what is often an incredibly challenging time. This national award recognises Carol's outstanding contribution and the meaningful difference she makes every day to the lives of both patients and her nursing colleagues.

NHS
Lincolnshire Community and Hospitals NHS Group

# LCHG Development: Next Phase Delivery Plan Progress Report

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6th January 2026* |
| Agenda item number | *6.1* |
| Report title | *LCHG Development: Next Phase Delivery Plan Progress Report* |
| Report Purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | • *Discussion* |
| Accountable Director | *Professor Karen Dunderdale, Group Chief Executive* |
| Author(s) | *Jayne Warner, Group Director of Corporate Affairs* |
| Financial implications, if applicable | *[insert details of any financial implications arising from the proposals within the report]* |
| Action / decision required | *ELT is asked to:*<br>• *review progress with the delivery of the group development programme plan and note the issues for escalation* |

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

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

## Executive Summary

### Background & Introduction

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

### Current Position including Issues for Escalation

There has been continued good progress on delivery of the agreed programme milestones.

In the main, slippage on agreed timescales for some actions remains as previously reported. In all instances, revised timescales for seeking the necessary approvals have been included within the plan.

Other issues for escalation:

· the number of out of date policies (primarily within ULTH) is a risk for the group. Improvement plan and trajectories to be agreed for bringing out of date policies back into compliance and performance improved

- Develop the Estates Strategy dependent on clinical services strategy

- 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

### Executive Leadership Team Action Required

The Executive Leadership Team is asked to:
· review progress on delivery of the group development programme plan and note the issues for escalation

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

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| Complete the group executive leadership recruitment process including the development of an appropriate induction programme and agreement of the contractual arrangements for the new group executive roles<br><br>Complete the Fit & Proper Person Test (FPPT) checks for all relevant posts and ensure there are arrangements in place for the audit of "processes, controls and compliance supporting the FPPT assessments", in accordance with the NHSE FPPT Framework | 31 August 2024 **(initial appointments)** | **Partially Complete:** Appointments made to group executive leadership roles; some on an interim basis initially. Contracts issued for initial cohort but outstanding for recent substantive appointments. Where roles remain interim, substantive appointments to be made over the period March – August 2025. Testing of FPPT compliance within Internal Audit Programme for 2025/26 | |
| Once the executive leadership recruitment process is concluded, formalise the externally-set executive director statutory & regulatory accountability roles (to be reviewed alongside executive portfolios) | 30 September 2024 | **Complete:** Externally set executive director statutory roles reviewed and formalised to reflect the new leadership structure and shared at board. Schedule recently updated to confirm that the Group Chief Medical Officer is the executive (clinical) lead for medical devices in line with current national guidance | |
| Formally approve the overarching group model structure and associated implementation plan including the proposed re-design of the existing directorates to introduce a new Alliance Division as part of an enhanced collaborative operating model, enable each division / directorate to operate on a wider footprint and ensure that clinical leadership remains central to the group model as a key function of group leadership | 31 December 2024 **(socialise & engage)**<br><br>4 March 2025 **(board approval)**<br><br>1 April 2025 **(implementation)**<br><br>**30 June 2025 (embedded)** | **Complete:** Operating model socialised through the re-launched Group Leadership Team (GLT) and implementation plan developed. Final operating model approved by the board in May 2025 and being communicated and embedded | |
| As part of the work to finalise the wider group and directorate structures, agree the division / balance of roles & responsibilities at group and trust level including alignment with Place, supported by the development of a clear Accountability & Performance Management Framework and aligned governance & decision-making processes and arrangements | As above | | |
| Implement and embed the new operating model and leadership structure, Performance Management & Accountability Framework and associated governance arrangements | 1 April 2025 **(implementation)**<br><br>30 June 2025 **(embedded)** | **Complete:** As above. PRMs are now in their sixth cycle and are scored as per the Performance Management & Accountability Framework **(but see also work stream 2)** | |
| Align the group support services and associated policies, processes and arrangements | 1 April 2025 **(implementation)**<br><br>30 June 2025 **(embedded)** | Underway but not yet complete – some pressures on teams currently | |
| Once all of the required changes to the trust's operating model including leadership and governance & decision-making arrangements have been made, communicate to staff across the group - to include the development of a simple visual representation of the trust's operating model and updating & reissuing of the '*Governance Framework – A Reference Guide for Staff*' | 1 April 2025 & Ongoing | Comms cascade undertaken through GLT roadshows. Visual representation of Operating Model uploaded to the Group Intranet. *Governance Framework – A Reference Guide for Staff* updated | |

# 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:<br><br>• is aligned to the aims & objectives of the group and strategic partners;<br>• is aligned to the relevant statutory and regulatory standards, requirements and contracts relevant to the trusts and wider group;<br>• flows from ward / patient to board;<br>• is aligned to and supports the board and board committee cycle;<br>• is based on clear metrics with defined performance thresholds reported through a harmonised Integrated Performance Report (IPR) from a group, trust directorate & service perspective;<br>• is balanced across strategy, quality & safety, performance: operational delivery, workforce, finance, governance & risk;<br>• is underpinned by a harmonised accountability & performance review policy & process;<br>• is action focussed in support of delivery and risk mitigation<br>and which reflects best practice as set out in the latest NHSE guidance: 'The Insightful Provider Board';<br><br>[**Note:** There is a need to ensure relevant improvement programmes e.g. ULHT Integrated Improvement Plan (IIP) is integral to and not separate from the above process including the alignment of group / trust KPIs] | **Performance Management & Accountability Framework:**<br><br>31 January 2025 **(draft outline)**<br><br>28 February 2025 **(socialise)**<br><br>3 March 2025 **(approval)**<br><br>1 April 2025 **(implementation)**<br><br>30 June 2025 **(embedded)**<br><br>**Final Metrics / Alignment of IPR:**<br><br>31 August 2025 | Group Performance Management & Accountability Framework approved and aligned PRMs in place (now in sixth cycle)<br><br>The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet complete.<br><br>New Performance reports for Committees going through 2nd cycle as of December 2025 with new format and metrics as agreed with Committee Chairs and relevant Executive SROs. These will replace old performance reports and direct focus on areas of under performance. These will then group up to new Board reporting from early 2026. | |
| 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)**<br><br>31 March 2025 **(Final Vision and Structure Proposal)**<br><br>30 April 2025 **(approval of structure)** | **Complete & ongoing:** Structure agreed. Director of Digital in post from 1 April 2025. Director of Performance Intelligence to go out to advert imminently. New performance information system now developed and being deployed (RACH). Next step is to deploy RACH to support PRMs and the IPR for board<br>Group structure in draft format (Dec-25) pending budget review and senior structure work. | |

# Work Stream 3: Aligned Governance & Decision-Making

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| **Board & Committee Governance** | | | |
| Complete the transition from boards-in-common to a joint or group board (once all appointments have been made to group executive leadership roles and NHSE approval has been received for the appointment of joint or group and trust specific Non-Executive / Associate Non-Executive Directors (NEDs / ANEDs) | 30 November 2024 **(complete – joint Trust Board in place)** | **Complete:** Group Board in place. Board Development Programme also in place supported by NHS Providers who have provided some initial observations and recommendations for strengthening the operation of the board – relevant actions incorporated within the group development programme plan. Well Led Assessment also planned for 2025 with NHS Providers support. Terms of Reference for Well Led Assessment drafted and assessment commenced | |
| Complete the work to align the board business cycle (work plan) | 31 December 2024 **(drafted)**<br><br>31 January 2024 **(approval)**<br><br>**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:<br>• delegated authority and matters reserved to the Group Board;<br>• membership (reflecting changes to group leadership structures);<br>• reporting up from sub-groups (reflecting any changes to and / or alignment of those groups)<br>• assurance ratings (ensuring these are aligned and consistent with those within the BAF)<br>• 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)**<br><br>1 January – 31 March 2025 **(implementation)**<br><br>**6 May 2025 (final terms of reference & work plans submitted to board)**<br><br>30 June 2025 **(arrangements fully embedded)** | **Complete:** Committees are now meeting jointly although arrangements continue to be embedded<br><br>Terms of reference and work plans refreshed to reflect the new group strategic aims & objectives and approved by the Group Board in May 2025 (together with the 'Assurance Map', 'Board & Board Committee Principles Framework)<br><br>'Assurance ratings within the BAF have been reviewed and wording updated. Assurance ratings used within reports to the board and board committees have also been updated as part of the strengthening of the board & board committee templates<br><br>Review of groups reporting into board committees is also complete. (The review of sub-groups reporting into those groups is a separate piece of work as part of BAU) | |
| Undertake a review of the operation and effectiveness of the Quality Committee nine months on and any required changes to the terms of reference, work plan & associated arrangements. Any learning to be used to inform the transition of the remaining committees to working jointly<br><br>**[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)**<br><br>31 January 2025 **(board receipt of & implementation of recommendations)** | **Complete:** Review of Quality Committee undertaken with support from Interim Governance Advisor and recommendations accepted and shared with the Group Board. Some changes made to reporting groups. Arrangements to be reviewed again in 12 months. Learning from the review is being used to inform the transition of the remaining board committees to working jointly | |
| Develop and seek approval from the trust board of terms of reference and a work plan for the proposed joint Integration Committee and agree the date for these meetings to commence and the required frequency | 30 November 2024 | **Complete:** but see also comments above on the need for embedding of all joint board committees | |
| Develop a 'board & committee principles framework' to ensure there is collective understanding of joint working principles; that both trusts can continue to make decisions and operate in accordance with the statutory & regulatory requirements that apply to them; and there is continued robust corporate reporting | 31 December 2024<br><br>6 May 2025 (submitted to board) | **Complete:** 'Board & committee principles framework' drafted and approved by the Group Board in May 2025 | |
| Develop (or make any required changes) to harmonised board & committee templates (report cover / front sheet, agenda, minutes, upward report & action log) and common report writing guidance in light of the move to group and working jointly. As part of the development or updating of the report writing guidance, consider the need for and introduce a programme of report writing training for key staff and develop an exemplar report front / cover sheet | 28 February 2025 **(templates & guidance)**<br><br>31 March 2025 **(training plan drafted)**<br><br>**6 May 2025 (submitted to board)** | **Complete** Revised suite of upward report and report templates and report writing guidance developed and published. | |

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

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| **Non-Executive Director (NED) & Associate Non-Executive Director (ANED) Roles** | | | |
| Complete the review of proposed NED / ANED roles for the group and secure the required internal and external approvals [**Note.** This is required to facilitate a formal move to a joint or group board and joint committees rather than 'in-common' board and committees] | 30 September 2024 | **Complete:** review of NED / ANED roles complete. Approvals received and arrangements effective from 1 October 2024<br><br>NHSE approval also received for the appointment of an additional NED who is now in post. Additional NED is a full NED on the ULTH board and an Associate NED on the LCHS board. This additional appointment reflects the award of teaching hospital status to ULTH | |
| **Board Development** | | | |
| Once the group executive leadership team is in post and informed by a board skills & knowledge assessment and aligned to the proposed group executive development programme, develop, agree & implement a Joint Board Development Programme.<br><br>As an outline, a Board Development Programme may typically include:<br>• board development days / time-outs ensuring dedicated time on key topics and priorities including group development and strategy;<br>• information sharing / briefings (e.g. national policy, regulatory changes, learning and good practice from elsewhere);<br>• board training / compliance requirements;<br>• tailored sessions in response to identified development needs (including those identified from the skills & knowledge assessment or arising from the annual review of board effectiveness or any well led or governance review etc.) | From 1 October 2024 onwards | **Complete & ongoing:** Board Development sessions being undertaken with NHS Providers support<br><br>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)<br><br>Programme shared with the Group Board in May 2025 | |
| Consider undertaking an annual board maturity assessment which in turn will contribute to any well led assessment and will inform the board development programme for the following year | 31 March 2025 | Well Led Assessment, which is being undertaken by NHS Providers, commenced in June 2025 and is expected to last 3 months. Feedback to Board planned in Nov 25 | |

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

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| **Executive Governance** | | | |
| Design, approve and implement the group executive governance & decision-making structure to include a review and alignment, as appropriate, of the sub-groups reporting up to the Executive Leadership Team (ELT) / Group Leadership Team (GLT). The design of the new structure to ensure:<br>• there are effective & timely governance & decision-making arrangements in place that support operational delivery and meet the needs of the trusts and wider group;<br>• there is appropriate alignment with the proposed Accountability Framework for the group;<br>• the governance & decision-making arrangements in place support the trust and wider group to meet the relevant statutory and regulatory requirements;<br>• there is consistency in how information and assurance is reported up to group executive and board & committee level;<br>• there is a clear separation between management (escalation and decision-making) and assurance meetings;<br>• the structure feeds and supports the new board and committee meeting cycle in a timely way;<br>• there is scope for tailoring arrangements where necessary to specific trust-level risks and needs | 31 January 2025 **(draft outline)**<br><br>28 February 2025 **(socialise)**<br><br>31 March 2025 **(approval)**<br><br>1 April 2025 **(implementation)**<br><br>30 June 2025 **(embedded)** | **Complete:** Review of executive governance / meeting structures undertaken – final iteration submitted to and approved by ELT on Thursday, 6 June 2025. Structures to be socialised through GLT and embedded | |
| As part of the above work, review the terms of reference for the Executive Leadership Team (ELT) & Group Leadership Team (GLT) to ensure that roles & responsibilities are clear and that clinical leadership / input remains central to decision-making across the group | As above | **Complete:** Final Terms of Reference agreed | |

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

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| **Board Reporting Framework (BAF) & Risk Registers** | | | |
| Phase 1: Complete the work to align the two trust BAFs including a review and alignment of 'assurance ratings' and ensure that each strategic risk is cross-referenced with related risks on the corporate risk registers. **[Note:** Whilst the aligned BAF will reflect risks to the delivery of the strategic objectives which have been agreed for the group and the controls, assurance, gaps and actions may be the same for each organisation, where there are risks which are specific to either ULHT or LCHS, the controls, assurances, gaps and actions to be explicitly referenced for each separate organisation]<br><br>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<br><br>Phase 3: Implement the new style BAF | 31 October 2024 **(underway)**<br><br>21 January 2025 **(Group Board workshop)**<br><br>1 April 2025 **(implementation of new style BAF)** | **Complete:** Strategic aims & objectives for 2025/26, a revised BAF format and BAF review cycle agreed by the Group Board. BAF is now operating in new format through board committees and the Group Board. Work to further refine the BAF will continue over the coming months<br><br>Underpinning risks on the ULTH and LCHS risk registers have been aligned to the relevant strategic risks within the BAF. Very high and high risks were included within the BAF initially but all underpinning risks will start to be included from June 2025 onwards | |
| Agree the group risk appetite and ensure this is appropriately referenced within the BAF for each strategic objective | 18 March 2025 **(Group Board workshop)** | **Complete:** Group risk appetite agreed by the Group Board and incorporated within the BAF | |
| Review and standardise the risk register and approach to risk management and risk reporting across the group including the management of Datix | 31 December 2024 | **Complete:** A new joint Risk Policy was launched on 1 December 2024.<br><br>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<br><br>Risk Register – Confirm & Challenge Group terms of reference and membership refreshed to ensure executive input | |
| **Alignment of Group Meeting Cycle** | | | |
| Once the work to design and align the board, committee, sub-group and other key trust meetings is complete, develop and update annually a single group meeting schedule (ensuring alignment with the Accountability & Performance Management Framework and performance review meetings) | 31 January 2025 | **Complete:** Meeting cycle in place. PRMs to be added | |

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

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| **Document Control & Policy Approvals** | | | |
| Agree and implement a harmonised and strengthened approach to document control and policy approvals for the group | Policy & Policy Approvals:<br><br>31 March 2025 **(policy in place) - complete**<br><br>31 June 2025 **(embedded) – not yet complete**<br><br>Compliance<br><br>30 September 2025 **(agreement of improvement plan & trajectories)**<br><br>31 March 2026 **(improved performance)** | A combined document control policy and process is in place. The move to a single Intranet will enable policies to be retained in one place<br><br>A historical backlog of out of date policies & guidelines (primarily at ULTH) remains – this represents a risk to the group. Improvement plan and trajectories to be agreed for bringing out of date policies back into compliance and performance improved | |
| **Review of Key Trust Documents & Governing Instruments** | | | |
| Complete the review, alignment and approval of key documents & governing instruments to reflect the move to group and changes to the operating model to include but not limited to:<br><br>• Standing Orders<br>• Standing Financial Instructions<br>• Scheme of Delegation & Powers Reserved for the Boards<br>• Division of Responsibilities Schedule between the Group Chair and Chief Executive<br>• Performance Management & Accountability Framework<br>• Fit & Proper Persons Policy & associated processes<br><br>Other trust documents to be aligned as part of work to implement the directorate structures and align the group support services and to socialise / launch the group brand | 25 July 2025 **(Audit Committee)**<br><br>2 September 2025 **(Group Board approval)** | Interim amendment to Standing Orders made to reflect the appointment of a Group Chief Executive and joint Leadership Team, changes to ELT and GLT decision-making and the proposed move to joint board and committees and any changes to voting rights<br><br>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<br><br>Performance Management & Accountability Framework drafted and approved by GLT on 4 April 2025 and by the Group Board on 6 May 2025<br><br>Final amendments to the Standing Orders (including the Division of Responsibilities Schedule), Standing Financial Instructions and Scheme of Delegation approved by the board on 2 September 2025 | |
| Review and update relevant policies, documentation and templates to reflect the move to group and the group brand | As above | As above | |

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

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

# Work Stream 4: Communications & Engagement

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

# Work Stream 4: Communications & Engagement cont'd

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| **Group Intranet & Internet** | | | |
| Create and roll-out a group Intranet (including the migration of ULTH to nhs.net). **[Note:** All staff across the group to have access to the group Intranet from 1 April 2024. Full migration to nhs.net to take up to a year] | 30 June 2025 | **Complete:** LCHS staff now have access to ULTH intranet which became the group intranet from 6 August 2025 | |
| Create a single group three URL website which provides information at both a group and individual trust level and which meets accessibility legislation requirements | 31 March 2026 | Case of Need drafted – timescale for implementation to be confirmed and agreed as part of approval of the Case of Need | |
| **Communications & Engagement Team** | | | |
| Continue to embed and develop the combined group Communications & Engagement Team building on the implementation of cross-group portfolios from September 2024 | 30 September 2025 | Combined team in place but some changes are proposed as part of the planned restructure therefore arrangements are not yet fully embedded | |
| Continue to provide communications & engagement support, as required, to the group development programme work streams & SROs e.g. development of group strategy, aims & objectives, values and culture | 31 March 2026 | Comms & engagement support in place and ongoing | |
| Continue to embed the merged media monitoring / horizon scanning and escalation process | Ongoing | Ongoing – group wide media monitoring / horizon scanning and reporting to the Group Chief Executive and GLT is in place | |

# Work Stream 5: HR & Workforce

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| For any consultation process moving staff into group roles from individual trusts, undertake an equality impact assessment in accordance with ACAS best practice | Ongoing | **Complete:** Ongoing process is BAU as part of consultation and included in new group policy | |
| Develop a package of individual support for staff who will be affected by the change of the move to group | Ongoing | **Complete:** range of options in place including a team-wide and individual offering together with an e-learning programme. A 3rd tier is ready to launch to support managers to lead during change from both a process and behavioural perspective | |
| Harmonise contractual policies and processes across the group, working with union colleagues: six priority policies identified and agreed with union colleagues from both trusts in the first instance. Plan and timescale to be agreed for harmonising remaining policies and processes | 31 March 2025 (priority policies)<br><br>31 March 2026 (remaining) | Priority policies have been harmonised and formally ratified. The Managing Attendance Policy remains outstanding and has been discussed several times with staff side at Policy Committee. This is scheduled for further discussion on 29th October and it is anticipated will then be ratified. Once the final contractual policy is agreed, we expect to see an increase in the pace of policy harmonisation. Work will remain ongoing to harmonise all relevant remaining policies | |
| Harmonise T&Cs – *linked to policy work* | As above | **Complete:** Harmonised Change Management Policy for the group approved | |
| Harmonise Reward & Recognition including the development of a group Reward & Recognition Policy | 31 December 2024 | **Complete:** Arrangements harmonised and policy developed and approved. Comms issued June 2025 | |
| Move to a group induction using the following blended approach:<br>• Development of joint induction video<br>• Harmonisation of joint face to face induction | 31 December 2024<br><br>30 June 2025 | **Complete:** group face to face and video inductions in place.<br><br>Following staff feedback, joint virtual induction option to be launched in June 2025. Alternative induction venues also being explored across the county | |
| Ensure all training, progression, career development opportunities, apprenticeships and support are offered consistently across the group – *linked to policy work and supported by aligned of teams and portfolios* | 31 January 2025 **(review of portfolios)** | **Complete:** Ongoing & monitored through Workforce Strategy Group | |
| Ensure portability of staff for cross-site working | 1 November 2024 **(interim solution)**<br><br>1 April 2025 **(long term solution)** | **Complete:** Staff in both Trusts can access vacancies across the group now, with a link provided on the respective intranet sites and the recruitment teams at each Trust are working in partnership to facilitate transfers across the group | |

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| Continue to provide ongoing support to those staff most affected by the move to a group model | Ongoing | **Complete & Ongoing:** Engagement 'Tube Map' and Change Workshops in place & ongoing **(Appendix C refers).** Additional staff / GLT engagement roadshows held during May & June 2025 | |
| Develop proposals for a long term Organisational Development programme to support the transition to group and the new operating model with a focus on:<br>• Directorate leadership development<br>• Executive development<br>• Board development | Ongoing **(Group Board and ELT) Development Programmes)**<br><br>31 March 2026<br>**(Division / Directorate Leadership Programme (The 'Leeds Way') to be embedded** | Board Development sessions are currently being undertaken with NHS Providers support. EDI specific half-day board development session has been scheduled<br><br>12 month ELT Development Programme in place and being supported by Acqua<br><br>Following the launch of the "LCHG Way" and LCHG leadership development programme at BTF in October, the first module is being piloted, with 2 further modules becoming available in January/February.(subject to national sign off).<br><br>Integrate action from well led review ensuring that the Group Board and its senior leaders remain connected, aware and empathetic to the two trusts so that expectation and pace of delivery is matched to organisational capacity | |
| 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)**<br><br>3 March 2025<br>**(board approval)** | **Complete:** New group values – Compassionate, Collaborative and Innovative – approved by the Group Board and implemented w/c 14 April 2025. Underpinning behavioural framework for each value ('Our Values in Action') developed and launched with leaders at Better Together in October 2025. Formal launch postponed to January 2026 as requested by ELT. | |
| Continue to develop the staff health & well-being offer across the group including the introduction of menopause support | 31 May 2025 | **Complete & ongoing:** The LCHG staff health & well-being offer continues to be developed and harmonised across the group. The menopause service was extended across the group in July 2025 and is now available to both ULTH and LCHS staff | |

# Work Stream 7: Digital

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| Develop a digital strategy, infrastructure & capabilities for the group with a focus on digital transformation and new ways of working to include the following specific actions / milestones: | 31 March 2025 | **Complete:** Strategy considered by the Integration Committee in June 2025 and approved by the Group Board on 1 July 2025 | |
| • undertake an exercise to map the digital systems in place across the group & develop a plan for alignment of systems where feasible to do so e.g. ESR, Datix, Intranet, Document Management System etc. | 31 January 2025 **(Map)**<br><br>31 March 2025 **(Plan)**<br><br>30 June 2025 **(Group Intranet)** | Mapping complete and plan developed.<br><br>• EDMS initiation in progress<br>• LCHS Datix moved to cloud and linked to NHS net login. ULTH already in cloud and moving to NHS net login<br>• Group Intranet remains on track for deadline<br>• Other systems continue to be aligned, where possible. Some limitations due to existing contracts and sovereignty requirements e.g. finance, ESR | |
| • move to a single Microsoft 365 teams platform with the migration of ULTH to the national tenancy | 31 March 2025 | **Complete & ongoing** – work continues to optimise and standardise processes | |
| • move to a single domain / directory login process - ambition and scope has changed since the decision to move in full the AGEM service (exc. LPFT) to LCHG. This will support a more ambitious approach supporting integration between Acute, Community and Primary Care. | 31 March 2025 **(Implementation Plan)**<br><br>31 July 2025 **(Hand Over of Domain)**<br><br>1 Nov 2025 **(AGEM transition)** | • **Complete and ongoing** – work continues to optimise and standardise processes<br><br>• Superseded by AGEM transition to LCHG | |
| • move to standardised printing & print codes – significant piece of work – workarounds to be simplified in short term these will continue as full replacement will likely need to be aligned to contract end dates, ULTH July 2026 and LCHS April 2027. | 31 March 2026 **(Procurement outcome expected)** | **In progress & on track:**<br><br>• Interim arrangements and process in place between ULTH and LCHS<br>• Procurement contract team has been formed | |

# Work Stream 7: Digital cont'd

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| • transition LCHS from the current AGEM IT support contract to the Group Digital support system - **Scope expanded to align novation of service for ICB and Primary Care (GP IT)** | 24 January 2025 **(Finalised Plan)**<br><br>1 November 2025 **(Full Service Migration – some things may take longer)**<br>1 November + 12/18 months – **(integration and optimisation of service)** | **Complete & ongoing** – work continues to optimise and standardise processes<br><br>• 28 WTE colleagues from AGEM TUPE'd to ULTH from 1st November.<br>• AGEM / Group consultation process completed 17th October.<br>• LCHS AGEM Digital service partially transfer to in LCHG in house provision on 20th November.<br>• Full AGEM transfer completed 1st November.<br>• Due to significant expansion of scope, the work to optimise the digital services will continue over a 12-18 month period, post AGEM transition. | |
| • create a common identity for the Digital Team (linked to the group brand & associated actions) | 31 October 2025 (due to merger of LCHS and GPIT teams) | **Complete & ongoing** – work continues to optimise and standardise processes<br><br>LCHG Digital consultation completed 1st December. Full system digital alignment plan in place and underway<br>Linked to AGEM transition – team brand to be LCHG Digital Services, with associated new uniforms and logos being created. | |
| • 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<br><br>30 April 2025 **(agreement of structure)** | **Complete & ongoing:** Structure agreed. Director of Digital in post from 1 April 2025. Director of Performance Intelligence to go out to advert imminently. New performance information system developed and being deployed (RACH) | |
| • move to aligned telecoms | 30 May 2026 **(Secured single contract for Telephony Services)** | In progress & on track:<br>• Single team lead in place, new group contract in place for 12 months<br>• Plan to move LCHS to current ULTH system to deliver saving<br>• Procurement of required group level services planned during 2025/26 into 2026/7<br>• Finalisation of roles as part of integration of LCHS and ULTH digital teams being planned as part of structure | |
| • data hosting | 31 October 2025 **(AGEM project closure)**<br><br>End January 2026 **(completion)** | Underway – on track:<br>• AGEM project has now been closed.<br>• LCHG Digital to pickup residual activity to move Print Management Services for LCHS, ICB and LPFT. Work attempted but had to be rolled back due to an issue related to some more specialist ways of working in LPFT. In dialogue with supplier.<br>• At this time, expected to be end of Jan due to the failure | |

# 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)**<br><br>2 September 2025 **(board approval)** | Underway although completion dependent on finalisation of the clinical service strategy and also likely to be impacted by the decision on the future model for the provision of EFM services – *see next action. Approval not expected until 31 March 2026* | |
| • consider & evaluate the different models for the provision of EFM services across the group to include the option of a wholly owned subsidiary model and present the findings and recommendations for approval to the Group Leadership Team and Trust Board | 30 September 2025 | Assessment of options undertaken and currently being evaluated. Further guidance awaited from NHSE on legal requirements in respect of wholly owned subsidiary option. Date for approval of agreed option to be confirmed | |
| • undertake an estates rationalisation review with a focus on decompressing the acute site and agile working and present the findings and recommendations to the Group Leadership Team and Trust Board. This work to be undertaken in line with "left shift" proposals | 30 June 2025 | Underway: external support to undertake the review being sourced at an estimated cost of £22.5k. Procurement process commenced. Work to be progressed in the 2025/26 financial year<br>New Space Manager in place, however, issues remain with under utilisation. New process for booking open space being implemented. Future GLT sessions planned on space and space management<br>New procurement exercise to commence Q4 for the whole estate, funding required as expected cost of circa £250,000 | |
| • continue the programme of ward refurbishments, as funding is available | Ongoing | No funding currently available – programme to be reviewed in new financial year | |
| • undertake a review of all leases and licences across the group | 30 June 2025 | **Complete & ongoing:** All LCHS leases now obtained. New MOTO being negotiated with NHSPS which will move a number over to being in place and compliant. In respect of ULTH, there are a number of minor occupancies to work through and formalise. New Property Manager being recruited and will lead on this area of work | |
| • produce a visual 'map' of all services and where they sit within the group and ensure this is aligned with each trust's CQC registration / Statement of Purpose' | 31 December 2024 | **Complete:** 'Map' of services produced and shared with ELT | |
| • deliver the agreed 2024/25 EFM transformation projects and EFM improvement plans | 31 March 2025 | **Complete:** Plan and projects delivered for 2024/25. Plan in development for 2025/26 | |

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

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| **Restructure of EFM** | | | |
| Complete the restructure of the EFM senior management team and underpinning workforce plans and associated work plans to ensure the two trusts are able to meet and, where necessary, improve compliance with statutory requirements to include the bringing together of the emergency planning and health & safety teams | 31 August 2025 | Deferred further to August 2025 due to lack of HR capacity to support the process. Also likely to be impacted by the decision on the future model for the provision of EFM services<br>Some gaps in the senior management team currently which is a risk | |
| **Equality & Inclusion** | | | |
| Continue to promote equality & inclusion and reduce workforce inequalities within EFM: | 30 September 2025 | Linked to future model for the provision of EFM services | |
| • develop a single approach to the movement of EFM staff across the group | 30 September 2025 | As above | |
| • commission a cultural review of estates services and continue to deliver the improvement actions identified in the facilities services cultural review | 30 September 2025 | As above<br>Facilities (Housekeeping) Cultural Review completed<br>Scope for wider review being finalised. | |
| • align and improve the processes for staff development, on boarding etc. across EFM | 30 September 2025 | As above | |
| **EFM Governance & Assurance** | | | |
| Undertake a review of and strengthen the EFM governance structure and associated assurance processes across the group and ensure that the EFM governance structure is appropriately aligned to the wider group governance structures and decision-making arrangements: | 30 September 2025 | Underway – EFM Head of Compliance recruited. Also linked to future EFM model. Full group PPM audit – specification developed and company being sourced to undertake work. Complete: Safety Groups in place, Group Health & Safety Committee in place | |
| • align the process for the completion and submission of the annual Premises Assurance Model (PAM) assessment and for monitoring delivery of the agreed improvement actions | 30 September 2025 | Commenced – on track. Latest NHSE guidance and assessment tool received. Submission due 30 September 2025<br>Completed | |
| • undertake a review of Approved Persons (APs) for the relevant HTMs and as a key element of the EFM governance & assurance processes | 30 September 2025 | Not yet due – deadline may be impacted if gaps & capacity issues in the team remain unresolved | |
| • review, update and align the EFM policies and procedures across the group | 31 December 2025 | Review of EFM policies & procedures is underway: Fire Policy & Health & Safety Policy currently going through ratification process | |

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

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

# Work Stream 9: Strategy & Planning

| Key Tasks / Milestones | Timescales | Current Position including agree remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| Harmonise the strategy & planning process across the two trusts including the development of a single strategy management policy and strategy group | 31 December 2024 | **Complete** | |
| Develop a combined strategy and set of strategic aims & objectives for the group: to include the development of an integrated delivery plan setting out the programmes and projects to be delivered in Year 1 of the Strategy against the strategic aims, and the associated measures and outcomes<br><br>[**Note:** The joint Trust Board has agreed to move from 5 to 3 strategic aims – board workshop planed for early 2025 to agree the underpinning strategic aims and linked to the review and alignment of the BAF and agreement of the 'risk appetite' for the group] | 31 March 2025 | **Complete:** Strategic aims & objectives finalised. Further work undertaken through the board development session on 1 April 2025 on finalising the programme and projects required to deliver the strategy. Final strategy approved by the Group Board in May 2025 | |
| Harmonise the underpinning strategies e.g. clinical, quality, people, digital etc. | 30 June 2025 | **Complete & ongoing:** work underway to support reviews / updates of enabling plans including corporate nursing, health & safety, finance, quality & governance, estates and R&I | |
| Develop a single operational & financial plan for the group including the responsibilities of divisions / directorates for the delivery of the strategic aims & objectives and priorities for the group (linked to the development of the Accountability & Performance Management Framework) | 31 March 2025 | **Complete:** Operational & financial plan developed, approved & submitted. Final triangulated plan expected by 30 April 2025 | |
| Develop transformation and improvement programmes to facilitate the delivery of the strategy | 31 March 2025 | **Complete:** new Productivity & Transformation Framework developed and approved by GLT on Friday, 4 April 2024. Productivity, Improvement & Transformation Group set up and reporting to GLT but with reporting from an assurance perspective to the Finance Committee (Productivity) and the Integration Committee (Improvement). Care Groups outlined their key transformation & improvement programmes at GLT on Friday, 4 April 2024. Work complete to allocate resources from the strategy, improvement and design teams to support the Care Groups to work up and deliver their programmes | |
| Develop a common Project Management Office (PMO) approach to enable accurate reporting aligned to the new governance arrangements across the group | 31 March 2025 | **Complete:** PMO approach in place | |

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

| Key Tasks / Milestones | Timescales | Current Position including agree remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| Develop a Group Quality Improvement (QI) strategy and commence implementation of the Quality Management System (QMS) as a key enabler to delivery of our productivity and transformation programme. QI strategy to focus on culture/shared purpose/leadership behaviours and a dosing model for building improvement capacity | 31 March 2025 (QI Strategy)<br><br>31 October 2025 (QMS) | QI approved by Integration Committee and GLT. QMS note yet started | |
| Develop a proposal for primary, community and acute care collaboration (Alliance Model) and a spectrum of integration | 31 March 2025<br><br>31 August 2025 (Phase 2) | **Complete:** Alliance Model and programme confirmed and approved via Integration Committee. Communications plan in development for internal awareness. New Terms of Reference to include a review of external members to be received by the Integration Committee in August 2025 | |
| Develop a Partnership Strategy for the group | 30 September 2025<br>30 December 2025 | The Partnership Strategy for the group has been developed however will be refreshed in line with the group strategy and the creation of an Alliance Model<br>Team capacity continues to be impacted by the ongoing staff consultation process, which has required significant time and attention from key personnel. In parallel, there has been an increasing need to reprioritise workload to support the commencement of the annual planning round, identification of CIP opportunities and the co-creation of Integrated Neighbourhood Teams (INTs).This shift in focus reflects our strategic commitment to place-based care and collaborative service design. While this has temporarily constrained delivery capacity in some areas, it is enabling the organisation to lay the foundations for more integrated partnership strategy. This is being updated to reflect our key developments such as setting up of Integrated Neighbourhood Partnership Board. | |
| Support development of the Group Sustainability & Green Plan - Phase 1 | 31 March 2025 (Phase 1)<br><br>2 September 2025 (board approval) | Phase 1 - Refreshed Green Plans drafted using the national template and approved by the group board on 2 September 2025<br><br>Work remains ongoing with the ICB to support the system sustainability agenda. The sustainability agenda is being embedded in the new LCHG strategy and the SRO for the programme is the Group Director of Estates & Facilities | |
| Develop a clinical services and practitioners strategy for the group | 31 August 2025 | **Complete:** Strategy agreed A detailed model on a health campus approach is being developed for agreement by the end of the financial year. | |
| Build and shape a new group strategy and planning team with OD support to fully align with required functions | 31 August 2025<br>30 Dec 2025 | **Underway & on track:** The launch of the final team structure and consultation has been delayed due to the complexity of the team and new HR requirements around job matching. This has required the review and update of 26 roles, each undergoing formal job matching and consistency checks.Although the structure is agreed, finalisation of job descriptions is ongoing, with HR advice being sought on various options. The team has demonstrated a strong commitment to transparent communication by: | |

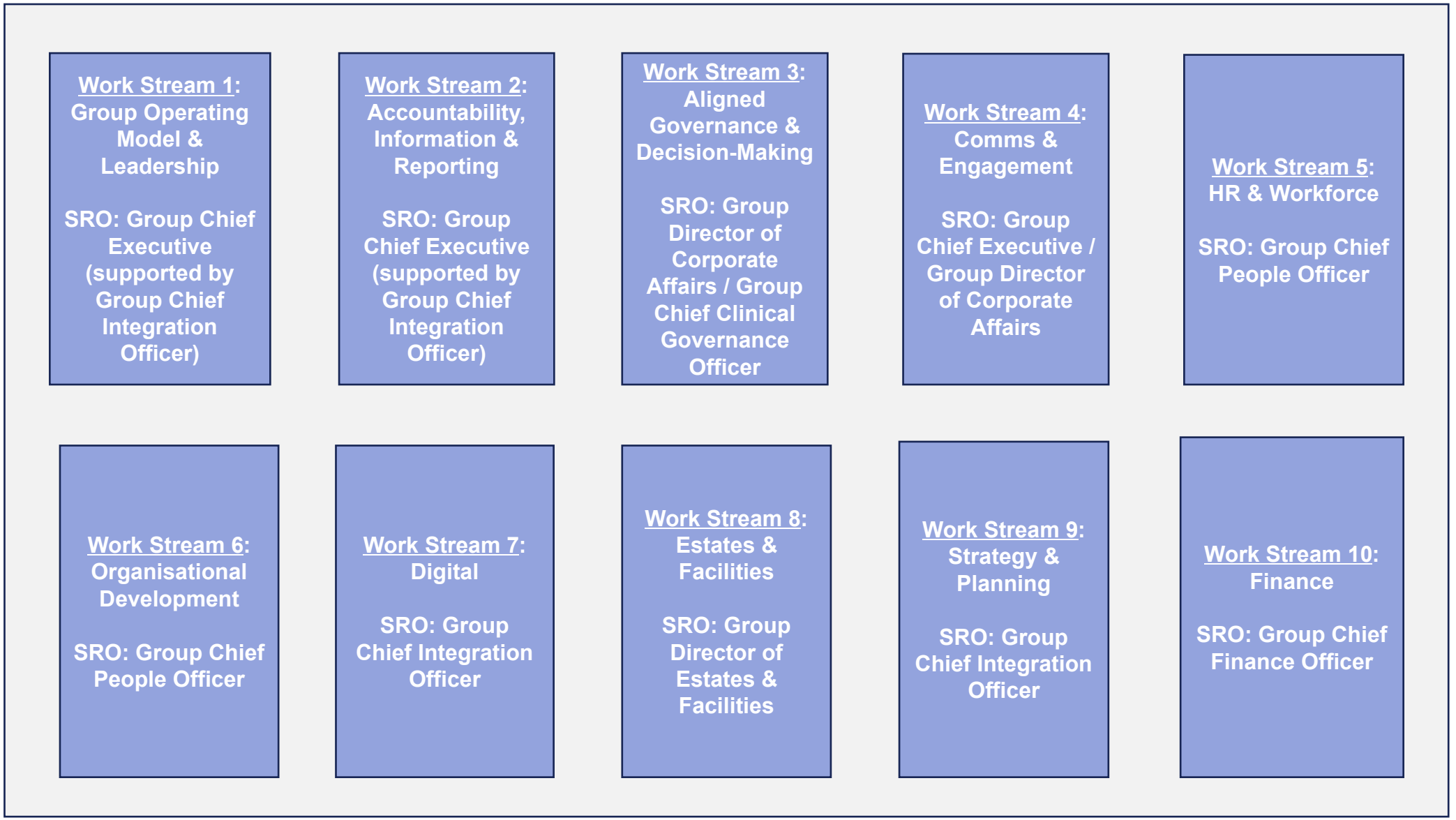
# Work Stream 10: Finance

| Key Tasks / Milestones | Timescales | Current Position including agreed remedial actions where progress is 'off track' | RAG |
|---|---|---|---|
| Develop the Finance Strategy for the group in support of delivery of the agreed group strategic aims & objectives | 1 July 2025 **(strategy drafted)**<br><br>31 October 2025 **(board approval)** | Proposal to delay timescale to allow increased engagement. Finance away day planned for 26 June 2025. Draft to be developed in July 2025 with engagement with care groups and committees and approval in October 2025 This work is behind schedule, going through governance in December~~November~~ (GLT, FPC). | |
| Harmonise the financial planning & budget setting processes across the group | 31 January 2025 | Completed Planning assumptions and budget setting processes aligned but need embedding. Budget setting complete for 2025/26 | |
| • produce and roll-out a revised budget holder manual | 28 February 2025 | Completed Single budget holder manual developed and published | |
| Develop a single operational & financial plan for the group including the responsibilities of divisions / directorates for the delivery of the strategic aims & objectives and priorities for the group (linked to the development of the Accountability Framework) | 31 March 2025<br><br>**(see also work stream 9: strategy)** | Completed Operational & financial plan developed, approved and submitted | |
| Align and strengthen financial reporting ensuring reporting from a group, individual trust and service level perspective and including the development of financial information dashboards reflecting user feedback | 31 March 2025 | Completed Financial reporting is now consistent across the group. Work to further strengthen information dashboard is ongoing<br><br>Bottom up review of budgets complete | |
| Harmonise the business case development, review and approval process ensuring a consistent approach and methodology | 31 July 2025 | **Complete:** Capital, Revenue & Investment Group (CRIG) reviewed and strengthened | |
| As part of the development of the Accountability & Performance Management Framework for the group, align and strengthen the mechanisms for holding divisions / directorates to account for budgetary control, the delivery of financial plans and cost improvements | 31 March 2025 | **Complete & ongoing:** Performance Management & Accountability Framework approved<br><br>Aligned IPR and final KPIs / metrics for 2025 / 26 still being worked up<br><br>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:<br><br>• Standing Financial Instructions<br>• Scheme of Delegation & Powers Reserved for the Board | 25 July 2025 **(Audit Committee)**<br><br>2 September 2025 **(Group Board approval)** | Updated Standing Financial Instructions and Scheme of Delegation & Powers Reserved for the Board approved by the group board on 2 September 2025 | |
| Harmonise the financial policies and processes across the group | 31 December 2025 | Underway – on track. Current financial policies all up to date. Mapping exercise to be undertake to identify those still to be aligned and to agree timescales. Oversees Visitors & Private Patients policy aligned and approved | RAG changed to green |
| Align the Internal Audit arrangements | 31 August 2025 | **Completed**. Internal audit arrangements have been aligned. A joint Audit Committee is in place with auditors working to develop a single report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability | |
| Review, harmonise and strengthen the financial training offer and culture | 30 June 2025 | **Completed** – First finance roadshow training event held in February 2025. Budget holder refresher training held in February & March 2025. Ongoing training offer available within ESR | |

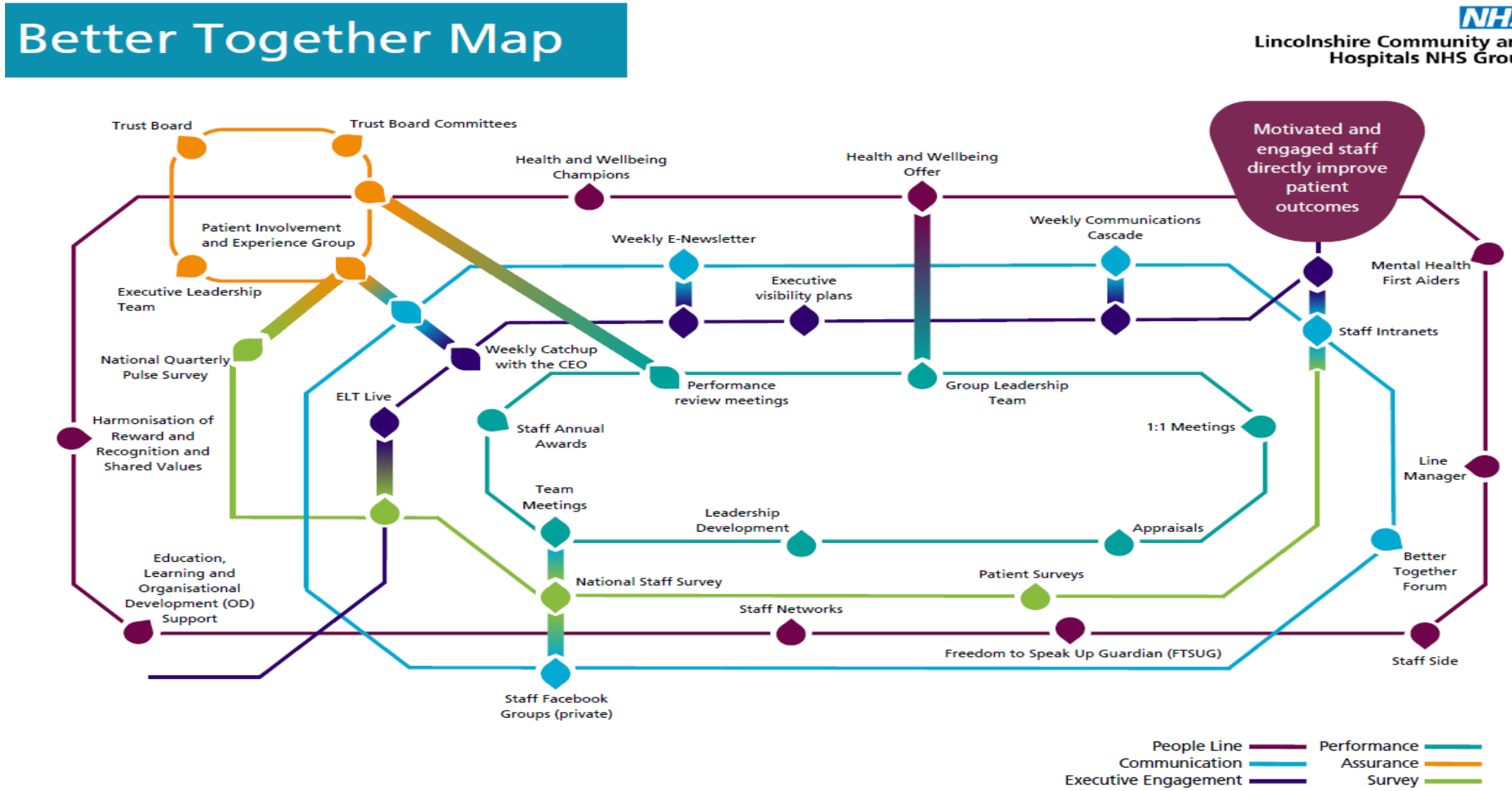
# Appendix A: Group Development Programme: Work Streams & SROs



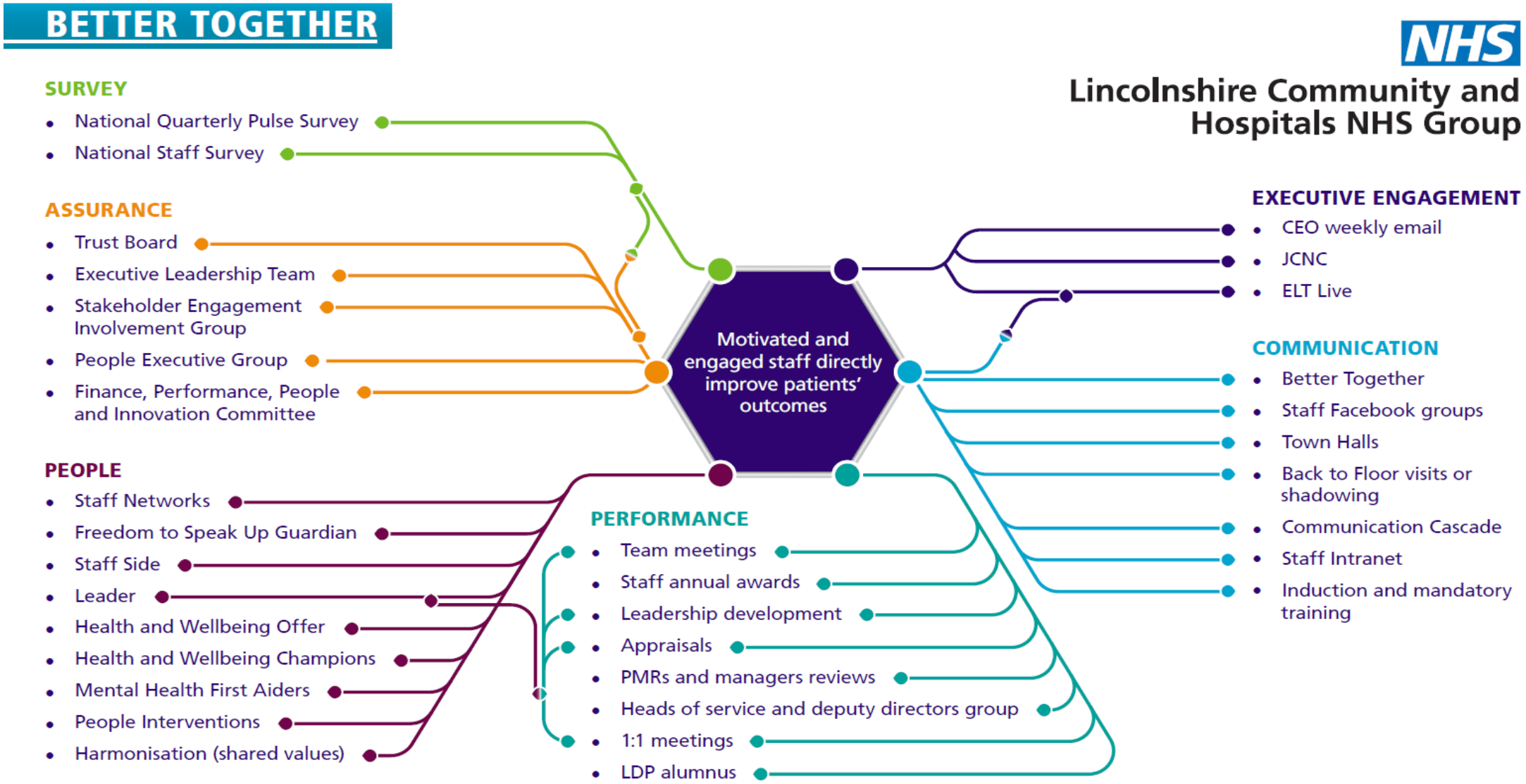
# Appendix B: Group Development Programme Delivery RAG Rating

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

# Appendix C: Staff Engagement 'Tube Map'



# Appendix C: Staff Engagement 'Tube Map'



NHS
Lincolnshire Community and Hospitals NHS Group

# Winter Plan and Operational Update

# January 2026

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6th January 2026* |
| Agenda item number | *6.2* |
| Report title | *Winter Plan and Operational Update* |
| Report purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | *Assurance* |
| Accountable Director | *Caroline Landon, Group Chief Operating Officer* |
| Author(s) | *Lee Taylor, Group Deputy Chief Operating Unplanned Care* |
| Assurance rating:<br>• Substantial assurance<br>• Reasonable assurance<br>• Limited or no assurance | *Reasonable assurance* |
| Prior approval process, if applicable | *Unplanned Care Oversight Group and Finance and Performance Committee* |
| Financial implications, if applicable | *n/a* |
| Action / decision required | *The Board is asked to note the discussions and assurance on matters relating to the LCHG Winter Plan 2025 – 2026 (Winter Ready).* |

*Assurance Rating Key:*

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

| How the report supports the delivery of the LCHG strategic aims & objectives: | |
|---|---|
| *Patients: Better Care – Timely, affordable, high quality care in the right place:* | |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | *X* |
| 1b: Reduce waiting times for our patients | *X* |
| 1c: Improve productivity and deliver financial sustainability | *X* |

| | |
|---|---|
| 1d: Provide modern, clean and fit for purpose care settings | |
| *People: Better Opportunities – Develop, empower and retain great people:* | |
| 2a: Enable our people to fulfil their potential through training, development and education | |
| 2b: Empower our people to continuously improve and innovate | *X* |
| 2c: Nurture compassionate and diverse leadership | *X* |
| 2d: Recognising our people through thanks and celebration | |
| *Population: Better Health – Improve population health:* | |
| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | *X* |
| 3b: Move from prescription to prevention, through a population health management & health inequalities approach | |
| 3c: Enhance our digital, research & innovation capability | |
| 3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan | |

**Winter Plan and Operational Update**

## 1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Winter Oversight Group at its meetings held on 4th & 18th December 2025 including assurances received and those matters which the group wish to escalate to the Board.

## 2.0 Matters considered by the group

2.1 The Winter Planning Oversight Group met on 18 December to review delivery and assurance across winter schemes, workforce resilience, vaccination programmes, infection prevention and control, and system preparedness as the organisation transitioned from November performance into heightened December pressures.

### 2.2 Funded and Non-Funded Winter Schemes

The Group reviewed progress across funded and non-funded winter schemes, with detailed discussion on IV Therapy, OPAT, paediatric front door streaming, cardiology hot clinics, and additional flow and discharge capacity.

Updates confirmed that operational capacity for IV Therapy and OPAT was in place, however utilisation remained lower than anticipated. The Group explored challenges in patient identification and pathway optimisation, particularly the shift in clinical practice from IV to oral antibiotics and the impact this has on demonstrating outcomes. Work is underway to refine pathways, consider additional patient cohorts, and strengthen governance arrangements to ensure available capacity is appropriately used. The importance of accurate data capture, including repatriated patients, was emphasised to support assurance to commissioners and inform future commissioning decisions.

The paediatrics at the front door scheme was reviewed, with confirmation that the service is operational within UTCs and demonstrating increasing activity, particularly at Lincoln. Coverage at Boston remains variable. The Group discussed the need for clearer performance metrics, including four-hour performance, conversion rates, and benchmarking against previous years. It was agreed that paediatrics must retain ownership of the scheme and its outcomes, with UTC support, and that improved data alignment is required to fully evidence impact.

The cardiology hot clinic was confirmed as live, with early activity reported and initial operational issues resolved. The Group acknowledged that further data collection and evaluation are required to demonstrate effectiveness and support assurance.

### 2.3 Vaccination Programmes

The Group received an update on the staff vaccination programme, confirming strong uptake and performance above national stretch targets for both acute

and community services. Additional clinics have been delivered, including weekends and unsociable hours, to maximise accessibility over the festive period. New stretch targets have been set, and efforts continue to reach remaining unvaccinated staff.

Patient vaccination was discussed as part of the wider winter resilience approach, recognising its contribution to demand mitigation and patient safety.

Flu Campaign week 12:

Frontline staff
**ULTH**-55.45%
**LCHS**-56%

In summary, Week 12 has been substantial, reflecting a clear 3% increase in overall vaccine uptake—1% for ULTH and 2% for LCHS. We remain committed to maintaining our top positions and addressing low uptake areas effectively.

Below is a table illustrating the data. Please note the final percentage for ULTH and LCHS at the conclusion of the campaign in 2024/25, as well as the current percentages at the end of week 11 for all staff groups.

| ULTH 2024/2025 | ULTH 2025/2026 – Week 12 |
|---|---|
| 33.2% | **55.4%** |

| LCHS 2024/2025 | LCHS 2025/2026 – Week 12 |
|---|---|
| 45.8% | **54.1%** |

**Care Group Breakdown ULTH:**

| **Area** | **Percentage** | **Number of staff vaccinated** |
|---|---|---|
| Surgery Care Group | 46.73% | 972 |
| Medicine Care Group | 46.17% | 1315 |
| Family Health Care Group | 50.14% | 540 |
| Director of Estates and Facilities | 36.05% | 411 |
| Corporate* | 28.67% | 780 |
| Alliance Care Group | 50.43% | 1235 |

**Please note all corporate areas are within this grouping, including Chief Executive area.*

**Care Group Breakdown LCHS:**

| **Area** | **Percentage** | **Number of staff vaccinated** |
|---|---|---|
| Chief Executive | 20% | 1 |
| Clinical Governance | 36.4% | 4 |
| Corporate Affairs | 60.0% | 9 |

| | | |
|---|---|---|
| Finance | 16.0% | 48 |
| Group Chief Medical Officer | 25.9% | 7 |
| Integration Division | 33.0% | 37 |
| Nursing | 56.0% | 14 |
| People | 30.9% | 17 |
| Planned Care Division | 39.5% | 528 |
| Unplanned Care Division | 24.8% | 161 |

**2.4 Infection Prevention and Control**

An update was provided on infection trends, including increasing influenza A cases and active outbreaks across inpatient areas. The Group was advised that enhanced mask wearing guidance will be implemented across inpatient and outpatient settings, subject to final procurement confirmation. Paediatric flu and RSV levels remain low, and COVID-19 prevalence is minimal, with norovirus outbreaks being actively managed.

**2.5 Prepared and Responsive Services**

The Group considered system preparedness, including workforce resilience and the ability to maintain elective recovery alongside winter pressures. It was noted that a formal workforce update was not available due to staff absence, and this will be addressed at the next meeting.

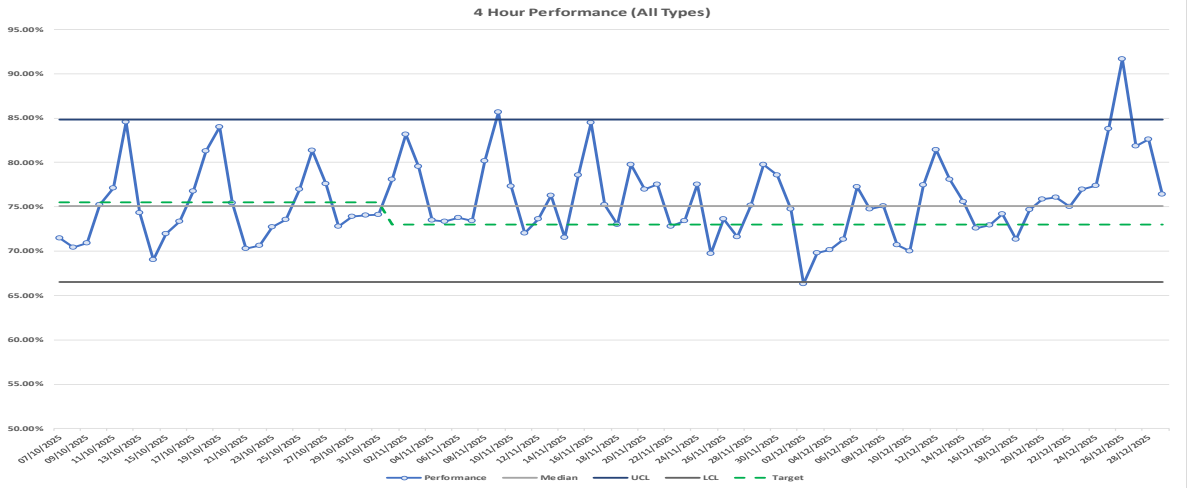
**2.6 Upward Reporting and Governance**

The Group discussed the approach to upward reporting to the Winter Delivery Group and the ICB, noting ongoing work to improve the quality, relevance, and consistency of submitted data. The importance of internal review and sign off prior to submission was emphasised, given the potential implications for funding and system support.

**2.7 UEC Performance Overview**

The Group reviewed the current state of performance, noting that overall Emergency Access Standard delivery for November is reported at 76.3%, above plan of 73%. Despite this, the Group recognised that performance remains fragile and variable across sites, with continued challenge in ambulance handovers, admitted 12-hour waits, and front-door flow.

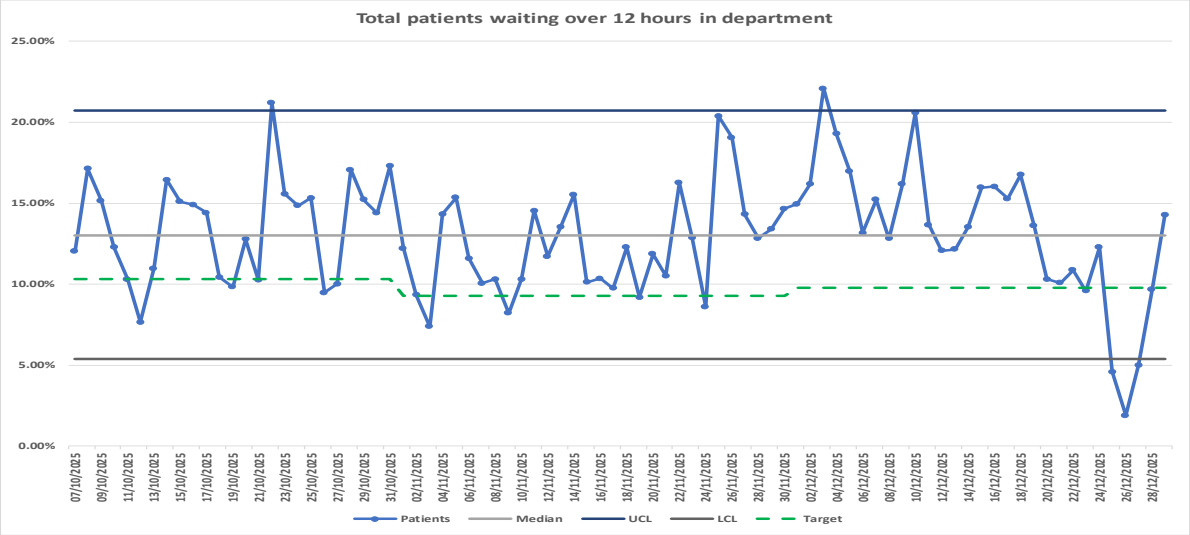
## 4-Hour Emergency Access Standard Performance




| Month | 2024/2025 | 2025/2026 | |
|---|---|---|---|
| April | 74.25% | 77.36% | ↑ |
| May | 72.04% | 75.87% | ↑ |
| June | 72.86% | 75.06% | ↑ |
| July | 72.05% | 73.80% | ↑ |
| August | 73.61% | 75.09% | ↑ |
| September | 74.35% | 74.92% | ↑ |
| October | 72.83% | 74.90% | ↑ |
| November | 72.93% | 76.32% | ↑ |
| December | 71.51% | 75.48% | ↑ |
| January | 73.50% | | |
| February | 73.71% | | |
| March | 78.33% | | |

## Patients waiting over 12 Hours in Department

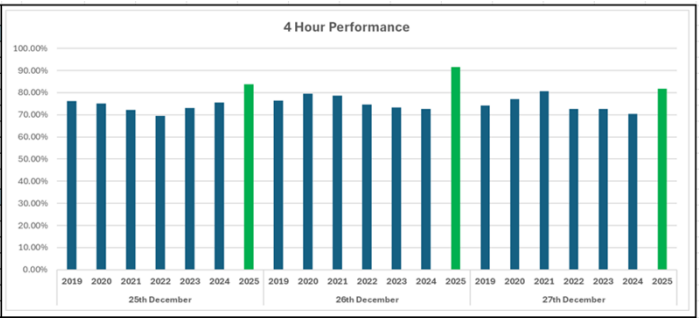
| Month | 2024/2025 | | 2025/2026 | | |
|---|---|---|---|---|---|
| Apr | 1657 | 17.21% | 1732 | 10.68% | ↓ |
| May | 2291 | 21.86% | 1914 | 11.05% | ↓ |
| Jun | 2164 | 21.91% | 2003 | 12.02% | ↓ |
| Jul | 2133 | 21.05% | 2071 | 12.01% | ↓ |
| Aug | 1658 | 17.68% | 2093 | 12.67% | ↓ |
| Sep | 1880 | 19.86% | 2006 | 12.10% | ↓ |
| Oct | 2221 | 21.42% | 2343 | 13.44% | ↓ |
| Nov | 1930 | 17.81% | 2048 | 12.40% | ↓ |
| Dec | 2106 | 18.63% | 2171 | 13.50% | ↓ |
| Jan | 2286 | 14.67% | | | |
| Feb | 1961 | 13.28% | | | |
| Mar | 1222 | 7.38% | | | |
| **Yesterday** | | | **79** | **14.26%** | ↑ |




Christmas Holidays UEC performance.

| 25th December - 4 Hour Performance | | |
|---|---|---|
| Year | Performance | Attendances |
| 2019 | 76.23% | 551 |
| 2020 | 75.00% | 368 |
| 2021 | 72.11% | 459 |
| 2022 | 69.42% | 667 |
| 2023 | 72.98% | 618 |
| 2024 | 75.51% | 543 |
| 2025 | 83.78% | 598 |

| 26th December - 4 Hour Performance | | |
|---|---|---|
| Year | Performance | Attendances |
| 2019 | 76.32% | 874 |
| 2020 | 79.58% | 578 |
| 2021 | 78.66% | 628 |
| 2022 | 74.57% | 987 |
| 2023 | 73.36% | 912 |
| 2024 | 72.72% | 876 |
| 2025 | 91.63% | 932 |




83.78% for 4-hour standard was achieved for the 25th of December despite an increase of 55 patients compared to the previous year- an increase of 8.27% for 4-hour standard.
December the 26th seen 4-hour performance of 91.63% despite an increase of attendances of 54 additional presentations.

| 27th December 4 Hour Performance | | |
|---|---|---|
| Year | Performance | Attendances |
| 2019 | 74.26% | 773 |
| 2020 | 77.03% | 666 |
| 2021 | 80.69% | 932 |
| 2022 | 72.51% | 1193 |
| 2023 | 72.72% | 942 |
| 2024 | 70.48% | 935 |
| 2025 | 81.84% | 1063 |

27th of December continued to show statistically significant improvement in 4 hour performance compared to previous years with an 11% increase in attendances – an increase of 128 presentations

## 3.0 Matters for reporting / escalation to the Board

3.1 While progress was noted across several winter initiatives, the Group identified several areas where assurance was limited and further evidence is required.

### 3.2 IV Therapy and OPAT Utilisation

The Group was not fully assured regarding the utilisation of available IV Therapy and OPAT capacity. Although pathways and staffing are in place, challenges persist in identifying suitable patients and demonstrating measurable impact. Further assurance is required on patient cohort identification, pathway adherence, and outcome reporting, particularly in relation to commissioner expectations.

### 3.3 Demonstration of Scheme Impact

Across several funded schemes, the Group highlighted insufficient consistency in performance data, outcome metrics, and benchmarking. This limits the ability to provide robust assurance on effectiveness and value and presents a risk in the context of ongoing commissioning and funding decisions.

### 3.4 Paediatric Front Door Data and Ownership

While the paediatric front door scheme is operational, the Group was not fully assured that data capture and reporting are sufficiently mature to evidence impact. Further clarity is required on performance metrics, including four-hour breaches and conversion rates, with clearer ownership and alignment across data sources.

### 3.5 Workforce Assurance

The absence of a workforce update meant the Group was unable to gain assurance on workforce resilience, capacity, and risk heading into the peak winter period. This represents a gap in oversight that will need to be addressed urgently.

## 4.0 Industrial Action December 2025

See Appendix One.

## 5.0 Board Action Required

5.1 The Board is asked to note the position of the system as it enters the peak winter period, receive assurance on the governance and oversight arrangements in place through the Winter Planning Oversight Group, and acknowledge the areas where further evidence and assurance are being sought.

NHS
Lincolnshire Community and Hospitals NHS Group

# LCHG
# Resident Dr IA 17th – 22nd December 2025
# Group Response

Caring and building a healthier future for all

# Rhythm of the Day

- Daily Strategic Cell calls 9am – Commencing 9th December
- Daily Tactical Cell Calls – Commencing 8th December
- Daily system wide Operational Calls 09:30
- Capacity Calls 3 times per day
- Daily System Strategic Calls 11am
- Striking data submission for 11am Daily
- Daily HDOF IA Update

# System Coordination

| Date | Coordination in place |
|---|---|
| Tuesday 16th December | 1330hrs - System Strategic<br>15300hrs – ICB Briefing |
| Wednesday 17th December | 0830hrs – IA Regional Update Meeting (TBC)<br>0900hrs - ICB Handover<br>0930hrs – System Ops (BAU)<br>1100hrs – System Strategic<br>1300hrs – IA Regional Update Meeting<br>1415hrs – Regional System Ops (BAU)<br>1800hrs – IA Regional Update Meeting |
| Thursday 18th December | 0830hrs – IA Regional Update Meeting<br>0900hrs - ICB Handover<br>0930hrs – System Ops (BAU)<br>1100hrs – System Strategic<br>1300hrs – IA Regional Update Meeting<br>1415hrs – Regional System Ops (BAU)<br>1800hrs – IA Regional Update Meeting |
| Friday 19th December | 0830hrs – IA Regional Update Meeting<br>0900hrs - ICB Handover<br>0930hrs – System Ops (BAU)<br>1100hrs – System Strategic<br>1300hrs – IA Regional Update Meeting<br>1415hrs – Regional System Ops (BAU)<br>1800hrs – IA Regional Update Meeting |
| Saturday 20th December | 0830hrs – IA Regional Update Meeting<br>0900hrs - ICB Handover<br>0930hrs – System Ops (BAU)<br>1100hrs – System Strategic<br>1300hrs – IA Regional Update Meeting<br>1415hrs – Regional System Ops (BAU)<br>1800hrs – IA Regional Update Meeting |
| Sunday 21ct November | 0830hrs – IA Regional Update Meeting<br>0900hrs - ICB Handover<br>0930hrs – System Ops (BAU)<br>1100hrs – System Strategic<br>1300hrs – IA Regional Update Meeting<br>1415hrs – Regional System Ops (BAU)<br>1800hrs – IA Regional Update Meeting |
| Monday 22nd November | 0900hrs - Handover<br>0930hrs – System Ops (BAU)<br>1100hrs – System Strategic (Will be stood down if not required) |

# Current Financial Asks

- Costings are currently being processed, but additional asks are listed below:
- Additional ACP support H@N service Additional Cannulation/ Phlebotomy provision PHB/LCH - Approved
- Ambicorp for Pilgrim and Lincoln during IA - Cancelled
- EDD Dr x 2 for medicine and Surgery 1 Day prior to strike and 2 days after - Approved
- Additional Pharmacy hours – Partially Approved
- Additional CSM cover - Approved

# Predicted Spend – Dec 2025

| Division | Day | Shift | Additional Hours requested | Department | Site | Band | Basic Pay inc 30% uplift (based on hourly rate) | Unsocial Enhancements | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| Surgery | Wed | 07:00-20:00 | 11hrs | CSS | LCH | B3 | 246.18 | - | 246.18 | |
| | Thur | 07:00-20:00 | 11hrs | CSS | LCH | B3 | 246.18 | - | 246.18 | |
| | Fri | 07:00-20:00 | 11hrs | CSS | LCH | B3 | 246.18 | - | 246.18 | |
| | Sat | 07:00-20:00 | 11hrs | CSS | LCH | B3 | 246.18 | 86.16 | 332.34 | |
| | Sun | 07:00-20:00 | 11hrs | CSS | LCH | B3 | 246.18 | 169.87 | 416.05 | |
| | Wed | 20:15-08:30 | 11hrs 15mins | H@N | LCH | F1/2 dr | 756.84 | - | 756.84 | Based on F2 |
| | Thur | 20:15-08:30 | 11hrs 15mins | H@N | LCH | F1/2 dr | 756.84 | - | 756.84 | Based on F2 |
| | Fri | 20:15-08:30 | 11hrs 15mins | H@N | LCH | F1/2 dr | 756.84 | - | 756.84 | Based on F2 |
| | Sat | 20:15-08:30 | 11hrs 15mins | H@N | LCH | F1/2 dr | 756.84 | - | 756.84 | Based on F2 |
| | Sun | 20:15-08:30 | 11hrs 15mins | H@N | LCH | F1/2 dr | 756.84 | - | 756.84 | Based on F2 |
| Medicine | Tues | 10:00 - 18:00 | 7.5hrs x 2 Each Site, 2 Each Day | EDD Dr | PHB/LCH | F1 Dr | 1,569.75 | - | 1,569.75 | |
| | Mon | 10:00 - 18:00 | 7.5hrs x 2 Each Site, 2 Each Day | EDD Dr | PHB/LCH | F1 Dr | 1,569.75 | - | 1,569.75 | |
| | Tues | 10:00 - 18:00 | 7.5hrs x 2 Each Site, 2 Each Day | EDD Dr | PHB/LCH | F1 Dr | 1,569.75 | - | 1,569.75 | |
| Ops | Sat | 08:00 - 20:00 | 11.5hrs | H@N CSW | PHB | B3 | 257.37 | 90.08 | 347.45 | |
| | Sat | 08:00 - 20:00 | 11.5hrs | H@N ACP | PHB | B8A | 614.31 | 184.29 | 798.60 | |
| | Sat | 20:00 - 08:00 | 11.5hrs | H@N ACP | PHB | B8A | 614.31 | 304.49 | 918.80 | |
| | Sun | 08:00 - 20:00 | 11.5hrs | H@N CSW | PHB | B3 | 257.37 | 177.59 | 434.96 | |
| | Sun | 08:00 - 20:00 | 11.5hrs | H@N ACP | PHB | B8A | 614.31 | 368.59 | 982.90 | |
| | Sun | 20:00 - 08:00 | 11.5hrs | H@N ACP | PHB | B8A | 614.31 | 248.40 | 862.71 | |
| | Wed | 08:00-18:00 | 1 hr each site | Pharmacy | LCH | B8A | 53.42 | - | 53.42 | |
| | Thur | 08:00-18:00 | 1 hr each site | Pharmacy | LCH | B8A | 53.42 | - | 53.42 | |
| | Fri | 08:00-18:00 | 1 hr each site | Pharmacy | LCH | B8A | 53.42 | - | 53.42 | |
| | Wed | 08:00-18:00 | 1 hr each site | Pharmacy | PHB | B8A | 53.42 | - | 53.42 | |
| | Thur | 08:00-18:00 | 1 hr each site | Pharmacy | PHB | B8A | 53.42 | - | 53.42 | |
| | Fri | 08:00-18:00 | 1 hr each site | Pharmacy | PHB | B8A | 53.42 | - | 53.42 | |
| | Wed | | | Ambicorp vehicle | LCH | | | - | - | Removed as not using |
| | Thur | | | Ambicorp vehicle | LCH | | | - | - | Removed as not using |
| | Fri | | | Ambicorp vehicle | LCH | | | - | - | Removed as not using |
| | Wed | | | Ambicorp vehicle | PHB | | | - | - | Removed as not using |
| | Thur | | | Ambicorp vehicle | PHB | | | - | - | Removed as not using |
| | Fri | | | Ambicorp vehicle | PHB | | | - | - | Removed as not using |
| | | | | | | | | | 14,699.78 | |

Assumptions for costings

Top of band agenda for change PAYSCALE 25/26
Inc enhancement rates
Employer pension at 14.38% inc in hourly rate
Employer NI at 15% inc in hourly rate
F1 / F2 / ST3 2025 updated payscale used for hourly rate
F1 / F2 / ST3 - 30% uplift previously paid for strike cover
No overtime rate factored into these costings

# Workforce Priorities

- Ensure Emergency cover for Bleep holder teams, with focus on out of hours period
- Ensure Workforce allocation assists in prioritisation of elective activity to maintain 95% of current service.
- Ensure all UEC pathways are safely staffed to maintain safety and flow
- Ensure Maternity and Paediatric services maintain minimum safe staffing levels
- Utilise ACP workforce to assist in delivery of care
- Medical Rate guidance under review, but will likely be unchanged
- Derogations to be considered via strategic, if any of the priorities above can not be achieved.

# Number of Dr Taking part in IA

| | Wednesday 17th December | | | |
|---|---|---|---|---|
| | Due to Work | On Strike | Not Striking | % |
| Medicine | 194 | 152 | 42 | 78.35% |
| Surgery | 110 | 90 | 20 | 81.82% |
| Family Health | 33 | 24 | 9 | 72.73% |
| Alliance | 15 | 6 | 9 | 40.00% |
| Total | 352 | 272 | 80 | 77.27% |

| | Thursday 18th December | | | |
|---|---|---|---|---|
| | Due to Work | On Strike | Not Striking | % |
| Medicine | 171 | 137 | 34 | 80.12% |
| Surgery | 104 | 86 | 18 | 82.69% |
| Family Health | 38 | 27 | 11 | 71.05% |
| Alliance | 13 | 5 | 8 | 38.46% |
| Total | 326 | 255 | 71 | 78.22% |

| | Friday 19th December | | | |
|---|---|---|---|---|
| | Due to Work | On Strike | Not Striking | % |
| Medicine | 163 | 133 | 30 | 81.60% |
| Surgery | 89 | 75 | 14 | 84.27% |
| Family Health | 40 | 33 | 7 | 82.50% |
| Alliance | 15 | 7 | 8 | 46.67% |
| Total | 307 | 248 | 59 | 80.78% |

| | Saturday 20th December | | | |
|---|---|---|---|---|
| | Due to Work | On Strike | Not Striking | % |
| Medicine | 52 | 46 | 6 | 88.46% |
| Surgery | 31 | 29 | 2 | 93.55% |
| Family Health | 13 | 12 | 1 | 92.31% |
| Alliance | 5 | 4 | 1 | 80.00% |
| Total | 101 | 91 | 10 | 90.10% |

| | Sunday 21st December | | | |
|---|---|---|---|---|
| | Due to Work | On Strike | Not Striking | % |
| Medicine | 53 | 48 | 5 | 90.57% |
| Surgery | 31 | 29 | 2 | 93.55% |
| Family Health | 13 | 12 | 1 | 92.31% |
| Alliance | 5 | 4 | 1 | 80.00% |
| Total | 102 | 93 | 9 | 91.18% |

# Roles of Junior Drs taking IA

| Wednesday 17th December | |
|---|---|
| Role | Count of Employee Number |
| Foundation Year 1 | 73 |
| Foundation Year 2 | 42 |
| Specialty Registrar | 75 |
| Trust Grade Doctor or Dentist - Foundation Level | 34 |
| Trust Grade Doctor or Dentist - Specialty Registrar | 48 |
| Grand Total | 272 |

| Thursday 18th December | |
|---|---|
| Role | Count of Employee Number |
| Foundation Year 1 | 67 |
| Foundation Year 2 | 39 |
| Specialty Registrar | 71 |
| Trust Grade Doctor or Dentist - Foundation Level | 32 |
| Trust Grade Doctor or Dentist - Specialty Registrar | 46 |
| Grand Total | 255 |

| Friday 19th December | |
|---|---|
| Role | Count of Employee Number |
| Foundation Year 1 | 64 |
| Foundation Year 2 | 40 |
| Specialty Registrar | 63 |
| Trust Grade Doctor or Dentist - Foundation Level | 28 |
| Trust Grade Doctor or Dentist - Specialty Registrar | 53 |
| Grand Total | 248 |

| Saturday 20th December | |
|---|---|
| Role | Count of Employee Number |
| Foundation Year 1 | 23 |
| Foundation Year 2 | 17 |
| Specialty Registrar | 16 |
| Trust Grade Doctor or Dentist - Foundation Level | 11 |
| Trust Grade Doctor or Dentist - Specialty Registrar | 24 |
| Grand Total | 91 |

| Sunday 21st December | |
|---|---|
| Role | Count of Employee Number |
| Foundation Year 1 | 23 |
| Foundation Year 2 | 18 |
| Specialty Registrar | 14 |
| Trust Grade Doctor or Dentist - Foundation Level | 11 |
| Trust Grade Doctor or Dentist - Specialty Registrar | 27 |
| Grand Total | 93 |

# Current Forecasted Activity (09/12/2025)

| | Elective | | OP1st | | OPFUp | |
|---|---|---|---|---|---|---|
| | DC | EL | Appts | Clinics | Appts | Clinics |
| 17/12/2025 | 151 | 16 | 680 | 158 | 1930 | 262 |
| 18/12/2025 | 152 | 17 | 639 | 153 | 1634 | 252 |
| 19/12/2025 | 152 | 17 | 479 | 104 | 1163 | 188 |
| 20/12/2025 | 29 | 0 | 138 | 16 | 123 | 11 |
| 21/12/2025 | 21 | 2 | 65 | 6 | 6 | 1 |
| 22/12/2025 | 113 | 20 | 568 | 128 | 1399 | 212 |
| | | | | | | |
| | Date Offered OR | | | | | |
| | Offer Accepted | | | | | |

# Approved & Reported Cancellations

**Outpatient Appointments**

| | Mon | Tue | Wed | Thu | Fri | Sat | Sun | Mon | Tue | Wed | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 15-Dec-25 | 16-Dec-25 | 17-Dec-25 | 18-Dec-25 | 19-Dec-25 | 20-Dec-25 | 21-Dec-25 | 22-Dec-25 | 23-Dec-25 | 24-Dec-25 | |
| Went ahead | 3134 | 3287 | 3116 | 2832 | 2321 | 416 | 126 | 2596 | | | 17,828 |
| Left unbooked - due to IA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| Cancelled - due to IA | 0 | 0 | 28 | 31 | 35 | 0 | 0 | 0 | | | 94 |
| Total capacity *(went ahead + left unbooked + cancelled)* | 3,134 | 3,287 | 3,144 | 2,863 | 2,356 | 416 | 126 | 2,596 | | | |

**Day Case**

| | 15-Dec-25 | 16-Dec-25 | 17-Dec-25 | 18-Dec-25 | 19-Dec-25 | 20-Dec-25 | 21-Dec-25 | 22-Dec-25 | 23-Dec-25 | 24-Dec-25 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Went ahead | 274 | 259 | 266 | 291 | 266 | 35 | 19 | 241 | | | 1,651 |
| Left unbooked - due to IA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| Cancelled - due to IA | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | | 1 |
| Total capacity *(went ahead + left unbooked + cancelled)* | 274 | 259 | 266 | 291 | 267 | 35 | 19 | 241 | | | |

**Ordinary electives**

| | 15-Dec-25 | 16-Dec-25 | 17-Dec-25 | 18-Dec-25 | 19-Dec-25 | 20-Dec-25 | 21-Dec-25 | 22-Dec-25 | 23-Dec-25 | 24-Dec-25 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Went ahead | 34 | 21 | 22 | 26 | 23 | 4 | 8 | 28 | | | 166 |
| Left unbooked - due to IA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| Cancelled - due to IA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| Total capacity *(went ahead + left unbooked + cancelled)* | 34 | 21 | 22 | 26 | 23 | 4 | 8 | 28 | 0 | 0 | 166 |

**Long waits - of the cancellations/underbookings above how many were long waiters?**

| | 15-Dec-25 | 16-Dec-25 | 17-Dec-25 | 18-Dec-25 | 19-Dec-25 | 20-Dec-25 | 21-Dec-25 | 22-Dec-25 | 23-Dec-25 | 24-Dec-25 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 53-65 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| 65+ weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| Total | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Cancer Waits**

| | 15-Dec-25 | 16-Dec-25 | 17-Dec-25 | 18-Dec-25 | 19-Dec-25 | 20-Dec-25 | 21-Dec-25 | 22-Dec-25 | 23-Dec-25 | 24-Dec-25 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| First Cancer Outpatient | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| 62d Cancer Treatment Surgery | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| 62d Cancer Treatment Oncology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| 62d Cancer Treatment Total *(surgery + oncology)* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 104d Cancer Treatment Surgery | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| 104d Cancer Treatment Oncology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| 104d Cancer Treatment Total *(surgery + oncology)* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| **Overall Performance** | **99.51%** |
|---|---|

NHS
Lincolnshire Community and Hospitals NHS Group

# Quality Committee Upward Report

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *8.1* |

# *Quality Committee Upward Report of the meeting held on 25 November 2025*

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

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

**Board Committee Upward Report to the Group Board**

| | |
|---|---|
| **Report for meeting of the Group Board to be held on:** | 6 January 2026 |
| **Report from:** | Quality Committee |
| **Report from meeting held on:** | 25 November 2025 |
| **Quoracy requirements met:** | Yes |

## 1.0 Purpose of the report

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

## 2.0 Matters considered by the committee

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

Assurances in respect of Objective 1a(i):

a) Patient Safety Group Upward Report inc Ophthalmology focussed discussion
b) High Profile Cases

The bed rail Central Alert System (CAS) notification remained overdue for both ULTH and LCHS with an admin review being undertaken for the affected ULTH patients. This would be cross referenced to LCHS to avoid duplication.

Significant assurance was received in relation to the Group incident management report and future reporting arrangements were agreed. The Committee was please to note that no Never Events had been declared across the Group in 2025/26, and duty of candour compliance remained high.

Further work was noted to be required in respect of the ophthalmology recovery plan which the Patient Safety Group had requested. Digital Clinical Safety reporting was being confirmed with upward reporting expected via the group to the Committee.

Ongoing work was noted in respect of pressure ulcers both in the community and acute and C-difficile infections were reported 12 above trajectory. Work also remained ongoing in respect of aseptic issues with improvements being seen due to the work of the microbiologists. However, an impact on the

trajectory rates, due to contamination rates, was noted with further communications being undertaken, linked to education.

Assurances in respect of Objective 1a(ii):

a) Patient Experience and Involvement Group Upward Report
b) Children and Young People Oversight Group Upward Report
c) Safeguarding and Vulnerabilities Oversight Group Upward Report inc Children in Care Update

Mixed Sex Accommodation (MSA) breaches were reported with recognition of the validation challenges being faced due to inconsistent reporting processes. These were being addressed through a task and finish group which would also consider the process for reporting, validation and external submissions.

Positive engagement was noted at the most recent Children and Young People Oversight Group meeting with work taking place to ensure the structure of the meeting was more robust.

Progress was noted for the hybrid close loop journey for diabetes, supporting children on the regime with psychological support in place for children as well as transitional support for moving to young adult services.

From a safeguarding perspective the Committee noted the continued number of section 42 reports being received, despite this progress was being seen. The Committee noted concern in respect of training attendance and uptake with appropriate escalations being made.

Work continued to appoint to the Looked After Children vacancy and the Committee would continue to be updated on progress.

The Modern Slavery statement (**appended**) was received by the Committee and recommended to the Board for approval.

Assurances in respect of Objective 1a(iii):

a) Clinical Effectiveness Group Upward Report
b) Focussed Discussion: Pharmacy Medicines Management

The outlier status for ileostomy closures and hip fractures were noted with action being taken to meet with the Chiefs of Service to determine actions for improvement.

The Committee held a focussed discussion in respect of Pharmacy Medicines Management and noted the significant volume of work that had been undertaken in this area, following ongoing concerns, and the development of the action plan. This covered three core areas including Pharmacy/Medicines Management Governance and Leadership Arrangements, Safer Meds Initiative and wider actions including value, cost

improvement and right sizing. The Committee noted the refocusing and invigoration of the Medicines Quality Group, which would be chaired by the Group Chief Medical Officer and would directly report to the Committer for a period of time.

Assurances in respect of other areas:

a) Patient Story
b) Board Assurance Framework 2025/26
c) Committee Performance Dashboard
d) Risk Register
e) Policy Position Update
f) Quality Impact Assessment Assurance Report
g) Topical, Legal and Regulatory Update
h) Investment Decisions Risks
i) Internal Audit Recommendations

The Committee received the new style performance report noting the development that had been undertaken and recognised the alignment to the National Oversight Framework. Further discussions were required to ensure the correct metrics were reported however the Committee agreed that the previous style reports would no longer be required.

Positive improvements were noted in respect of policy documents with recognition of changes to governance which required embedding. The Quality Impact Assessment report was noted with recognition that the Cost Improvement Programmes being undertaken were not having a negative impact on patients.

The Committee noted the investment decisions paper which indicated areas where investment would not be possible in the current year, and work was ongoing to review risks associated with investment.

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

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

a) None

## 4.0 Matters for reporting / escalation to the Group Board

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

a) Lack of ICB funding in respect of the additional 12 WTE maternity staff to support the staffing standards. 3 applications have been made by ULTH and rejected; internal mitigations were in place.

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

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

## 6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the Quality Committee
- consider the matters which the committee wish to escalate to the Group Board and note and agree the action required
- approve the Modern Slavery statement for publication

***Jim Connolly, Non-Executive Director***

***25 November 2025***

Lincolnshire Community and Hospitals NHS Group

# MODERN SLAVERY Annual Statement 2025-2026

This is a 'group statement' for Lincolnshire Community and Hospitals NHS Group (LCHG) pursuant to S54 of the Modern Slavery Act 2015 and sets out the steps that LCHG has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain. The aim of this statement is to demonstrate that the Group follows good practice, and reasonable steps are taken to prevent, to understand potential modern slavery and human trafficking risks and to implement effective systems and controls.

Modern slavery encompasses domestic servitude, forced labour, criminal exploitation, and sexual exploitation. The Group has a zero-tolerance approach to any form of modern slavery or human trafficking. We are committed to acting ethically and with integrity and transparency in all business dealings and to put effective systems and controls in place to safeguard against any form of modern slavery taking place within our business or our supply chain.

As a Group we are committed to ensuring that all of our employees are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that the individual may be or is at risk of modern slavery/human trafficking.

## Group Structure.

Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospital NHS Trust (ULTH) have now come together formally as a Group, called Lincolnshire Community and Hospitals NHS Group (LCHG). This arrangement does not constitute a formal merger of the two organisations but brings the two Trusts together under a single Board and Executive Leadership Team, with the goal of improving the care that is provided to patients both in the community and hospital settings across Lincolnshire.

The group consists of;

- United Lincolnshire Teaching Hospitals NHS Trust, one of the largest Trusts in the country, providing services from 3 acute hospitals in Lincolnshire - Lincoln County Hospital; Pilgrim Hospital, Boston, and Grantham and District Hospital. The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals or local GP clusters. The Trust provides a wide range of healthcare services delivered by over 8,500 trained staff.

And

- Lincolnshire Community Health Services NHS Trust (LCHS), the primary community healthcare provider in Lincolnshire delivering community-based services aimed at

supporting people to manage their own health at home and reducing the need for people to go into hospital. The service provides a wide range of healthcare services delivered by over 2,500 trained staff.

As a group we work closely with a range of partners including commissioners, local councils, NHS England, the private sector, and voluntary organisations to deliver innovative and integrated care to our communities.

**LCHG statement of response**:

We are fully aware of the responsibilities we bear towards our patients, employees, and local communities. We are guided by a strict set of ethical values in all our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking, and management are expected to act upon them in accordance with our policies and procedures.

LCHG is committed to fulfilling our responsibility to ensure that there is a zero-tolerance approach to Modern Slavery and/or Human Trafficking within our supply chains or within any part of our business. Any identified concerns regarding Modern Slavery and Human Trafficking will be escalated in line with the Organisation's Safeguarding processes, working in conjunction with our partner Agencies. As such:

- The Group adheres to the National NHS Employment Checks/Standards (including employees' UK address; their right to work in the UK and obtaining suitable references). We ensure all UK Workers receive minimum wage and robust immigration checks, to safeguard against human trafficking or individuals being forced to work against their will.
- Our payroll systems monitor modern slavery concerns (i.e. people bought into the Country illegally will not have a National Insurance number).
- We implement a range of controls to protect staff from poor treatment and/or exploitation, which comply with all respective laws and regulations. These include provision of fair pay rates, fair Terms of Conditions of employment and access to training and development opportunities, Consulting and negotiating with Trade Unions on proposed changes to employment, work organisation and contractual relations.
- LCHG has systems in place to encourage the reporting of concerns and for the protection of those who do raise concerns.
- LCHG Safeguarding Policies, Training packages and Intranet site contain information relating to the indicators of Human Trafficking/Modern Slavery, for staff awareness and usage.

- The referral process for Adults/Children at risk, along with links to both the Lincolnshire Safeguarding Adult and Lincolnshire Safeguarding Children Boards are located on the Safeguarding section of our Intranet sites.
- Modern slavery is incorporated within safeguarding policies and included within mandatory training programmes for all staff employed by the Group. Training in relation to Modern Day Slavery has been delivered to all staff through our mandatory e-learning training as part of Safeguarding Adults Training level 1 and further training is provided to staff working with children and vulnerable adults. Training compliance is monitored through local governance meetings and overseen by the Board.
- The Freedom to Speak Up Guardians support staff to escalate concerns, Both FTSUG's have a team of FTSU Champions who can listen and signpost staff to the appropriate channels. The FTSUG's also work to identify and breakdown barriers to Speaking Up and raise awareness of its importance to both staff and patient safety across the Trust. The role of the Freedom to Speak Up Guardian is covered at the Trust's monthly corporate induction; the Trust has adopted the National Freedom to Speak Up Policy in line with national guidance and the importance of speaking up is celebrated annually via October Speaking Up week. The FTSUG's also provide the Trust Board with reports quarterly and an Annual Report is produced, summarising all key activity. Trust activities and policies are required to have an Equality Impact Assessment (EQIA) completed
- LCHG aims to be as effective as possible in ensuring that Modern Slavery and Human Trafficking is not taking place in any part of its business or supply chains. The Group adheres to NHS Terms and Conditions relating to Supply of Goods & Services, minimising the risk of slavery practices. This requires suppliers to (i) comply with all relevant Law and Guidance and use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and (ii) notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains to support this we;
- LCHG procurement contracts make specific reference to social value and the prevention of modern slavery.
- We endeavour to build long-standing relationships with our suppliers and make clear our expectations of business behaviour. Where national or international supply chains are used, we expect these suppliers to have suitable Anti-Slavery and Human Trafficking Policies and Procedures and, where there is a risk of Slavery and Human Trafficking taking place, steps have been taken to assess and manage that risk.
- We seek assurance that there is a level of communication with the next link in the supply chain and their understanding of, and compliance with, our expectations in relation to the NHS terms and conditions. These conditions relate to issues such as bribery, slavery, and other ethical considerations.
- Require evidence that providers are publishing their modern slavery statement when we procure a new contract.

- LCHG Purchase a significant number of products through the NHS Supply Chain and framework agreements, whose ‘supplier code of conduct’ includes a provision around forced labour.
- We require all suppliers to comply with the provisions of the UK Modern Slavery Act (2015) through our purchase orders and tender specifications, which set out our commitment to ensuring no modern slavery or human trafficking in relation to our business.
- The Statement will be reviewed and updated on an annual basis and presented to the board.

**Conclusion**

This statement has been presented to the Board of Directors and approved by the Board on …….

Signature:

**Chief Executive Officer, Lincolnshire Community and Hospitals NHS Group.**

NHS
Lincolnshire Community and Hospitals NHS Group

# Quality Committee Upward Report

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *8.1* |

# *Quality Committee Upward Report of the meeting held on 16 December 2025*

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

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

**Board Committee Upward Report to the Group Board**

| | |
|---|---|
| **Report for meeting of the Group Board to be held on:** | 6 January 2026 |
| **Report from:** | Quality Committee |
| **Report from meeting held on:** | 16 December 2025 |
| **Quoracy requirements met:** | Yes |

## 1.0 Purpose of the report

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

## 2.0 Matters considered by the committee

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

Assurances in respect of Objective 1a(i):

a) Patient Safety Group Upward Report
b) Maternity and Neonatal Oversight Group Upward Report

The Committee noted the gap analysis in respect of the DASH review with the national position awaited however it was believed the Group was slightly ahead and anticipated being sighted in the Quality Strategy.

The Patient Safety Incident Investigation process had been reviewed with some identified gaps and areas to be strengthened through the new framework.

Healthcare Acquired Infections were noted with C-Difficile and E-Coli trajectory having seen a slight reduction with a focus on work in the community. Flu maintained a steady position with the Group introducing mask wearing to support the well-being of patients and staff.

An improved position was noted in respect of water safety, for the positive detection of legionella and pseudomonas with augmented care flushing reported at 91%. A water safety action plan was being developed and would be shared with the Committee.

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

- CNST Standard 1- PMRT
  - Upwardly report the Q2 PMRT report (**Appendix 1.6**) including details of the deaths reviewed from 1 December 2024, any themes identified and the consequent action plans. Reviews of deaths and consequent action plans are available to the Board in the reading room.

- CNST Standard 3-
  - ATAIN: Note update relating to continuation of the Quality Improvement Project 'Midwives as second checkers for neonatal IV antibiotics' available within **Appendix 1.0.**
  - TC- Note Trust position of compliance with the minimum evidence requirement for CNST MIS Year 7 for pathway of care for babies from 34+ weeks. Perinatal services acknowledge that there are areas requiring improvement including recommendations from the ODN Peer Review; these actions are monitored via the PeriSIP and agreed reporting routes.

- CNST Standard 4- Clinical Workforce:
  - **Obstetric workforce:**
    - Note that the Trust has implemented RCOG guidance on engagement of both short-term and long-term locums and is compliant with criteria having been met for employment of locum doctors in Obstetrics and Gynaecology. This has been demonstrated through a 6-month audit.
    - Note that the Trust is 97% compliant with consultant attendance in person to the clinical situations listed in the RCOG workforce document. This has been demonstrated through a 3-month audit.
    - Note progress on the previously agreed action plan to support working towards implementation of the RCOG guidance on Compensatory rest.
  - **Neonatal workforce:**
    - Note that the neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of medical staffing
    - Record in Trust Board minutes progress against the previous Board agreed QIS action plan and trajectories and that this is on the services risk register. **Appendix 1.0** provides further information.

- CNST Standard 5- Midwifery Workforce:
  - Upward report to Board the staffing report in its entirety **Appendix 1.8**.
  - Record in Trust Board minutes receipt of the midwifery staffing oversight report covering staffing/safety issues in line with NICE midwifery staffing guidance.
  - Note and record in the Board meeting papers the update on the agreed plan, including timescales, for achievement of the appropriate uplift in

funded establishment along with mitigations to cover this shortfall, specifically the following:

- The Trust has adopted a phased, milestone-based approach, to achieving the required uplift within mitigations including the case of need, business case and three separate attempts to secure funding through the ICB Weighted Value Framework (WVF)
- The Trust has committed £450k to recruit 5.75 WTE Band 6 midwives. This represents an interim milestone towards the overall uplift, delivered as a cost pressure while awaiting a longer-term funding decision.
- Following the most recent unsuccessful attempt to secure funding through the Weighted Value Framework (WVF), the Quality Committee is asked to note, for assurance purposes, the Trust has committed, funded as a cost pressure, to commence recruitment of the additional workforce to close the 12.1 WTE midwifery deficit from 1 April 2026, recognising that as interim mitigation, 5.75wte midwives have already been recruited to. Commissioners are fully aware of the position.

- CNST Standard 6- Saving Babies Lives Care Bundle:
  - Record in Trust Board minutes progress has been made towards full implementation of Saving Babies Lives Care Bundle, in line with the locally agreed improvement trajectories. Progress has been confirmed by the ICB as demonstrated in the SBLCB implementation tool.

- CNST Standard 7- MNVP: Note the formal escalation of risk, via the PQSM relating to the MNVP provision.
  - Record in Trust Board minutes that the service, in collaboration with the LMNS, have concluded that the current MNVP lead contracted hours, compounded by reduced ICB/LMNS capacity to support is no longer sufficient to meet the year 7 requirement.
  - Record in Trust Board minutes that escalation via the PQSM model at Trust and LMNS level, reported via MNOG/QC upward reporting process is ongoing with mitigation currently under review to ensure the service continues to listen to women and families in a way that is proportionate to MNVP resourcing available until the MNVP is commissioned in line with guidance.
  - Note progress with co-produced action plan

- CNST Standard 9- Floor to Board:
  - Record in Trust Board minutes, as evidenced via the PQSM document, that:
    - A non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC).
    - A review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM bi-monthly

        - Board Safety Champion(s) meet with the Perinatal leadership team and the Quad leadership team at a minimum of bi-monthly
    - Note receipt of the quarterly Claims Scorecard **Appendix 1.7**.
    - Record in Trust Board minutes progress with the Staff Experience Group (maternity and neonatal culture plan).

- CNST Standard 10- MNSI:
    - For upward reporting and formal inclusion within Group Board Minutes:
        - Note receipt of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.
        - Note receipt of evidence that families have received information on the role of MNSI and NHS Resolution's EN scheme in an accessible format in the patient's own language.
        - Note receipt must have sight of evidence of compliance with the statutory duty of candour.
        - Further detail available in **Appendix 1.0**

Interim early findings have been released by Baroness Amos (**Independent Investigation into Maternity and Neonatal Services in England - Reflections and Initial Impressions - National Maternity and Neonatal Investigation**) with initial benchmarking undertaken which would be discussed further at MatNeosip meeting and any actions adding to MatNeosip action plan as required.

The following statement has been offered from Mrs Brown, Non-Executive Director Maternity Safety Champion:

*'Alongside my fellow Board Safety champion, the Group Chief Nurse, and in collaboration with the MNVP lead and other ICB colleagues, we meet with the Perinatal Leadership team on a bi-monthly basis via the Maternity and Neonatal Oversight Group or MNOG to review progress and identify areas where support is required from the Quality Committee and the Group Board. Any such examples of support are escalated via the upward reporting arrangements to Group Board, where myself and Nerea, highlight such areas of support and work to implement these with the support of fellow members of the Board'.*

Assurances in respect of Objective 1a(ii):

a) Patient Experience and Involvement Group Upward Report

The Committee received key highlights from the group noting no escalations following the meeting. Limited assurance was noted in respect of equality and diversity due to gaps in compliance however it was recognised that this would be resolved through the appointment of an EDI lead.

Improvement was noted in respect of the data for Mixed Sex Accommodation breaches however the Committee sought to better understand the process and authorisation of breaches to receive assurance of the governance process.

Concern was noted in respect of patient moves at night and discharge letters with improvements required in both areas. The Committee was reassured of the focused work which would commence in 2026 in these areas.

Assurances in respect of Objective 1a(iii):

a) Clinical Effectiveness Group Upward Report

The outlier alert for the laparotomy audit was noted with an improvement plan in place which would be monitored on a weekly basis with updates offered through the department's governance structure. It was recognised that there was a need for consider the previously completed data in order to determine prospective actions with an audit lead appointed.

Assurances in respect of other areas:

The Committee worked to a reduced agenda in order to undertake a workshop session focused on further developing the content of the Board Assurance Framework (BAF) and the Performance Report. This enabled the Committee to undertake a thorough review of the content of both reports and for developments to be identified which would be actioned and seen in the coming months.

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

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

a) None

## 4.0 Matters for reporting / escalation to the Group Board

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

a) The loss of the Maternity and Neonatal Voices Partnership (MNVP) provision due to current MNVP lead contracted hours having been concluded and the provision not being sufficient to meet the year 7 requirement

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

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

## 6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the Quality Committee
- note the escalation made to the Board

***Jim Connolly, Non-Executive Director***

***16 December 2025***

NHS
United Lincolnshire Teaching Hospitals
NHS Trust

# Perinatal Assurance Report

Emma Upjohn
Director of Midwifery

V1.0
November 2025

CQC rating: Good

Caring and building a healthier future for all

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## Executive summary

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

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

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

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

# 2: National drivers

## 2.2 Perinatal Quality Oversight Model (PQOM)

Appendix 1.1

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

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

*NHSE have released, in draft form, a revised Perinatal Quality Oversight Model (PQOM) that will replace the PQSM. In collaboration with the ICB and ODN, ULTH are benchmarking and revising the local document in preparation for the final document release. Once finalised, the assurance reporting template will reflect the changes and the document will be shared.*

| Minimum data measure for Trust Board overview | Location of information within Perinatal Assurance Report | Additional papers within agenda | Links to National/Local drivers |
|---|---|---|---|
| Findings of review of all perinatal deaths using the real time data monitoring tool | • Maternity and Neonatal Dashboards<br>• Learning lessons<br>• CNST MIS Year 7 update | Q2 PMRT report | CNST MIS SA:1<br>CNST MIS SA:10 |
| Findings of review of all cases eligible for MNSI | • Learning lessons<br>• Maternity and Neonatal Dashboards<br>• CNST MIS Year 7 update | | CNST MIS SA:1<br>CNST MIS SA:10 |
| Number of incidents graded as moderate or above and what action is being taken | • Learning lessons<br>• Maternity and Neonatal Dashboards | | |



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| | | | |
|---|---|---|---|
| Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training | • Maternity and Neonatal Dashboards<br>• CNST MIS Year 7 update | | CNST MIS SA:8 |
| Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively | • Maternity and Neonatal Dashboards<br>• Maternity in-month update<br>• Neonatal in- month update<br>• CNST MIS Year 7 update | | CNST MIS SA:4<br>CNST MIS SA:5 |
| Service User Voice feedback | • Listening to our families<br>• CNST MIS Year 7 update | | CNST MIS SA:7 |
| Staff feedback from frontline champions and walk-abouts | • Listening to our staff<br>• CNST MIS Year 7 update | | CNST MIS SA:9 |
| MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust | • Learning lessons<br>• Maternity and Neonatal Dashboards<br>• CQC update | | |
| Coroner Reg 28 made directly to the Trust | • Learning lessons<br>• Maternity and Neonatal Dashboards | | |
| Progress in achievement of CNST 10 | • CNST MIS Year 7 update | | CNST MIS SA1-10 |

| Theme/trend/escalation | Additional actions being taken |
|---|---|
| **CNST MIS Year 7.**<br>**SA7: MNVP**<br><br>• The service, in collaboration with the LMNS, have concluded that the current MNVP lead contracted hours, compounded by reduced ICB/LMNS capacity to support is no longer sufficient to meet the year 7 requirement. Therefore the Trust will not be required to provide any further evidence as detailed below in 7.4 & 7.5 to meet compliance for MIS for this safety action. | **14/11/2025**<br><br>• Return of MNVP comments on ULTH contribution to work plan. To continue to work collaboratively to agree actions and responsibilities during the last few months on current MNVP term. |

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

### CNST MIS Year 7- November update (Appendix 1.2)

| Safety Action | Anticipated compliance | Comments | Upward reporting |
|---|---|---|---|
| SA1<br>PMRT | On track to achieve | • Q2 to be presented at November's MNOG with upward reporting to GQC and Trust Board | • Note receipt of Q2 PMRT report including details of the deaths reviewed **from 1 December 2024**, any themes identified and the consequent action plans. |
| SA2<br>MSDS | Achieved-awaiting evidence review | • 100% of July's data contained valid birthweight information (requirement 80%)<br>• 97.8% of July's data contained a valid ethnic category (requirement 90%)<br>• Final statistics confirm compliance has been achieved | |
| SA3<br>TC/ATAIN | On track to achieve | • QIP update- Progress with agreed actions monitored through the PeriSIP- action N.OE15 (formerly NeoSIP):<br>○ Competency pack now complete and has been sent to the Competency Panel for review and approval<br>○ Once approved training plan to be developed<br>• As a Trust we can demonstrate compliance with the minimum evidence requirement for CNST MIS Year 7 (local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04). While we can evidence compliance, we acknowledge that there are areas requiring improvement including recommendations from the ODN Peer Review, these actions are monitored via the PeriSIP and agreed reporting routes (MNOG). See appendix 1.2.2 of CNST report (appendix 1.2) | • Note update relating to QIP progress<br>• Note Trust position of compliance with the minimum evidence requirement for CNST MIS Year 7 for pathway of care for babies from 34+ weeks. Perinatal services acknowledge that there are areas requiring improvement including recommendations from the ODN Peer Review; these actions are monitored via the PeriSIP and agreed reporting routes (MNOG). |
| SA4<br>Clinical workforce | On track to achieve | • **Obstetric workforce**<br>○ *Short-term locums:* The Trust employed no short-term locums in obstetrics and gynaecology during the 6-month audit period (Feb-Jul 2025). See appendix 1.2.3 of CNST report (appendix 1.2) for further detail<br>○ Long-term locums: Following and audit of a 6-month period (Feb-Jul 2025), the Trust can demonstrate that is has implemented the RCOG guidance on engagement of long-term locums in full with supporting evidence to demonstrate compliance. See appendix three of CNST report (appendix 1.2) for further detail<br>○ *Consultant attendance:* Audit of a 3-month period (Feb-Apr 2025) demonstrates that the Trust is 97% (requirement of 80%) compliant with consultant attendance in person to the clinical situations listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. See appendix 1.2.4 of CNST report (appendix 1.2) for further detail<br>○ *Compensatory rest:* While not reportable in MIS Year 7, the service can confirm that there has been progress on the previously agreed action plan to | • **Obstetric workforce:**<br>○ Note that the Trust has implemented RCOG guidance on engagement of both short-term and long-term locums and is compliant with criteria having been met for employment of locum doctors in Obstetrics and Gynaecology. This has been demonstrated through a 6-month audit.<br>○ Note that the Trust is 97% compliant with consultant attendance in person to the clinical situations listed in the RCOG workforce document. This has been demonstrated through a 3-month audit.<br>○ Note progress on the previously agreed action plan to support working towards implementation of the RCOG guidance on Compensatory rest.<br>• **Neonatal workforce:**<br>○ Note that the neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of medical staffing |



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| | | | |
|---|---|---|---|
| | | support working towards implementation of the RCOG guidance on Compensatory rest, with only one outstanding action relating to facilitation of a fixed on-call during the week. On track for full compliance by December with planned rota changes. See appendix 1.2.5 of CNST report (appendix 1.2) for further detail<br>• **Anaesthetic workforce**<br>○ Rotas and supporting evidence reviewed, demonstrating evidence that the duty anaesthetic consultant is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times.<br>• **Neonatal medical workforce**<br>○ As previously reported the neonatal unit meets the BAPM national standards for neonatal medical staffing. See appendix 1.2.6 of for further detail CNST report (appendix 1.2 ) for further detail<br>• **Neonatal nursing workforce**<br>○ As previously reported the neonatal unit does not meet the BAPM national standards for neonatal nursing staffing<br>○ The previously agreed action plan, including updates on progress and mitigations, is available in the QIS report<br>○ The QIS report has been shared via MNOG reporting routes bi-monthly and through LMNS board reporting routes with EMNODN oversight<br>○ This risk is also monitored via the risk register | ○ Record in Trust Board minutes progress against the previously agreed QIS action plan and trajectories and that this is on the services risk register. |
| SA5 Midwifery workforce | At risk | • BR+ business remains under review at ICB weighted values Framework.<br>○ BR+ establishment uplift business case approved by CRIG on 29th July<br>○ Declined at ICB weighted values Framework on the 15th September with a request for further evidence<br>○ Declined following second attempt at ICB values Framework on the 22nd October with a request for further evidence<br>○ Case strengthened with additional evidence and to be presented at ICB weighted values Framework on 17th November<br>• Following escalation via MNOG and GQC, the Trust has committed 450k to recruit 5.75 wte B6 midwives at a cost pressure whilst decision is taken.<br>• The Trust committed to continue cost pressure and review on 1/4/26 and consider further cost pressure to ensure full recruitment into the 12.1wte deficit.<br>• Action plan with mitigations against short-fall is reported via the bi-annual staffing report due at MNOG this month<br>• Outside of the CNST MIS reporting period progress with this action will be monitored via MNOG and upward reporting route | • Upward report to Board the staffing report in its entirety.<br>• Record in Trust Board minutes receipt of the midwifery staffing oversight report covering staffing/safety issues in line with NICE midwifery staffing guidance and the agreed plan, including timescale for achieved the appropriate uplift in funded establishment including mitigations to cover shortfalls. |
| SA6 SBLv3.1 | On track to achieve | • Quarterly meetings with LMNS continue, with adequate progress at each touch point.<br>• Where full implementation is not yet in place, sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectories and confirmed by the ICB as demonstrated in the SBLCB implementation tool.<br>• Evidence of this progress, risks and mitigations has been shared bi-monthly for Trust Board oversight within the Perinatal Assurance Report and the Upward report to GQC | • Record in Trust Board minutes progress has been made towards full implementation of Saving Babies Lives Care Bundle, in line with the locally agreed improvement trajectories. Progress has been confirmed by the ICB as demonstrated in the SBLCB implementation tool. |



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| | | | |
|---|---|---|---|
| SA7<br>MNVP | At risk | • **Mitigation to ensure the service continues to listen to women and families**<br>  ○ Return of LMNS comments on ULTH contribution to MNVP work plan.<br>  ○ To continue to work collaboratively to agree actions and responsibilities during the last few months on current MNVP term.<br>• **Co-produced action plan**<br>  ○ Progress continues with co-produced action plan following joint review of the annual CQC Maternity Survey free text from 2024 (further detail available in Q2 Patient Experience Report). This has been reported bi-monthly to MNOG.<br>  ○ The November CQC Maternity Survey free text has not yet been made available to Trusts. There is a risk that if the release of the survey occurs later than the end of November there will be no MNVP lead in place to jointly review and agree actions. Early escalation to the LMNS should this occur. | • Record in Trust Board minutes that the service, in collaboration with the LMNS, have concluded that the current MNVP lead contracted hours, compounded by reduced ICB/LMNS capacity to support is no longer sufficient to meet the year 7 requirement.<br>• Record in Trust Board minutes that escalation via the PQSM model at Trust and LMNS level, reported via MNOG/QC upward reporting process is ongoing with mitigation currently under review to ensure the service continues to listen to women and families in a way that is proportionate to MNVP resourcing available until the MNVP is commissioned in line with guidance.<br>• Note progress with co-produced action plan |
| SA8<br>Training | At risk | • Remains significant risk of non-compliance<br>• All anaesthetists due an update are now booked onto the final PROMPT of the CNST period 27th November 2025. | |
| SA9<br>Floor to Board | On track to achieve | • All Trust requirements of the Perinatal Quality Surveillance Model (PQSM) are fully embedded with evidence of working towards the revised Perinatal Quality Oversight Model (PQOM)<br>  ○ Co-produced (ULTH & LMNS) PQSM reported bi-monthly via the Perinatal Assurance Report at MNOG with direct routes to Trust Board. Progress continues with update to PQOM document<br>• Q2 Claims scorecard to be presented at MNOG in November<br>• Progress with maternity and neonatal culture improvements evidenced via Staff Experience Group workstream within the Perinatal Assurance Report bi-monthly to MNOG with direct routes to Trust Board | • Record in Trust Board minutes, as evidenced via the PQSM document, that:<br>  ○ A non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC).<br>  ○ A review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM bi-monthly<br>  ○ Board Safety Champion(s) meet with the Perinatal leadership team and the Quad leadership team at a minimum of bi-monthly<br>• Note receipt of the quarterly Claims Scorecard.<br>• Record in Trust Board minutes progress with the Staff Experience Group (maternity and neonatal culture plan). |
| SA10 MNSI | On track to achieve | • The accumulative patient event numbers for CNST MIS Year 7 to date are as follows<br>  ○ 8 cases have been referred to MNSI, with 1 qualifying for EN<br>  ▪ DOC verbal and written (including EN and MNSI information in accessible format in the patient's own language) –8 (100%)<br>  ▪ Three cases were subsequently rejected by MNSI<br>  ▪ 5 cases remain ongoing | • Note receipt of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.<br>• Note receipt of evidence that families have received information on the role of MNSI and NHS Resolution's EN scheme.<br>Note receipt must have sight of evidence of compliance with the statutory duty of candour. |

## 2.3 Saving Babies Lives Care Bundle V3.2

| Touchpoint | E:1 | E:2 | E:3 | E:4 | E:5 | E:6 | Total | Comments/actions |
|---|---|---|---|---|---|---|---|---|
| **1:** Q2 July-Sept 2023 02/10/2023 | 50% | 90% | 100% | 20% | 74% | 33% | 69% | **Non-compliance actions**<br><br>**Element 1 – Smoking:**<br>• CO at booking – Badgernet field has now been made mandatory from 11/11/2025 therefore anticipate achieving compliance from December data.<br>• VBA training – Training has been added as mandatory to Midwives ESR. Discussions with ELOD for all maternity staff groups to have added to their ESR, we can then review compliance more easily.<br>• CO monitoring Training – Training is completed at Midwives mandatory training days and PROMPT. Lag in training for midwives and maternity support workers. Plan to catch all in next couple of months. CHCSW added as staff, plan to discuss with education how to improve this training compliance.<br>**Element 2 – FGR:**<br>• Vitamin D advised – Was made mandatory in August 2025. Compliance achieved for September 2025, requires 3 months of compliance before sign off. |
| **2:** Q3 Oct-Dec 2023 29/12/2023 | 70% | 90% | 100% | 100% | 74% | 83% | 81% | |
| **3:** Q4 Jan-Mar 2024 18/03/2024 | 90% | 95% | 100% | 100% | 81% | 100% | 90% | |
| **4:** Q1 Apr-Jun 2024 24/07/2024 | 90% | 100% | 100% | 60% | 93% | 100% | 93% | |
| **5:** Q2 Jul-Sep 2024 1/10/2024 | 90% | 100% | 100% | 80% | 96% | 100% | 96% | |
| **6:** Q3 Oct-Dec 2024 30/12/2024 | 100% | 100% | 50% | 80% | 93% | 100% | 94% | |
| **7:** Dec-Jan 2025 21/02/25 | 100% | 100% | 50% | 100% | 96% | 100% | 97% | |
| **8:** Feb- March 2025 25/04/2025 | 100% | 100% | 50% | 100% | 96% | 100% | 97% | |
| **9:** April-Jun 2025 31/07/2025 | 80% | 95% | 50% | 100% | 100% | 83% | 80% | |
| **10.** Q2 July-Sep 2025 17/11/2025 | 70% | 90% | 100% | 100% | 100% | 100% | 93% | |

*The above data demonstrates the percentage of interventions fully implemented following LMNS validation. Where full implementation is not yet in place, sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectories and confirmed by the ICB as demonstrated the SBLCB implementation tool. SBLCB v3.2 released May 2024.*

## 2.4 Three Year Delivery Plan (3YD)

| Theme | Position<br>Comments/actions |
|---|---|
| Listening to women and families with compassion<br>Supporting our workforce<br>Developing and sustaining a culture of safety<br>Meeting and improving standards and structures | - 3YDP Oversight Tool identified ULTH as a positive outlier for postnatal care at home, midwives satisfaction, midwife turnover and obstetric sickness rate<br>- Negative outlier for BFI Stage 3 Accreditation and quality of out of hours supervision for doctors<br><br>Largely compliant with Trust led 3YDP actions, areas outstanding include:<br>– Introduction of national MEWS. Awaiting digital release and WebV update by NLAG, digital matron aware<br>– Embed analysis of ethnicity and deprivation data in all specialist reporting<br>– BR+ undertaken as required but gap in establishment remains 12.1wte<br>– Equity & Equality plan actions for reducing workforce inequalities required<br>– Continue to monitor NETS and GMC survey results for actions related to trainee feedback<br>– Develop future leaders via succession planning, ensuring this reflects the ethnic background of wider workforce<br>– Inclusion of MNVP lead in complaints processes and governance meetings<br>– Maintain status of Saving Babies Lives care bundle |

# Maternity and Neonatal Three Year Delivery Plan Oversight Tool - Outlier summary

Contents page

NHS England

This sheet shows, for each ICB and Trust, how many measure results are demonstrating better outcomes / progress or needing further support / improvement, and which measures these relate to

MBRRACE-UK metrics: Better outcomes — Poorer outcomes

All other metrics: More positive — Improvement / support needed

**Select organisation (table)**: United Lincolnshire Hospitals NHS Trust

**Select ICB or Trust level map**: Trust

**Select positive/negative outlier map**: Negative

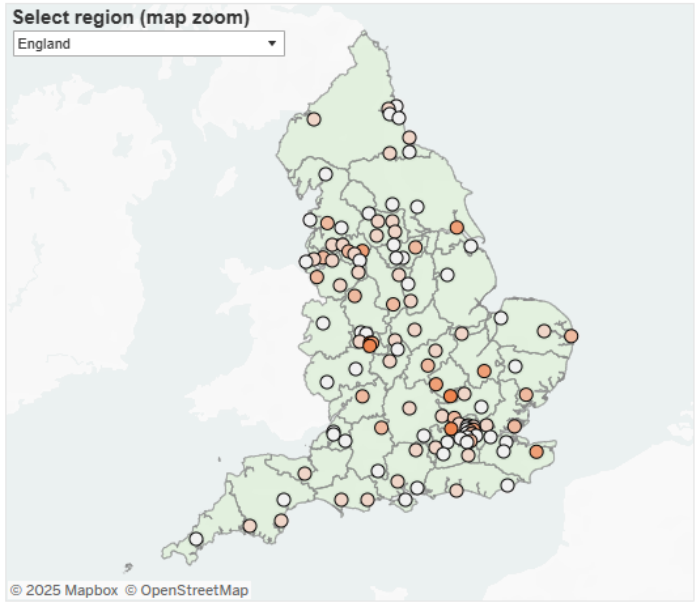
## United Lincolnshire Hospitals NHS Trust outlier summary: comparison to national result / benchmark

| | Total measures | Negative outliers | Positive outliers |
|---|---|---|---|
| **Total** | 31 | 3 | 6 |
| Listening to and working with women and families with compassion | 12 | 2 | 2 |
| Growing, retaining and supporting our workforce | 8 | | 3 |
| Developing and sustaining a culture of safety, learning and support | 8 | 1 | |
| Standards and structures that underpin safer, more personalised, and more equitable care | 3 | | 1 |

| | |
|---|---|
| T1h:Consideration of personal circumstances during postnatal care at home | 85.8% |
| T1i:Being listened to during postnatal care | 89.2% |
| T1ni:Baby Friendly Accreditation - Maternity | 0.0% |
| T1nii:Baby Friendly Accreditation - Neonatal | 0.0% |
| T2bi:Midwives' satisfaction with work being valued by your organisation | 48.5% |
| T2hi:Midwife Turnover Rate | 5.4% |
| T2iii:Obstetric Sickness Rate | 1.8% |
| T3g:Quality of clinical supervision out of hours for doctors | 52.0% |
| T4biii:Neonatal Mortality Rate (Stabilised) (MBRRACE) | 0.9 |

## England Trust outliers map: Number of Negative outliers

Select region (map zoom): England




Please contact england.matneo-oversighttool@nhs.net with any queries or feedback on this tool. This version of the tool is a Beta version and will be developed iteratively based on your input.



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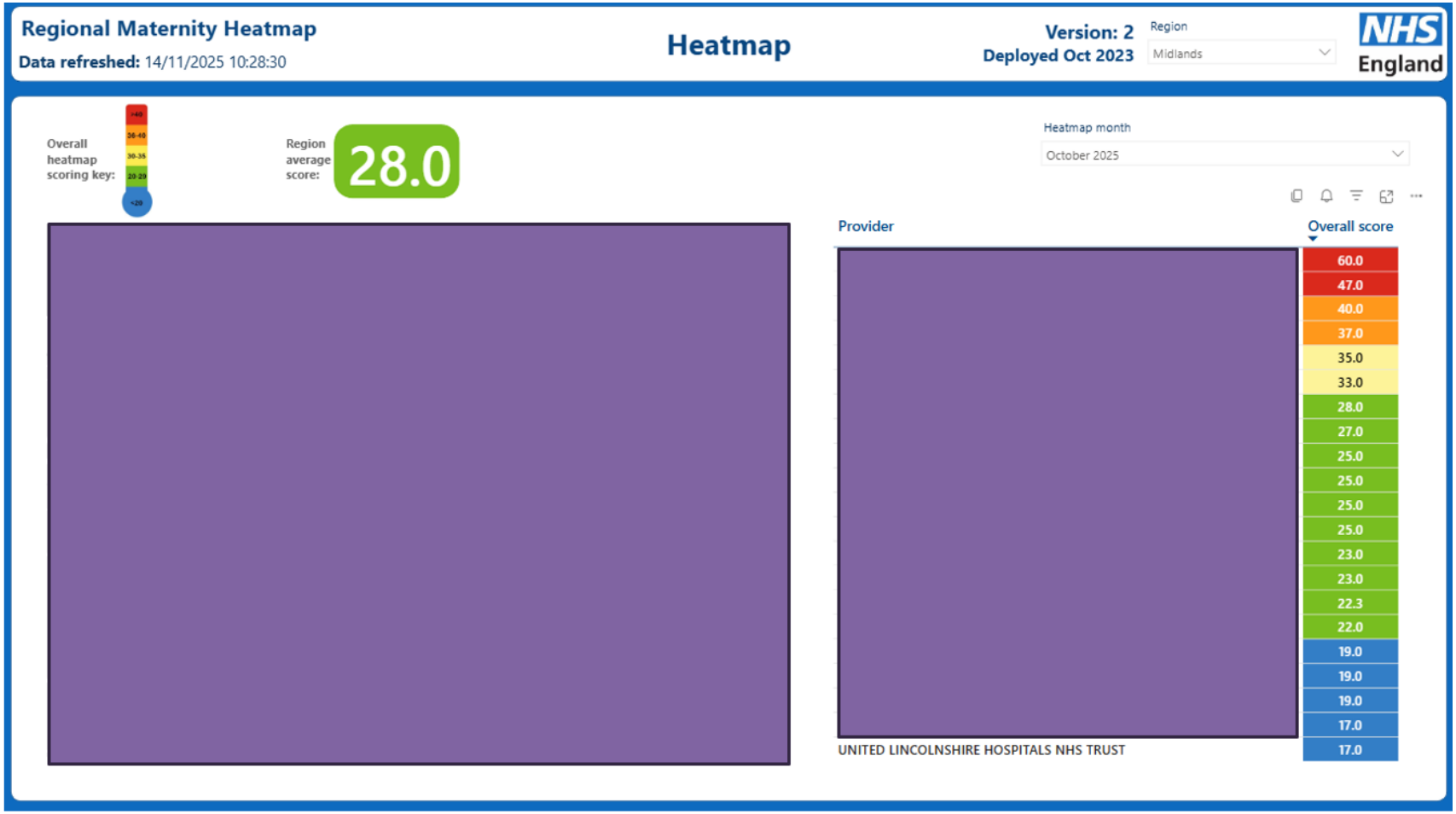
## 2.5 Regional Maternity Heat Map



## 2.6 Care Quality Commission (CQC)

| CQC readiness pathway and exception reporting |
| --- |
| No pertinent updates |

# 3: Local drivers

## 3.1 Maternity and Neonatal Safety Improvement Plan (PeriSIP)

Appendix 1.3

The Perinatal Safety Improvement Plan (PeriSIP) is a dynamic live document for the collation and monitoring of improvement actions arising from national maternity reports and assurance requirements as well as internally identified improvement actions e.g. actions identified through PSIF.

Actions have been added in relation to reviewing the self-administered medication process, improving the implementation of the PeriPrem Passport and associated documentation relating to magnesium sulphate and antenatal steroids. The recommendations following the Birth Choices Clinic (BCC) Report (2025) have also been added, including a decision tool to support post-dates induction of labour, ensuring equity of access for women from Black, Asian and Eastern European backgrounds to the BCC, improving communication with staff regarding common themes discussed at BCC through articles within the Perinatal Newsletter, auditing the use and implementation of BadgerNet personalised care plans, creating a MS Form for BSS feedback, and finalising the Trauma Informed Care Action Plan. Further actions have also been added to ensure regular skills drills are undertaken within the clinical areas, implementation of the updated elective LSCS theatre pathway at Lincoln County Hospital, and implementation of the Neonatal Afterthoughts service

A number of actions have been archived; two CNST Year 6 actions relating to the MNVP infrastructure and funding as these have been superseded by the CNST Year 7 actions which had significant differences, an action relating to the adequacy of anaesthetic documentation which has been achieved by the completion of an documentation audit which will be repeated every two years unless concerns arise, an action relation to updating the blood pressure monitoring guidance including the use of automated machines, an action relating to an updated APH flow chart within the guideline that has now been approved, an action relating to the Safer Learning Environment Charter (SLEC) encouraging regular breaks for learners and supervisors together to maintain supernumerary status, and the new hypertension guideline which includes a risk assessment for FGR and digital blood pressure monitoring with machines validated for pregnancy.

| Section | Total Actions | **Red** Not yet completed / significantly behind agreed timescales or non-compliance expected | **Amber** In progress / on track / completion expected | **Green** Completed & ongoing and / or not yet fully embedded (awaiting evidence of embedding) | **Blue** Completed & embedded with evidence, to be signed off at MNSC prior to closure |
|---|---|---|---|---|---|
| **Maternity** | | | | | |
| Optimise Experience | **13** (=) | **0** (=) | **12** (=) | **1** (=) | **0** (=) |
| Optimise Safety | **53** (=) | **4** (-2) | **34** (+3) | **7** (=) | **8** (-1) |
| Improve Leadership | **4** (=) | **0** (=) | **4** (=) | **0** (=) | **0** (=) |
| Choice & Personalised Care | **10** (+6) | **2** (-1) | **7** (+4) | **0** (=) | **1** (+1) |
| Provide Assurance | **1** (=) | **0** (=) | **0** (=) | **1** (=) | **0** (=) |
| Maternity Staff Experience Group | Awaiting Actions | | | | |
| **Perinatal** | | | | | |
| CNST | **15** (+1) | **7** (=) | **3** (=) | **5** (+1) | **0** (?) |
| SBL | **5** (+2) | **0** (=) | **3** (+1) | **1** (+1) | **1** (?) |
| 3YDP – ULTH | **47** (=) | **4** (+4) | **9** (-1) | **15** (-5) | **19** (?) |
| 3YDP – ICB | **29** (=) | **4** (+4) | **10** (-1) | **14** (-4) | **1** (?) |
| **Neonates** | | | | | |
| Optimise Experience | **30** (+1) | **2** (=) | **15** (+1) | **13** (=) | **0** (=) |
| Optimise Safety | **9** (-11) | **1** (+1) | **3** (=) | **1** (-3) | **4** (-0) |
| Neonatal Leadership | **1** (=) | **0** (=) | **0** (=) | **1** (=) | **0** (=) |
| Choice & Personalised Care | **0** (=) | **0** (=) | **0** (=) | **0** (=) | **0** (=) |
| Provide Assurance | **0** (=) | **0** (=) | **0** (=) | **0** (=) | **0** (=) |
| Peer Review | **27** (=) | **1** (+1) | **15** (-1) | **5** (=) | **5** (-1) (+1 black) |
| Critical Care | **26** (+26) | **3** (+3) | **7** (+7) | **4** (+4) | **12** (+12) |
| GIRFT | **14** (=) | **0** (-3) | **7** (-1) | **0** (-3) | **7** (+7) |
| **TOTAL** | **284** (+25) | **28** (+9) | **129** (+12) | **68** (-9) | **59** (+13) |

| | | |
|---|---|---|
| Archived Actions | **27** (+17) (24 Awaiting Archiving in December) | Completed, embedded and signed off by Perinatal Safety Collaborative for closure and archiving |

The following actions are currently rated red due to expected completion date being passed or there is a concern that compliance will not be achieved by the expected completion date.

| | Action No | Action Milestone | Responsible Lead | Due Date | Comments |
|---|---|---|---|---|---|
| **Maternity** | | | | | |
| **3** | M.OS.MTT.13.1 | Recommendation 13: Ensure calls are taken outside the clinical area in a dedicated and protected quiet space – to ensure confidentiality<br><br>Midwifery establishment to include, Trust wide, sufficient midwives to support a telephone helpline 24/7 apart from the Triage clinical area. | DoM & Project Lead | March 2025 | June 25; Telephone triage needs to be reviewed and improved as a separate project. We have a telephone line, but not a 24/7 triage service as per the recommendations for a dedicated triage line. This has been added to the Risk Register.<br>July 25; Awaiting business case decision. No progress re separate telephone triage service.<br>09/09 GR update re Risk Register; graded as 12, added on the 7th August. Will then be reviewed in November 25.<br>15/09 No further progress. |
| **4** | M.OS.MTT.13.2 | Recommendation 13: Ensure calls are taken outside the clinical area in a dedicated and protected quiet space – to ensure confidentiality<br><br>Identify an appropriate IT system for a Trust wide maternity telephone helpline. | Matron & Project Lead | March 2025 | February 25; Slippage due to lack of decision re Business Case. Midwifery establishment required to develop a telephone triage helpline.<br>June 25; As above. There needs to be a separate project completed around telephone triage helpline.<br>July 25; Awaiting business case decision. No progress re separate telephone triage service.<br>15/09 No further progress. |
| **5** | M.OS.MTT.13.3 | Recommendation 13: Ensure calls are taken outside the clinical area in a dedicated and protected quiet space – to ensure confidentiality<br><br>Ensure calls are taken outside the clinical area in a dedicated, quiet space ensuring confidentiality and an undistracted midwife. | HoM, Matrons & Project Lead | January 2025 | February 25; Slippage due to lack of decision re Business Case. Midwifery establishment required to develop a telephone triage helpline.<br>June 25; As above, unable to proceed with this at present. Requires independent project, including improvements to estates.<br>July 25; Use of BadgerNet telephone triage workflow is standardising the process across the service and 24/7, safer practice.<br>15/09 No further progress. |
| **6** | M.OS.MTT.13.4 | Recommendation 13: Ensure calls are taken outside the clinical area in a dedicated and protected quiet space – to ensure confidentiality | Project Lead & Education Team | March 2025 | Training package identified through BSOTS programme, discussions taking place with Education team re roll out of training. |



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| | | Ensure calls are taken by a midwife who is clinically active and familiar with maternity triage, but whose duties at that time are solely for telephone triage. | | | February 25; Slippage due to lack of decision re Business Case. Midwifery establishment required to develop a telephone triage helpline.<br>June 25; Midwives are trained, however are not able to provide a midwife solely for a telephone triage line. This needs completing as a separate project.<br>July 25; Awaiting business case decision. No progress re separate telephone triage service.<br>15/09 No further progress. |
| **7** | M.CPC19.1 | All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.<br><br>Post-Mortem Consent Training | Bereavement Midwife RB<br><br>Obstetric Service Leads VA, MS, CC | 30/09/2024 | 10/06 Following a discussion at MNOG, decision made to split out the compliance RAG rating to show the mandatory post-mortem consent training, and the non-mandatory bereavement training compliance.<br>11/06 MNSC aware of continued non-compliance. Have been chased by Education Admin, Cons Midwife. Emma to follow up.<br>18/06 NP sent compliance to KA, VA, HA, EU, JB.<br>28/07 Updated states receive from education team, as below. Email sent to KA, VA, HA, EU, JB to inform of those who remain non-compliant.<br>28/07 Updated from HA; Katherine Phipps on long term sick, asn leaves 5th August, therefore stats updated.<br>13/08 MNSC discussion; The consultant has asked for support with training. We have new doctors, so compliance expected to drop initially. This training has also been added to the new resident doctors intranet page and welcome booklet.<br>22/09 Stats updated, as seen below. All previous stats can be seen on the previous PeriSIP.<br>10/10/25 Stats updated, as below. Sue has sent monthly reminders to these people, which were sent the previous week to this update.<br><br>**Post Mortem Consent**<br>**LCH Consultants – 18/09/25 92%,** 10/10/25 92% - Andrejs Smirnovs<br>**LCH Registrars – 18/09/25 40%,** 10/10/2025 47% - Rebecca Hutchinson, Chinedu Ifemelumma, Chinwe Nwkodinobi, Eze Okubuiro, Naheen Oseni, Lee-Li Tan, Oluwatosin Salami, Ashok Kumar Shivashankara<br>**PHB Consultant – 18/09/25 91%,** 10/10/2025 91% - Marwa Shousha<br>**PHB Registrars – 18/09/25 60%,** 10/10/2025 55% - Fatima Nasreen, Mohammed Ahmed, Dennis Gong, Rafiat Jimoh, Gareth Ogden |
| **8** | M.CPC25.1 | Develop a Decision tool to support discussion about post dates induction of labour | Consultant Midwives | 31/12/2025 | 26/08/25 Action added to the PeriSIP, following the Birth Choices Clinic (BCC) Report.<br>28/10/25 Unable to progress at present due to capacity. |
| **Perinatal** | | | | | |
| **9** | CNST.Y7.01.03 | Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, | Risk Midwife | November 2025 | 07/10 AG update; One case was not reported within the time frame, in December 2024. This means that current compliance sits under 95%, which |



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| | | from 1 December 2024 been started within two months of each death?<br>This includes deaths after home births where care was provided by your Trust. | | | would mean a submission of non-compliance. We will remain under 95% should no further cases occur.<br>08/10 Shared at MNSC, regarding risk of compliance. Currently 94.7%. Reassurance that processes are in place to avoid any further cases not having the PMRT's started within two months. |
| **10** | CNST05.01 | Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? | DoM | March 2025 | July 25; BR+ establishment uplift business case submitted for discussion at CRIG on 29th July. Will then go to ICB through Values Framework. Recruitment of newly qualified midwives is underway at LCH. All qualifying students on the PHB site have been offered jobs.<br>07/10 AG update; the staffing deficit, relating to maternity triage (12.1 WTE). Progress against agreed action plan was discussed including confirmation BR+ establishment uplift business case approved by CRIG on 29th July and awaiting result of ICB values Framework on the 15th September. Declined at ICB Values Framework, resubmission required by the end of October. Business Case under review to strengthen case. |
| **11** | CNST.Y7.07.02 | Evidence of MNVP infrastructure being in place from your LMNS/ICB. | ICB | November 2025 | 07/10 AG update; The ICB has received £38k in additional funding (£19k per site). Discussions are currently underway regarding the potential outsourcing of the roles, responsibilities and associated funds, with the aim of ensuring sustainability, transparency, and alignment with strategic priorities. System colleagues have plans to review the MNVP self-assessment but due to capacity this has been delayed<br>MNVP work plan benchmarking complete, gaps in service provision identified and actions to be agreed to ensure the service continues to listen to women and families in a way that is proportionate to MNVP resourcing available until the MNVP is commissioned in line with guidance. Gaps in service provision and actions to be agreed and shared with ICB colleagues for input/approval/plan by October 2025. |
| **12** | CNST.Y7.07.03 | If the above evidence of an MNVP, commissioned and functioning as per national guidance, is unobtainable, there should be evidence that this has been escalated via the Perinatal Quality Surveillance Model (PQSM) at trust, ICB and regional level. | ICB | | |
| **13** | CNST.Y7.07.04 | Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level. | ICB | | |
| **14** | CNST.Y6.08.02 | Can you demonstrate the following attendance at the end of the 12 month period 1 December 2023 to 30th November 2024:<br><br>Maternity emergencies and multiprofessional training | Clinical Education Team | November 2025 | 07/10 AG update; Anaesthetic PROMPT compliance: Current trajectory indicates that the service will be non-compliant owing to the consistently high rate of 'did not attend' (DNA) from the anaesthetists. Escalation to the Quad for support and close monitoring with updates following each PROMPT and early escalation of non-attendance. |
| **15** | CNST.Y6.08.04 | Can you demonstrate the following attendance at the end of the 12 month period 1 December 2023 to 30th November 2024:<br><br>Neonatal basic life support | Clinical Education Team | November 2025 | 07/10 AG update; Neonatal NLS updates: Ongoing lack of engagement from consultants resulting in trajectory that will result in a submission of non-compliance without immediate action. Escalation to the Quad for support and close monitoring. Challenge compounded by the new requirement that only GIC trained staff can facilitate the NLS sessions. GIC trained midwives allocated responsibility of completing training for the outstanding doctors/consultants. |



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| **16** | 3YDP.ICB.03 | Improve equity for mothers and babies<br>Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups. | ICB | | Links with below action<br>Links with CNST.Y7.07.02, .03 and .04<br><br>Sept 25: MNVP commissioned role at risk. In process of reviewing proposals for the new financial year. Currently due to ICB restructuring and uncertainty unable to commit to how this will be in the future. This has been escalated to the LMNS via the Trust and programme team, aligned to CNST requirements. Recommendation that this is escalated to SQPEC. |
| **17** | 3YDP.ICB.04 | Work with service users to improve care<br>Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above. | ICB | | Links with above action<br>Links with CNST.Y7.07.02, .03 and .04<br><br>Sept 25: MNVP commissioned role at risk. In process of reviewing proposals for the new financial year. Currently due to ICB resutructing and uncertainty unable to commit to how this will be in the future. This has been escalated to the LMNS via the Trust and programme team, aligned to CNST requirements. Recommendation that this is escalated to SQPEC.<br>We do not have MNVP leads to cover each site, allocated one for the Trust. |
| **18** | 3YDP.ICB.05 | Grow our workforce at all levels<br>Align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity. It is expected that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services. | ICB | | Sept 25: Neonatal commissioning on pause. Commissioning of services remains consistent however challenges with understanding the workforce profile across specialties. |
| **19** | 3YDP.ICB.20 | Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users | ICB | | Sept 25: Digital Lead to be taking leave of absence imminently, no succession plan or proposal how full implementation of BadgerNet/Badgernotes will be upheld and therefore impact on agenda for personalisation . Risk: Lack of project lead. Awaiting Project Plan and timelines. |
| **Neonates** | | | | | |
| **20** | N.OE.03.2.5 | BFI Action Plan - Stage 1 Accreditation; Implementing & Auditing<br><br>Information and support for families<br><br>Development and implementation of a written mechanism for ensuring that expressing reviews take place as per standards and of support for the delivery of care should an issue be identified. | Neonatal Matron | January 2026 | February 25; Expressing log not implemented. This requires action. Will need to await BFI lead, as need the launch to be accompanied by training and audit.<br>May 25; Log not implemented, requires action, however unable to complete without BFI lead in place. Log can be used, however not utilised for all families, and requires improvement work.<br>June 25; Require BFI lead.<br>July 25; Awaiting BFI lead.<br>August 25; Some members of the NNU team are going to take this on as their own role, until the BFI lead commences in post. Paperwork has already been created, and ready for use.<br>29/09 BFI Lead interviews 6th October. |

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| **21** | N.OE.03.3 | BFI Action Plan - Stage 1 Accreditation; Implementing & Auditing<br><br>Internal Audit<br><br>Development and implementation of a programme of internal audit for all BFI standards with results submitted to the Baby Friendly office at regular intervals | Neonatal Matron | January 2026 | February 25; Audit forms are available from BFI, but these need implementing. Will be undertaken by the BFI Lead, alongside the managers.<br>May 25; Unable to progress without a BFI lead.<br>July 25; As above, awaiting BFI lead.<br>August 25; Continue to await BFI lead in post. The expectations are quite large, therefore the team will try to implement elements as capacity allows.<br>29/09 BFI Lead interviews 6th October. No further progress at present. |
| **22** | N.OS09 | To review AHP workforce | Neonatal Matron<br>CYP Lead Nurse | July 2026 | 07/02/25 Workstream ongoing and includes dietician (in place, but requires further hours), physiotherapy (in place, but requires further hours), occupational therapist (do not have in place), psychologist (but she is on maternity leave, and support coming from LPFT), SALT practitioner (do not have), neonatal pharmacist (do not have, although there is a network pharmacists). This is also on the Risk Register.<br>13/05 Ongoing.<br>29/09 Psychologist remains on maternity leave. Business case for SLT, SALT, dietician, pharmacy, physio and OT work ongoing. Business case is with the LMNS, therefore require an update from Clare Brumby. RW will request update.<br>08/10 Trust work ongoing regarding pharmacy support. |
| | EMNODN.18 | The LMNS and Trust should continue to work collaboratively with the Network AHP and psychology team to further develop the AHP&P business case. Any AHP business case should specifically request an increase in pharmacy provision as this is extremely limited and way below the national recommendations. | Neonatal Matron<br>CYP Lead Nurse | May 2025 | Linked with above. |
| | CCAP4.2 | Occupational Therapists | Neonatal Matron<br>CYP Lead Nurse | July 2026 | Linked with above.<br><br>01/09/2025 We have no dedicated time. ODN have recommend 0.75WTE. This is on the risk register. |
| | CCAP4.4 | Speech & Language Therapists | Neonatal Matron<br>CYP Lead Nurse | July 2026 | Linked with above.<br><br>01/09/2025 We have 0WTE, ODN have recommended 0.61WTE. We do often need the SLT's, and without this, these babies are transferred to other units for review. Datix's are submitted on these occasions. |
| | CCAP4.5 | Pharmacists | Neonatal Matron<br>CYP Lead Nurse | July 2026 | Linked with above.<br><br>01/09/2025 We currently have 0WTE. We do have a CYP pharmacist. However, we should have 0.6WTE neonatal pharmacist. RW and Hayley |



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| | | | | | are meeting with the lead pharmacist in September 2025, to discuss how we can achieve a 0.6WTE neonatal pharmacist. |

## Maternity Dashboards – Appendix 1.4

| Dashboard item | SPC trigger | Current position | Comments/actions |
|---|---|---|---|
| Rate of stillbirth per 1000 births | 3.8 | 3.44 | **Issue:** We have been consistently below the national threshold however are aware that this is now displaying a special cause of concerning nature.<br>**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.<br>A task & finish group with the LMNS as external representation has been set up to complete thematic review. TOR drafted for inclusion criteria, demographic assessment, and thematic review of PMRT actions and issues, due to be completed end Oct 25 includes late fetal losses, NND >22wks and stillbirths. Data triangulated with MIS, PMRT & bereavement team.<br>**Mitigations:** The stillbirth rate is consistently monitored and reviewed, displayed on the maternity dashboards and outcomes of reviews are actioned. The rate of stillbirth for the Trust is in line with the national picture however our local data is causing concern due to the SPC charts flagging. Although this reports on the Trust data, we acknowledge the higher rate at Pilgrim due to a cluster of stillbirths in Oct 24 |
| Number of births | 385 | 364 | **Issues:** Due to the geographical location of Lincolnshire women can choose to birth at out of area hospitals but this figure has not increased. The number of births is in line with the bookings carried out. LCH - 239 births, PHB - 125 births.<br>**Actions:** Actively promote ULTH maternity service. With the expansion of the COCO teams this will hopefully encourage women to birth within ULHT. ULTH are monitoring the number of women who choose to birth elsewhere, and a piece of work will be carried out to understand why this is their choice.<br>**Mitigations:** We are monitoring monthly the women who are booked to birth at other trusts, and this is not increasing. The birth rate has decreased over the last decade and 2023 had the lowest number of births since 1977 (ONS, 2023) |

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| Smoking at time of delivery | 6% | 4.99% | **Issues:** Historically, Lincolnshire has had one of the worst SATOD rates both regionally and nationally and for 2023/24 Lincolnshire had the 6th worst SATOD rate in England. The SATOD rate for ULHT has fallen from 17.1% in 2020/21 to 11.9% in 2023/24; a decrease of 5.2%. The last 12 months have also seen a decrease of over 3%.<br>**Actions:** The STAAR project team is in place, working with the ICB and the trust. SBLv3 has increased intervention for smokers, this has been benchmarked and will hopefully help to reduce our smoking rates. Postal NRT has recently started for women in remote areas and the issuing of vapes is in the final stages. Since Jan 23 NRT has been prescribed in house. Incentives started in Dec 24 in line with the national program.<br>**Mitigations:** All women are offered smoking cessation referral which is opt out. Additional funding was secured for TDA advisors and therefore all women are now covered by the STAAR team.<br>Funding was also secured from Lincolnshire County Council Tobacco Support Team to install window coverings in ANC windows at LCH and PHB sites to promote smoking cessation.<br>There is a continued trend in monitoring CO testing compliance. The overall trend since Apr 21 has seen a decrease. |
| Breastfeeding Initiation Rate | 72.9% | 71.22% | **Issues:**<br>*The threshold has increased to 72.9%<br>*Significant investment into infant feeding teams and support is needed to enable improvement- ULHT infant feeding team is significantly smaller than 1) teams in comparable Trusts and 2) other specialist teams at ULH relevant to workload*There are no universal antenatal infant feeding classes provided by midwifery staff/ or the infant feeding team<br>*A County Wide Infant feeding strategy has been agreed by the LMNS, which recommends an uplift in ULTH infant feeding team, no increase in funding has yet been agreed/received.<br>**Actions:**<br>*CMWs are providing basic individual antenatal infant feeding information using the Antenatal toolkit<br>*Translations for parents' version of Antenatal toolkit on the Better Births Website -QR code provided to CMW on stickers and will be on Antenatal Passport<br>* Some MSWs in community teams are providing one to one antenatal sessions<br>* QIP on improving skin to skin in theatre post LSCS<br>* An engagement meeting will be set up to review and a QIA to be completed<br>**Actions:**<br>*The Antenatal toolkit is well used by CMWs. Audit results show mothers have improved knowledge of benefits & how to BF<br>*Parents version of antenatal toolkit in English and translated versions are available on Better Births Website<br>*ANC/AAU areas have laminated parents' versions of antenatal toolkit available while parents are waiting.<br>*Mothers guide leaflet universal provision- antenatally<br>*Universal offer of Antenatal hand expression kits (including translations of leaflet) |
| PMRT commenced | 95% | 95% | **Issues:** |

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| within CNST timeframe | | | Following a meeting with the risk leads within Maternity, from July 25 PMRT is being reported as a rolling rate to align with CNST. The 92% is due to a historic case in Dec 24. We are anticipating full compliance with all remaining deadlines at the end of the reporting period for CNST (Nov 25).<br>**Actions:** There is a regular checking process to ensure dates are monitored and standards are met, there are also PMRT meetings that review every case. Additional support is now in place as a fail-safe in the event of staff sickness/absence.<br>**Mitigations:** We are anticipating full compliance with all remaining deadlines at the end of the reporting period for CNST (Nov 25) |

## Neonatal Dashboards Appendix 1.4.1

| Dashboard item<br><br>PHB | YTD Average | Oct 25 | Comments/actions |
|---|---|---|---|
| Number of admissions to SCBU | 16 | 17 | |
| Number of admissions to Transitional Care | 8 | 11 | Work underway with maternity colleagues to reduce term admissions to both SCBU and TC. TC Lead when in post to complete audit plans and provide education |
| Number of term admissions | 7% | 9.2% | Admission rates for term births continues to exceed national average of 5%. Work ongoing to review term admissions. Avoidable admissions currently undeterminable as review of all cases ongoing. |
| Number of babies admitted with hypothermia | 2 | 1 | All hypothermia's reviewed with several initiatives in place to support this. Temperature in theatres – ongoing discussions, use of warm towels and skin to skin to be promoted. |

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| Number of neonatal deaths | 0 | 2 | These have been recorded on the dashboard however these were identified as stillbirths so therefore needs discussion with the maternity team. |
| Mandatory training | | Amber | Ongoing. New ward manager appointed commencing in post January 12th 2026. Priority will be to focus on staff mandatory training |
| Appraisals | | | As above |
| Sickness | 8% | 9.52% | 2 members of staff on long term sick, both leaving the service shortly. Short term sickness is within acceptable parameters. All sickness reviewed in line with Trust policy. |
| QIS | | 66.3% | Training ongoing with trajectory in place to achieve full compliance. See separate paper for details |

| **Dashboard item**<br><br>**LCH** | **YTD Average** | **Oct 25** | **Comments/actions** |
|---|---|---|---|
| Number of admissions to NNU | 31 | 43 | October admission significantly higher than previous months due to increase in term admissions. |
| Number of admissions to Transitional Care | 12 | 10 | Work underway with maternity colleagues to reduce term admissions to both NNU and TC. TC Lead when in post to complete audit plans and provide education |
| Number of term admissions | 7.3% | 11.7% | Admission rates for term births continues to exceed national average of 5%. Work ongoing to review term admissions. Avoidable admissions currently undeterminable as review of all cases ongoing. See ATAIN report |
| Number of babies admitted with hypothermia | 2.1 | 4 | All hypothermia's reviewed with several initiatives in place to support this. Temperature in theatres – ongoing discussions, use of warm towels and skin to skin to be promoted. |

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| Number of neonatal deaths | 0 | 0 | |
| Mandatory training | | | Ongoing with priority focusing on full compliance. See figures on dashboard. |
| Appraisals | | 100% | Good News Story |
| Sickness | 5.81% | 7.7% | 1 RN on long term sickness, 2 staff have now returned from long term sickness. |
| QIS | | 59.1% | Training ongoing with forward trajectory in place to achieve 70%. See separate paper |

# 4: In-month updates

## 4.1 Maternity updates

| **Maternity updates** | |
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| Escalations | • Lack of agreed funding for 12.1WTE in regard to Triage uplift. Third submission to ICB Values Framework for discussion and review at November panel.<br>Ongoing challenges within tertiary centres for Fetal Medicine referrals. Unexpected workforce challenges at NUH causing a reduction in capacity. Both regionally and nationally the FM service is a fragile service. Regional agreement is that Derby, Kingsmill and Leicester will support the FM service for ULTH until NUH are in a more advantaged position. |
| Celebrations | • **Multiple staff awards for the Family Health Core Group. Specific to Maternity:**<br><br>**Collaboration Award**<br>**Winner-** Black and Asian Maternal Health Group, countywide<br>**Unsung Hero Award – Clinical**<br>**Highly commended-** Louise Dixon, Community Midwife, Lincoln<br><br>• SATOD rates have fallen well below national target for the first time within ULTH. |

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| Quality improvement/deep-dives/benchmarking/audit | • We've now received NHSE funding to review our current sonography service and project plan how to move the service forward in line with current demand and need. The project commenced 10th October and will end March 2026 and is being led by Anusha Houldershaw.<br>• Funding received from NHSE to support the SLEC programme and LWC Framework. Monies will support name badges for students and away days for LWC to increase knowledge gap as identified during the self-assessment.<br>Benchmark of recent Coroner report in regard to deaths of Jennifer and Agnes Cahill (Manchester Homebirth OOG) |
| Training and education | • Community PROMPT training sessions ongoing for all community and coco teams. |
| Midwifery workforce | • Triage uplift of 12.1WTE has yet to be agreed via the ICB Values Framework. Third submission to panel has now occurred for review during November's meeting.<br>Incorrect data submission for MSW vacancy has seen an inaccuracy in points to the Regional Heatmap. Deep dive into data submission and where inaccuracies lie. Moving forward data should accurately reflect MSW vacancy position. |

## 4.2 Neonatal updates

| **Neonatal updates** | |
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| Clinical Pathways | Cot reconfiguration at LCH to be agreed at Divisional Cabinet November 25. The new pathway recommended for previous year's activity will be 2 ITU cots, 3 HDU and 9 SC. Cot configuration is adapted accordingly on a day to day basis dependent upon activity and acuity. Staffing template remains unaffected as ratio's within BAPM standards. |
| Quality Improvements | 1. Transitional Care Lead B6 post being developed – the post holder will be required to submit TC audits and plans to ensure optimal provision, avoiding separation of mother and baby.<br>2. A business case is currently being written to purchase recliner chairs for most cot spaces. This will allow parents to sleep at the cot side, avoiding separation due to unavailability of parent bedrooms. This will also promote skin to skin and breast feeding due to enhanced comfort and positioning.<br>3. Parents present when baby being weighed. Baby's weight is a significant milestone and parents often miss out due to the timing of baby's being weighed. |
| Training and education | Redeployed a very experienced member of staff into the role of clinical educator for a period of 3 months. This will prove invaluable due to the current educator moving into the role of BFI Lead. See separate paper for updates (appendix 1.5) Guidelines at 94% - really good position with plans for remaining outstanding policies. |
| Medical workforce | · Medical NLS updates: Consultants fully CNS compliant on both sites<br>· GP trainees at PHB –Risk has been added to the risk register due to GP trainees lacking Newborn Life Support – this is mitigated through the use of locums when it is identified a GP trainee has insufficient newborn experience. |

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| QIS workforce | Recognising the risks and mitigations, the service has set out a realistic trajectory, to achieve the 70% QIS target by January 2027, taking into account projected turnover rates. This is demonstrated in the following charts for Lincoln and Boston. Whilst not compliant with BAPM standards, we are moving in the right direction with a clear training plan to demonstrate future compliance. The Group Board have received and approved previously an action plan for improvement. This is included within the 5-year strategy.<br>**Current position:**<br>○ LCH 59.1%<br>○ PHB 66.3% |
| NNAP | See separate paper for updates and actions. (appendix 1.5.1) |

# Item 5: Learning lessons

## 5.1 Incidents overview

Appendix 1.5

| **Incidents**<br>*As 1st November 2025* | **Obstetrics and community midwifery** | **Neonates** | **Actions being taken** |
|---|---|---|---|
| Patient safety incidents reported Sep - Oct '25 by severity | No Harm: 200<br>Low Harm: 38<br>Moderate Harm: 3<br>Fatal: 0 | No Harm: 19<br>Low Harm: 5<br>Moderate Harm: 0<br>Fatal: 0 | |
| Open incidents on Datix by month | **September:**<br>Closed on time: 53<br>Not closed on time: 47<br>Still open: 46 | **September:**<br>Closed on time: 9<br>Not closed on time: 8<br>Still open: 0 | Datix's monitored by the risk team to try and improve the compliance with timeframes. |
| | **October:**<br>Closed on time: 78<br>Not closed on time: 11<br>Still open: 76 | **October:**<br>Closed on time:11<br>Not closed on time: 2<br>Still open: 2 | |
| Open MNSI | Total 5 cases open: - | | 2 cases published and for trust MDT to review recommendations and update action plans |



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| | 3 cases closed at executive oversight group<br>2 ongoing cases<br>3 new cases | | 1 case to proceed due to family concerns<br>1 case awaiting patient consent to proceed with the investigation<br>1 case going through MNSI triage |
| PSII | 5 (All MNSI investigations) | 0 | All PSII are MNSI cases, therefore external investigations |
| AAR | 0 | 0 | |
| Outstanding/Completed Duty of Candour | 3 – completed | 0 | |
| PMRT<br>(Sept - Oct 2025) | Stillbirths: 4<br>Late fetal losses: 1<br>Neonatal deaths: 1<br>ULHT published: 3<br>External reviews: 0 | | For individual actions from published reports, please see quarterly report. |
| Outstanding actions | 22 actions open<br>15 actions overdue | 0 outstanding actions | Re-viewed monthly at the action review meeting with divisional and corporate governance teams.<br>All 2023 actions now closed. |
| Accumulative Patient Event Numbers 1st Dec '24 – 30th of Nov '25 (CNST year 7) | | | |
| MNSI – 8<br>(3 cases declined, 5 ongoing) | Qualifies for Early Notification - 1 | DOC verbal and written (including EN and MNSI information in accessible format in the patient's own language) – 8 (100%) | |

## 5.3 Detail of incidents graded moderate or above

| **CNST Year 6 cases (8th Dec '23 – 30th Nov '24)** | | | | |
|---|---|---|---|---|
| MNSI number | Qualify for EN? If Yes, include reference | Have the family received notification of role of MNSI/EN? | Compliant with Duty of candour? | Details/update |
| MI – 036719 | Yes | Notification of both | Yes, written and verbal | Report published, 3 safety recommendations:<br>1) The trust to ensure there is a robust system that supports IOL to be booked for the gestation that has been agreed and staff are supported to use this.<br>2) The Trust to ensure that Mothers are provided with information and discussion about the risks, benefits and options once a |

| | | | | |
|---|---|---|---|---|
| | | | | pregnancy reaches 41+0 weeks to support their involvement in the decision for and the timing of IOL.<br>3) The Trust to update the intrapartum fetal monitoring guideline and Cardiotocograph (CTG) assessment tool in line with national guidance, to support robust interpretation of fetal heart rate tracings.<br><br>Closed and actions published. |
| MI – 037281 | No | MNSI (don't qualify for EN) | Yes, written and verbal | Report published, 1 safety recommendation:<br>1) It is recommended the acute NHS trust and the NHS ambulance Trust work together to develop a process to communicate and record relevant clinical information so the decisions for care are made based on the whole clinical picture.<br><br>Closed and actions published. |
| MI - 037631 | Yes | Notification of both | Yes, written and verbal | Report published, no safety recommendations<br><br>Closed and actions published. |
| MI - 038500 | Yes<br><br>Declined | Notification to both | Yes, written and verbal | Report published, 1 safety recommendation:<br>1) The Trust to ensure that all mothers who report reduced fetal movements have a full risk assessment completed, including a computerised cardiotocograph, to assess fetal wellbeing in line with national guidance. (NHS England, 2023).<br><br>Closed and actions published |
| MI - 038706 | No | MNSI (don't qualify for EN) | Yes, written and verbal | Report published, 2 safety recommendations:<br>1) It is recommended that the Trust implement a telephone triage with a dedicated telephone line, dedicated staff and |

| | | | | |
|---|---|---|---|---|
| | | | | standardised documentation to ensure mothers contacting the maternity unit are safely assessed.<br>2) It is recommended that the Trust strengthen the process for referring mothers to the antenatal clinic for review by a doctor where there is no improvement in their iron levels.<br><br>Closed and actions published |
| MI - 039079 | Yes | Notification to both | Yes, written and verbal | Report published, 2 safety recommendations:<br><br>1) The Trust to support the introduction of maternity specific hyponatraemia guidance and to support all staff involved to be familiar with the risks of hyponatraemia and follow the guidance.<br>2) The trust to review its guidance on impacted fetal head and introduce multi-disciplinary training to improve communication and establish practice to facilitate safe birth.<br><br>Closed and actions published |

| **CNST Year 7 cases (1st Dec '24 – 30th Nov '25)** | | | | |
|---|---|---|---|---|
| MNSI number | Qualify for EN? If Yes, include reference | Have the family received notification of role of MNSI/EN? | Compliant with Duty of candour? | Details/update |
| MI – 039183 | No | MNSI (doesn't qualify for EN) | Yes, written and verbal | Referred on 30/12/24, timeline circulated.<br><br>AAR undertaken 25/2/25<br><br>TOR received and accepted.<br><br>Draft report received for factual accuracy comments to be returned by 18/09/25. |

| | | | | |
|---|---|---|---|---|
| | | | | Final report received, MDT to be arranged to update action plan. |
| MI – 039234 | No | MNSI (doesn't qualify for EN) | Yes, written and verbal | Referred on 10/01/25, timeline circulated<br>AAR undertaken 20/2/25<br>Case declined by MNSI 17/2/25 as unable to get patient engagement.<br>**Case Rejected by MNSI** |
| MI - 040715 | No | MNSI (doesn't qualify for EN) | Yes, written and verbal | Referred on 18/03/25, timeline circulated<br>AAR planned 8/5/25<br>Awaiting TOR from MNSI<br>Awaiting draft report for factual accuracy<br>Draft report received for factual accuracy and returned, awaiting final report.<br>Final report received, MDT to be arranged to update action plan. |
| MI – 044475 | Yes | MNSI and EN – verbal and written | Yes, written and verbal | Referred on 21/07/25, timeline circulated<br>AAR to be planned<br>MNSI not yet commenced investigation as family not yet ready.<br>Unable to get family engagement<br>**Case Rejected by MNSI** – letter sent by trust as still eligible for EN – No response yet. |
| MI - 046196 | No | MNSI (doesn't qualify for EN) | N/A – maternal death, coroners' investigation | Referred on 09/09/25, timeline circulated<br>**Case Rejected by MNSI** - most likely related to mental health. |

| | | | | |
|---|---|---|---|---|
| | | | | Coroner investigation ongoing. |
| MI - 047284 | No – no evidence of HIE on MRI scan | MNSI (doesn't qualify for EN) | Yes, written and verbal | Referred on 2/10/25, timeline circulated<br>AAR to be planned<br>No evidence of HIE on MRI but accepted by MNSI due to family concerns. |
| MI - 047466 | No | MNSI (doesn't qualify for EN) | Yes, written and verbal | Referred on 07/10/25, timeline circulated.<br>PMRT to be undertaken.<br>MNSI not yet got engagement from family |
| MI - 048338 | No | MNSI (doesn't qualify for EN) | Yes, written and verbal | Referred on 28/10/25, timeline circulated.<br>PMRT to be undertaken.<br>? still police investigation, therefore MNSI will not investigate yet until confirmed. |

| ***Datix number and detail*** | ***Obstetric/ Neonatal*** | ***Grading (Moderate or above, cases considered at PSRP, AARs, PSII)*** | ***Learning/action taken/update*** |
|---|---|---|---|
| 44901 – Maternal death following an RTC at 18 days postnatal, PNMH team involvement due to mental health deterioration | Obs | No Harm – Taken to PSRP as potentially met criteria for MNSI | Case referred but declined by MNSI, case is still with the coroner and most likely related to her mental health.<br>Statements being provided to the legal team for the coroner. |

| | | | |
|---|---|---|---|
| 45919 – 4.1l PPH following a normal birth with episiotomy, full neonatal resus required and baby transferred out for active cooling at a level 3 unit. MRI scan no evidence of HIE | Obs | Moderate – Taken to PSRP as met criteria for MNSI | Case referred to MNSI – No evidence of HIE on MRI but accepted due to family concerns.<br><br>AAR to be undertaken |
| 45850 – 37+4 patient called and attended reporting abdominal pain (not labour). IUD confirmed on USS. Retroplacental clot also seen, therefore diagnosed as placental abruption. Decision for Cat III LSCS. | Obs | Low Harm - Taken to PSRP as term stillbirth | No immediate care concerns identified, case to follow the PMRT process |
| 46869 – 37+1, attended in active labour, no fetal heart, confirmed intrapartum stillbirth. Spontaneous vaginal delivery, cord around the neck x5 | Obs | Low Harm - Taken to PSRP as met criteria for MNSI | Case referred to MNSI and awaiting family engagement prior to commencing the investigation. To follow the PMRT process by division. |
| 45403 – Type 1 diabetic, recurrent admission with hyperemesis, admitted at 29 weeks in unstable DKA, Em LSCS and admitted to ICU for stabilisation. | Obs | Moderate Harm – Taken to PSRP | Joint MDT Learning Review to be undertaken between the Medicine and Family Health team to review the patient pathway with support from the Pharmacy team. |
| 47394 – Day 5 neonatal death in the community? due to suffocation | Obs | No Harm – Taken to PSRP as criteria met for MNSI | Case referred to MNSI, currently being triaged as may reject if police investigation is still ongoing.<br><br>To follow the PMRT process within division. |
| 46966 – 38+5, community midwife unable to auscultate the FH, on USS no fetal heart, IUD confirmed. CAT 3 LSCS undertaken as already planned. | Obs | Low Harm – Taken to PSRP as term stillbirth | No immediate care concerns identified, case to follow the PMRT process |

## 5.44 Key themes & trends

| Theme/trend | Additional actions being taken |
|---|---|

| | |
|---|---|
| As a division we have a high number of Datix's open under investigation which has been highlighted at PSG. | - Commenced weekly reviews at the Monday ops meeting to review all previous weeks datix's<br>- To formalise the datix review meetings to monitor the progress of the cases that need MDT review, meeting with corporate governance team Dec '25. |

## 5.5 Maternity and Neonatal Risk Register

No new risks added Sep – Oct.

| Risk Description | Risk Score | Updates |
|---|---|---|
| As a result of insufficiencies within the current maternity services triage system, there is a risk that not all pregnant individuals will be able to access safe and timely care, which could lead to harm to the mother and baby. | 16 | Added following the MNSI escalation of concern following discussion at Risk confirm and challenge meeting 30/4/25. |
| Lack of adequate provision for appropriate clinical care of bereaved families within Obstetrics at Lincoln County Hospital. | 16 | Charitable funds are working with team at Lincoln to redesign room 4, although complete sound proofing is unlikely to be possible. |
| There is no second theatre within the confines of the labour ward within which to undertake any theatre-based procedures when Theatre 8 is already in use. | 16 | This issue is ongoing and will remain the same until the refurbishment programme has been completed. Continue to receive poor patient feedback about being moved through corridors. |
| 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. | 12 | Risk reduced from 16 to 12, reviewed following the increase in LSCS lists at LCH to 4 times a week.<br><br>Capacity remains an issue on Boston site, but conversations are on going with surgery. |
| The Trust is implementing a new maternity triage system, but this doesn't currently have facilities away from the clinical area, a bespoke telephone system or sufficient staff to run a designated telephone line 24/7. As a result of this, there is a risk that patients may not be able to access the required care in a timely manner which may lead to mothers and babies suffering harm. | 12 | Added on 7/8/25, for planned review 6/2/25. |

# 6: Listening to our families

## 6.1 Maternity Patient Experience Report

Appendix 1.6 and 1.6.1.

## 6.2 Feedback overview

| Feedback type | Obstetrics and community midwifery | Neonates | Comments/actions |
|---|---|---|---|
| Open complaints | 6 | 0 | |
| Overdue complaints | 2 | 0 | |
| Open PALS contact | 2 | 0 | |
| Overdue PALS contact | 2 | 0 | |
| Compliments (SUPERB) | 0 | 0 | |
| Social media interactions | **Lincoln** Maternity Social media-<br>September stats –<br>Dms: 3<br>Comments: 26<br>Likes/Shares: 618<br><br>October stats –<br>DMs: 14<br>Comments: 72<br>Likes/Shares: 1467 | | |

| | | |
|---|---|---|
| | **PHB** Maternity Social Media<br>September Stats -<br>DMs: 3<br>Comments: 93<br>Likes/Shares: 121<br><br>October stats –<br>DMs: 4<br>Comments: 27<br>Likes/Shares: 223 | |
| MNVP Co-produced patient experience improvement plan | | PEG Action Group has new invite and attendance list.<br>Last PEG Action Group meeting well attended.<br>Challenge with collection of data and thematic analysis within Trust ongoing as no standardised method of collection or thematic analysis tool. Exploring use of new digital collection package to allow for a centralised collection service. Exploring the use of Healthwatch Lincs to support more focussed feedback and cover the gap between MNVP Leads (current MNVP lead leaves in December). |
| Family and Friends Test | Patient Experience Team have procured a new contract for the FFT which will be supplied by Civica, this will enable a relaunch of FFT within maternity and will include free text options. PET plan to launch in January and Maternity have expressed interest in being an early adopter of this. | |
| Family Health Patient Experience Meeting escalation | Themes remain around improving communication and information sharing between staff and service users, as well as personalised care and informed decision making and access and equity for diverse populations. We have not integrated all of the actions from the 15 Steps feedback into the current plan but have created an action to maintain oversight of a standalone improvement plan on the back of this feedback.<br><br>We are working on a strategy to increase Action group attendance to move the 14 outstanding actions forward. | |

# 7: Listening to our staff

## 7.1 Maternity Staff Experience report

See update below

## 7.2 Feedback overview

| Feedback type/source | Number/detail | Comments/actions |
|---|---|---|
| Staff experience group | • All actions for the staff experience improvement plan to be reviewed at the next PeriSIP focus Perinatal Safety Collaborative Meeting<br>• Progress with the maternity and neonatal culture improvement work to be presented at a national webinar in January<br>• Negative outlier on 3YDP NHSE oversight tool dashboard related to results of the NETS survey completed by our O&G trainees. Summary of proposed actions to improve these results next year and ensure our trainees are feeling valued and safe to speak up about any of their concerns:<br>  ○ Obstetric induction pack and intranet page co-produced with college tutor SN in response to feedback and escalation via NETS and PG surveys- positive feedback following launch of induction booklet and intranet<br>  ○ Ongoing feedback in relation to civility and behaviour to be utilised to support midwives in supporting junior doctors (SHO/GP trainees)<br>  ▪ Project underway to increase knowledge and understanding of the different roles and responsibilities in obstetrics<br>• Staff experience story shared monthly at Obs and Gynae Governance<br>• Civility toolkit and 'a jar of stars' feedback mechanism introduced at PHB<br>• Feedback and escalation relating to the new ELLSCS pathway have been received via different routes including FTSU, with on-going actions and improved communication to staff groups | |
| Greatix | Over 600 Greatix' have now been received | Nettleham ward have seen a rise in Greatix nomination with feedback relating to hard-work, dedication and contribution to both staff and patient safety and experience.<br><br>Olivia Marsh<br>*Liv recently cared for a lady in the Penny suite who had sadly suffered a loss. Liv, the compassion dignity and professionalism you showed in a very emotional and sensitive situation was exceptional. You truly are the most wonderful midwife.* |

| | | |
|---|---|---|
| | | Lucy Osbourne<br>*I want Lucy to know how much I appreciate her in her role as ward manager. Since her appointment our ward has felt supported and heard. Lucy works very hard for us and it is not always recognised how hard she supports us behind the scenes. I just want to say Thank You Lucy.* |
| DoM Drop-in forums | | Emma is hosting a series of informal drop-in sessions for midwifery staff. Each session is arranged for specific staff groups and being held without managers present, to create a safe and open space for honest conversation. It's a chance to share thoughts, raise concerns, ask questions, or simply have a chat—whatever feels important! |
| Freedom to Speak Up | See above | |

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

## Appendices:

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

| Appendix number | Title |
|---|---|
| Appendix 1.1 | PQSM |

| | |
|---|---|
| Appendix 1.2<br>-Appendix 1.2.1<br>-Appendix 1.2.2<br>-Appendix 1.2.3<br>-Appendix 1.2.4<br>-Appendix 1.2.5<br>-Appendix 1.2.6 | CNST MIS Y7 Update Report |
| Appendix 1.3 | PeriSIP Headline Report |
| Appendix 1.4 & 1.4.1 | Maternity & Neonatal Dashboards |
| Appendix 1.5 | Education Guideline Report |
| Appendix 1.6 | NNAP |
| Appendix 1.7 | Learning Lessons Report |
| Appendix 1.8 and 1.8.1 | PEG report and PEG Action Plan |

# PERINATAL MORTALITY REVIEW TOOL (PMRT) QUARTERLY REPORT (QUARTER 2 – July - September '25)

## 1. INTRODUCTION

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

## 1.1 DEFINITIONS

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

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

**MIS Year 7 requirements to notify:**

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

- **Late fetal losses** – the baby is born at 22 or 23 completed weeks' gestation showing no signs of life, irrespective of when the death occurred.

- **Stillbirths** – the baby is born from 24 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- **Neonatal deaths** – the death of a live born baby born from 20 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) occurring before 28 completed days after birth.

## 2. STANDARDS

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

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

**External member presence**

Following the publication of CNST year 7 released April '25 there is a further requirement for 50% attendance by an external panel member. External panel member(s) should be relevant senior clinicians who are currently practicing clinically and work in a hospital external to the trust

undertaking the review and external to any trust involved in the care at any stage. Their role is to be present at the review panel and actively participate in the review to provide a 'fresh pair of eyes', independent and robust view of the care provided. With the 4 reviews that have been undertaken for the year 7 reporting period we are currently at 0%.

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

**Year 7 CNST MIS reporting**

In-line with Year 6, all quarterly reports will be made available to the Trust Executive Board each quarter evidencing that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. To maintain confidentiality, the quarterly reports, including the details of the deaths reviewed, any themes identified and the consequent action plans, will be made available to the Trust Executive Board via the reading room prior to the Public Board meeting (Appendix 1-5). Subsequently, the quarterly report will be shared at the Public Board meeting (Appendix 6).

## 3. RECOMMENDATIONS

### 3.1 Eligible Incidents in 2024-2025 (table 1)

There have been a total of 11 incidents (9 internal cases and 3 external cases) reported to MBRRACE-UK via the PMRT in Quarter 2.

Of these cases 2 have met the threshold for referral to the Maternity Neonatal Safety Investigation (MNSI) 1 is currently going through the triage process and the family declined a referral being made for the 2nd case.

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

### 3.2 Summary of all incidents closed in Quarter 2 (Table 2)

There have been 2 incidents closed in Q2 (1 cases from the CNST year 6 and 1 cases from the Year 7 reporting period). This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. (1 case is external and therefore only the care provided by ULTH was graded)

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

- 1 - care issues which they considered may have made a difference to the outcome for the baby

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

- 2 - care issues which they considered would have made no difference to the outcome for the mother

Grading of care provided from birth up until the baby died (review following a NND)

- 1 - care issues which they considered would have made no difference to the outcome for the baby

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

### 3.3 CNST Compliance as per MIS Year 7 Standards (Table three)

For CNST Year 7 we have achieved compliance within all eligible standards across the reporting period 1st December 2024 – 30th November 2025.

| MBRRACE-UK/PMRT standards for eligible babies following the PMRT process | % | Q4 | Q1 | Q2 | Q3 | Total |
|---|---|---|---|---|---|---|
| | 100 | 7 | 3 | 8 | | 18 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Notification of all perinatal deaths eligible to be notified to MBRRACE-UK to take place within 7 working days (Standard A) | | 100% | 100% | 100% | | 100% |
| A PMRT review must be commenced within two months following the death of a baby. (Standard C) | 95 | 5 | 4 | 8 | | 17 |
| | | 80% | 100% | 100% | | 94.4% |
| A PMRT must be completed within six months of the death of a baby's death. (Standard C) | 75 | Date not yet reached | 7 | 1 | | 8 |
| | | - | 100% | 100% | | 100% |
| All parents will have been told that a review of their baby's death is taking place*/ and asked for their contribution of questions and/or concerns**. (Standard B) | 95 | 7/4 | 9/8 | 18/13 | | 9/8 |
| | | 100%/57% | 100%/72% | 100%/72% | | 100%/72% |
| An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT. | 50 | Date not yet met | 5/5 | 8/8 | | 8<br>100% |
| | | - | 100% | 100% | | 100% |
| Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions (Standard D) | 100 | 100% | 100% | 100% | | 100% |

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

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

### 3.4 Learning and Action Logs for Outstanding Cases (Appendix 5)

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

### 4.0 Saving Babies Lives Version 3.2 (Table Four)

SBLCBv3 provides evidence-based best practice for providers and commissioners of maternity care across England, to reduce perinatal mortality. There is an expectation that as well as organisations reporting on their implementation of each element, there will be complimentary reporting of ongoing improvement work (with associated detail of interventions and improvement in process measures and outcomes) for each element. An integral component of this improvement work will be a focus on learning from incidents or enquiry. Harm may have occurred in relation to implementation of or non-compliance with an element of the SBLCB. The use of the Perinatal Mortality Review Tool will complement the investigation and learning in this context.

Of the 2 cases reviewed there was only 1 action created in relation to SBL CBv3 elements, this was in relation to element 5.

### 5.0 Escalation

- Current areas for concern with CNST year 7 compliance are in meeting the 50% of reviews with external representation and we are currently sitting below the 95% standard for reviews being commenced in 2 months.

- There has been a fall in the number of PMRT's completed this quarter due to no longer having band 6 support, despite this there have been no compliance issues with the CNST standards due to being well within time frames at the end of the last quarter.

### Appendices

Appendix 1.0 – PMRT 96561

Appendix 2.0 – PMRT 98866

Appendix 3.0 – Outstanding Action Log

Appendix 4.0 – PMRT Q2 July - Sept 25 (non-identifiable data)

**Author – Gemma Rayner, Risk and Clinical Governance Midwife**

**Date – 15th October 2025**

## Claims Scorecard - April '14 – March '24

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

## Complaints Q2 '25

There have been 15 complaints received:
8 – Clinical treatment
7 – Communication
4 – Values and Behaviour
1 – Access to treatment or Drugs

## Incidents Q2 '25

1. Delayed transfer / ARM >24hrs – 50
2. Term Baby admitted to neonatal unit – 50
3. Readmission of mother – 30
4. PPH >1500mls – 28
5. Delayed treatment or procedure – 24

The top 5 haven't changed from Q1 but there has been a rise in the number of delayed ARM's and ATAIN admissions.

Number of datix's submitted for Obstetrics and Community Midwifery: 329

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

NHS
United Lincolnshire Hospitals
NHS Trust

## Themes Q2 '25

- Delayed transfer for ARM's is consistently in the top 5 maternity care triggers; this is being looked at as part of a wider review of the IOL pathway being led by the inpatient matrons.
- ATAIN admissions are being reviewed as part of a monthly rolling review and a quarterly report is submitted.

## Learning Q2 '25

**MNSI Recommendations** –
1. The trust to review the local escalation process so that staff are supported to escalate when they are providing care outside of guidance and to ensure there is obstetric oversight.
2. The trust to review the local escalation process for when there are clinical concerns requiring obstetric review, and on call obstetric staff are already busy with other clinical tasks. This may include consideration of contacting an alternative member of obstetric staff.

## Action Plan Q2 '25

| Not started | In progress | Completed |
|---|---|---|

| | | |
|---|---|---|
| Increased the EI LSCS capacity and relocation from labour ward to relieve pressure and improve patient flow. | 31/05/26 | |
| Deep dive into postnatal readmissions to identify themes and trends | 01/02/26 | |
| IOL pathway to be reviewed including how to reduce the waiting times for ARM's | 01/03/25 | |

# Bi-annual Midwifery Staffing Oversight Report

## April 2025 – September 2025

Emma Upjohn
Director of Midwifery
ULTH
November 2025 – Version 1.1.

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# Midwifery Staffing Oversight Report

April 2025- September 2025

## Introduction

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

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

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

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

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

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

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

## Background

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

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

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

## Birthrate Plus (BR+) Findings

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

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

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

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

## Comparison of clinical roles

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

## Summary of results (planned vs actual midwifery staffing)

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

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

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

## One-to-One Care and Supernumerary Labour Ward Coordinator

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

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

The following table depicts this performance:

| | | | | | | Workforce Indicators ULHT | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric | Threshold | | | Data Source/ Standard | | Apr | May | Jun | Jul | Aug | Sep |
| | R | A | G | | | | | | | | |
| Midwife to Birth Ratio (funded) | 01:27 | | 01:26 | | | 01:26 | 01:26 | 01:26 | 01:26 | 01:26 | 01:26 |
| Midwife to Birth Ratio (Actual) | 01:27 | | 01:26 | | | 01:24 | 01:25 | 01:26 | 01:26 | 01:26 | 01:26 |
| 1-1 in labour | <100% | | 100% | BN/CNST | 1-1Labour | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| | | | | | | | | | | | |
| Co-ordinator Supernumerary | <100% | | 100% | Inpatient Matron/CNST | Co-ordinator | 99.65% | 99.20% | 98.50% | 98.64% | 97.00% | 98.00% |

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

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

## Midwife to birth ratio

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

## Maternity escalation plan: mitigations and escalations for managing shortfalls

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

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

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

## Conclusion and Proposed Actions

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

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

- Continue successful recruitment and retention efforts into the agreed temporary uplift of 10.25 wte B6's & B3's (action: 1.5).
- Business case has been agreed through internal governance processes and is under review at the ICB Weighted Values Framework panel. This would be for agreement of 12.1 wte Band 6 in line with BR+ review (new action: 1.6)
- Risk Assessment has been completed and added to the risk register regarding the current staffing deficit (action: 1.7)
- BSOTS model has gone live on both sites from 30/4/25 (updated action: 1.1).

## Escalations for upward reporting

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

# Maternity and acuity red flag report
## April 25 – Sept 25

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

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

The following data shows acuity information for the period April 2025 – September 2025 and includes all data entries.

### Summary

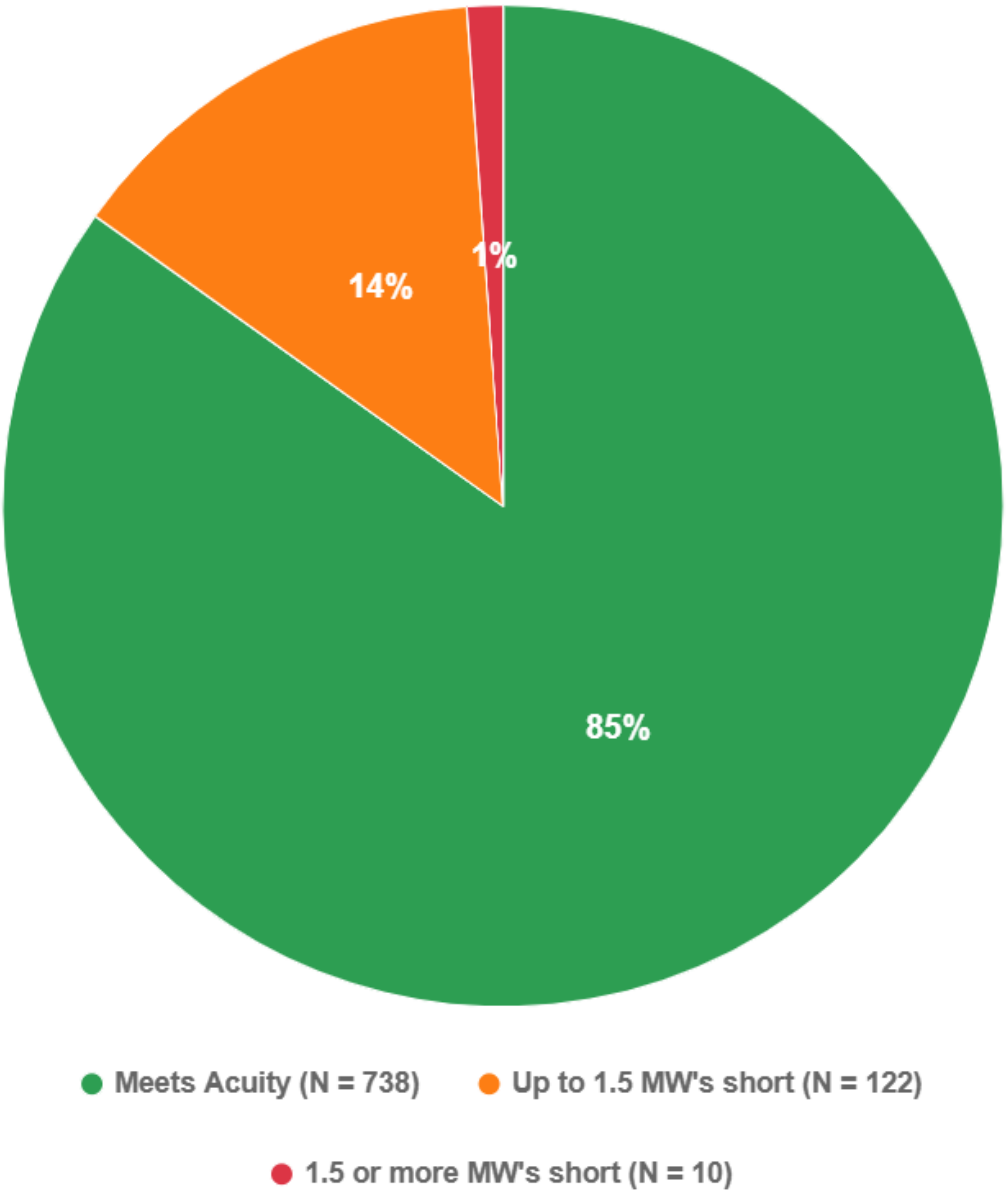
The birth-rate plus acuity tool displays a RAG dashboard and displays green when no staffing vs acuity issues, amber when an entry shows that a unit is up to 1.5 midwives short for the documented activity, then red when there is a calculated shortage of 1.5 or more registered staff at any data entry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

Pilgrim hospital's results for the period April 2025 to Sept 25 showed that they were green, on average, 85% of the time, amber 14% and red 1% of the time. This is a very similar picture to previous reports.

Lincoln hospitals result for the same period showed that they were green 69% of the time (a slight increase from 65% during the last reporting period), amber 29% and red 2% of the time.

### Pilgrim Hospital Boston

There were 870 data entries out of a possible 1098. Compliance for data entry at pre-set timed at 79.23%, which is an increase with previous compliance. However, there were 99 additional data entries made which demonstrates although acuity may not have been entered at the specific time – acuity was captured when the coordinator was able to input.
Acuity met on average, on 85% of data entries:




Staffing factors recorded included unexpected staff absence, unfilled rosters and no HCSW on shift. The most frequently recorded factor was unable to fill vacant shifts which occurred on 150 occasions. There were vacant posts in this reporting period, but these vacancies have been filled so we would expect to see that reduce in the next report.

## Number of Staffing Factors

01/04/2025 to 30/09/2025

Download Results

| Factors | Breakdown of Factors | Times occurred | Percentage |
|---|---|---|---|
| SF1 | Unexpected staff absence | 96 | 21% |
| SF2 | Unable to fill vacant shifts | 150 | 33% |
| SF3 | Staff on transfer | 7 | 2% |
| SF4 | Staff redeployed to another area | 49 | 11% |
| SF5 | No ward clerk | 22 | 5% |
| SF6 | No HCSW on duty | 34 | 7% |
| SF7 | Continuity of Carer Midwife present | 70 | 15% |
| SF8 | Continuity of Carer Midwife not available | 27 | 6% |
| TOTAL | | 455 | |

*The % is rounded to nearest whole number

## Number of Clinical Actions

01/04/2025 to 30/09/2025

Download Results

| Actions | Breakdown of Actions | Times occurred | Percentage |
|---|---|---|---|
| CA1 | Delay in commencing IOL more than 2 hrs | 28 | 22% |
| CA2 | Delay in ARM of more than 4 hours | 76 | 61% |
| CA3 | Delay in scheduled LSCS of more than 4 hours | 1 | 1% |
| CA4 | Refusal of in-utero transfers due to acuity | 0 | 0% |
| CA5 | IOL-Delay in transferring to delivery suite following SROM for more than 4 hours | 2 | 2% |
| CA6 | Shift leader non supernumerary | 18 | 14% |
| TOTAL | | 125 | |

*The % is rounded to nearest whole number

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

It has been recorded that the shift leader was not supernumerary on 18 occasions (although not providing 1:1 care). This is a decrease picture to the last reporting period. This is reflected in the shifts where escalation was required to ensure complete supernumerary status was returned. As detailed earlier in the report any instances where supernumerary status was lost are investigated to ensure that labour ward coordinators were not providing 1:1 care to a woman in labour. This provides assurance patient care was not compromised.

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

- reallocation of staff across areas based on clinical need

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

## Number of Management Actions

01/04/2025 to 30/09/2025

Download Results

| Actions | Breakdown of Actions | Times occurred | Percentage |
|---|---|---|---|
| MA1 | Escalation to community midwives | 19 | 13% |
| MA2 | Redeploy staff internally | 46 | 31% |
| MA3 | Staff unable to take allocated breaks | 47 | 32% |
| MA4 | Redeploy staff from non-clinical duties | 3 | 2% |
| MA5 | Staff stayed beyond rostered hours | 15 | 10% |
| MA6 | Management team/specialist midwives supporting clinically | 6 | 4% |
| MA7 | Patients transferred within the trust | 9 | 6% |
| MA8 | Full service closure | 3 | 2% |
| TOTAL | | 148 | |

*The % is rounded to nearest whole number

The unavailability of breaks increased to 32% which is increase from 29% of the reported actions in the previous report.

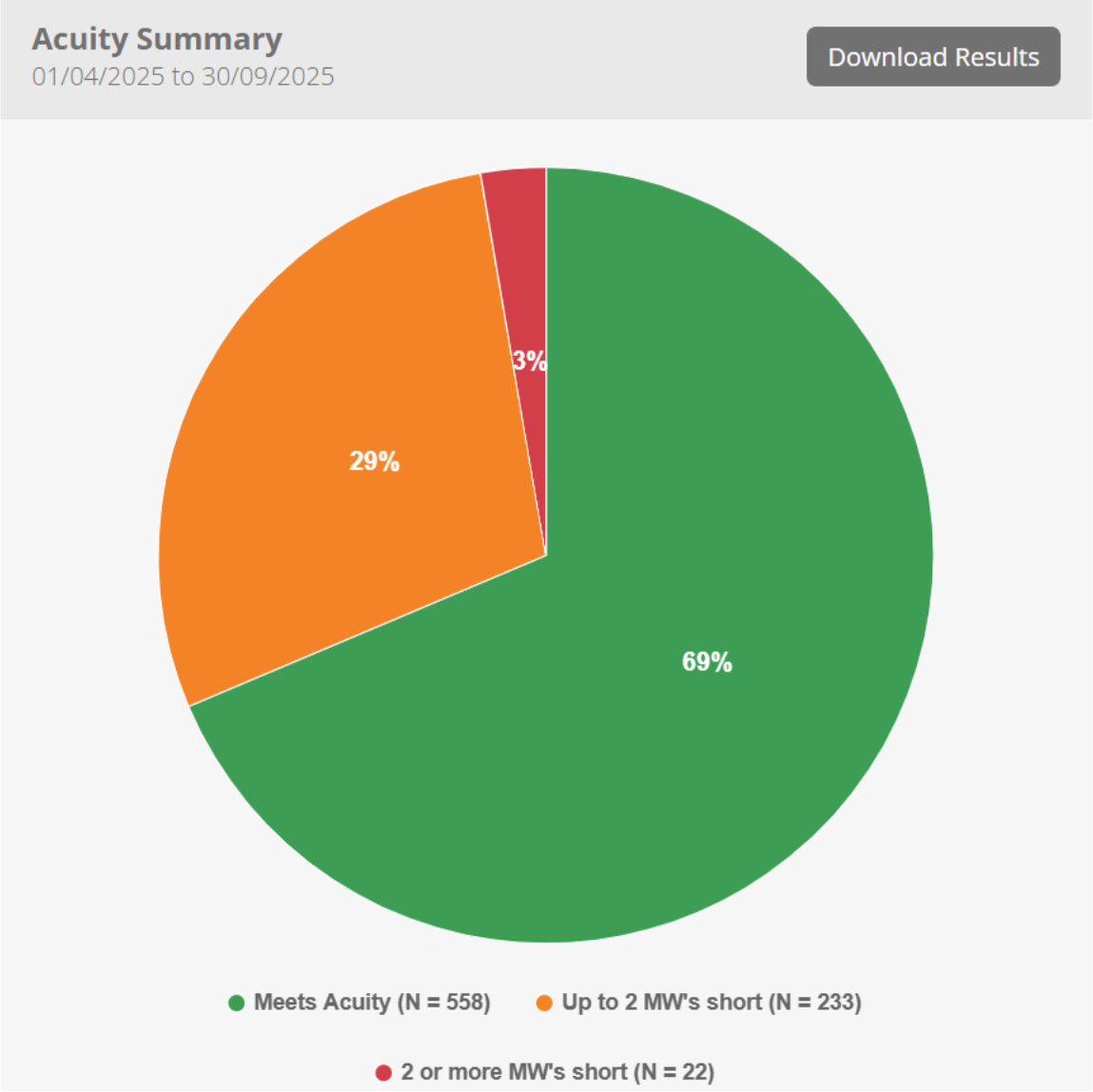
| Flags | Breakdown of Red Flags | occurred | Percentage |
|---|---|---|---|
| RF1 | Delayed or cancelled time critical activity | 2 | 100% |
| RF2 | Missed or delayed care - Delay in suturing more than 1 hour post birth except for water-births | 0 | 0% |
| RF3 | Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication) | 0 | 0% |
| RF4 | Delay in providing pain relief | 0 | 0% |
| RF5 | Delay between presentation and triage | 0 | 0% |
| RF6 | Full clinical examination not carried out when presenting in labour | 0 | 0% |
| RF7 | Delay between admission for induction and beginning of process | 0 | 0% |
| RF8 | Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) of more than 1 hr | 0 | 0% |
| RF9 | Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour | 0 | 0% |
| TOTAL | | 2 | |

**Red flags were recorded on less than 1% of all data entries for the period – 2 occasions in total.**

## Lincoln Hospital

There were 831 data entries during the period, out of a possible 1098, with compliance for data entry at pre-set timed at 74.04%, which is similar to last reporting period. There were 115 additional data entries made which demonstrates although acuity may not have been entered at the specific time – acuity was captured when the coordinator was able to input.

Acuity met on average, on 69% of data entries. This is an increase from the last reporting period which was 64%. Lincoln had some vacancies during this period which have since been recruited to. Therefore, the expectation would be to continue to see this rise still further in the next report.



## Number of Staffing Factors

01/04/2025 to 30/09/2025

Download Results

| Factors | Breakdown of Factors | Times occurred | Percentage |
|---|---|---|---|
| SF1 | Unexpected staff absence | 85 | 17% |
| SF2 | Unable to fill vacant shifts | 71 | 14% |
| SF3 | Staff on transfer | 1 | 0% |
| SF4 | Staff redeployed to another area | 37 | 7% |
| SF5 | No ward clerk on duty | 127 | 25% |
| SF6 | No HCSW on duty | 17 | 3% |
| SF7 | Staff absence due to illness/shielding/symptoms Covid-19 | 14 | 3% |
| SF8 | Continuity of Carer Midwife present | 81 | 16% |
| SF9 | Continuity of Carer Midwife not available | 76 | 15% |
| TOTAL | | 509 | |

*The % is rounded to nearest whole number

Staffing factors included were unexpected staff absence and unable to fill vacant shifts. This is a decrease from the last report and largely attributed to the vacancy. Continuity of Care midwife was available more in this reporting period.

## Number of Clinical Actions

01/04/2025 to 30/09/2025

Download Results

| Actions | Breakdown of Actions | Times occurred | Percentage |
|---|---|---|---|
| CA1 | Delay in commencing IOL of more than 2 hours | 21 | 5% |
| CA2 | Delay in ARM of more than 4 hours | 377 | 87% |
| CA3 | Delay in scheduled LSCS of more than 4 hours | 0 | 0% |
| CA4 | Refusal of in-utero transfers due to acuity | 2 | 0% |
| CA5 | IOL-Delay in transferring to delivery suite following SROM for more than 4 hours | 21 | 5% |
| CA6 | Delay in transfer to delivery suite following prostin for PSROM for more than 2 hours | 5 | 1% |
| CA7 | Shift leader non supernumerary | 5 | 1% |
| TOTAL | | 431 | |

*The % is rounded to nearest whole number

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

It has been recorded that the shift leader was not supernumerary on 5 occasions. This was reviewed and was rectified with escalation. As detailed earlier in the report any instances where supernumerary status was lost are investigated to ensure that labour ward coordinators were not providing 1:1 care to a woman in labour. This provides assurance patient care was not compromised.

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

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

## Number of Management Actions

01/04/2025 to 30/09/2025

Download Results

| Actions | Breakdown of Actions | Times occurred | Percentage |
|---|---|---|---|
| MA1 | Escalation to community midwives | 14 | 8% |
| MA2 | Redeploy staff internally | 89 | 54% |
| MA3 | Staff unable to take allocated breaks | 35 | 21% |
| MA4 | Redeploy staff from non-clinical duties | 9 | 5% |
| MA5 | Patients transferred within the trust | 4 | 2% |
| MA6 | Staff stayed beyond rostered hours | 9 | 5% |
| MA7 | Management team/specialist midwives supporting clinically | 6 | 4% |
| MA8 | Full service closure | 0 | 0% |
| TOTAL | | 166 | |

*The % is rounded to nearest whole number

Management actions recorded are a similar picture to the last reporting period. The unavailability of breaks decreased within this reporting period to 21% which is positive for the staff. Redeployment of staff to support and escalation of care needs decreased from 60% to 54%. This will have impacted those staff needing to be redeployed. Full-service closure remained low and was only recorded on 0 data entries. This is reflected in the increase of patients being transferred within the Trust, and that is monitored on an ongoing monthly basis.

| Flags | Breakdown of Red Flags | occurred | Percentage |
|---|---|---|---|
| RF1 | Delayed or cancelled time critical activity | 2 | 100% |
| RF2 | Missed or delayed care - Delay in suturing more than 1 hour post birth except for water-births | 0 | 0% |
| RF3 | Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication) | 0 | 0% |
| RF4 | Delay in providing pain relief | 0 | 0% |
| RF5 | Delay between presentation and triage | 0 | 0% |
| RF6 | Full clinical examination not carried out when presenting in labour | 0 | 0% |
| RF7 | Delay between admission for induction and beginning of process | 0 | 0% |
| RF8 | Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) of more than 1 hr | 0 | 0% |
| RF9 | Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour | 0 | 0% |
| TOTAL | | 2 | |

**Red flags were recorded on <1% of all data entries for the period – 2 occasions in total**

# Appendix one: Action plan addressing shortfalls

| Action number | Objective | Action | Lead | Timescale | Progress | Evidence | RAG rating |
|---|---|---|---|---|---|---|---|
| 1.0 | Review triage and antenatal assessment services across ULTH in line with BSOTTs | Appoint B7 to lead on Triage and AAC | Karen Ludkins (Matron) | Aug 2024 | **11/07/2024:** B7 appointed and due to commence post in August<br>**01/11/2024:** Commenced in post 16th September<br>**1/8/2025:** Secondment extended to 31/03/2025 | Job description | |
| 1.1 | Review triage and antenatal assessment services across ULTH in line with BSOTTs<br>Maintain safe staffing in the period before uplift agrees and staff recruited | Review service in line with BSOTTs standards | Fran Stephens (B7 Triage lead) | Dec 2024 | **11/07/2024:** Await B7 start<br>**01/11/2024:** Benchmarking completed against RCOG Good Practice paper and CQC National Review. Triage action plan underway based on benchmarking activities. Red/amber actions to be added and monitored through MatSIP and all other actions to be monitored through Triage action plan by B& lead and ANC matron. Action plan to be reviewed in November MNSC and will subsequently follow usual reporting route through MNOG/QC and LMNS<br>**01/11/2024:** Case in need submitted 31/10/2024 and plan for review at CRIG<br>**30/04/2025:** BSOTs model introduced into practice following education and training lead<br>**15/05/2025:** Business case written suggests 25 WTE required to fully implement BSOTs including one single point of contact, triage of labourers, PN care. Refer to action1.6 for new business case progress -BSOTs implementation monitored through risk register<br>-in: Number 854, risk register rating 16- severe (including MNSI letter of concern)<br>**01/11/2025:**<br>• BR+ business remains under review at ICB weighted values Framework.<br>○ BR+ establishment uplift business case approved by CRIG on 29th July<br>○ Declined at ICB weighted values Framework on the 15th September with a request for further evidence<br>○ Declined following second attempt at ICB values Framework on the 22nd October with a request for further evidence<br>○ Case strengthened with additional evidence and to be presented at ICB weighted values Framework on 17th November | Benchmarking Action plan | |
| 1.2 | | Recommendations/report around provision of service to be written | Fran Stephens (B7 Triage lead) B7 lead and matron | Dec 2024 Jan 2025 | | Report | |
| 1.3 | | Report to be presented to MNOG/LMNS to gain approval | | | | Minutes Report | |
| 1.4 | | Business case process to be followed to gain agreement to proceed to fully implement BSOTs | | Feb 2025 | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | • Following escalation via MNOG and GQC, the Trust has committed 450k to recruit 5.75 wte B6 midwives at a cost pressure whilst decision is taken.<br>• The Trust committed to continue cost pressure and review on 1/4/26 and consider further cost pressure to ensure full recruitment into the 12.1wte deficit.<br>• Action plan with mitigations against short-fall is reported via the bi-annual staffing report due at MNOG this month<br>  • Outside of the CNST MIS reporting period progress with this action will be monitored via MNOG and upward reporting route | | |
| 1.5 | | Continue successful recruitment and retention efforts into the agreed temporary uplift of 10.25 wte B6's & B3's | Matrons | December 2025 | Out to advert – majority of vacancies filled. 1.6wte out to advert at PHB | | |
| 1.6 | | Business case under review for agreement of 12.1 wte in line with BR+ review. | EU | December 2025 | **15/05/2025:** Discussion with finance re source of funding<br>**01/11/2025:**<br>• BR+ business remains under review at ICB weighted values Framework.<br>  ○ BR+ establishment uplift business case approved by CRIG on 29th July<br>  ○ Declined at ICB weighted values Framework on the 15th September with a request for further evidence<br>  ○ Declined following second attempt at ICB values Framework on the 22nd October with a request for further evidence<br>  ○ Case strengthened with additional evidence and to be presented at ICB weighted values Framework on 17th November<br>• Following escalation via MNOG and GQC, the Trust has committed 450k to recruit 5.75 wte B6 midwives at a cost pressure whilst decision is taken.<br>• The Trust committed to continue cost pressure and review on 1/4/26 and consider further cost pressure to ensure full recruitment into the 12.1wte deficit.<br>• Action plan with mitigations against short-fall is reported via the bi-annual staffing report due at MNOG this month<br>  • Outside of the CNST MIS reporting period progress with this action will be monitored via MNOG and upward reporting route | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1.7 | | Add to the risk register regarding the current staffing deficit | EU | Complete | Risk register number: 734, risk register rating 16- 12 (moderate) | | |
| 2.0 | Maintain safe staffing in the period before uplift agrees and staff recruited | Daily safety huddle to review staffing across all sites and areas | Matrons | Ongoing until uplift agreed Ongoing until uplift agreed | 11/07/2024: All actions in place and ongoing<br>01/11/2025: Mitigations remain in place | Daily huddle reports, escalation policy, incident reports, bi-annual staffing report | |
| 2.1 | | Twice weekly forward staffing review to ensure all services appropriately covered | | | | Daily huddle reports, escalation policy, incident reports, bi-annual staffing report | |
| 2.2 | | Robust escalation policy in place | | | | | |
| 2.3 | | Monitoring of incident reporting related to staffing | | | | | |

NHS
Lincolnshire Community and Hospitals NHS Group

# Finance Briefing M8

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *8.2* |
| Report title | *Finance Briefing M8* |
| Report purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | • Information |
| Accountable Director | *Paul Antunes Goncalves*<br>*Group Chief Financial Officer* |
| Author(s) | *Finance Team* |
| Assurance rating:<br>• Substantial assurance<br>• Reasonable assurance<br>• Limited or no assurance | • *Reasonable assurance* |
| Prior approval process, if applicable | *Content discussed at Finance and Performance Committee* |
| Financial implications, if applicable | *None* |
| Action / decision required | *The board is asked to:*<br><br>• *Note the contents of the Finance report in respect of Revenue, Capital, Cash and CIP positions.*<br>• *Note the three key areas of internal focus – delivery of our variable income, delivery of our efficiency target and workforce controls (bank and agency).*<br>• *Note the forecast risk that is being mitigated through internal and external actions..* |

*Assurance Rating Key:*

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

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

## Executive Summary

Trust Board is asked to note the following:

- 2025/26 Revenue position M8 YTD (Year to date)

The Group delivered a £12.3m deficit (£2.4m adverse than planned).

- 2025/26 Capital position M8 YTD

The Group delivered capital expenditure of £28.4m (£21.1m lower than planned).

- 2025/26 CIP position M8 YTD

The Group delivered savings of £41.9m (£0.7m lower than planned).

- M8 Cash position

The Group ended the month with a cash balance of £25.7m (£13.6m lower than planned).

**Lincolnshire Community and Hospitals NHS Group**
**Trust Board – 6 January 2026**
**Finance Briefing M8**

## Executive Summary

At month 8 the year-to-date position for the Group is a £12.3m deficit, £2.4m adverse to plan. The Group have delivered actual surplus positions in month 7 and 8, however the plan required a further improvement. This deficit position was mainly built in quarter 1, with quarter 2 seeing an improvement in our monthly run rate. The Group is required to increase our savings as we progress through the year which will return the Group to financial balance by 31 March 2026.

The Group have three key areas of internal focus to support the revenue position: variable income delivery, efficiency delivery and workforce controls (bank and agency). These are at the centre of our discussions with our care groups and corporate leads to ensure delivery of our financial plan. The Group are also working with external parties to support the forecast position, including local system partners and regional colleagues.

As outlined previously the financial position is challenging, with circa £14m of risk within the forecast position, Industrial Action increases this challenge unless there is a funding mechanism. The Group are confident that through internal and external actions we will be able to deliver our breakeven year end position.

Our capital spend is behind our planned level, mainly driven by delays in approval, it is anticipated that this will be recovered by the end of the financial year. Mitigation options are being developed to ensure that all capital is utilised by 31 March, this will be spent on scheme that support our strategic direction and improve our working environment (e.g. equipment). The Group continue to seek additional capital as it becomes available and have a proactive relationship with regional and national colleagues.

The cash position is £13.6m behind plan, with a cash balance at the end of month 8 of £25.7m. The Group are monitoring our cash position daily and this continues to be a key area of focus in our Finance and Performance Committee.

In November, our junior doctor workforce undertook industrial action over a 5-day period, this impacted the position (£0.4m adverse) through a combination of reduced activity/income and increased costs due to cost of backfilling staff who were absence from work.

## Summary Position

| Month 7 Position | Group performance | | | LCHS performance | | | ULTH performance | | |
|---|---|---|---|---|---|---|---|---|---|
| | Year to Date | | | Year to Date | | | Year to Date | | |
| | Plan £m | Actual £m | Var. £m | Plan £m | Actual £m | Var. £m | Plan £m | Actual £m | Var. £m |
| Surplus / (Deficit) | (10.0) | (12.3) | (2.4) | (2.1) | (1.5) | 0.7 | (7.8) | (10.9) | (3.0) |
| CIP Delivery | 42.6 | 41.9 | (0.7) | 4.2 | 5.1 | 0.9 | 38.4 | 36.8 | (1.6) |
| Capital Spend | 49.4 | 28.4 | (21.1) | 2.5 | 2.2 | (0.3) | 46.9 | 26.2 | (20.7) |
| Agency Spend | (9.9) | (11.3) | (1.3) | (1.1) | (0.5) | 0.5 | (8.9) | (10.7) | (1.9) |
| Cash Balance | 39.3 | 25.7 | (13.6) | 25.4 | 14.9 | (10.5) | 13.9 | 10.8 | (3.0) |

**Revenue Position**

The Group's year to date financial position is a £12.3m deficit at month 8, this position is £2.4m adverse to our planned position. The Group have seen run rate improvements and in M7 and 8 delivered actual surplus position however these have been below our planned level and required recovery plan actions. The revenue position requires further improvements in our run rate to delivery our breakeven position at the end of the year.

The month 8 position includes the impact of Industrial Action by our resident doctors, this has had an adverse impact of £0.4m through the combination of activity/income reductions and cost increase (backfill costs); noting further industrial action has taken place in December.

There are three key internal areas of focus to ensure delivery of our financial position:

1. **Delivery of our variable income** – The Group is required to delivery on our planned care activity, which is subject to variable payment e.g. we will only be paid for the work we undertake. ULTH has made improvements in our theatre productivity and outpatient productivity that will improve our performance by the end of the financial year. Current projections are outlining a small over performance of our variable income by the end of the financial year.

2. **Delivery of our efficiency target** – Our efficiency plan is slightly (£0.7m) behind plan, some schemes have not delivered as intended and mitigations are being developed. Additional assurance meetings have taken place with our care groups to develop mitigations and ensure forecast scheme are on track for delivery. The month 7 and 8 positions include recovery actions to support the year end position. This position is a key area of focus and is reported weekly to executive colleagues.

3. **Workforce controls (Bank and Agency)** – Although our whole-time equivalent position has reduced since the beginning of the year, the level of reduction is behind our workforce plan. A key driver of this is our temporary workforce, good progress has been made on our agency position, however our bank position is not reducing at the pace our plan requires. Workforce colleagues are working with our nursing and medical teams on addressing this position and additional vacancy controls have been put in place during December. We have seen reductions from our MARs scheme with full year effect savings identified for 26/27.

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

The Group continues to have in place enhanced vacancy controls through our executive led vacancy control process, this is informed by our Quality Impact Assessment. In additional, in December, we have introduced a 3-month deferment on start dates so support the year end position. We are also targeting our non-pay discretionary spend with enhanced approvals also required for spend on specific categories.

The month 4 and month 8 positions, includes the impact of the Junior Doctor Industrial Action. This impacted ULTH in two ways, first reduced our activity/income in month due to reduced planned care activity and secondly through increasing our pay costs due to the premium paid to backfill staff that were absent from work. Non-recurrent efficiency savings

have been brought forward to mitigate the expenditure in month 4, however in month 8, £0.4m impacted the in month Trust position.

The Group are going through a detailed review of the forecast position for the month 9 position, the current view has circa £14m of risk identified mainly due to shortfalls in our efficiency systems. Internal and external mitigations are being developed and implemented, and the Group are confident that we will be able to deliver our breakeven year end position.

**Capital Position**

The Group has the largest ever capital programme of £119.8m (small reduction since last update due to rephasing of Boston Community Diagnostic Centre scheme due to approval delay), key schemes including Community Diagnostic Centre at Boston, first year of our ePR, new ED department at Pilgrim Hospital and Endoscopy improvements.

At month 8 the Group were £21.1m behind our capital plan, this was driven by delays on approvals for our ePR and Community Diagnostic Centre. These have now been received, and progress is underway.

The Group are confident of utilising all capital funds available in year and mitigation options have been developed if schemes are delayed further. All mitigation options are in line with our strategic direction of travel and improve our working environment (e.g. equipment).

The Group have submitted a cash request for the additional funds allocated relating to 24/25 4 hour performance, this has been discussed with regional colleagues who are supportive.

The Group continue to explore further capital opportunities and have recently been approved addition energy efficiency measures for delivery in year.

NHS
Lincolnshire Community and Hospitals NHS Group

# Finance and Performance Committee Upward Report

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *8.3* |

# *Finance and Performance Committee Upward Report of the meeting held on 20 November 2025*

| | |
|---|---|
| Accountable Director | *Paul Anutunes-Goncalves, Group Chief Finance Officer* |
| Presented by | *Sarah Buik, Associate Non-Executive Director* |
| Author(s) | *Karen Willey, Deputy Trust Secretary, ULTH* |
| Recommendations / decision required | *The Group Board is asked to:*<br>• *note the discussions and assurance received by the Finance and Performance Committee;*<br>• *approve the Health and Safety Committee annual report* |

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

**Board Committee Upward Report to the Group Board**

| | |
|---|---|
| **Report for meeting of the Group Board to be held on:** | 6 January 2026 |
| **Report from:** | Finance and Performance Committee |
| **Report from meeting held on:** | 20 November 2025 |
| **Quoracy requirements met:** | Yes |

## 1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Finance and Performance Committee at its meeting held on 20 November 2025 including assurances received and those matters which the committee wish to escalate to the Group Board.

## 2.0 Matters considered by the committee

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

Assurances in respect of Objective 1b:

a) Operational Performance Report – Planned and Unplanned Care (inc planned care trajectory)
b) Winter Plan monitoring – to inc Board Assurance Statement evidence

The Committee received the suite of performance reports which were considered together with the Committee Performance Dashboard and PRM report. The new performance dashboard was received with the Committee noting some final adjustments were required however noted the alignment with the National Oversight Framework (NOF).

Performance for LCHS was noted to be as expected and 52-week wait breaches were only present within the lymphoedema service, which were anticipated to be resolved by the end of November.

UTC performance remained high, despite a slight reduction in month and Urgent Community Response (UCR) was noted to have doubled activity with no additional cost of degradation in performance.

The Discharge to Assess (D2A) service had increased capacity however a reduction in length of stay had not been achieved within ULTH due to ongoing discharge challenges. Action had been taken to improve discharge processes however the Committee noted that this was not a sustainable

solution and key actions following the Newton diagnostic work required implementation.

ULTH performance was noted with deterioration for cancer 28-day faster diagnostic standard (FDS) however due to additional funding being received this was expected to improvement from October.

Challenges were noted to remain in diagnostic services, particularly MRI, audiology and ENT, with recognition of the national shortage of Audiologists. Achievement of the 52 and 65-week position was expected by the end of December with additional activity taking place to ensure delivery.

Urgent and Emergency Care performance was noted, which had delivered above plan in October, and further improvements noted for November. There remained persistent 12-hour waits in EDs with the Committee noting a review that was due to be undertaken to determine performance improvements.

The PRM upward report was noted with 3 care groups reported green and one noted to be in escalation with actions in place to support the position and delivery. Corporate PRMs were noted to take place on a quarterly basis.

Assurances in respect of Objective 1c:

a) Finance Report inc CIP, Capital and CRIG

The Committee noted the challenges faced in month 7 with the plan stepping up from a £0.7m deficit to a £2.1m surplus, as anticipated due to the delivery of Cost Improvement Programmes (CIP). It was noted that the ruling of the Brockenhurst VAT claim had impacted, resulting in a shortfall and increased pressure.

Recovery plans continued to be developed and delivered, with a focus on non-recurrent items to mitigate the position and support was in place via the Group Leadership Team (GLT) to understand the CIP position and impact on the forecast.

The LCHS position was reported favourable to plan with a correction noted for the IFRS16 adjustment. The month 8 position of the Group was expected to continue to be challenging, impacted in part due to industrial action and the cancellation of activity.

The capital position was noted with agreement to re-profile the Boston Community Diagnostic Centre (CDC) spend, linked to the delay in the approval of the scheme. Challenges remained for in year delivery of the Electronic Patient Record (EPR) scheme, moving spend into the 2026/27 year.

Assurances in respect of Objective 1d:

a) Estates and Facilities Update inc Martyn's Law
b) Health and Safety Committee Upward Report

Reasonable assurance was received in respect of estates and facilities with 8 high risk actions noted as remaining in respect of first safety compliance, following the Authorised Engineer (AE) audit.

Issues were noted in respect of lift maintenance with action in place to resolve current issues causing lift failures at Pilgrim Hospital. Plans were in place to address issues associated with medical gases and a number of items required addressing in respect of electricity and water safety however these were not escalating.

Significant improvements were noted for Planned Preventative Maintenance (PPM) compliance however a number of reactive jobs were noted to be impacting and adding pressure to the team.

An update was received in respect of Martyn's Law and the requirements on the Group as a result, which would come into effect in April 2027. Work was taking place to ensure that the appropriate actions were taken with the Committee noting the challenges of achieving lockdown on hospital sites and security requirements would require additional funding.

The Health and Safety Committee upward report was received with the Committee noted the completion of the material breach for confined spaces contravention. The British Safety Council (BSC) audit engagement had been confirmed for the next financial year and planning was underway to support this across the Group.

The Health and Safety Annual Report (**appended**) was received by the Committee and was recommended to the Board for approval.

Assurances in respect of other areas:

a) Board Assurance Framework 2025/26
b) Committee Performance Dashboard
c) PRM Upward Report
d) Risk Register
e) Policy Position
f) Information Governance Group Upward Report
g) Cyber Compliance Report
h) Internal Audit Recommendations

The Committee received and noted the position in respect of the risk register and policy position.

The Information Governance Group Upward report was received with the Committee noting the ULTH Data Security Protection Toolkit (DSPT) and

associated action plan had been submitted and approved by NHS England. This had resulted in the Trust being formally recorded as approaching standards.

Improvements in Subject Access Request performance continued to be achieved, despite this not yet being at the required level. The escalation associated with the Clinical Records Group was noted by the Committee with Executive action being taken due to concerns.

Increase in demand of the IG service was noted with escalation made to the Committee for awareness due to the potential risk of legal non-compliance and potential data breaches.

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

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

a) None

## 4.0 Matters for reporting / escalation to the Group Board

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

a) None

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

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

## 6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the Finance and Performance Committee;
- approve the Health and Safety Committee annual report

***Dani Cecchini, Non-Executive Director***
***20 November 2025***

NHS
Lincolnshire Community and Hospitals NHS Group

# Health & Safety Annual Report 2024-25

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Finance & Performance Committee* |
| Date of meeting | *November 2025* |
| Agenda item number | |
| Report title | *Health & Safety Annual Report 2024-25* |
| Report purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | • *Discussion*<br>• *Approval*<br>• *Assurance* |
| Accountable Director | *Group Chief Estates & Facilities Officer* |
| Author(s) | *Philippa Fitzmaurice Senior Health & Safety Manager*<br>*Andy Miles Health & Safety Manager*<br>*Mike Betts Manual Handling Advisor* |
| Assurance rating:<br>• Substantial assurance<br>• Reasonable assurance<br>• Limited or no assurance | *Reasonable Assurance* |
| Prior approval process, if applicable | *Health & Safety Committee* |
| Financial implications, if applicable | |
| Action / decision required | *The board / committee is asked to:*<br>*Consider the report for assurance* |

*Assurance Rating Key*:

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

| How the report supports the delivery of the LCHG strategic aims & objectives: | |
|---|---|
| *Patients: Better Care – Timely, affordable, high quality care in the right place:* | |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | |
| 1b: Reduce waiting times for our patients | |
| 1c: Improve productivity and deliver financial sustainability | |
| 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 | |
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| 3c: Enhance our digital, research & innovation capability | |
| 3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan | |

## Executive Summary

This purpose of this report is to provide Finance & Performance Committee members with the Health and Safety arrangements and performance for the period 1 April 2024- 31 March 2025 inclusive of business activities undertaken by the Health & Safety Team.

Lincolnshire Community Hospitals Group (LCHG) has fulfilled its duty under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Where required investigation, administration, and monitoring of outcomes for the performance period completed. There have been no external inspections made by HSE to the Trust during the reporting period.

The report set out the significant achievements made during the year in formulating our Health and Safety business objectives, to assist ward departments and Community outreach sites in achieving health and safety compliance against best practice indicators. Under the assigned elements for health & safety a detailed action plan was used setting out the actions identified, and progress made to achieve levels of assurance against assigned timelines. To note the support being provided by Health & Safety remains active with consultation and communication involving Clinical Service Teams/ Leads, Hospital and Community based.

The report sets out the provision of services to support staff through education, learning and training and most significantly through practical patient handling improving patient experience and clinical outcomes.

The report also focuses on the agreed objectives for the effective management of health and safety within the Trust for 2025-26, with an emphasis on seeking to explore and use innovative solutions to manage health and safety risks, such as Health and Safety Champions. The Group Health & Safety Strategy will form an integral part of the Group's Health and Safety Management arrangements, together with the Group Health & Safety Policy and associated documents measure improvements in health and safety practice and performance over the next five years. This will ensure that as a Group we become an increasingly safer and healthier place to work and receive care.

Health and Safety Annual Report for 2023/2024, was received by FPEC and this report has been approved by the Health & Safety Committee to proceed to the Finance & Performance Committee.

## Health and Safety Management

Management for Health and Safety within United Lincolnshire Teaching Hospitals NHS Trust (the Trust) has adopted the British Safety Councils Five Star Occupational Health and Safety Audit process. This continues to be the vehicle to ensure compliance with health and safety legislation, reduce levels of harm to staff members and limit the Trusts exposure to further regulatory activity. With a focus on continually developing health and safety management systems and culture.

Health and Safety Governance reviewed in partnership with Staff side representatives the business functions of the Trust Health & Safety Committee using the Forward Reporting Schedule. The schedule included reviewing the management and reporting structures, escalations, revised Terms of Reference for the Health and Safety Committee (HSC), site-based health and safety forums and engagement with clinical divisions. Upward escalation reports from the HSC feed up to the Group Finance & Performance Committee which the Group Chief Estates & Facilities Officer attends.

The ULTH Health and Safety Committee met on three occasions and achieved the responsibilities outlined in the Terms of Reference. Scheduled Teams' meetings provided a continuity of business, with attendance log recording 50% of members achieved the 65% attendance target. This represents an increase on the previous year's attendance.

During 2024-25 LCHS Health & Safety Committee meetings were held of which Health & Safety Management Team ULTH was present. With effect from April 2025 the LCHG Health and Safety Committee (H&SC) was formed as part of the committee alignment across the group. As part of the governance structure H&SC would report into Group Finance & Performance Committee. In terms of the sub-groups reporting into H&SC, there would be locality-based H&S groups by area covering all sites across the Group.

The specific safety subject matter groups, which feed into the HSC to provide assurances and issues for escalation, include the Fire Safety Group, Local Security Management Group and Radiation Protection Group. Specialist Estates Groups such as Confined Spaces/ Working at Height, Water Safety, Electrical Safety, Lift Safety, Ventilation and Medical Gases. All these groups are required to present escalation reports on matters of concern/ risk to the HSC from which Group Finance & Performance Committee have received quarterly health and safety upward reports.

Ongoing monitoring of completed Health & Safety Audits indicates that our target of 12.7 clinical audits, 2.8 non- clinical to be completed monthly has been achieved and in months August, January and February exceeded. The total yearly audits for Clinical, non-clinical and Pan Trust have been calculated as 249 and at the time of this report 238 of audits have been completed by the health and safety team which demonstrates a positive approach taken by managers. LCHS audits undertaken by the Health & Safety Team, data indicates compliance at 70% overall (Urgent Treatment Centres 88%, Children, Young People and Specialist Services 50%, Collaborative Community Care 55%, and Community Hospitals 89%). Representing a total of completed audits 48 at this time of this report.

Trust Health and Safety Policy due for review June 2024 received permissions from Corporate Policies to extend to 2026 at which point it would reflect the Group model and align to other Group policy documents. All existing documents were reviewed according to policy status and assigned schedule through approved consultation and approval processes. The Corporate

Policies section continues to provide staff with access to a suite of policies/ guidance on the Health & Safety Share Point site.

Datix Cloud IQ system has during 2024-25 provided access on a daily basis to the Datix Health & Safety Dashboard. Together with our generic email account the Health & Safety Team monitor incidents, near misses and Dangerous Occurrences. The data analysis spreadsheet and slide show presentation on incident type enables monthly data to be shared at Forum meetings and HSC meetings and to all staff via the Health & Safety Share point.
There was a downward trend reported in year 2024-2025, slips/ falls, trip/ falls, and Lifting/ Manual Handling. With the rolling number of incidents reported higher on Lincoln County Hospital site. It was noted that from October through to November the number of incidents peaked with an average of 42 assigned to health & safety. It is to be noted that an average percentage of incidents reported (73%) recorded no harm with less than 5% reportable under RIDDOR. Incident data has shown moving and handling remain consistent with previous year's trend but elevated at both LCH and PHB for Dec 24 citing limited staff resources, which have been recorded as a contributory factor to incidents reported for patient handling.
Datix web-based reporting system, accessed by ULTH Health and Safety Management have monitored patient/ staff incidents reported across LCHS. Of those reported 8 were RIDDOR incidents involving LCHS staff members, zero near misses and or dangerous occurrences recorded during this reporting period. It is to be noted that LCHS staff have actively engaged with the team and consequently robust summary of evidence as appropriate provided to the Health and Safety Executive (HSE).
All incidents investigated by the Health & Safety Team and those requiring reporting under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) were reported to the HSE within the guidance time limit. At the time of completing this report, no incident enquiries had been submitted by HSE. Monthly report submissions were completed and presented to Senior Management Team (Estates & Facilities) and as part of the report to Finance & Performance Committee in 2024-25.

## Background

### Health and Safety Governance

All organisations have a duty under the Health and Safety at Work etc. Act 1974 and associated regulations to ensure that they have suitable arrangements in place for the effective management of Health and Safety in compliance with regulatory requirements.
The Health & Safety Team has a Chartered Member of the Institute of Occupational Safety and Health (IOSH) as their 'Competent Person' for health and safety and at the time of completing this report will be submitting a thesis document for the award of Doctorate in Professional Practice.
The Group Board are committed to the ongoing development of a positive health and safety culture for staff patients and visitors, which is outlined Trust's Health and Safety Policy. This document aligns to the Health and Safety Executive (HSE) guide HSG65 'Managing for Health and Safety' that enables an integrated approach of developing health and safety into general good management and achieving a balance between systems and behavioural approaches.

The current Trust's Health and Safety Policies in place with ULTH & LCHS contain statements underpinned by a full range of health and safety procedures, that are reviewed and monitored will during 2025 become a Group policy document.

Health and Safety Team

During 2024/25, the Health and Safety Team achieved many personal and professional achievements including recognition for Long Service and academic qualifications.
Philippa Fitzmaurice receiving her 25-year service award from the Executive Team, Mark Taylor receiving his 10-year service badge from Andy Miles, Health & Safety Manager and Ellie Guilfoyle recognised for her 40-year service to the Trust.

Professional CPD attainments during 2024/5 have included Becky Maginess, awarded Level 3 PTTLS, Nic Oliver awarded Level 5 Diploma Leadership Training/ Management.
The Senior Manager for Health and Safety attends Estates & Facilities SMT/ FPAM meetings and delivers a monthly report on the work programmes and key issues that the Health & Safety Team are managing. The Management Team of Health and Safety are represented at other governance groups both within the clinical and non-clinical directorates.
The Health & Safety Management Team continue to provide support for staff across the Group in relation to health & safety. Under the assigned elements identified, observations and actions have been taken to mitigate the risks. These elements include.

- The health & safety reporting mechanisms in place for incidents, diseases, and dangerous occurrences.
- The management and auditing of health & safety systems to ensure compliance with Health & Safety legislation primarily through Auditing, risk assessment and investigation.
- Support in delivery to Group Fit testing there has been positive engagement from LCHG colleagues.
- The governance and management of health & safety business through communication, consultation with LCHS staff. With attendance at LCHS Health & Safety Committee meetings where detailed reports setting out the progress made to achieve levels of assurance are presented.

**Health and Safety Committee (HSC)**

During this reporting period the Health and Safety Committee Forward Reporting Schedule has provided the framework of business/ governance. This ensures that the business of the Committee remains fit for purpose and is essential to the HSG65 'Managing for Health and Safety' model.
The Fire Safety Group, Local Security Management Specialist Group and Radiation Protection Group are subject specific groups who provide related assurances and any items for escalation via the Health and Safety Committee.
Standing agenda items include reports from Estates specialist safety groups.

- Asbestos
- Confined Spaces/ Working at Height
- Ventilation
- Medical Gases
- Lift Safety
- Electrical Safety
- Water Safety

Reports received include information pertaining to Datix Cloud Incidents and Risk Register items and Clinical Governance external visits. Many of these reports are also shared with groups such Infection Prevention and monitored through SMT Estates & Facilities meetings.
The Health and Safety Committee provides assurances to the Finance & Performance Committee, concerning the performance of the Committee. This includes compliance with current legislation to facilitate a safe environment for staff, patients, visitors, and all others affected by the activities of LCHG. The Committee agreed the Health & Safety Committee (H&SC) Forward Reporting Schedule for 2024/25, with any exceptions reported to the executive groups as detailed above. The Committee met on three occasions in 2024-25; 10/04/24, 10/07/24, 23/10/24, January's meeting was not held, awaiting confirmation of the Group Health & Safety Committee. All meetings were held via Microsoft Teams.

Listed below activities/ reports received/ monitored by the group include: -

a) Health and Safety Update on business activities
b) British Safety Council Audit Five Star- recommendation post Four-Star Award.
c) Health and Safety Risk Register items
d) External Visits Register, specific to health & safety, fire, and estates
e) Policies and Procedures
f) RIDDOR incidents reported and Health & Safety investigations
g) Safety Qube Manager Audit
h) Manual Handling updates, objectives, and training
i) Quarterly Report and Incident Trends
j) Fit Testing training/ courses and policy update.
k) Manual Handling Advisors Report summary and escalations
l) Fire Safety Advisor report and associated Group Action Points summary and escalations
m) Security Management Group- Action Points summary and escalations
n) Radiation Protection Group- Action Points summary and escalations
o) Dangerous Goods Safety Advisor Report
p) Estates Safety Group reports.

Committee meetings held via Teams and Chaired by Group Chief Estates & Facilities Officer has shown improved engagement on health & safety matters with staff side and Committee members. Finance & Performance Committee continue to receive feedback from the Committee meetings in the form of an upward report presented by Group Chief Estates & Facilities Officer.

## Key achievements

Launch of SafetyQube

Commenced in April 2024, SafetyQube is an approved Operational/Occupational Health & Safety Management System, a digital management tool developed by Qubertech. SafetyQube is the software used by the Trust's Health & Safety team to manage the operational/environmental health & safety for all staff, patients, and visitors to the Trust. SafetyQube has been designed to streamline the processes for Operational/Occupational H&S Audits, making the audit process consistent across the organisation. Utilising the system for OH&S risk assessments and incident/accident/near-miss investigations. All department managers are accountable for their domain. Manager's roles and responsibilities can include but are not limited to monitoring health and safety risks and hazards in their department.

We have during 2024/25 extended the portfolio to include the community estate inclusive of and more recently to assist in the management of car parking sites and Space Management using bespoke audit templates. Establishing a dashboard system, analytics have been produced and shared with SMT, examples of which have been included later in this report.

Operational Health & Safety Risk Assessments

All wards and departments on at least an annual basis are also required to review their Operational Health & Safety Risk Assessments. These documents contain information on any general health and safety hazards and actions required by local management to control and any issues found relating to workplace compliance. These assessments recorded and monitored on the Shared U drive. Local managers are responsible for ensuring that any actions arising through a risk assessment are monitored locally until complete and thereafter reviewed to ensure systems remain in place. This governance process was acknowledged by British Safety Council as a standard of best practice and continues to evolve to ensure consistent approach has been adopted.

Health & Safety Investigations

Health & Safety Team using the SafetyQube template for Investigation of Incident, have undertaken the following investigations of note during this reporting period. These three incidents were shared with members of Trust Health & Safety Committee.

1. *Endoscopy: chemical mix PHB*. The incident involved a member of staff mixing two chemicals together outside of any instruction, information or training that was required within his role and scope of his position. Lincolnshire Fire and Rescue Service and the parent company agreed that they had never noted this incident to ever happen. The company noted that they had never had the two initial products mixed together. The incident was handled very well between the organisation and the external companies. This incident was shared

with the Decontamination meeting and forwarded up to IPC with the learning outcomes of the investigation. Working with the department they have created a new safe system of work and now no one works alone within the mixing area, and they have reflected on how they do their business and create a safer area.

2. *Split bottle of Hydrogen Peroxide GDH.* This involved the use hydrogen peroxide, and a split bottle found left in the machine by housekeeping team. The bottle was segregated and moved to a safe locked location. The health and safety team were involved as initially was reported by Datix sometime after the event so the team followed up to find out why there was a delay, and it was noted the lead ported went on annual leave which left the container in an allocated area but was not disposed of as it should have been done. The waste management providers were contacted to ensure the bottle was removed and disposed of in a correct manner. Learning lessons for the housekeeping teams, safe systems of work on the product and how the machine is used, and this has been rolled out and reiterated by the health and safety team.

3. *Health & Safety Formalin- Path Lab LCH.* This investigation came through as a request from Pathology Lab it involved their dissecting rooms and processor room and the high levels of recorded formalin vapour which was outside of acceptable levels. It was noted that the root cause was a build-up of formalin tissue, and the bins are being filled rather than emptied a regular basis. There were some human factors, and their practice was being looked at by their Department Managers, to change the bins to a sealed bin rather than open bins, replacing the bin bag more frequently due to the increased service need.

<u>Health and Safety Risk Register</u>

Progress reports on active Health and Safety risks on the Trust's Enterprise Risk system 2024/25 have been delivered at the Health and Safety Committee meetings. Where appropriate assurances have been given to the Risk Register Confirm and Challenge Group, a sub-group of the Trust Leadership Team.

At the time of drafting this report Risk items entered on to Datix Cloud IQ have undergone reviews according to their risk score status. Of note whilst the list below is specific to health & safety active risks, Estates & Facilities risks inclusive of fire, security have been reviewed by their risk leads/ owners. Active Health & Safety Risk recorded on Enterprise Risk Manager include ID 223, 348 and 368 which relate to:

**Risk ID 223**- Health & Safety Executive regulatory action from non-compliance to health & safety legislation. Training resources to deliver patient handling is not sufficient and could expose the Trust to litigation. Current risk level 12.

**Risk ID 348**- Health & Safety Executive regulatory action from non-compliance to health & safety management systems. Working in partnership with the British Safety Council, Five Star Occupational Health Audit reviews have been completed. Current risk level 6.

**Risk ID 368**- Department of Health and Social Care - enforcement for non-compliance FFP3 Resilience in the Acute setting. Trust has in place processes, systems of procurement and training for FFP3. All such elements will continue to be monitored, and evidence/ assurance provide to Trust Committees/ groups. Current risk level 4.

Policies and Procedures

The following policies and guidance documents updated and approved by the HSC are listed below. A schedule of documents has been populated for Estates & Facilities documents covering all elements relating to Fire, Security Facilities and Estates including Health & Safety. The shared drive available to Estates & Facilities staff provides a document folder with an active schedule of policies and procedures. This schedule provides a secure depository and a register of active and or in progress documents awaiting publication.

| **Policy and guidance documents** |
|---|
| Health and Safety Policy |
| Health & Safety Board Statement of Intent (separate statement signed by GCEO) |
| Health & Safety Strategy |
| Trust Health & Safety Committee Constitution and Terms of Reference |
| Trust Health & Safety Site based Forums Terms of Reference |
| Asbestos Policy |
| Control of Substances Hazardous to Health |
| Control of Substance Hazardous Health Regulations 2002 (COSHH) Policy |
| Confined Space Policy |
| Display Screen Equipment Policy |
| Lone Worker Policy |
| First Aid Guidance |
| Respiratory Protection Guidance (RPE) Fit Testing |
| Management of Health and Safety at Work |
| Manual Handling Policy and associated assessment documentation |
| New and Expectant Mothers at Work Guidance |
| Noise and Vibration Guidance |
| Personal Protective Equipment at Work Guidance |
| Reporting of Incidents, Diseases & Dangerous Occurrences (RIDDOR) Guidance |
| Respiratory Protective Equipment (RPE) Fit Testing Guidance |
| Slips and Trips in the Workplace Guidance |
| Work at Height Guidance |
| Health & Safety of Young Persons guidance and risk assessment |
| Safe Hot Water and Surface Temperature Standard Operating Procedure (SOP) |

For this reporting period a Policy Progress Group was established to monitor policy review. These meetings include the authors assigned to Estates & Facilities documents, with a key focus on the assurances assigned to the validity and therefore governance of the documents held under Estates & Facilities function. Upward reporting to Trust Board through “forward looking” of policies has been completed for 2024/25 and submitted. 2025 will see the monitoring of Group documents under health & safety ownership, and the publication of Group policies in Fire Safety, Health & Safety which at the time of this report are being drafted for consultation.

Group Health & Safety Strategy

The Health & Safety Strategy is being developed to reflect the key strategic aims and objectives that Lincolnshire Community and Hospital Group (LCHG) are collectively working towards. This strategy will support both the commitment to the Group Strategy and the Trusts 'Integrated Improvement Plan and National Staff Survey LCHSG Action Plan, which recognises the tremendous wealth of diversity in our workforce; by making improvements in quality and safety so that staff feel valued and engaged. This will lead to a sustainable safety culture and reduce the risk of health and safety incidents to staff and patients.

Five strategic goals for health and safety will include.

1. In accordance with the vision of "Caring and building a healthier future for all" the three values Compassionate | Collaborative | Innovative values show what we stand for, how we want to be known and how we behave. Keeping our staff safe at work, listen when staff raise concerns regarding risk and safety and take any necessary action.
2. Ensure demonstrable involvement by management at all levels in the development, implementation and continual improvement of the health and safety management system. Community hospitals and transitional care provide a critical role across services and system providers we will actively engage through Health & Safety Locality Groups supporting our staff to embed a proactive health and safety culture
3. Monitor safety management systems and processes recommended from the British Safety Council Five Star Audit Review Autumn 2023.
4. To progress from a dependant health and safety culture to independent health and safety culture.
5. Underpin the health and safety management system with suitable information, instruction, training, and supervision.

During 2025/26 this strategy will be shared across the group with a view to achieving formal sign off in Q4 of 2025/26.

## Key components

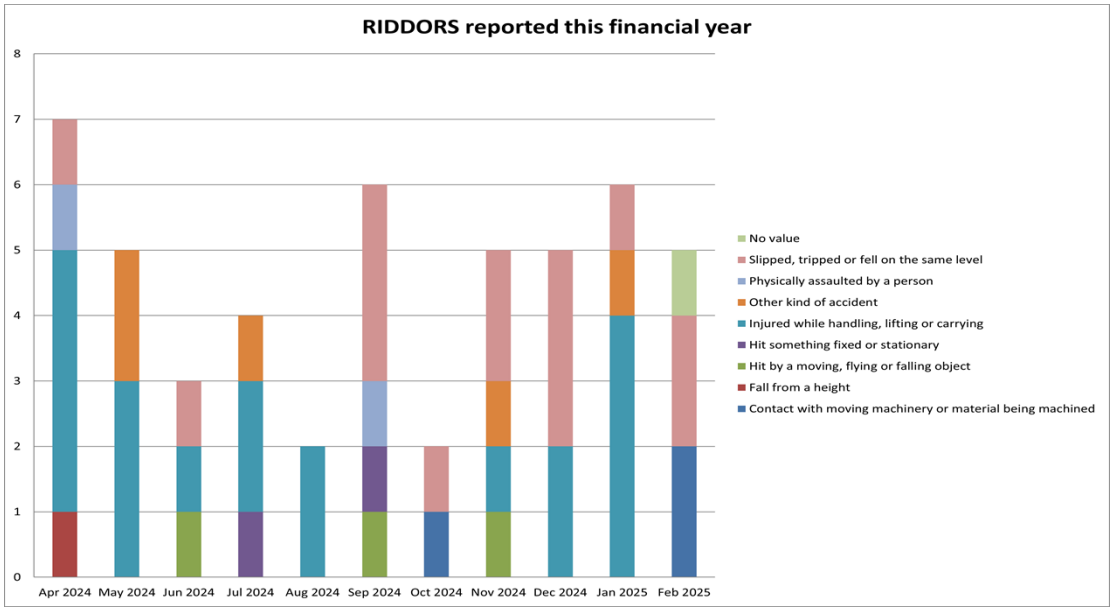
ULTH RIDDOR incidents reported for this financial year recorded on Datix Cloud.

Full Time equivalent numbers provided by Workforce Intelligence as of 5th March 2025 have been included below to illustrate the staff total across the Trust and also by sites.

| Location | Total |
|---|---|
| County Hospital Louth | 103.77 |
| Lincoln County Hospital | 5260.76 |
| Grantham Hospital | 810.97 |
| Pilgrim Hospital | 2809.97 |
| John Coupland Hospital | 9.81 |
| Beech House | 27.47 |
| Boole Aseptic Unit | 12.51 |
| Skegness Hospital | 27.59 |
| Johnson Hospital | 13.58 |
| Sleaford Children's Centre | 4.40 |
| Sleaford Medical Group | 1.00 |
| St Francis Special School | 7.79 |
| **Grand Total** | **9089.62** |

There were 48 incidents reported up to February 2025 to the Health and Safety Executive (HSE) as required by the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR).

Table 1 shows RIDDOR incidents reported/ breakdown of injury type.




Comparing this data to figures recorded for

- 2023/24 = 48 incidents
- 2022/ 23 = 42 incidents.

Quarterly Report – Incident Trends

Incidents monitored by HSC on a quarterly basis, uses the methodological approach to analyse Datix incidents / trends has continued during the reporting period.

A QSIR approach to the analysis of Datix data.

In line with the NHSE/I Quality, Service Improvement and Redesign (QSIR) framework, this methodology utilises raw data in order to better identify and quantify improvement opportunities and verify sustainable change. The number of incidents as of February 2025 set out from FY2021 have been represented below.

**NUMBER OF INCIDENTS**
**(as at Feb 2025 inc.)**

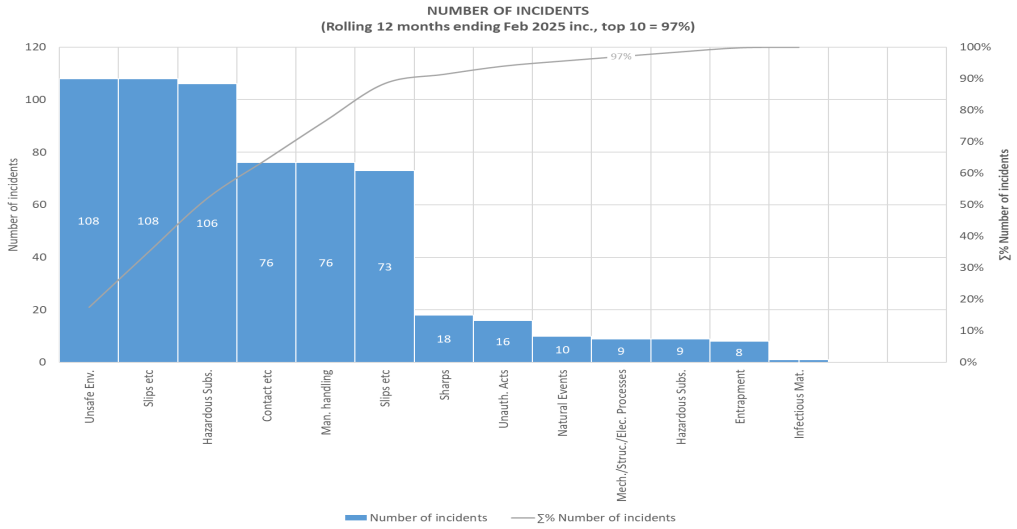
| Total | FY2021 | FY2022 | FY2023 | FY2024 | FY2025 | FY2026 | FY2027 | FY2028 | FY2029 | FY2030 | FY2031 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Falls/slips/trips (unwitnessed) | 157 | 163 | 121 | 103 | | | | | | | |
| Workplace Stressors/Demands | 156 | 140 | 39 | 0 | | | | | | | |
| Exposure to Unsafe Environmental Conditions | 148 | 148 | 216 | 92 | | | | | | | |
| Contact/Collision with Objects/Animals (not sharps) | 112 | 128 | 81 | 68 | | | | | | | |
| Contact with Sharps | 109 | 114 | 63 | 18 | | | | | | | |
| Exposure to Hazardous Substances | 99 | 103 | 90 | 98 | | | | | | | |
| Lifting/Manual handling | 97 | 101 | 103 | 67 | | | | | | | |
| *Other Categories* | *44* | *71* | *113* | *115* | | | | | | | |
| **All Categories** | **922** | **968** | **826** | **561** | | | | | | | |

| Avg per month | FY2021 | FY2022 | FY2023 | FY2024 | FY2025 | FY2026 | FY2027 | FY2028 | FY2029 | FY2030 | FY2031 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Falls/slips/trips (unwitnessed) | 13 | 14 | 11 | 10 | | | | | | | |
| Workplace Stressors/Demands | 13 | 12 | 4 | 0 | | | | | | | |
| Exposure to Unsafe Environmental Conditions | 12 | 12 | 20 | 9 | | | | | | | |
| Contact/Collision with Objects/Animals (not sharps) | 9 | 11 | 7 | 7 | | | | | | | |
| Contact with Sharps | 9 | 10 | 6 | 2 | | | | | | | |
| Exposure to Hazardous Substances | 8 | 9 | 8 | 10 | | | | | | | |
| Lifting/Manual handling | 8 | 8 | 9 | 7 | | | | | | | |
| *Other Categories* | *4* | *6* | *10* | *12* | | | | | | | |
| **All Categories** | **77** | **81** | **75** | **56** | | | | | | | |

n.b. The Incident Categories detailed cover 95% of the incidents in FY2021.

Chart 1/2-

The Pareto chart below illustrates the number of incidents by category over the last 12 rolling months (including the reporting month) and breakdown by site.



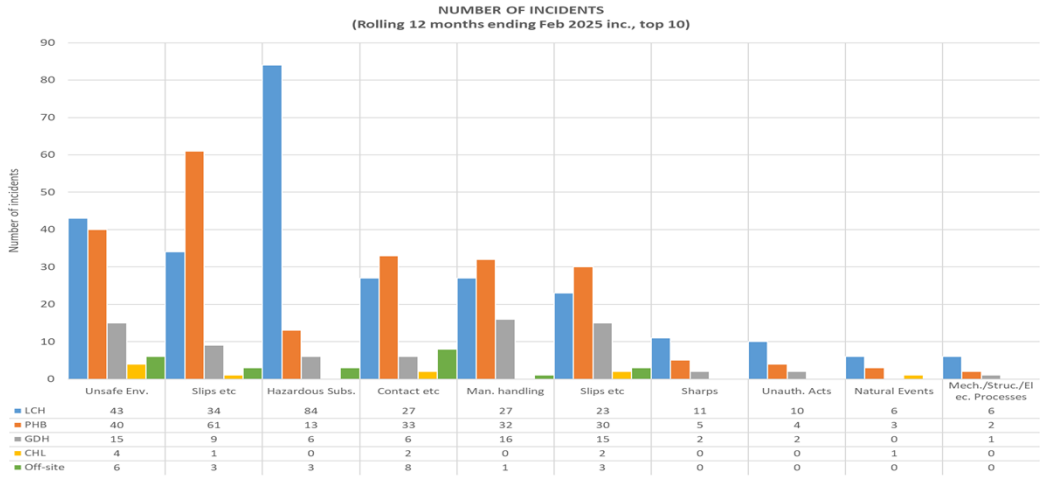




Chart 3 – All incidents – Trust wide

Although the last 6 points in the chart is averaging out we would continue to monitor the data to see whether the trend of 1 point outside of the control limit points to an downward trend in the number of incidents reported. Factors such Escalation / operational pressures, and staff resources have been cited for Jan 2024. To note June 2024 data was not reported across due to health & safety team member on annual leave.

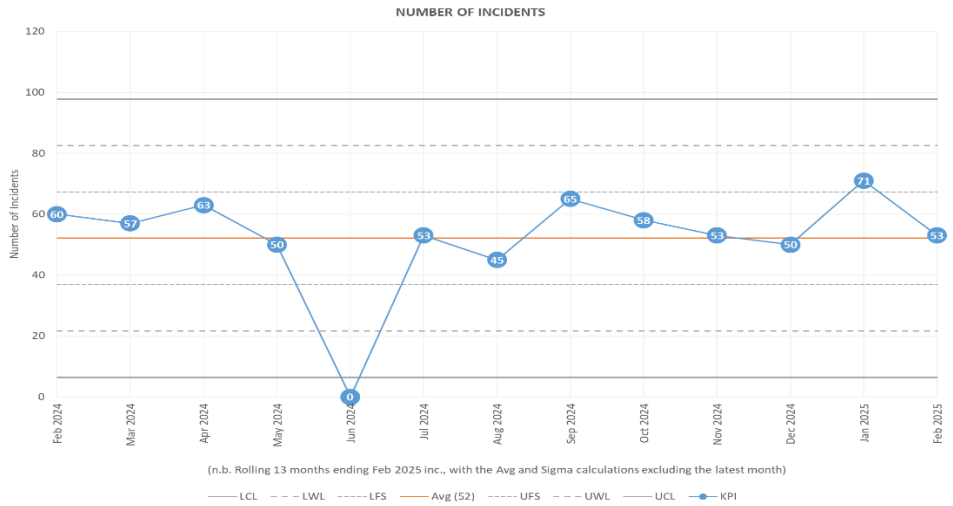
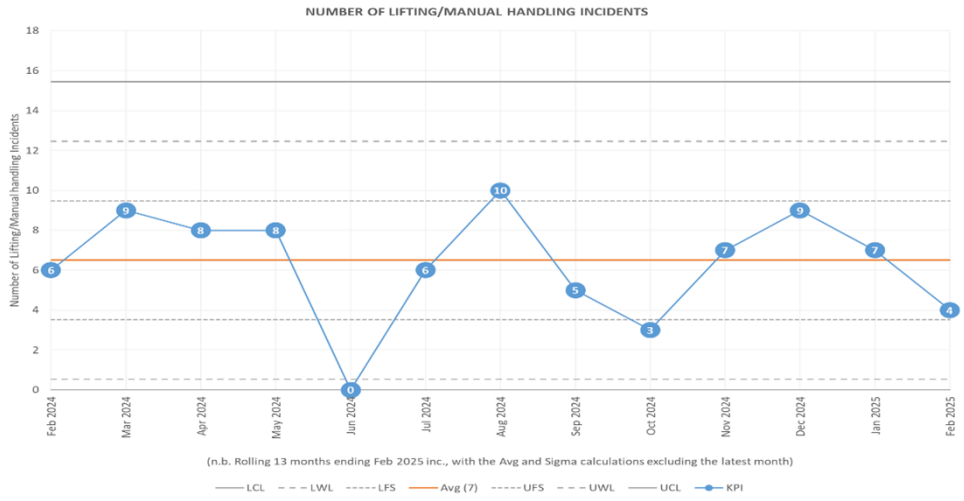



Chart 4- Lifting / manual handling incidents – Trust wide

With 1 point outside of a control limit a large shift in the process centre and/or large increase in sigma and/or special cause variation has taken place we would continue to monitor the data to see whether the trend of 6 consecutive points is decreasing, for us to conclude that we are seeing a downward trend in the number of incidents reported. To note June 2024 data was not reported across due to health & safety team member on annual leave.




Datix web LCHS incidents

With recent permissions granted a health & safety dashboard has been developed to display certain categories. Data available for the period of April 2024- January 2025 by RIDDOR incidents service & reported month.

RIDDOR Incidents by Service & Reported Month

| | Apr 2024 | May 2024 | Jun 2024 | Jul 2024 | Aug 2024 | Sep 2024 | Oct 2024 | Nov 2024 | Dec 2024 | Jan 2025 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Operations Service Centre | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 |
| Urgent Care Home Visiting | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Urgent Treatment Centre Skegness | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Boston Central Integrated Team | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Medical Devices | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Sleaford Integrated Team | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| South Lincolnshire ICT | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Total | 1 | 2 | 0 | 1 | 0 | 2 | 0 | 1 | 0 | 1 | 8 |

A breakdown of the RIDDOR incidents all to staff are as follows.

X1 Lifting inanimate load / sprain strain (workplace activity performed by staff member inventions being considered).

X1 physical assault by patient on staff (UTC) patient aggressive grabbing employee reaching over the booking desk.

X 2 falls patient property- steps/ driveway.

X 2 fall / slip LCHS premises (no environmental issues affected the outcome).

X1 fall staff motorbike on their way to LCHS site to handover a patient's blood sample during work, (no environmental issues affected outcome, employee believes it may have been a skid but lost control of his e- bike.

X 1 fall/ trip residential home on carpeted stairs (carpeted stairs employees foot caught one step awkwardly).

All incidents reported to HSE via online submission process, permission obtained for personal details and documents uploaded to Datix. No communication received by health & safety team from HSE on the incidents reported.

The next page sets out non-clinical claims received by ULTH and LCHS.

## Non-Clinical Public Liability Claims 2024 – 2025 prepared by Legal services received 31/03/2025

| ID | Description | Speciality | Incident date | Linked Incident |
|---|---|---|---|---|
| 826 | Member of staff slipped on wet floor/corridor. | Estates | 24/11/2024 | 1 |
| 824 | Needlestick injury. | ICU | 21/01/2025 | 1 |
| 815 | Claim for occupational stress and personal injury. Protection from harassment, breach of contract/negligence. | Orthopaedics | Various | 0 |
| 813 | Tripped over a box in a storeroom. | A&E | 28/06/2024 | 1 |
| 798 | Staff member was pushing a basket trolley with notes in the top basket only, up the ramp from coding to Health Records. They reached the 2nd part of ramp and the trolley caught the ramp between the level floor and start of ramp, causing it to tip violently forward. The employee was thrown forward right over the trolley landing heavily on her left hand and knees. The impact caused their shoulder to jolt where they already had a previous fracture. | Estates | 06/09/2024 | 1 |
| 724 | Housekeeper sustained an electric shock from Regen oven on ward. | Shuttleworth Ward | 21/09/2024 | 1 |
| 692 | Breach of GDPR for failing to provide medical records in an accessible format. | Corporate | 01/07/2023 | 0 |
| 674 | Returning the traction table to TH10 after cleaning, attempted to move table automatically but wasn't successful, did not work ?broken. Other ODP assisted in pushing the heavy table with me whilst trying to keep doors open, Surgeon came through doors and assisted also to try and help. Table then was pushed over my toes resulting in a a fracture of 1st and 2nd toe | Theatres | 31/10/2024 | 1 |
| 672 | Housekeeper tidying up the kitchen from the previous evening and was putting something on a shelf when a box of fresubin fell which I tried to catch and in turn it twisted my shoulder causing considerable pain and a restriction of movement. | Ward 7a | 10/12/2024 | 1 |
| 645 | Exposure to asbestos whilst working at LCH and PHB. This claim relates to a contribution request as occupiers of the premises. | Estates | 1967 - 1972 | 0 |
| 626 | Data breach by employee has caused anxiety and distress. | Oncology | 01/01/2023 | 0 |
| 579 | Data breach by employee has caused anxiety and distress. | Oncology | 01/01/2023 | 0 |
| 575 | Member of catering staff suffered a large deep laceration to her left wrist resulting in significant blood loss which required a blood transfusion. Vertical glass side panel on the fridge and as she was adjusting this the shelf, the glass panel fell down and shattered causing a shard of glass to cut her left wrist. | Catering | 08/07/2024 | 1 |
| 559 | In the high winds on Friday 23/8/24 vehicle was damaged in the at approx 9.00 am. The damage was caused by a car park barrier being blown onto car bonnet, bonnet was dented and scratched. The barrier should have been weighted sufficiently to avoid this happening. This incident could have been avoided if the barrier was weighted properly. | Estates | 23/08/2024 | 1 |

| | | | | |
|---|---|---|---|---|
| 516 | Member of staff injured by patient. Failed to provide adequate staffing levels, failed to safeguard staff on duty, failed to warn staff about vulnerable patient, failed to risk assess, failed to communicate patient was dangerous. | Neustadt-Welton Ward | 06/08/2024 | 0 |
| 444 | Tripped and fell in hospital grounds following an out patient appointment. | Estates | 24/04/2024 | 1 |
| 325 | Patient fell/tripped near Main Entrance. | Estates | 09/05/2024 | 0 |
| 255 | HCA returned to base following night shift, was walking through hospital car park to office building when tripped on a raised area of the pavement. Member of staff fell and hit shoulder, immediately got up and realised they could not move their arm. | Estates | 21/03/2024 | 1 |
| 227 | The Claimant had removed bags of clinical waste from the theatres, she was placing the bags of waste in the outdoor industrial sized bins. One of the bags had been overfilled and was heavier. As she lifted the bag with her left hand, she felt a popping sensation and pain in the left wrist. If the bags had not been overfilled, making them heavier, the claimant's incident would have been prevented. Staff are told not to overfill the clinical waste but this continues to happen. | Theatres | 06/03/2022 | 0 |

**Report highlights for ULTH**

2023-2024 total number 24 x1 patient (fall on raised paving slab)
2024-2025 total number 20 x2 patient (external environments)
To note 2024/25 these are all new claims received during the financial year, so are all open as of 31/3/25.

**Non-Clinical Claims Received 2024 – 2025 LCHS**

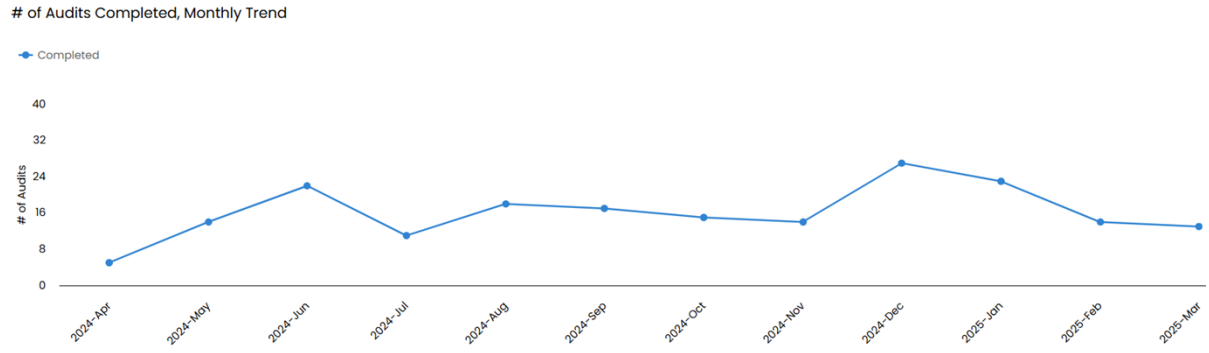
| Description | Specialty | Incident date | No. of Linked Incidents |
|---|---|---|---|
| Claimant injured when metal notice board fell onto them | Integrated Urgent & Emergency Care | 19/05/2023 | 0 |

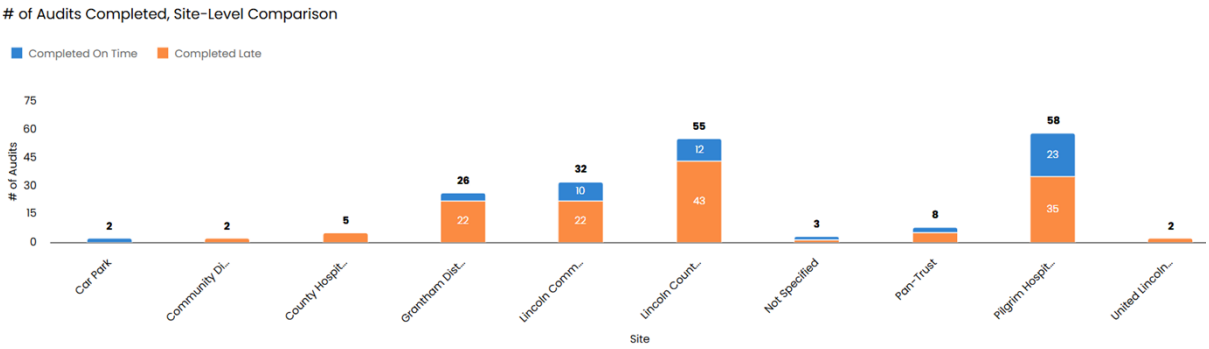
## Operational Health, Safety and Welfare Audit

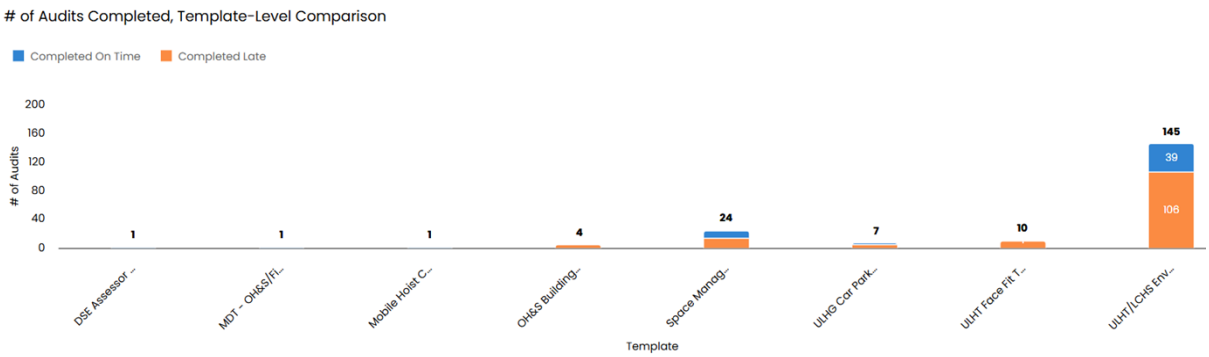
SafetyQube is the platform used by the Health & Safety Team for Group Operational Health, Safety and Welfare Audits that covers safety management, allowing staff to monitor and report on incidents and observations related to safety risk and to create bespoke risk assessments, audit, and incident investigation proformas. The Data below provides a snapshot, of the data designed to monitor the audits undertaken by the health & safety team in consultation with ward/ department leads. HSC and SMT receive an update quarterly/monthly including themes/ trends on compliance results from the audits undertaken.

Summary from Apr 2024- March 2025

| Total # of Audits Completed | Audits Completed on Time | Audits Completed Late |
|---|---|---|
| 193 | 56 | 137 |



**Control of Substances Hazardous to Health**

LCHG has a responsibility to manage safely hazardous substances used at work. A data base created on the Shared U drive provides the system of management and documentation for chemicals used. It also allows staff to search under their department for products and COSHH assessments. The Health & Safety department, with the help of department managers, has identified appropriate staff from each department to take on this role as part of the Health & Safety Audit requirements and such evidence of COSHH assessments forms part of their audit scores recorded on SafetyQube.

**Dangerous Goods Safety Advisors Audit report 2024/25**

Waste Management Consultant and DGSA (ISSL) appointed by the Trust to act as Dangerous Goods Safety Advisor completed a series of workplace audits during the month of November 2024. Key stakeholders and leads for specified areas were present and a report prepared shared for departments to consider the recommendations. The below extract from the Carriage of Dangerous Goods Annual Report March 2025 sets out the management summary and a full report was made available to members at the April's Health & Safety Committee meeting.

Trust engagement with the DGSA was very good, with staff demonstrating a commitment to ensuring the dangerous goods regulations are complied with where applicable and implementing change, as necessary. In general, the Trust has complied with its duty to consign and carry dangerous goods in accordance with the relevant provisions of the carriage regulations. However, the audit observed a number of instances where the strict requirements of ADR were not being implemented. To ensure compliance existing procedures will need to be modified or new processes introduced. It is recommended that the relevant requirements of the carriage regulations are included in written policies and SOPs as applicable.

During the current audit period the Trust has improved the processes for disposing of chemically contaminated containers being generated by the Endoscopy team. The Fleet and Logistics Team and Nuclear Medicine department continue to demonstrate a high degree of competency with well-developed processes. The Trust should prioritise the development of a security risk assessment and security plan in accordance with ADR 1.10.3.2.1. Where applicable the Trust should ensure it has arrangements in place to dispose of any Category A Clinical waste (assigned to UN3549) including a stock of appropriate packaging materials and a suitable secure storage area for each site. Staff whose duties included the carriage or consignment of dangerous goods must receive training in accordance with the requirements of Chapter 1.3 of ADR. This should include security related training in accordance with the requirements of Chapter 1.10. There have been no reportable dangerous goods incidents in the last year.

**Notification of external agency visits (including regulatory agencies e.g. CQC and HSE)**

To support improved awareness and oversight of external agency visits the Trust's Compliance Team have published a new policy for the Management of External Agency Visits, Inspections and Accreditations (Including VIP Visits). All External Agency Visits (to include those for accreditation, assurance, internal audit, inspection and peer review and including VIP visitors) should now be registered on the Trust's central External Visits Register External

Visits Register - Home (sharepoint.com). The Health and Safety Committee during 2024/25 received regular reports from the Compliance Team outlining any Fire, H&S linked visits undertaken or expected/planned.

TASK56889 FOR ACTION HSE Inspections 2023-24 of NHS Trusts / Boards on Management of Workplace Risk from MSDs and V&A.

During this reporting period the Trust received a Task Action from the Health & Safety Executive. A letter sent to for the attention of Trust Chief Executive Officers and Health and Safety Leads was to consider the findings of the report and review our operations to ensure the Trust / Board is managing these areas in compliance with our duties under health and safety law. The summary report on the Health and Safety Executive (HSE) findings relate to Managing worker risk from Violence and Aggression and Musculoskeletal Disorders in the NHS. An ELT paper has been submitted which sets out the next steps and an action plan. Based on the information contained within the HSE letter there is moderate assurance that the systems in place are fit for purpose. The actions identified to address elements recommended will be implemented, reviewed, and monitored against the outcomes assigned within the Action Plan. Reporting on progress to the Health & Safety Committee in an upward report.

**Health & Safety involvement with Capital Projects/ CDC builds and refurbishment.**

During this reporting period the Health & Safety Team have provided support/ advice relevant to the scope of works being undertaken. Particular engagement has been with the Lincolnshire Community Diagnostic Centre (CDC) Programme for Lincoln and Skegness. With commencement of key projects such as Endoscopy Lincoln, Lincoln ED phase 4 and Boston Emergency Department. Trust wide advice has been provided for road and pathways, and Mortuary.

**Manual Handling / Patient Handling**

The Manual Handling Team continue to provide a comprehensive service to the Trust although changes in staff has been unsettling.

Appointments

In May 2024, one member of the team left for a role outside of the NHS and her post was advertised and filled in October 2024. A new member of staff also joined to a vacant position in April 2025 and an existing trainer on a fixed-term contract, was changed to a substantive post in January 2025.

Matrons' Monthly reports

The Manual Handling Team have been providing the Trust's Matrons with a monthly report, since July 2023, detailing the following information:

- Training Statistics including numbers of courses offered, booked, and attended and our overall Level 2 Compliancy
- Daily hoist checks.

- Themes from training such as inappropriate equipment usage
- Manual Handling news

Hoist servicing, Repairs, replacements, and daily checks.

Hoist repairs and servicing has been an issue for quite some time and a decision was made for the Manual Handling Team to take over the management of hoist servicing and repairs, as of January 2025 with the aim of improving oversight from a manual handling compliance perspective. A Standard Operating Procedure is in the process of being written with the aim of improving the process for hoist repairs and maintenance.
At the time of writing, new Maxi Move hoists arrived on the following wards to replace hoists that are older than ten years, the generally accepted safe life span of a mobile hoist:

**Pilgrim:** Outpatients
IAC
Clinical Skills
Ward 3B
Ward 7B
X-Ray

**Grantham:** EAU
Ward 2

A Guldmann ceiling track hoist has also been fitted in the new Pilgrim ED build and two more Maxi Moves, along with a Flo Jac, have been ordered for the new build, giving them a fantastic array of equipment. Training has been arranged with Guldmann for the ED staff.

Hoists will soon be arriving at Lincoln, and go to the following wards:

**Lincoln:** Burton
Bariatric Hoist (Viking XL)
Rainforest
Shuttleworth
Stroke Unit
Neustadt Welton

In June 2023, the Manual Handling Team introduced daily hoist checks to ensure that hoists are working prior to use with a patient, and to reduce the risk of an adverse event involving hoists. Using QR Codes, we are able to monitors those checks and there has been a huge improvement across the Trust. In January, 17 wards / departments were demonstrating consistent checks (Hospice in the Hospital hitting the 100% mark) and 29 wards and departments showing significant improvements.

Training provision
The Manual Handling Team continue to provide the following training:

- Updates.
- Care Camp (Manual Handling)
- International Nurse Training (Manual Handling)
- ErgoCoach Training courses including updates and supplementary 5th day courses.

- Bespoke Level 2 Courses to meet the specific needs of some departments and bespoke equipment days.
- Emergency Handling
- Bedrail awareness (within the Level 2 courses).

Core Compliance ESR Patient Handling

Compliancy for Level 2 has reached 65.39%, an increase of 1.01% from the previous month. Whilst this is below the expected 90% to reach compliancy, compliancy has continued to improve month on month, since January 2024. The reason for the low compliancy is staffing within the team but it is hoped that once the new trainer starts and has completed his induction, more courses will be provided and the compliancy will improve, and then need to train all Nursing grades, instigated in December 2023. Between February 2024 and February 2025, 621 staff DNA'd their Level 2 Manual Handling Training.

Policy review

The following Policies in 2024 have been reviewed and published:

- Manual Handling Policy
- DSE Policy
- Bedrail Policy

A two further Policies are being drafted in readiness for consultation:

- Safer Handling of the Plus Size Person
- Safer Handling of the Falling and Fallen Person

Activities that the Manual Handling Team have achieved during 2024-25

On the 29th of October, the team ran a Bariatric Study Day in the Social Club Hall at Lincoln County Hospital. 62 learners attended from across ULTH, LCHS, LPFT, LCC, and St Barnabas Hospice. We were supported by Five Mobility and the feedback was superb.

On the 7th of February, one of the team visited the Lincoln Mosque and taught a group of ladies, led by one of the ULTH Anaesthetists, how to move and handle deceased persons, with safety and dignity, following last offices. This was hugely successful, and the Anaesthetist will show other mosques across the county, how to do the same.

The team have supported the Armed Forces Network with training for some of the military medics coming into the Trust. The team also continue to train 3rd and 4th Year Medical Students.

The Manual Handling Advisor has worked with Procurement and GBUK, an equipment provider, and by changing over to their slide sheets and lateral transfer sheets, a project that is still ongoing, we will save the Trust approximately £10k per year. The same joined up working with mean we will be provided with bariatric slide sheets at a much-reduced cost and potentially more savings on other GBUK equipment.

**Health & Safety Training**

Training continued throughout 2024-25 with face-to-face sessions scheduled for the delivery of practical skills/ competencies for health and safety. These sessions have been reviewed, and classes created on ESR for 2025/26. Senior Health & Safety Manager and Manual

Handling Advisor are members of the Mandatory Training Governance Group and provide input to new / existing programmes required by the NHS Skills Framework for mandatory subjects required for NHS staff.

| Site(s) - use the dropdown to filter by site | Month - use the dropdown to filter to different months/years back to Apr 2014 | Target | Health and Safety - 3 Years | Moving & Handling for Inanimate Load Handlers - 3 Years | *Overall Compliance %* |
|---|---|---|---|---|---|
| Trust | Apr-24 | 90% | 96.82% | 96.20% | *93.71%* |
| Trust | May-24 | 90% | 97.53% | 96.63% | *93.67%* |
| Trust | Jun-24 | 90% | 97.41% | 96.73% | *93.42%* |
| Trust | Jul-24 | 90% | 97.22% | 96.73% | *93.71%* |
| Trust | Aug-24 | 90% | 97.33% | 96.88% | *93.99%* |
| Trust | Sep-24 | 90% | 97.14% | 96.64% | *93.81%* |
| Trust | Oct-24 | 90% | 96.93% | 96.32% | *93.75%* |
| Trust | Nov-24 | 90% | 96.78% | 96.27% | *93.55%* |
| Trust | Dec-24 | 90% | 96.67% | 96.19% | *93.69%* |
| Trust | Jan-25 | 90% | 96.39% | 95.76% | *93.53%* |
| Trust | Feb-25 | 90% | 96.06% | 95.57% | *93.26%* |

| % Core Plus Compliance in ESR | From Apr 24 | 0-87% | 88-89% | 90% |
|---|---|---|---|---|

| Org L1 | 357\|LOCAL\|Health & Safety Declaration - 1 Year\| [Introduced 12 Nov 24] | 357\|LOCAL\|Patient Handling Level 2 - 3 Years\| [introduced Nov 19 - HCSWs. Dec 23 additional requirements added] |
|---|---|---|
| Apr-24 | | 54.32% |
| May-24 | | 55.70% |
| Jun-24 | | 55.58% |
| Jul-24 | | 56.42% |
| Aug-24 | | 58.50% |
| Sep-24 | | 59.57% |
| Oct-24 | | 60.24% |
| Nov-24 | 44.84% | 62.45% |
| Dec-24 | 66.93% | 63.27% |
| Jan-25 | 79.70% | 64.38% |
| Feb-25 | 84.95% | 65.39% |

During this reporting period Health & Safety Declaration was approved and since its launch in Nov 2024 whilst compliance indicates red below 87% the percentage is on trajectory towards amber.

During this period Patient Handling (Face to face training) whilst compliance indicates red below 87% significant improvement from Nov 23 and furthermore includes all nursing grades

Continuous Professional Development – Health & Safety

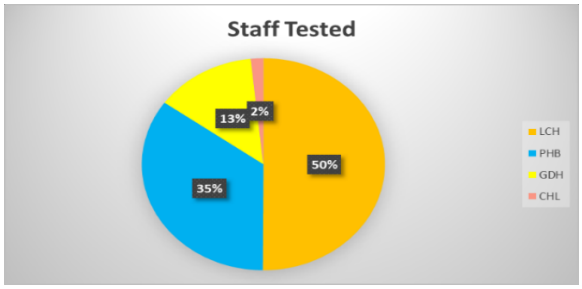
One-day course tailored for working in ULTH, approved and certified by CPD the course is focused on a comprehensive approach to health & safety and provides professional development that will enhance staffs' personal skills and knowledge. The course is a classroom-based period of training to enable learners to gain an understanding of the fundamentals of Health and Safety and the responsibilities of both employers and employees. Attendance recorded via ESR continues to be monitored and 2024/25 recorded average of 3 held per month with courses offered to LCHS as part of collaborative engagement. Funding for the CPD License has been approved for financial year 2025/26 with application for further courses approved.

Fit Testing – upskill of staff to wear RPE.

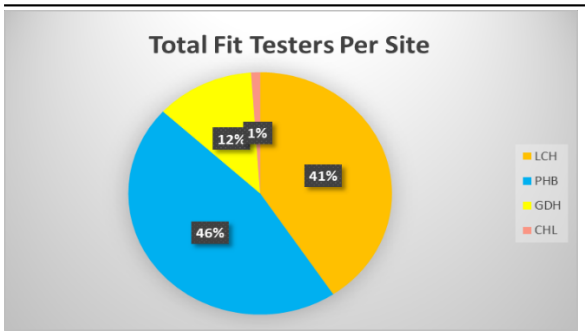
During this reporting period the Health and Safety Management Team continue to provide a proactive, robust approach to Fit Testing within the Trust to give assurance to all departments that the programme of Fit Testing all staff was going to continue. This has continued within the Group Model to support LCHS staff. As part of the ULTH Armed forces network we were

approached to support Defence Medical Staff in delivery of fit testing and patient handling training, in readiness for their secondment to the Urgent Treatment Centres.
Recorded data has been populated on to a designed spreadsheet which records accumulating totals of staff attending fit testing, inclusive of clinicians. This data does not reflect the Estates staff (Pan Trust) who require RPE as part of Job / task specific roles. Current numbers recorded are provided for upward reporting to Finance & Performance Committee, IPCG as to areas of compliance and non-compliance. A selection of data presented as pie charts have been included below.

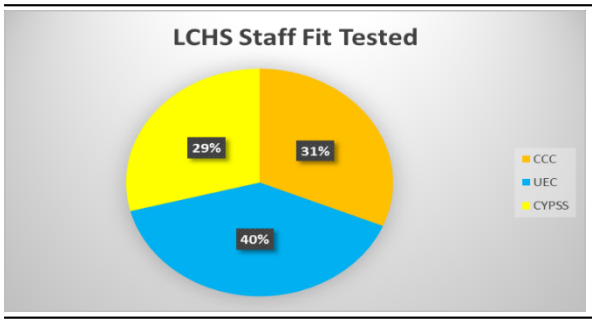
Fit Test data of Health Care Professionals from Apr 24 – February 2025




| Site | Actual Staff Tested |
|---|---|
| LCH | 990 |
| PHB | 688 |
| GDH | 266 |
| CHL | 33 |
| | 1977 |




| No of Fit Testers Per Site | |
|---|---|
| LCH | 37 |
| PHB | 42 |
| GDH | 11 |
| CHL | 1 |
| | 91 |




| LCHS Fit testing | |
|---|---|
| CCC | 29.16% |
| UEC | 37.08% |
| CYPSS | 27.11% |
| | 93.35% |

Training of Department Fit Testers

The current in post Fit Tester (Trainer) holds both Qualitative and Quantitative Fit Tester accreditation, a Certificate of learning L3 (CoL L3) and also the NEBOSH General Certificate and that enables training to be delivered to United Lincolnshire Hospital Trust staff. Staff who complete the scope of Fit Tester training in both Qualitative and Quantitative testing are accredited with a Continuous Professional Development (CPD) certificate that forms part of the Health and Safety CPD accredited deliverable courses.

## Conclusions

2024-25 the Group Health & Safety Team has seen continuing progression on many key health & safety projects during this reporting period of April 2024/ April 2025 and continue to support staff working to provide improved patient experience and clinical outcomes.

## Recommendations

This report was submitted to the Group Health & Safety Committee for consideration, approved now proceeds to the Finance & Performance Committee for assurance and information.

NHS
Lincolnshire Community and Hospitals NHS Group

# Finance and Performance Committee Upward Report

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *8.3* |

# *Finance and Performance Committee Upward Report of the meeting held on 18 December 2025*

| | |
|---|---|
| Accountable Director | *Paul Anutunes-Goncalves, Group Chief Finance Officer* |
| Presented by | *Sarah Buik, Associate Non-Executive Director* |
| Author(s) | *Karen Willey, Deputy Trust Secretary, ULTH* |
| Recommendations / decision required | *The Board is asked to:*<br>• *note the discussions and assurance received by the Finance and Performance Committee;*<br>• *approve the request for delegated authority for capital spend, increasing the approval limit to £2m for the Group Chief Finance Officer* |

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

**Board Committee Upward Report to the Group Board**

| | |
|---|---|
| **Report for meeting of the Group Board to be held on:** | 6 January 2026 |
| **Report from:** | Finance and Performance Committee |
| **Report from meeting held on:** | 18 December 2025 |
| **Quoracy requirements met:** | Yes |

## 1.0 Purpose of the report

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

## 2.0 Matters considered by the committee

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

Assurances in respect of Objective 1b:

a) Operational Performance
b) PRM Upward Report
c) Committee Performance Dashboard

The Committee received the suite of performance reports which were considered together with the National Oversight Framework (NOF) 2025/26 Q2 Segmentation, Committee Performance Dashboard and PRM report.

Following the release of the Q2 NOF the Committee noted the movement for both ULTH and LCHS with both Trusts now in segment 4. There was recognition of the work required to achieve improvements with areas of focus for ULTH being cancer performance and 52-week waits. The statistical issue previously seen with 12-hour waits had been resolved.

For LCHS it was noted that there had been a significant deterioration in the position however this was understood to be as a result of national data processing and therefore work would be required to ensure consistency of data reporting and quality.

From an operational performance perspective, the Committee noted that there had been no significant change in respect of cancer performance however improvement was expected in the November position.

Significant improvement was expected for 52-week waits in November and December with recovery plans in place. A decline in diagnostic performance was noted as a result of the focus given to long waits however a plan was being developed to recover the position.

Unscheduled care performance was noted with challenges in respect of 12-hour waits, primarily due to the delays being seen in discharge impacting on flow. Work streams for front door streaming were due to commence in January.

Community performance was noted with Urgent Community Response 2 hours and virtual beds seeing an occupancy rise, above the national 80% target. The Committee was delighted to note the clearance of all community 52-week waits.

The new style dashboard was received for month 8 with recognition of the need to continue to develop this to ensure all performance metrics were captured, alongside trajectories, with the Committee agreeing that the previous dashboards were no longer required.

Assurances in respect of Objective 1c:

a) Finance Report inc CIP, Capital, CRIG and Productivity, Improvement and Transformation Oversight Forum (PITOF) upward report (Nov)
b) Finance Strategy
c) Procurement Report to inc CIP scheme and CAR timelines

The month 8 position was noted as a £12.3m deficit, adverse to plan however was noted as the second month in a row delivering a surplus. The impact of the industrial action in November had been seen with an increase cost and a slight reduction in activity.

It was anticipated that the impact of the productivity position would be seen in full in December however a further period of industrial action was also scheduled and whilst it was hoped that cancellations would be minimal, as previously achieved, there would be an adverse impact.

The Cost Improvement Programme (CIP) was noted with the position within the surgery care group having significantly improved, however, overall there remained two key risks to CIP delivery, these being the Patient Services Hub and Medical Workforce Temporary spend reductions.

Capital was reported to be off plan with a revised trajectory for recovery with a £7.7m internal delivery risk, linked to the impact of schemes being delayed and the position moving into the 2026/27 year. As a result, there was an over commitment into the following year for capital which would require management.

Delegated authority was requested for the Group Chief Financial Officer, Group Chief Integration Officer, Group Chief Operating Officer and Group

Chief Estates and Facilities Officer, with a 2 of 4 approval to support the re-profiling and delivery of capital spend. This alongside a temporary increase in the Group Chief Financial Officer approval limit to £2m for capital expenditure, would ensure that capital funds can be fully utilised by 31 March. Retrospective approval will be taken through our governance structure for full documentation.

The Finance Strategy was received with the Committee noting the intent of the document to bring together the finance teams across the Group. This detailed and outlined the focus of the team and aligned to the Group strategy and values for delivery.

Positive CIP performance was noted from the Procurement Team with a stretch target in place of £4m, with £3.7m achieved YTD. The pipeline of schemes was noted coming forward, including those where different approaches were being considered, and post investment evaluations would be undertaken.

Assurances in respect of Objective 1d:

a) Estates and Facilities Update

The Committee received the report noting the Carbon Energy project contract had been signed and progress across the Group for Authorised Engineer Audits was positive.

Operational performance continued to be an area of concern due to the significant number of jobs being raised through the helpdesk. The review of Planned Preventative Maintenance (PPM) was noted to be on target for completion in January 2026.

The Committee considered the proposal to reduce the very high risk held in the BAF and supported this being put forward to the Board.

Assurances in respect of other areas:

a) Board Assurance Framework 2025/26
b) National Oversight Framework 2025/26 Q2 Segmentation results and NHS League tables
c) Draft Planning Submission
d) Risk Register
e) Internal Audit Recommendations
f) Policy Position
g) Topical, Legal and Regulatory Update

The Committee received and noted the position in respect of the risk register, policy position, internal audit recommendations and the topical update.

The draft planning submission had been made on the 17 December with the Committee noting this had required 3 parts, workforce, finance and

performance. The submission would be offered to the Board and it was noted that a key change was the move from block contracts to cost and volume.

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

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

a) None

## 4.0 Matters for reporting / escalation to the Group Board

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

a) None

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

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

The risk for objective 1d, initially recorded as very high, 20, was proposed to be reduced to a high, 16, due to the increased assurances being offered across the Group.

## 6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the Finance and Performance Committee;
- approve the request for delegated authority for capital spend, increasing the approval limit to £2m for the Group Chief Finance Officer

***Dani Cecchini, Non-Executive Director***
***18 December 2025***

Lincolnshire Community and Hospitals NHS Group

# First cut - LCHG Plan 26/27 Draft Planning Submission

**LCHG Board 06 January 2026**

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | Lincolnshire Community and Hospitals Group Board |
| Date of meeting | 6th January 2026 |
| Agenda item number | 8.4 |
| Report Title | First cut - LCHG Plan 26/27 Draft Planning Submission |
| Report purpose: | • Assurance |
| Accountable Director | Daren Fradgley, Deputy CEO, CIO |
| Author(s) | Sameedha Rich-Mahadkar Group Director Strategy, Improvement & Redesign<br>Jon Singfield, Group Deputy Director of Strategy & Planning<br>Paul Bulman, Deputy Group Director of Strategic Finance,<br>Paula Sargeant, Associate Director of Finance, – Financial Improvement, Planning & Investment.<br>Georgina Grace, Associate Director of Workforce<br>Shaun Caig, Associate Director of Performance |
| Assurance rating: | Reasonable assurance |
| Prior approval process, if applicable | ELT 11.12.25 |
| Financial implications, if applicable | Includes agreeing initial financial plan for 26/27 – 27/28 and outlines subsequent impact of the plan |
| Action / decision required | Board are asked to:<br>• **Note** the assumptions on which this plan is based<br>• **Note** the work and approach required to develop this plan further ahead of final submission in February 2026 |

| How the report supports delivery of the LCHG strategic aims & objectives | |
|---|---|
| **Patients: Better Care: Timely, affordable, high quality care in the right place:** | |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | |
| 1b: Reduce waiting times for our patients | X |
| 1c: Improve productivity and deliver financial sustainability | X |
| 1d: Provide modern, clean and fit for purpose care settings | |
| **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 | |
| 3c: Enhance our digital, research & innovation capability | |
| 3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan | X |

# Executive Summary

This pack sets out the Trust's latest position for the first draft plan submission to NHS England due on 17th Dec and share with ICB on 12th Dec. The submission is primarily a technical plan, comprising numerical returns on activity, performance trajectories, finance, and workforce.

National planning timescales have been accelerated and the scope extended to cover multi-year plans, significantly reducing the time available for development and creating challenges. In line with other regional providers, this first draft focuses on delivering a plan that is broadly compliant with national expectations, while highlighting areas of challenge as risk positions. Work will continue to refine these risks and identify mitigations.

A key issue for LCHG to resolve:

- While activity levels are expected to meet plan, balancing level of activity to deliver performance across care groups will be challenging.
- Financial delivery is at risk given the scale of required efficiency savings and dependency on ICB funding adjustments.

The final submission, due 12th February 2026, will require further development across the full planning period and will include a detailed narrative. It should be noted that this draft reflects ongoing internal and system-level changes; minor refinements may occur post-approval and will be signed off at Trust Board.

# Executive Summary

To support delivery: we are undertaking the following steps

| Item | Completion date* |
|---|---|
| **step1-** Revised 25/26 plan (Sept version) plus 2% productivity (our productivity gains are directed at performance / doing more work for no more cost.) | 10/12/2025 |
| **step 2-** model all the performance trajectories<br>**step 3**- compare performance trajectories vs. activity model and remodel activity on this basis | 12/10/2025<br>19/10/2025 (tbc) |
| **step 4-** Develop a costed activity plan | Early Jan (tbc) |
| **step 5**- Once activity agreed (to meet performance trajectories) use this plan to commence job planning | End of Jan (tbc) |
| **step 6-** based on CIP target, commence CIP planning with productivity (based on NHSE P&E) etc. step 6 runs in parallel with step 2 onwards | End of Jan (tbc) |
| **step 7-** rebased budgeting exercise complete | End of Jan (tbc) |
| **step 8-** Complete PITOF phasing for key programmes | End of Jan |
| **step 9-** Model key scenarios and agree 26/27 PITOF and CIP programmes | First week of Feb |

Work is already underway to strengthen productivity and efficiency and CIP plans

- 2 x Initial workshops already held with ULTH and LCHS to set out the challenge
- 6 x in person ‘boot-camps’ in process of being arranged for early Jan to flesh out opportunities into quantifiable delivery plans

*tbc as these are accelerated timescales that need to be agreed with SMEs to deliver through the planning steering group.

# Board Action Required

The Board is asked to:

- Note the assumptions on which this plan is based
- Note the work and approach required to develop this plan further ahead of final submission in February 2026

# Assurance Rating Key:

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

Lincolnshire Community and Hospitals NHS Group

# 26/27 Planning Update
Version 3

# GLT 19th Dec 2025
# Trust Board 6th Jan 2026

*Sameedha Rich-Mahadkar, Group Director Strategy, Improvement and Redesign*
*Jon Singfield, Group Deputy Director of Strategy & Planning*
*Paul Bulman, Deputy Group Director of Strategic Finance,*
*Paula Sargeant, Associate Director of Finance, – Financial Improvement, Planning & Investment.*
*Georgina Grace, Associate Director of Workforce*
*Shaun Caig, Associate Director of Performance*

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| Version control | updates |
|---|---|
| 3 (17/12/2025) | Updates include finance updates sent by PAG post ELT approval of first draft submission. Updated summary slides and next steps based on where we have landed |
| | |

# Outline

The following slides provide an overview of:

1) Key messages from Exec-to-Exec ICB Cluster meeting on 9th December.

2) Key headlines from our draft plan submission (activity/workforce/finance)

3) Outline key next steps from our second draft submission

4) Appendix 1 consists further submission details

5) Appendix 2 is a reminder of our overarching planning submission

Board are asked to:

- **Note** the assumptions on which this plan is based
- **Note** the work and approach required to develop this plan further ahead of final submission in February 2026

# External context: DLN ICB Cluster Strategic Intents

All Providers were asked to submit responses against three areas (performance, finance and workforce) which informed discussions at the **Exec-to-Exec ICB Cluster meeting on 9th December. Key Messages Below:**

- **Productivity & Elective Care**
  - Providers expected to deliver **2–2.5% productivity improvement**.
  - **Referral to Treatment-** Non- admitted: improve performance by recycling follow up capacity (~25% reduction) to close more pathways and using capacity released from reducing unnecessary first attendances (~25% reduction). **Admitted**: strengthen performance through commissioning fully productivity services, reducing EBO activity and reallocating funding from non RTT elective services
  - Moderate impact anticipated from **EBI (Evidence-Based Interventions)** reductions.
  - Focus on commissioning the **necessary volume of work** and agreeing delivery plans with providers.

- **Cancer & Diagnostics**
  - Setting **compliant trajectories** for **28-day and 62-day cancer standards**.
  - Assumption: delivery through **consistent best-practice pathways** and targeted investment where needed.
  - Diagnostics capacity remains a priority.

- **Community Services**
  - Trajectory: **78% of waits within 18 weeks by March 2027**, **80% by March 2028**.
  - Underpinned by **3% productivity improvement**.
  - Work needed to establish current productivity baseline

- **Urgent & Emergency Care (UEC)**
  - No submission on A&E standard but focus on **reducing UEC demand** and **non-elective admissions**.
  - Developing **5-year commissioning strategy** to achieve reductions in A&E admissions and overnight bed days.
  - Negotiations with providers planned **post-Christmas**.

- **Financial Planning**
  - All three ICBs to submit **break-even plans**.
  - **CIP targets**: ~5% in 2026/27, ~2% in 2027/28.
  - **Mandatory uplifts** accounted for (MHIS, NST, high-cost drugs, CHC).
  - Decisions on **distributing any remaining funds** will be subject to business case controls and balance bottom line improvement, **investing in cash releasing left shift initiatives (Gynae/MSK/ Dermatology**) and where necessary, funding additional activity to support performance (contingent on all productivity opportunities being fully maximised.
  - Providers to assume **nil growth** in first submission.
  - Ongoing work on **block deconstruction**; impact not yet reflected in December positions.

# First Submission – Where We Landed

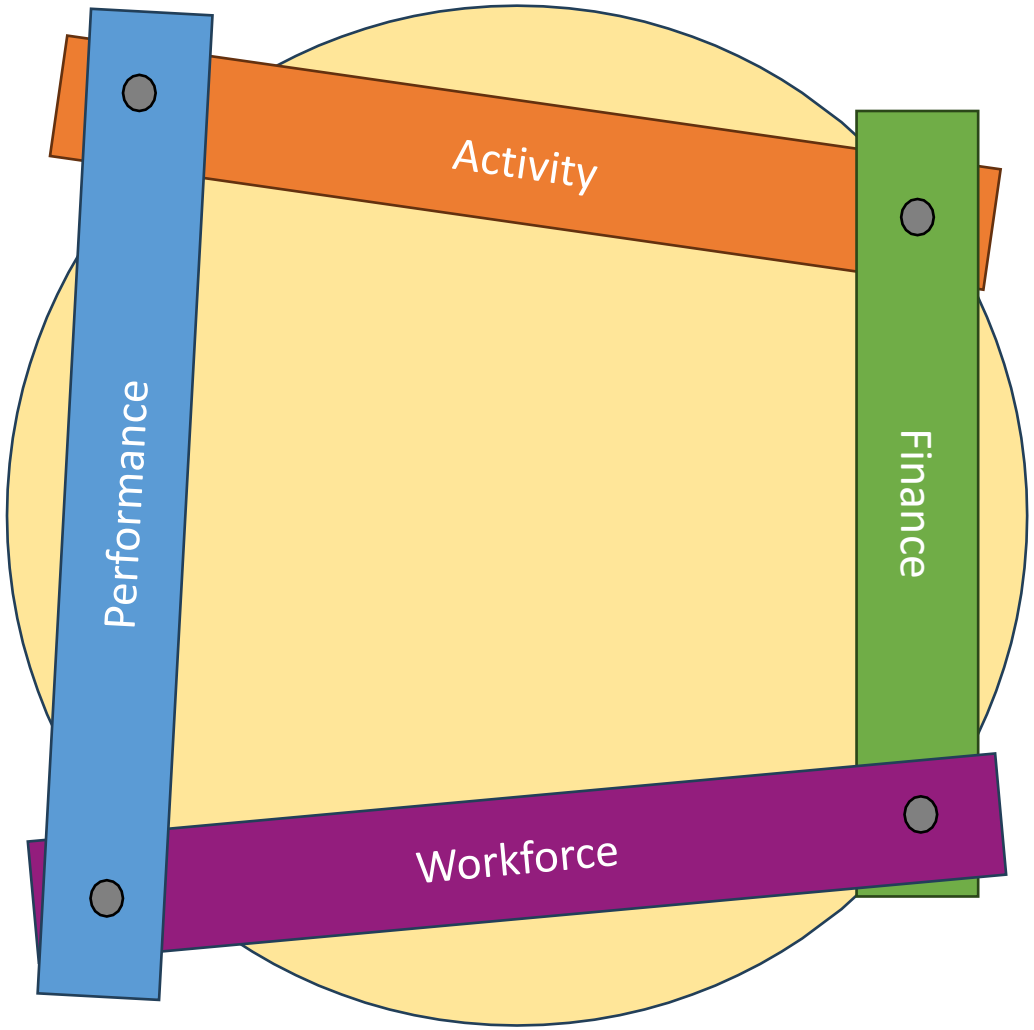
- ✓ Paper considered by ELT last week to approve position of first plan submission
- ✓ First draft plan templates successfully submitted on time on 16th & 17th December
- ✓ Submission consisted of several elements (all largely numerical):
  - Finance plan
  - Workforce plan
  - Activity plan
  - Performance trajectories
  - Triangulation and validation tool (including Board Assurance Statements)
- ✓ Broadly compliant position (i.e. meeting national expectations) achieved on paper

- ⚠ Submitted a noncompliant financial plan, whilst further modelling is undertaken and the real risks to delivery are explored and understood
- ⚠ Risks remain around all the key elements
- ⚠ Significant further work needed to improve robustness before final submission (**12th Feb**)

# Financial Reality

- Material shortfall in current position
- Submitted plan assumes deficit position for 2026/27 and 2027/28
- Achieving a CIP much greater than 6% is considered unrealistic
- Providers submitting larger CIP figures are being challenged on it
- This submission specifically excludes any impact from the activity modelling for 2026-27 and any increase in costs to meet the additional operational standards until these have been finalised. It also assumes that growth monies are received to support the impact expected from the deconstruction of the block and the differential impact across the cluster.
- A tension from national and ICB Cluster teams for plans to be both realistic and compliant
- National expectation for 2 - 2.5% productivity is in challenging against local constraints
- Work underway to strengthen productivity and efficiency and CIP plans
  - 2 x Initial workshops already held with ULTH and LCHS to set out the challenge
  - 6 x in person ‘boot-camps’ in process of being arranged for early Jan to flesh out opportunities into quantifiable delivery plans

# Trying to Square the Circle




- Four plans (activity, workforce, finance, performance) are interdependent but loosely aligned
- Relationships between them are not currently defined well enough to enable scenario modelling
- Need to strengthen the linkage to help us answer questions such as:
  - What activity levels are needed to achieve performance targets?
  - What workforce would that require?
  - How would that affect income and expenditure?
- This is our challenge between now and final submission
- It will not be perfect this year, but we can do something meaningful and work is underway
- Will require support and input from GLT members

# Our Approach

- We are currently representing our challenge in the finance plan, whilst showing a broadly compliant position across the remaining elements.
- As we work through our next submission, **we will model our required headcount reduction to meet our plan**.
- To achieve breakeven, **ULTH would require £67.0m CIP in 2026/27; LCHS faces a circa £10.7m CIP requirement**
- Due to the significant challenge the Group are currently **proposing to submit a £26.9m deficit plan in 26/27 and an £16.6m deficit plan for 27/28**. This would still include significant risk to delivery based on the levels of CIP both in full year effect and new into 26/27.
- Non-recurrent mitigations and cost pressures (e.g., EPR, service growth, inflation) compound the challenge, making credible phasing and realistic productivity assumptions essential.

a) We will need to outline expected CIP and phasing through our big productivity, transformation and improvement programmes such as:
   - Patient services hub
   - Newton work programme (Intermediate Care/Acute CTR/Integrated Neighbourhood Teams)
   - Theatres productivity

b) Consider opportunities to reduce headcount against long term vacancies

c) Consider left shift opportunities.

On the basis of the above, we will be able to estimate what % of headcount reduction we will be able to achieve, and the remainder balance will be allocated across care groups and corporate areas.

**Once we are able to model scenarios, we will need to agree the "sweetspot" of how we manage the trade-offs (e.g. what level of performance hit can we accept to offset the financial challenge? How could we reduce our workforce spend whilst minimising impact on activity etc?)**

# Next Steps

## Next Steps

- Continue negotiations and triangulation via cluster finance planning group.
- Ensure credible phasing; avoid unrealistic Q4 efficiency spikes.
- Validate planning assumptions against national guidance, model financial scenarios to confirm break-even trajectory, and prioritise workforce and productivity initiatives to close identified gaps.
- Agree Productivity & Transformation Improvement plans for 26/27 (Align Productivity & Efficiency plans with NHSE opportunities.)

| Item | Completion date |
|---|---|
| **step1-** Revised 25/26 plan (Sept version) plus 2% productivity (our productivity gains are directed at performance / doing more work for no more cost.) | 10/12/2025 |
| **step 2-** model all the performance trajectories<br>**step 3**- compare performance trajectories vs. activity model and remodel activity on this basis | 12/10/2025<br><br>19/10/2025 (tbc) |
| **step 4-** Develop a costed activity plan | Early Jan (tbc) |
| **step 5**- Once activity agreed (to meet performance trajectories) use this plan to commence job planning | End of Jan (tbc) |
| **step 6-** based on CIP target, commence CIP planning with productivity (based on NHSE P&E) etc. step 6 runs in parallel with step 2 onwards | End of Jan (tbc) |
| **step 7-** rebased budgeting exercise complete | End of Jan (tbc) |
| **step 8-** Complete PITOF phasing for key programmes | End of Jan |
| **step 9-** Model key scenarios and agree 26/27 PITOF and CIP programmes | First week of Feb |

# First Draft Submission
# Executive Summary

# Key Headlines- Activity

**For first headline submission we are submitting a compliant activity plan, based on the following assumptions and highlighting key risks**

- First submission modelled against planning assumptions:
  - Assume full delivery of the 2025/26 plan
  - **FOT (Revised 25/26 plan- sept) plus 2%** providing 26/27 activity projections
- While activity levels are expected to meet plan, balancing across care groups will be challenging:
  - The largest variance between M6 plan and actual activity is within OP 1sts
  - Both Surgery and Medicine have several specialties with significant gaps including T&O, Ophthalmology, Urology, Diabetic Medicine & Respiratory Physiology
  - Within Family Health, gynaecology also has a variance
  - Overall Elective spells are slightly down with the main area of focus being T&O.

- **LCHS activity planning**: Submitting a compliant plan for first draft submission. however, to note, additional UCR activity delivered, through closer working of CAS & Home Visit with the UCR team. Current year impact achieved in August, hence significant uplift in activity. Currently still awaiting finalisation of Community Waiting list figures around 18 week waits – 52 week waits expected to reduce to 0 ahead of start of financial year and maintain that level

- Financial delivery is at risk given the scale of required efficiency savings and dependency on ICB funding adjustments

- Further work and modelling required before final submission in February

# Key Headlines- Performance

**For first headline submission we are submitting a compliant plan, meeting nationally set performance standards in line with the required trajectories, based on the following assumptions and highlighting key risks (both for ULTH and LCHS)**

- First submission establishes a baseline position assuming all national standards will be met in line with the required timelines
- Further work and modelling will be required before final submission in February
- The performance trajectories will be used as a fixed starting point, then refining the activity numbers required to achieve these standards
- Any changes to the activity numbers will need to be reflected in the financial and workforce plans, whilst also focussing areas of priority for transformation and productivity improvements

# Key Performance Trajectories

| Statement in guidance | Planning Metric | 2026/27 Ask | 2026/27 Specific Target/ Baseline | 2026/27 Plan | Variance to target/ basline |
|---|---|---|---|---|---|
| Improve the percentage of patients waiting no longer than 18 weeks for treatment | Percentage of RTT waiting list within 18 weeks | Every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (in order to deliver national performance target of 70%) | 67.0% | 65.00% | **-2.02%** |
| Improve performance against cancer constitutional standards | 28-day cancer Faster Diagnosis Standard | Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80% | 80.0% | 80.54% | **0.54%** |
| | Percentage of patients receiving a first definitive treatment for cancer within 62 days | Every trust delivering 80% performance for 62-day standards | 80.0% | 80.00% | **0.00%** |
| | Percentage of people treated beginning first or subsequent treatment of cancer within 31 days | Every trust delivering 94% performance for 31-day standard | 94.0% | 94.29% | **0.29%** |
| Improve performance against the DM01 diagnostics 6-week wait standard | Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over | Every system delivering a minimum 3% improvement in performance or performance of 20% or better, whichever level of improvement is greater (in order to achieve national performance of no more than 14% of patients waiting over 6 weeks for a test)<br><br>Providers to agree local targets with commissioners | | | |
| 4-hour A&E performance | 4-hour A&E performance | Every trust to maintain/improve to 82% by March 2027, with no lower than 80% as an average across the year | 82.0% | 82.00% | **0.00%** |
| 12-hour A&E performance | 12-hour breaches | Higher % of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26<br><br>Plans to be assured by measuring % reduction in 12-hour breaches compared to previous year - as 2025/26 is not yet complete this tool measures 2026/27 plans against the latest 12 months to Sep-25 as a | 23,375 | 19727 | **-15.61%** |

# Key Performance Trajectories

| Statement in guidance | Planning Metric | 2026/27 Ask | 2026/27 Specific Target/ Baseline | 2026/27 Plan | Variance to target/ basline |
|---|---|---|---|---|---|
| Reduce in waiting list sizes will be expected at all trusts | Total Waiting List | Year-on-year reduction<br><br>Baseline is Mar-26 plan | 69,003 | 65288 | **-5.38%** |
| Plan ambulance services in accordance with the published ambulance service specification, reducing ambulance handover times toward the 15-minute standard | Average handover time (Total Handover time (ED and non ED)/No of handovers (ED and non-ED) | Plans to be assured by measuring year-on-year improvement in average handover time<br><br>Baseline is 2025/26 annual average<br><br>As 2025/26 is not yet complete this tool measures 2026/27 plans against the average for the latest 12 months to Sep-25 as a proxy | 00:33:56 | 00:32:28 | **- 01:28** |
| | Percentage of Handovers over 45 Minutes | No handovers over 45 minutes by Mar-27 | 0% | 7.03% | **100.00%** |
| Improve emergency department paediatric performance, with the expectation of returning to 95% over the coming months | Percentage of attendances at all type A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer for Children | Achieve minimum 95% by Sep-26 and maintain 95% or higher from that point onwards | 95% | 86.84% | **-8.16%** |

# Key Headlines- Workforce

- **Current Position**:
  - LCHG not delivering against plan; forecast shortfall of 369 FTE by Mar 2026 (income-backed schemes considered).
  - Driven mainly by ULTH substantive and bank workforce variance.

- **Contributing Factors:**
  - TUPE transfers, additional recruitment (Housekeepers/CHCSW), rotational doctors, lower turnover, fewer leavers post-MARS.Bank usage consistently above plan; tighter controls required.

- **Forward Assumptions**:
  - Recovery plans in Q3/Q4 critical to achieve balanced position by 31 Mar 2026.
  - Future plans assume delivery of 2025/26 workforce commitments.

- **Sickness:** Working towards the national ambition of 4.1% over the term of the 10 year plan (2025 - 2035) across LCHS and ULTH, with reductions planned over the next 3 years as part of planning submissions.

- **2026/27 to 2028/29 Plans** aim to operate within budgeted establishment over the next three years across LCHS and ULTH for 'Total Workforce' inclusive of substantive/bank/agency.

- Where there are planned increases in the number of staff in post, these will be primarily within staff groups that support direct clinical care and/or support to roles that do.

- **Bank and Agency Spend**: Projections remain within agreed financial envelopes, supported by strict controls and recovery plans.

- The Group commitment is to deliver the 2025/26 workforce plan within financial limits, with Q3/Q4 actions expected to achieve a balanced position by year-end.

- **Future Planning Assumptions**: For 2026/27 onward, plans assume:
  - No industrial action.
  - Continued improvement in sickness and turnover.
  - Bank and agency usage capped at budgeted establishment and below national price caps.
  - Individual Trust targets for bank and agency reductions are embedded (e.g., ULTH agency reduction of 33.15% in 2026/27, progressing to 55.56% by 2028/29).

# Key Headlines- Finance

**For the draft submission of the Financial plan due 17th December 2025, the GROUP will submit a noncompliant financial plan, whilst further modelling is undertaken and the real risks to delivery are explored and understood. This will take place between draft and final plans, ahead of the final submission in February 2026. This will not be deemed an acceptable plan for the Group by NHSE, despite the challenging 6% CIP assumption embedded in the plan.**

- Due to the complexity of changes planned to the funding mechanisms for next year and beyond, it is acknowledged that discussions/agreements will need to continue after the submission of the draft plan on the 17th Dec 2025 and there will be triangulation issues in place at the point of draft submission.

- This submission specifically excludes any impact from the activity modelling for 2026-27 and any increase in costs to meet the additional operational standards until these have been finalised. It also assumes that growth monies are received to support the impact expected from the deconstruction of the block and the differential impact across the cluster.

- A cluster finance planning group is in place to ensure that triangulation of financial plans & negotiations continue. Phasing should be credible & realistic avoiding large increases in efficiency & productivity in Q4. Productivity & Efficiency plans should be aligned to the outline opportunities shared by NHSE.

- **ULTH:**
- From the planned 2025/26 breakeven plan, an assessment has been made on the likely year end underlying position, incorporating the removal of non recurrent CIP delivery & mitigating actions, full year effect of investments and known cost pressures arising in 2025-26, which results in an underlying exit position of **£39.4m** (UDL), this is a reduction from circa £65m in 24/25

- National finance & contracting guidance, applied to the UDL and a view taken on the implications of resource allocation results in a Pre- CIP deficit of **£67.0m.**

- Post CIP at 6% (£56m inclusive of FYE from 2025-26), this results in a **£25.4m Deficit plan for 2026-27 Year 1;** and a Deficit £16.6m plan for 2027-28 Year 2.

- **LCHS:**
- From the planned 2025/26 breakeven plan, an assessment has been made on the likely year end underlying position, incorporating the removal of non recurrent CIP delivery & mitigating actions, full year effect of investments and known cost pressures arising in 2025-26, which results in an underlying exit position of **£7.3m** (UDL), this is a slightly reduction from £9m in 24/25.
-
- National finance & contracting guidance, applied to the UDL and a view taken on the implications of resource allocation results in a Pre- CIP deficit of **£10.7m**

- Post CIP at 6% (£9m inclusive of FYE from 2025-26), this results in a **£1.5m Deficit plan for 2026-27 Year 1;** and a Breakeven position for 2027-28 Year 2.

# Key Headlines- Finance

**Underlying Position Clarity**

- Current modelling indicates a **Group underlying deficit of £46.8m** exiting 2025/26, split as **ULTH £39.4m** and **LCHS £7.3m**.
- Applying national guidance and resource allocation assumptions, the **indicative pre-CIP deficit for 2026/27 is £83.8m**, subject to further negotiation with Lincolnshire ICB and cluster partners.

**Triangulation of Income and Expenditure**

- Income assumptions and commissioner expenditure plans require alignment, particularly given **block deconstruction risks** and differential impacts across cluster providers.
- ULTH faces significant exposure if the maximum 2.5% block deconstruction is applied, potentially reducing contract values by **£20.6m**, creating material negotiation challenges.

- Current figures are **indicative**, subject to triangulation and further negotiation post-draft submission (17 Dec 2025).

- **Assumptions & Exclusions:**
  - Activity modelling and cost increases for operational standards **not yet included**.
  - Assumes growth monies and ICB support for non-recurrent services continue. Ongoing discussions with Lincolnshire ICB and DLN Cluster on resource allocation.

- **Efficiency Delivery Risk**
  - To achieve breakeven, ULTH would require **£67m CIP** in 2026/27; LCHS faces a **circa £10.7m CIP requirement**, both of which are in excess of 7%, representing high delivery risk.
  - Due to the significant challenge the Group are currently proposing to submit **a £26.9m deficit plan for 26/27 and an £16.6m deficit plan for 27/28**. This would still include significant risk to delivery based on the the levels of CIP both in full year effect and new into 26/27.
  - Non-recurrent mitigations and cost pressures (e.g., EPR, service growth, inflation) compound the challenge, making credible phasing and realistic productivity assumptions essential.
  - Between draft submission and final submission, a path to breakeven will be developed

DLN Cluster Key Planning Data

| Organisation | Financial Position - (Deficit)/Surplus | | | | 2026/27 Efficiencies | | | | | | 2027/28 Efficiencies | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 26/27 Plan | 26/27 UDL | 27/28 Plan | 27/28 UDL | Gross Exp | Total | | Identified | Unidentified | | Gross Exp | Total | | Identified | Unidentified | |
| | £'m | £'m | £'m | £'m | £'m | £'m | % | £'m | £'m | % | £'m | £'m | % | £'m | £'m | % |
| Lincolnshire Community Health Services | (1.5) | (3.1) | 0.0 | (2.0) | 0.0 | 9.1 | 5.8% | 1.4 | 7.7 | 84.6% | 0.0 | 8.1 | 5.8% | 0.0 | 8.1 | 100.0% |
| United Lincolnshire Teaching Hospitals | (25.4) | (37.9) | (16.6) | (36.0) | 0.0 | 56.0 | 6.0% | 35.6 | 20.4 | 36.4% | 0.0 | 55.4 | 6.0% | 0.0 | 55.4 | 100.0% |

# Appendix 1-
# First Submission Details

# Activity Plan

# 26/27 Activity Planning - ULHT

## 26/27 Activity planning: Initial Aim, 25/26 M6 YTD position, Forecast and gap to FT plan (based on M6 SLAM)

| | 26/27 Aim | 25/26 Year Forecast | | | 25/26 YTD Position (M6) | | | | 25/26 Full Year to meet plan | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2% uplift to 25/26 plan | 25/26 FY Plan | 25/26 FOT (rolling 12mths) | Var | 25/26 YTD Plan | 25/26 YTD Actuals | Var % | Var Activity | Ave Activity per month YTD | Activity needed Per month to hit plan | Var |
| **Daycases** | **67,016** | **65,702** | **66,745** | **1,043** | **33,118** | **33,523** | **1.2%** | **405** | **5,587** | **10,950** | **- 5,363** |
| **Elective Spells** | **8,175** | **8,015** | **7,661** | **- 354** | **4,040** | **4,006** | **-0.8%** | **- 34** | **668** | **1,336** | **- 668** |
| **Outpatient Firsts - All Media** | **350,889** | **344,009** | **325,627** | **- 18,382** | **175,843** | **163,996** | **-6.7%** | **- 11,847** | **27,333** | **57,335** | **- 30,002** |
| OP 1st Non Procedure | **249,000** | **244,118** | 224,585 | - 19,533 | 125,514 | 113,492 | -9.6% | - 12,022 | 18,915 | 40,686 | - 21,771 |
| OP 1st Procedure | **101,888** | **99,890** | 101,042 | 1,152 | 50,329 | 50,504 | 0.3% | 175 | 8,417 | 16,648 | - 8,231 |
| **Outpatient Follow Ups - All Media** | **511,249** | **501,224** | **485,215** | **- 16,009** | **252,644** | **244,876** | **-3.1%** | **- 7,768** | **40,813** | **83,537** | **- 42,725** |
| OP FUP Non Procedure | **407,765** | **399,770** | 381,950 | - 17,820 | 201,510 | 192,378 | -4.5% | - 9,132 | 32,063 | 66,628 | - 34,565 |
| OP FUP Procedure | **103,483** | **101,454** | 103,265 | 1,811 | 51,134 | 52,498 | 2.7% | 1,364 | 8,750 | 16,909 | - 8,159 |

- Table shows some areas of potential challenge in meeting the 25/26 plan, which would create additional stretch for 26/27
- The largest variance between M6 plan and actual activity is within OP 1sts
- Both Surgery and Medicine have several specialties with significant gaps including T&O, Ophthalmology, Urology, Diabetic Medicine & Respiratory Physiology
- Within Family Health, gynaecology also has a variance
- Overall Elective spells are slightly down with the main area of focus being T&O.

# 2026/27 Activity Plan Projection - LCHS

| | 24/25 | 25/26 Plan | 25/26 FOT | 26/27 FOT | Increase | Increase % |
|---|---|---|---|---|---|---|
| UCR Referrals | 3,298 | 8,797 | 15,898 | 23,576 | 7,678 | 48.3% |
| Virtual Ward Admissions | 3,483 | 4,202 | 3,945 | 4,202 | 257 | 6.5% |
| Intermediate Care Admissions | 2,583 | 3,136 | 2,137 | 2,154 | 17 | 0.8% |
| Community Contacts Attended | 811,476 | 840,539 | 936,118 | 979,162 | 43,044 | 4.6% |

**Caveats/Limitations**:

- Additional UCR activity delivered, through closer working of CAS & Home Visit with the UCR team. Current year impact achieved in August, hence significant uplift in activity
- Increase in community contacts delivered through additional D2A capacity & increase to UCR referral number
- Virtual wards plan based on maintaining 172 beds with no changes to commissioning arrangements.
- Intermediate care plan based on current bed base with no changes to commissioning arrangements.
- Currently still awaiting finalisation of Community Waiting list figures around 18 week waits – 52 week waits expected to reduce to 0 ahead of start of financial year and maintain that level

# 26/27 Performance Trajectories – Key Points

**Assumptions based on meeting nationally mandated performance expectations in line with planning guidance**

- PIFU activity is 5% of total outpatient attendances
- 18 week RTT performance to improve to 65% by March 2027 and to 92% by March 2029
- Improve Cancer performance against the constitutional standards by ensuring 94% for 31 day and 80% for 62 day standards by March 2027. Additionally maintaining performance against the 31 day standard at 96% and 85% for the 62 day standard by March 2029. Performance against the 28 day cancer faster diagnosis will be maintained at the new threshold of 80%.
- Improve performance against the DM01 diagnostics 6 week waiting list standard so that 86% of patients are seen within 6 weeks by March 2027.
- Improve performance against the 4 hour metric to 82% by March 2027 and to achieve an average of 85% for the period 2027-2029
- Increase the percentage of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26.
- Within 2026/27, to improve category 2 ambulance handover times to reach an average response time of 25 minutes .

# RTT Assumptions

Draft for discussion

1. The demand was projected through the historic RTT clock start data covering the period April 2024 - July 2025.
2. The baseline capacity was projected through the historic RTT clock stop data covering the period April 2024 – July 2025.
3. The forecast was derived by multiplying last year's figures by this year's trends at the specialty level.
4. For the Scenario (with capacity from the productivity work), additional capacity in terms of new outpatients and theatre cases were considered for high-impact specialties. The productivity work included the impact of the outpatient clinic template standardisation and increased theatre session utilisation.
5. The additional capacity through the productivity work was converted into clock stops by assuming the following activity for each non-admitted and admitted pathway. The follow-up outpatient requirements were not considered.

| Pathway | OP new appts | Theatre cases |
|---|---|---|
| Non-admitted | 1 | |
| Admitted | 1 | 1 |

6. The impact of ROTT and WL validation was estimated as 10% on average of non-admitted pathways.
7. Diagnostics will not be used as a constraint for RTT pathways (only outpatients and theatre capacity will be considered).
8. The waiting list was prioritised based on <18 week waits, 18-51 weeks waits and >=52 week waits separately, where the available capacity was split into these three groups based on historic clock stops. The waiting list was then prioritised based on the profile of patients waiting by week.
9. The trajectories presented are very much dependent on the method of prioritization of patients. The method outlined in 6) above has been used across all specialties but this may vary by specialty within the Trust.
10. The trajectories have not been validated with the individual services.
11. ASIs (Allocated Slot Issues) data was also added to the model.

# RTT Trajectories for the Trust

Draft for discussion

## 1. Baseline

| KPI | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total WL size | 70,044 | 70,201 | 70,366 | 69,763 | 69,630 | 68,724 | 68,041 | 66,333 | 65,676 | 66,870 | 67,261 | 68,237 |
| <18wk WL | 37,687 | 37,988 | 38,421 | 38,051 | 37,321 | 37,455 | 38,865 | 38,157 | 37,422 | 38,681 | 38,048 | 38,174 |
| RTT perf % | 53.8% | 55.3% | 55.4% | 55.3% | 53.6% | 55.4% | 57.1% | 57.5% | 57.0% | 57.8% | 56.6% | 55.9% |
| >52wk WL | 1,775 | 1,965 | 1,805 | 1,882 | 2,012 | 2,046 | 2,067 | 2,147 | 2,340 | 2,144 | 2,542 | 2,980 |
| >52wk % | 2.5% | 2.8% | 2.6% | 2.7% | 2.9% | 3.0% | 3.0% | 3.2% | 3.6% | 3.2% | 3.8% | 4.4% |

## 2. Scenario 1 (Baseline + opportunity)

| KPI | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total WL size | 70,044 | 70,201 | 70,366 | 69,763 | 69,630 | 68,724 | 66,773 | 63,589 | 61,365 | 60,992 | 59,852 | 59,486 |
| <18wk WL | 37,687 | 37,988 | 38,421 | 38,051 | 37,321 | 37,455 | 38,712 | 37,944 | 36,952 | 37,664 | 36,408 | 35,955 |
| RTT perf % | 53.8% | 55.3% | 55.4% | 55.3% | 53.6% | 55.4% | 58.0% | 59.7% | 60.2% | 61.8% | 60.8% | 60.4% |
| >52wk WL | 1,775 | 1,965 | 1,805 | 1,882 | 2,012 | 2,046 | 1,761 | 1,638 | 1,778 | 1,701 | 2,053 | 2,391 |
| >52wk % | 2.5% | 2.8% | 2.6% | 2.7% | 2.9% | 3.0% | 2.6% | 2.6% | 2.9% | 2.8% | 3.4% | 4.0% |

Actuals Forecast

# Agreed: Scenario 2: Additional capacity with the £723K investment (Trust's proposed specialties)

Draft for discussion

Additional capacity that could be achieved with the investment have been targeted at the following specialties proposed by the Trust:

| Specialty | Extra Capacity |
|---|---|
| Neurology | 705 |
| Gynae | 633 |
| ENT | 619 |
| Audio | 356 |
| Rheumatology | 323 |
| Endo | 195 |
| MaxFax | 274 |
| Gastro | 208 |
| **Total** | **3313** |

## 1. Scenario 2 (Baseline + opportunity + extra capacity)

| KPI | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total WL size** | 70,044 | 69,950 | 69,728 | 68,955 | 69,630 | 68,724 | 66,773 | 63,589 | 58,840 | 58,466 | 57,327 | 57,111 |
| **<18wk WL** | 37,687 | 38,840 | 38,930 | 38,462 | 37,321 | 37,455 | 38,712 | 37,944 | 36,579 | 36,649 | 35,190 | 34,667 |
| **RTT perf %** | 53.8% | 55.5% | 55.8% | 55.8% | 53.6% | 55.4% | 58.0% | 59.7% | 62.2% | 62.7% | 61.4% | 60.7% |
| **>52wk WL** | 1,775 | 2,014 | 2,131 | 2,193 | 2,012 | 2,046 | 1,761 | 1,638 | 896 | 998 | 1,392 | 1,766 |
| **>52wk %** | 2.5% | 2.9% | 3.1% | 3.2% | 2.9% | 3.0% | 2.6% | 2.6% | 1.5% | 1.7% | 2.4% | 3.1% |

# Workforce Plan

# M07 > M08 > M12 WORKFORCE (LCHS > ULTH > LCHG)

| | LCHG | LCHS | ULTH |
|---|---|---|---|
| **OCT 2025 (M07) ACTUAL VARIANCE FROM PLAN** | | | |
| Total Substantive | 127.58 | 29.37 | 156.95 |
| Bank | 108.11 | 5.89 | 102.22 |
| Agency | 47.07 | 1.69 | 47.07 |
| **Total Workforce** | **186.93** | **25.17** | **212.10** |
| *Total Workforce (income backed)* | *113.84* | - | *139.01* |
| **NOV 2025 (M08) FORECAST VARIANCE FROM PLAN** | | | |
| Total Substantive | 230.10 | 12.19 | 242.29 |
| Bank | 100.91 | 9.96 | 90.95 |
| Agency | 77.35 | 2.36 | 74.79 |
| **Total Workforce** | **253.66** | **4.79** | **258.45** |
| *Total Workforce (income backed)* | *180.57* | - | *185.36* |
| **MAR 2026 (M12) FORECAST VARIANCE FROM PLAN** | | | |
| Total Substantive | 319.65 | 71.30 | 390.95 |
| Bank | 74.43 | 6.64 | 67.79 |
| Agency | 15.80 | 0.75 | 16.55 |
| **Total Workforce** | **378.28** | **63.91** | **442.19** |
| *Total Workforce (income backed)* | *305.19* | - | *369.10* |

| | |
|---|---|
| Red Text | Not delivering against plan (FTE) |
| Green Text | Delivering on or above plan (FTE) |

| CIP (665) | LCHG | LCHS | ULTH |
|---|---|---|---|
| **MAR 2026 (M12) TARGET VARIANCE** | **665.00** | **128.00** | **537.00** |
| **Total Workforce** | **245.09** | **43.64** | **288.73** |
| *Total Workforce (income backed)* | *172.00* | - | *215.64* |

- We envisage hitting our 2025/26 plan if the recovery actions that have been put in place (deferred start dates, recruitment of CHCSW, reduction in Medical & Dental temporary staffing use, recruitment of Housekeepers, although we were off plan by 305.19 FTE (taking income backed schemes into account) as at the forecast on 01 December 2025. As a group we had an ambition to deliver a 665 FTE CIP reduction, and as of 01 December 2025, we have achieved 493 FTE (taking the income backed position into account).
- The substantive position has been impacted by factors such which were not in the plan such as TUPE transfer from the ICB, additional Housekeeper/CHCSW cohort recruitment to mitigate back use and address large vacancies, the additional rotational Drs we have seen in year, reduced levels of overall turnover and less leavers following MARS. This position can be validated in terms of 'variance from plan' with additional mitigations having been put in place.
- The bank position is not delivering in line with plan and has not since the beginning of the financial year. Additional levels of grip and control have been implemented and are required for the remainder of 2025/26 to recover this position.
- The Group made a commitment to deliver its plan for Workforce within 2025/26, and on that basis the 2026/27 and beyond plans are being forecast on an assumed FOT of 'delivery of the 2025/26 workforce plan' with an assumption that the recovery plans in place within Q3/Q4 will deliver a balanced position which means that there is additional stretch required to achieve the FOT plan by 31 March 2026.

# Medium term planning guidance (workforce)

| AMBITION | REQUIREMENT | EXEC. | Success measure | 2026/27 target | 2028/29 target |
|---|---|---|---|---|---|
| **Fully implement the 10 Point Plan to improve resident doctors' working lives** | 1. Trusts should take action to improve the working environment and wellbeing of resident doctors<br>2. Resident doctors must receive work schedules and rota information in line with the Code of Practice<br>3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing<br>4. All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards.<br>5. Resident doctors should never experience payroll errors due to rotations<br>6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating<br>7. Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours<br>8. Resident doctors should receive reimbursement of course related expenses as soon as possible<br>9. Reduce the impact of rotations upon resident doctors' lives while maintaining service delivery<br>10. Minimise the practical impact upon resident doctors of having to move employers when they rotate | CMO | Reduce use of bank and agency staffing | Trusts to reduce agency and bank use in-line with individual trust limits, as set out in planning templates, working towards zero spend on agency by 2029/30 | |
| **Demonstrate progress in reducing sickness absence rates** | Providers must set out how they intend to support the 10 Year Health Plan ambition to reduce sickness absence rates to the lowest recorded national average level (approximately 4.1%) | CPO | | | |
| **Continue to reduce agency staffing usage** | Ambition to eliminate this by August 2029 | CMO & CNO | | | |
| **Implement the reformed statutory / mandatory training framework due for publication in March 2026** | Alongside a new approach to staff safety management | CPO | | | |
| **Implement the reforms to consultant job-planning** | Improve productivity and staff satisfaction (specifically, a trust-wide process for demand and capacity planning linked into service-level activity plans). Providers must:<br>• for each year, ensure that 95% of medical job plans are signed-off in line with the business cycle, underpinned by service-level demand and capacity planning<br>• by the end of 2026/27, ensure a system for monitoring and assurance is in place for tracking job planned activity<br>• by the end of 2027/28, achieve tracking of job planned activity for the full year<br>• by the end of 2028/29, ensure multiprofessional service level activity and job planning are in place | CMO | | | |

# **Sickness Absence** (Current > Ambition By 2028/29)

## ULTH

**Sickness Absence Rate (%)**

| | Sickness Absence Rate | | | |
|---|---|---|---|---|
| | Forecast Out-turn 31/03/2026 Year Ending % | Forecast Out-turn 31/03/2027 Year Ending % | Forecast Out-turn 31/03/2028 Year Ending % | Forecast Out-turn 31/03/2029 Year Ending % |
| **Total Substantive Workforce** | | | | |
| Sickness Absence Rate (%) | 5.5% | 5.2% | 5.1% | 4.9% |

## LCHS

**Sickness Absence Rate (%)**

| | Sickness Absence Rate | | | |
|---|---|---|---|---|
| | Forecast Out-turn 31/03/2026 Year Ending % | Forecast Out-turn 31/03/2027 Year Ending % | Forecast Out-turn 31/03/2028 Year Ending % | Forecast Out-turn 31/03/2029 Year Ending % |
| **Total Substantive Workforce** | | | | |
| Sickness Absence Rate (%) | 6.9% | 6.7% | 6.3% | 5.9% |

- LCHG ambition is to deliver the 4.1% sickness absence rate by 31 March 2035 in line with the 10 Year Health Plan.
- ULTH needs to reduce from 5.5% (FOT for 2025/26) which is a reduction of 1.4% overall to achieve this and the trajectory for the next three years is shown here.
- LCHS needs to reduce from 6.9% (FOT for 2025/26) which is a reduction of 2.8% overall to achieve this and the trajectory for the next three years is shown here.
- NHSE Sickness Guidance states that sickness trends between April 2013 to June 2025 show that Community Trusts to have absence between 2.5% - 6.5%, and Acute Trusts have absence rates between 1.8% - 6.2%.
- Therefore, both Providers within LCHG have significant stretch to achieve the ambition of 4.1% as they are both within the higher rates of absence trends.

# **Planning Assumptions** (Development Of 2026/27 - 2028/29 Workforce Plan)

- **No industrial action** in 2026/27.

- Continue to **improve sickness and turnover rates** as a priority to maximise available resource.

*i.* ***Sickness is a focus area****, and we* ***aim for to deliver the ambition of 4.1% sickness absence at LCHS and ULTH by 31 March 2029.***

*ii.* ***Turnover*** *–* ***no requirement to submit within Workforce Plan,*** *although expect levels to either remain as seen within 2025/26 or to reduce further.*

- **Budgeted Establishment** has been **assumed to be the same in the majority over the next 3 years** at the time of the plan, **other than** within **Nursing** (where changes due to shift pattern changes) and impact of **Boston CDC** (based on current workforce model at time of plan).

- Staff in post changes reflect the roles that have been determined as being 'exempt' from recent Executive review (eg: EPR, Health Records, Therapies, Housekeepers, CHCSW, all Medical & Dental, Porters, NQNs, Community Nurses)

- Keep **agency/bank rates below national price caps.**

- **Temporary Staffing should primarily be used only to a maximum of total budgeted establishment** , meaning it is the bridge between vacancy rate and budget. Clear levels of acceptable use by Care Group in year, and if need to **right size their workforce, take to CRIG**. If use **above establishment in a Care Group**, then this will need **to be justified with clear exit strategie**s in place (e.g.: escalation beds etc).

- **Individual Trust targets for bank and agency** have been issued and shared by ICB colleagues as below. These are **modelled i**nto the plan as **FTE % reductions.** This is an ambitious plan and is assuming that both LCHS and ULTH will deliver in line with the 2025/26 FOT plan.

| | 2026/27 | | 2027/28 | | 2028/29 | |
|---|---|---|---|---|---|---|
| | Bank | Agency | Bank | Agency | Bank | Agency |
| **LCHS** | +2.35% | -12.13% | -7.49% | -35.83% | -7.51% | -55.56% |
| **ULTH** | -9.97% | -33.15% | -9.54% | -35.72% | -9.78% | -55.56% |

# **Changes By Staff Groups** (First Submission December 2025)

| STAFF GROUP | |
|---|---|
| **ULTH Registered Nursing & Midwifery** | • Establishment +34.59 FTE because of early/late rota amendments.<br>• Staff in Post to reduce between Mar 2025 to Mar 2029 to bring in line with establishment and achieved through turnover.<br>• NQN intakes at 60 FTE per year (September) to account for continued ability to harness the relationship with the local Universities, with net impact taking turnover into account.<br>• Midwifery establishment increases by March 2025 due to Better Births and the Staff in post then increases after that in line with Business Case. |
| **ULTH Allied Health Professionals** | • Establishment changes in line with CDC plans for Boston.<br>• Staff in Post increases in line with Boston CDC plans and consider the interim use of bank when we are waiting for the newly qualified Radiographers to complete their studies (Mar 2027 to Sept 2027).<br>• AHP recruitment to be a focus over the next 3-5 years to support left shift and also the ability to deliver against the objectives within the 10 Year Health Plan. |
| **ULTH Healthcare Scientists** | • Establishment changes in line with CDC plans for Boston.<br>• Staff in Post increases in line with Boston CDC plans.<br>• Ambition to also be able to recruit to vacancies outside of the Boston CDC with targeted recruitment as temporary staffing within this staff group is costly. |
| **ULTH Support to Clinical Staff** | • Establishment changes in line with CDC plans for Boston (Support to AHPs).<br>• Staff in Post increases in line with Boston CDC plans (Support to AHPs).<br>• Continued plan to recruit through cohort recruitment for CHCSW and Housekeepers to mitigate the vacancy rate within this staff group and reduce reliance on temporary workforce. |
| **ULTH Infrastructure Support** | • EPR additional establishment and staff in post to support the further roll out within 2026/27, and then this is expected to reduce.<br>• Ambition to deliver a further reduction in line with further harmonisation of Group roles, and the ability to return to a pre-pandemic position for Admin & Clerical staff in line with previous national long-term ambitions. |
| **ULTH Medical & Dental** | • Close the vacancy gap to support reduced reliance on temporary staff.<br>• This may fluctuate by service type in year depending on service need and the level of spend on temporary staff and delivery of activity and associated productivity gains. |
| **LCHS All** | • Continue to close the vacancy gap with priority focus on clinical roles to enable deliver of left shift and care closer to home.<br>• Maintain current levels of Infrastructure staffing without growth to maintain the level of improvement that has been seen in year this year. |

# **Proposed Net Change** (First Submission December 2025)

| Summary Staff WTE Detail<br><br>ULTH | CWTE017 | CWTE018 | CWTE019 | CWTE020 |
|---|---|---|---|---|
| | Workforce | | | |
| | Forecast Out-turn 31/03/2026 Year Ending WTE | Forecast Out-turn 31/03/2027 Year Ending WTE | Forecast Out-turn 31/03/2028 Year Ending WTE | Forecast Out-turn 31/03/2029 Year Ending WTE |
| Total Establishment WTE | 9686.46 | 9827.88 | 9763.68 | 9763.38 |
| Total WTE substantive staff | 9118.17 | 9247.93 | 9300.87 | 9311.59 |
| Bank staff WTE | 398.93 | 359.16 | 324.90 | 293.12 |
| Agency staff WTE | 94.75 | 63.68 | 40.93 | 18.18 |
| Total staff WTE | 9611.85 | 9670.77 | 9666.70 | 9622.90 |

| Summary Staff WTE Detail<br><br>LCHS | CWTE017 | CWTE018 | CWTE019 | CWTE020 |
|---|---|---|---|---|
| | Workforce | | | |
| | Forecast Out-turn 31/03/2026 Year Ending WTE | Forecast Out-turn 31/03/2027 Year Ending WTE | Forecast Out-turn 31/03/2028 Year Ending WTE | Forecast Out-turn 31/03/2029 Year Ending WTE |
| Total Establishment WTE | 2118.15 | 2118.15 | 2118.15 | 2118.15 |
| Total WTE substantive staff | 1917.85 | 1950.35 | 1981.35 | 2013.52 |
| Bank staff WTE | 58.14 | 59.51 | 55.05 | 50.92 |
| Agency staff WTE | 7.57 | 6.65 | 4.27 | 1.90 |
| Total staff WTE | 1983.56 | 2016.51 | 2040.67 | 2066.33 |

# **Risks** (Development Of 2026/27 - 2028/29 Workforce Plan)

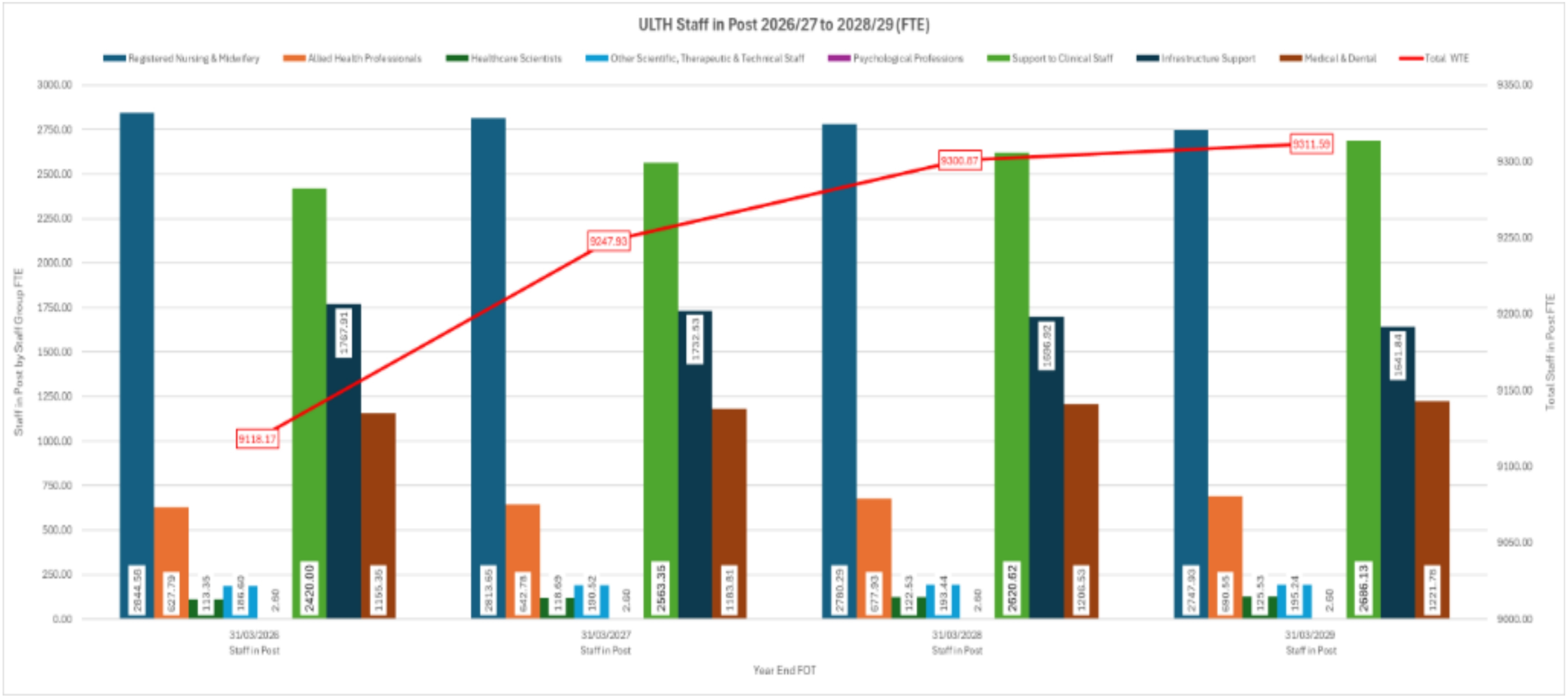
1. **That ULTH do not deliver the required level of reduction to support a balanced FOT position for the current 2025/26 workforce plan:** This would mean that there is a risk that we do not start 2026/27 from a balanced position and instead are delivering behind plan from M01 (this relates specifically to bank use, although is also relevant to the substantive position).

2. **Triangulation to Finance/Activity Plans:** Care Groups have not indicated significant changes to current workforce models over the next 2-3 years as the impact of left shift is not yet fully scoped in all areas. Therefore, the plan has been built on assumptions of current staffing levels. There will be scope to update the plans for future years as detailed submissions are developed year-on-year within the planning cycles. There is an assumption that productivity and/or increased levels of activity will be delivered through other routes (eg: job planning) rather than reduction in workforce.

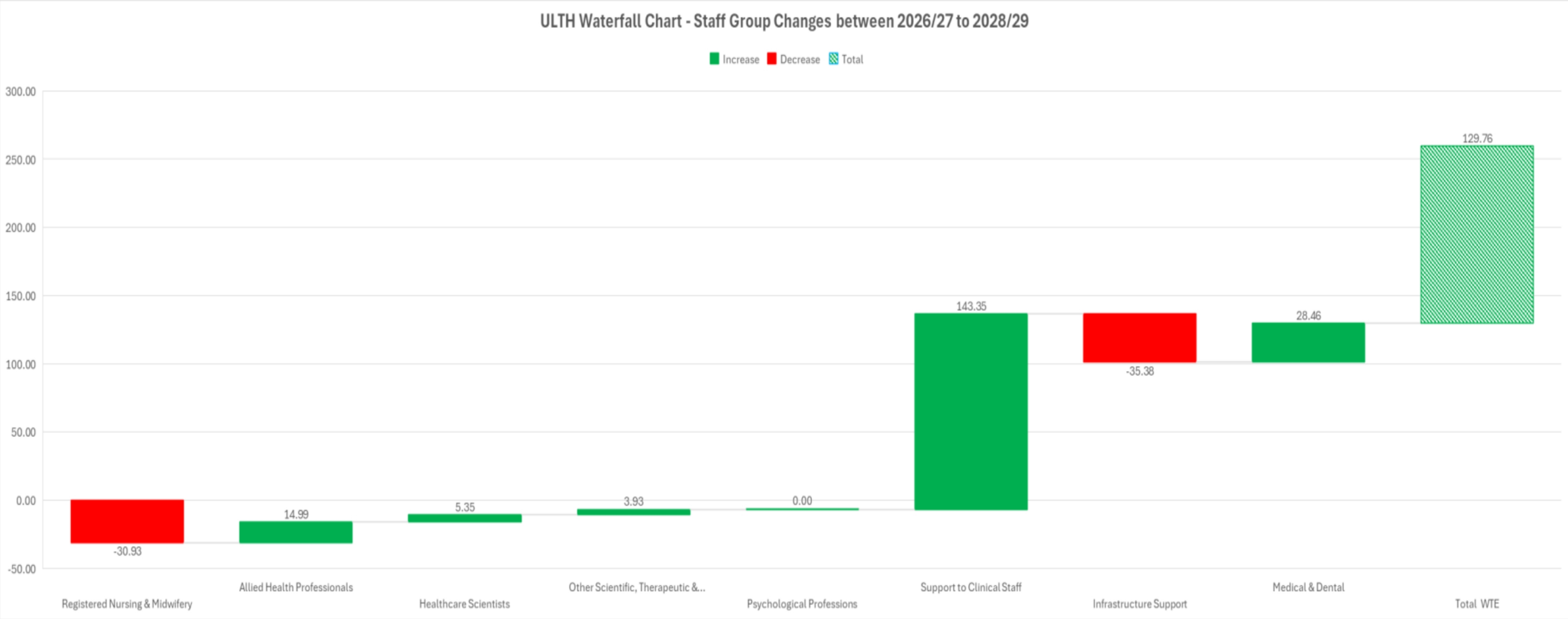
3. **Establishment for Admin & Clerical staff:** There is a continued need to review the establishment levels for Admin & Clerical following the large-scale organisational change (Patient Services Hub) to ensure that where there is scope to reduce this is actioned. This will further mitigate the vacancy position and close the gap between budgeted establishment and staff in post.

**Please note:** There may be changes between the December 2025 submission and the February 2026 as we continue to model the intentions for the next 3 years across all staff groups. This includes the impact of any vacancy control processes and any deferred start dates within Admin & Clerical roles as we deliver large scale organisational change (for example within the Patient Services Hub).

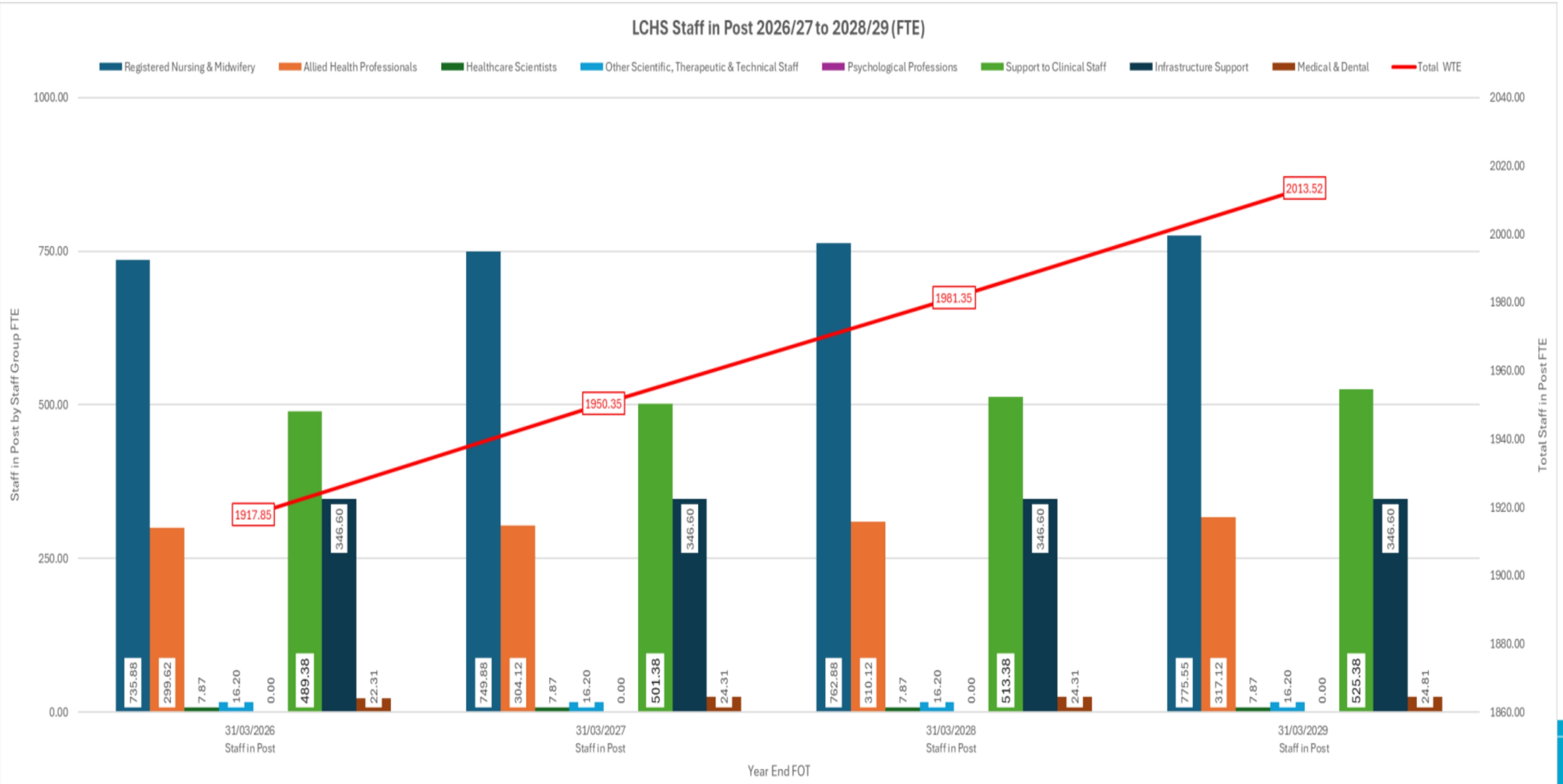
# ULTH Bridge Between 2026/27 - 2028/29 Workforce Plan



# ULTH BRIDGE BETWEEN 2026/27 - 2028/29 WORKFORCE PLAN



# LCHS BRIDGE BETWEEN 2026/27 - 2028/29 WORKFORCE PLAN



# LCHS BRIDGE BETWEEN 2026/27 - 2028/29 WORKFORCE PLAN

# Finance Plan

# Medium Term Financial Plan

**Important note:**

- As a result of conversations following the Exec Cluster Meeting, the level of CIP included in Y1 and Y2 has been reduce to match Cluster norm levels.
- In addition to this, for the draft submission it has been agreed that deconstructing the block impact will be matched by growth funding from the ICB
- The draft plan submission is not an acceptable position and work is ongoing to move to a compliant plan for final submission.

# Medium Term Financial Plan

For the draft submission of the Financial plan due 17th December 2025, the GROUP will submit a noncompliant financial plan, whilst further modelling is undertaken and the real risks to delivery are explored and understood. This will take place between draft and final plans, ahead of the final submission in February 2026. This will not be deemed an acceptable plan for the Group by NHSE, despite the challenging 6% CIP assumption embedded in the plan.

Discussions are ongoing with both Lincolnshire ICB and with the DLN Cluster on the approach to resource allocation, as the guidance outlines some significant changes and challenges to those seen in previous years. The impact of these changes will impact providers across the cluster on a differential basis.

Due to the complexity of changes planned to the funding mechanisms for next year and beyond, it is acknowledged that discussions/agreements will need to continue after the submission of the draft plan on the 17th Dec 2025 and there will be triangulation issues in place at the point of draft submission.

This submission specifically excludes any impact from the activity modelling for 2026-27 and any increase in costs to meet the additional operational standards until these have been finalised. It also assumes that growth monies are received to support the impact expected from the deconstruction of the block and the differential impact across the cluster.

A cluster finance planning group is in place to ensure that triangulation of financial plans & negotiations continue. Phasing should be credible & realistic avoiding large increases in efficiency & productivity in Q4. Productivity & Efficiency plans should be aligned to the outline opportunities shared by NHSE.

Key Risks to delivery and options available to close the gap are outlined in the following slides.

**ULTH:**
From the planned 2025/26 breakeven plan, an assessment has been made on the likely year end underlying position, incorporating the removal of non recurrent CIP delivery & mitigating actions, full year effect of investments and known cost pressures arising in 2025-26, which results in an underlying exit position of **£39.4m** (UDL), this is a reduction from circa £65m in 24/25.

National finance & contracting guidance, applied to the UDL and a view taken on the implications of resource allocation results in a Pre- CIP deficit of **£67.0m.**

Post CIP at 6% (£56m inclusive of FYE from 2025-26), this results in a **£25.4m Deficit plan for 2026-27 Year 1;** and a Deficit £16.6m plan for 2027-28 Year 2.

**LCHS:**
From the planned 2025/26 breakeven plan, an assessment has been made on the likely year end underlying position, incorporating the removal of non recurrent CIP delivery & mitigating actions, full year effect of investments and known cost pressures arising in 2025-26, which results in an underlying exit position of **£7.3m** (UDL), this is a slightly reduction from £9m in 24/25.

National finance & contracting guidance, applied to the UDL and a view taken on the implications of resource allocation results in a Pre- CIP deficit of **£10.7m**

Post CIP at 6% (£9m inclusive of FYE from 2025-26), this results in a **£1.5m Deficit plan for 2026-27 Year 1;** and a Breakeven position for 2027-28 Year 2.

# Medium Term Financial Plan:

DLN Cluster Key Planning Data

| Organisation | Financial Position - (Deficit)/Surplus | | | | 2026/27 Efficiencies | | | | | | 2027/28 Efficiencies | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 26/27 Plan | 26/27 UDL | 27/28 Plan | 27/28 UDL | Gross Exp | Total | | Identified | Unidentified | | Gross Exp | Total | | Identified | Unidentified | |
| | £'m | £'m | £'m | £'m | £'m | £'m | % | £'m | £'m | % | £'m | £'m | % | £'m | £'m | % |
| Lincolnshire Community Health Services | (1.5) | (3.1) | 0.0 | (2.0) | 0.0 | 9.1 | 5.8% | 1.4 | 7.7 | 84.6% | 0.0 | 8.1 | 5.8% | 0.0 | 8.1 | 100.0% |
| United Lincolnshire Teaching Hospitals | (25.4) | (37.9) | (16.6) | (36.0) | 0.0 | 56.0 | 6.0% | 35.6 | 20.4 | 36.4% | 0.0 | 55.4 | 6.0% | 0.0 | 55.4 | 100.0% |

- The above represents the proposed Draft plan submissions for 2026/27 and 2027/28.
- This is based on current modelling and does not meet the required breakeven plan for each year but still represents a significant efficiency challenge in both organisations.
- Within the £25.4m deficit plan for ULTH, there remains £7.7m of income risk where funding has not been confirmed by the ICB / NHSE. To note, this is in addition to the risk inherent from the guidance for the application of deconstructing the block.

Following discussions & negotiations with the ICB there remains an Income Risk of £7.7m. This will remain a disconnect with the ICB / NHSE for draft submission and covers 3 key areas:

- **CDC Support (£2.4m)** – Funded as a top up in 2025-26 by NHSE, not yet confirmed in current allocations. Lincs ICB raising cost pressure with NHSE on behalf of the trust.
- **EPR – (£3.5m)** Financial system support not agreed despite being agreed at the point that the business was approved. This is a phasing issue of cost pressures in year 2 and 3 of the implementation stage. Lincolnshire ICS partners all signed the required 'Letter of Support' as part of the ePR Full Business Case approval process.
- **SDF (EMCA) (£1.7m**) – Funding assumed for ongoing schemes which have been funded non recurrently. Work ongoing to understand the implications as some posts have been substantively recruited to. Change in agreement following cluster approach to not fund posts from EMCA allocations.

# Medium Term Financial Plan: High level

## ULTH:

High level movement

YEAR 1

| 2025-26 | |
|---|---|
| ULHT Plan | 0.000 |
| Current Year End Forecast 2025/26 | 0.000 |
| 2025-26 ULHT Underlying FOT position | -39.440 |
| Impact of Guidance | -18.858 |
| Known 2026/27 Cost Pressures | -8.727 |
| Total 2026-27 Plan (Pre CIP) | -67.025 |
| CIP @ 6% | 41.600 |
| 2026/27Draft Plan | -25.425 |

YEAR 2

| | |
|---|---|
| 2026/27Draft Plan | -25.425 |
| 2026-27 ULTH Underlying FOT position | -37.891 |
| Impact of Guidance | -17.505 |
| Known 2026/27 Cost Pressures | -6.311 |
| Total 2027/28 Plan (Pre CIP) | -61.707 |
| CIP @ 5.8% | 45.082 |
| 2027/28 Draft Plan | -16.625 |

- **ULTH is forecasting a £25.45m deficit at the end of Year 1 and a £16.6m deficit by the end of Year 2.**
- To achieve this the CIP challenge is 6% in each year, made up of:
  - Year 1 - £41.6m New and £14.4m FYE from 2025-26; **TOTAL £56.0m**.
  - Year 2 - £45.1m New and £10.3m FYE from 2026-27; **TOTAL £55.6m**.
- Following discussions with the cluster, the growth has been assumed to offset the impact from the applications of the deconstructing the block guidance.
- A £7.7m Income disconnect current exists in the triangulation of plans. If this income is not confirmed between draft & final submissions, this could deteriorate the deficit further in year 1.

## LCHS:

High level movement

YEAR 1

| 2025-26 LCHS Plan | 0.000 |
|---|---|
| Current Year End Forecast 2025/26 | 0.000 |
| 2025-26 LCHS Underlying FOT position | -7.343 |
| Impact of Guidance | -3.249 |
| Known 2026/27 Cost Pressures | -0.059 |
| Total 2026/27 Plan (Pre CIP) | -10.651 |
| CIP @ 5.8% | 9.124 |
| 2026/27Draft Plan | -1.527 |

YEAR 2

| 2026/27Draft Plan | -1.527 |
|---|---|
| 2026-27 LCHS Underlying FOT position | -3.100 |
| Impact of Guidance | -3.070 |
| Known 2026/27 Cost Pressures | -1.961 |
| Total 2027/28 Plan (Pre CIP) | -8.131 |
| CIP @ 5.8% | 8.131 |
| 2027/28 Draft Plan | 0.000 |

- **LCHS is forecasting a £1.5m deficit at the end of Year 1 and a Breakeven plan by the end of Year 2.**
- **To achieve this the CIP challenge is £9m in year 1 and £8.1m in year 2**.
- The exit underlying position from 2025-26 is £7.3m, inclusive of Cost Pressure Services totalling £1.9m and a CIP risk of £0.6m
- Non recurrent funding of £1.4m is assumed to be made recurrent by the ICB.
- No growth is currently assumed in the LCHS proposed plan.
- The ability of LCHS to make the level of savings required in next year to deliver a breakeven plan is a significant risk, given all the left shift work ongoing and the planned direction of travel.

# Appendix 2:

# Overall Planning Approach

# Overall Planning Process

**3 key workstreams to develop plans over the next weeks**

**1. Care Group 5-year integrated delivery plan development**

(light touch)

- Strategy & Planning team meet with Care Group Leadership Teams to develop and co create this (building on workshop 1 discussions)

**2. Task and Finish Groups at CBU level**

- SME from activity/finance/workforce with core CBU leads
- Review data packs on opportunities to inform productivity/improvement and left shift

**3. Three year numerical plan submission (ops/workforce/finance/capital/revenue)**

- SME from activity/finance/workforce/capital working through the technical planning meetings and Planning Steering Group

**Submission of first draft plan by 12th December**

# Medium Term Planning Headlines

- **Overall Position:**
  - Confidence that by the first planning submission LCHG will be in a position to meet the planning requirements
    - Likely status: Emerging triangulated plan with narrative. (revised 25/26 activity plan + 2% productivity)
  - Confidence that by the final planning submission LCHG will be in a position to meet the planning requirements
    - Likely status: Fully developed triangulated plan with narrative at a Group level, however ensuring the Care Group view is built in remains a concern given the timescales to meet ICB and NHSE requests.

- In excess of 30 CBU level task and finish group meetings / mop up sessions have taken place across LCHG, with each meeting discussions being captured including action points.

- Approval meetings are planned with each Care Group Leadership team to sign off the 5 year plan (Narrative) and the numerical plans for 26/27, 27/28 & 28/29 – taking place WC 24*th* November

- Discussions ongoing to agree appropriate specialty level plans that provide an overall compliant position. Intention for first submission is to describe any outstanding areas of concern as clearly identified risks

- Productivity and CIP plans under development based on opportunity packs with intention to prioritise transformation support to the areas of greatest opportunity

- Longer term narrative (not required until second submission in Mid Feb) progressing well and helping to frame the technical planning elements

# 2026/27 Planning Governance Timeline

| Month | Date | Activity | ICB timeline |
|---|---|---|---|
| **Oct 2025** | 27th – 31st | Development of data and KLOE for Task and Finish Groups | |
| **Nov 2025** | 6th | ELT: Planning Assumptions and Medium Term Planning Framework Overview papers | |
| | 7th | GLT: Planning Assumptions and Opportunities Discussion | |
| | 6th – 28th | Care Group Leadership Meetings to develop 5 year narrative | |
| | 10th – 24th | Task and Finish Groups with CBUs | |
| | 26th - 28th | Care Group Leadership Team Sign Off | ICB and Providers to share key data (high level) from FIRST plans (unapproved) |
| **Dec 2025** | 1st | Planning Steering Group review consolidated position | |
| | 5th | GLT: First Submission | Provider and ICB Executive sessions to review FIRST plans and agree refinements |
| | 11th | ELT: First Submission | Provider and ICB refine FIRST plans and secure approval from respective Boards |
| | **12th** | **Providers and ICB share full suite of FIRST plans (approved) for alignment checks.** | |
| | 15-16th | | DLN Triangulation and Testing activity to conduct final alignment checks and resolve non-material issues of FIRST plans (approved) |
| | **17th** | **First Approved Submission to NHSE** | |
| **Jan 2026** | 15th / 16th Jan | ELT / GLT Update | |
| | 20th | Board Development Session – draft final submission | |
| **Feb 2026** | First week | Board – Final submission | |
| | 5th | ELT: Final Submission | |
| | 6th | GLT: Final Submission | |
| | 6th Approx | DLN - Final Submission Approval and Board Assurance Statements | |
| | **12th** | **Final Submission to NHSE** | |

NHS
Lincolnshire Community and Hospitals NHS Group

# People Committee Upward Report

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *9.1* |

# *People Committee Upward Report of the meeting held on 11 November 2025*

| | |
|---|---|
| Accountable Director | *Claire Low, Group Chief People Officer* |
| Presented by | *Vicki Wells, Non-Executive Director* |
| Author(s) | *Karen Willey, Deputy Trust Secretary, ULTH* |
| Recommendations / decision required | *The Group Board is asked to:*<br>• *note the discussions and assurance received by the People Committee;* |

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

**Board Committee Upward Report to the Group Board**

| | |
|---|---|
| **Report for meeting of the Group Board to be held on:** | 6 January 2026 |
| **Report from:** | People Committee |
| **Report from meeting held on:** | 11 November 2025 |
| **Quoracy requirements met:** | Yes |

## 1.0 Purpose of the report

1.1 This report sets out the items of business considered by the People Committee at its meeting held on 11 November 2025 including assurances received and those matters which the committee wish to escalate to the Group Board.

## 2.0 Matters considered by the committee

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

Assurances in respect of Objectives 2a:

a) Education Oversight Group Upward Report
b) Safer Staffing Nursing
c) Safer Staffing Medical

Assurance was received in respect of the position of statutory and mandatory training, recorded at 90% with work noted to be continuing in respect of the national training packages. Concern was noted regarding the incorrectly completed non-clinical Infection Prevention and Control (IPC) module with work taking place to rectify the issue. Assurance was provided that this was an isolated issue.

A referral would be made to the Quality Committee in respect of the IPC training issue due to the potential risk associated with the completion of incorrect training.

A positive position was noted in respect of the apprenticeship levy and use of Continuing Progressional Development Funding (CPD). A series of action plans are being monitored by the group, and this would include the 10 Point Plan for Resident Doctors with confirmation that the Committee would receive direct reports.

Safer Staffing position for both nursing and medical staff were considered by the Committee with a stable nursing position noted for nursing staff across

ULTH despite operational pressures and LCHS also remained stable with fill rates above target. Further work was being undertaken in order to report on the non-medical workforce, with strong recruitment pipelines noted for Allied Health Professionals.

Review of the data integrity for the safer staffing medical report had been completed with assurance offered on the position of the revalidated data from the September position. Turnover, vacancy and sickness rates remain stable across both ULTH and LCHS. The Committee noted the actions being taken in respect of the temporary staffing position.

Assurances in respect of Objectives 2b:

a) Workforce Strategy Group Upward Report inc Committee Performance Dashboard
b) Workforce Hub Upward Report inc Recovery update
c) Tackling Racism, including Antisemitism
d) Sexual Safety Charter
e) Guardian of Safe Working Quarterly Report

The Committee noted the positive vacancy rate across the Group with ULTH exceeding target and LCHS outside of target with nursing and midwifery rates exceeding targets across the Group. Turnover had reduced across the Group and sickness rates were noted to be outside of target.

Sickness absence Coordinator roles were being introduced to support and monitor areas of concern.

Job planning for medical and dental staff was reported at 80% and the Committee noted the transition of the medical workforce team to the Group Chief Medical Officers portfolio, from the People Directorate.

The Committee noted the current position in respect of the workforce hub noting the support in place for those staff on the redeployment list.

Substantial assurance was received in respect of the actions being taken in respect of tackling racism, with work underway as part of the EDI programme and objectives.

The sexual safety charter report (**appended**) outlined the key principes of the LCHG Sexual Safety Charter with the Committee assured on the completion of a further self-assessment undertaken during October. Progress had been made in a number of areas, and a stand-alone policy was progressing through governance.

The Guardian of Safe Working attended the Committee to offer the quarterly update with the Committee noting the ongoing concerns in respect of space, which were being addressed. There was recognition that the 10 Point Plan for Resident Doctors incorporated those points raised by the Guardian.

Assurances in respect of Objectives 2c:

a) Culture and Leadership Group Upward Report

The Committee noted the launch of the Behaviour Framework at the Better Together Forum on 1 October with briefings having commenced, including the leadership development programme, which was being received positively.

The National Staff Survey completion position was noted with ULTH reported at 38% and LCHS at 57%. This position was favourable compared to the previous year for both organisations with the national average noted at 48%.

Assurances in respect of Objectives 2d:

a) None

Whilst the Committee did not receive any formal reports for Objective 2d, it was recognised that the staff story had supported the objective.

Assurances in respect of other areas:

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

The Committee noted the powerful staff story related to the CODE/REACH staff network, proposing this be put forward to the Board as a future item.

The position in respect of the risk register was noted with the Committee recognising the ongoing work to review the risks and ensure these were received and considered by the appropriate Committee.

The policy position was noted with recognition of a number of these due for completion in quarter 4. An exercise would be completed to determine if documents continue to be required and appropriate action taken in response to the review.

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

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

a) None

## 4.0 Matters for reporting / escalation to the Group Board

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

a) None

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

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

## 6.0 Group Board Action Required

6.1 The Group Board is asked to:

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

***Vicki Wells, People Committee Chair***

***11 November 2025***

NHS
Lincolnshire Community and Hospitals NHS Group

# People Committee
# Sexual Safety Charter Update

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *People Committee* |
| Date of meeting | *11th November 2025* |
| Agenda item number | *9.4* |
| Report title | *Sexual Safety Charter Update* |
| Report purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | • *Assurance* |
| Accountable Director | *Claire Low, Group Chief People Officer* |
| Author(s) | *Kerry Swift, Deputy Director of People,* |
| Assurance rating:<br>• Substantial assurance<br>• Reasonable assurance<br>• Limited or no assurance | *Reasonable Assurance* |
| Prior approval process, if applicable | *N/A* |
| Financial implications, if applicable | *N/A* |
| Action / decision required | *N/A* |

*Assurance Rating Key:*

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

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

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

## Executive Summary

This report outlines the key principles of the LCHG Sexual Safety Charter and the support mechanisms available to ensure a safe and respectful environment for all individuals engaging with the organisation.

LCHG's Sexual Safety Charter was formally launched on 29th September 2025 and supported by a range of key stakeholders. The key principles of the LCHG Sexual Safety Charter approach include zero tolerance, together with clear definitions and behavioural expectations of what is and is not acceptable. A number of elements have been agreed as part of the organisational commitment, including a policy, reporting mechanisms and tools, and associated support available for people.

In August 2025, NHS England wrote to organisations asking all trusts and ICBs to undertake a number of further actions in relation to the sexual safety at work, which included a self-assessment, commitment to e-learning and a review of associated policies and processes. At this time NHSE also published a refreshed sexual safety assurance framework, enabling boards to assess progress against the Sexual Safety Charter.

LCHG has undertaken a further self-assessment based on the refreshed assurance framework and progress is reviewed by the Sexual Safety Working Group. The full audit details are contained within appendix one.

Key progress and actions noted since the previous self-assessment include: development of a stand-alone Sexual Safety At Work Policy to be signed-off in quarter 3, ahead of publication in quarter 4, good completion rates of the e-learning module at 89%, seven named and specially trained sexual safety support ambassadors in place, key awareness questions included in the National Quarterly Pulse Survey (NQPS) and National Staff Survey (NSS) to be reported on, quarterly and annual reporting arrangements agreed and to be reported in quarter 3, with the final step being to agree thresholds for escalating of sexual misconduct cases to Executive and Board level leads – to be agreed by the end of November 2025.

In addition, to the quarterly and annual deep dive reporting the Board Assurance Framework is currently being reviewed to ensure that the relevant controls and sources of assurance are updated accordingly to reflect the arrangements that have been agreed.

The recent review of the self-assessment against the refreshed framework demonstrates that LCHG have made good progress against the majority of areas. Once the stand-alone policy has been through the appropriate governance process and is published this will further strengthen a number of key actions, together with the embedding of the agreed reporting schedule. This self-assessment and outstanding actions will be monitored by the Culture and Leadership Group, with upward reporting into People Committee.

## Background

In September 2023, the Sexual Safety Charter was first published by NHS England with the aim of promoting a zero-tolerance approach towards sexual misconduct in the workplace. Every NHS trust and integrated care board (ICB) has since signed up to this Sexual Safety Charter to focus on making the NHS a safer place to work.

Trusts were asked to take further actions to identify and act against potential perpetrators of sexual misconduct in the NHS, with a reminder that NHS England is committed to supporting and challenging the system to ensure a sexually safe environment for our staff and patients.

The LCHG Sexual Safety Charter was developed with a range of key stakeholders and soft-launched in October 2024, with the formal launch taking place on 29th September 2025. This event was well-supported by the Executive Leadership Team and members of the working group, which included staff network leads, OD team, safeguarding. This event received positive feedback from those who were able to join live and is also available for all staff to view as it was recorded.

The key principles of the LCHG Sexual Safety Charter approach are:

- Zero tolerance for sexual abuse and harassment.
- Clear definitions of sexual abuse and harassment, including coercion, inappropriate touching, sexual jokes, and exposure to sexual content.
- Inclusive protection for all genders, sexual orientations, ethnicities, religions, abilities, and roles.
- Behavioural expectations: mutual consent, no coercion, awareness of impact, and speaking up against harm.

There are a range of support mechanisms in place including: Employers Against Abuse Ambassadors, Staff Networks, Freedom to Speak Up Guardians and Champions, Safeguarding Team, Wellbeing Services, Human Resources and Organisational Development. A range of reporting tools are available to report any issues/concerns including Datix and QR code access.

In August 2025, NHSE wrote to organisations asking all trusts and ICBs to:

- begin self-assessment against the assurance framework
- encourage staff to complete the e-learning on sexual misconduct, and consider specialist training
- review staff policies and processes to ensure appropriate sharing of concerns about healthcare professionals with future employers and host organisations
    - this should include investigation findings, relevant DBS information, and reflect cumulative patterns of behaviour
    - sexual misconduct should be considered through a patient safety lens as well as through HR processes
- ensure that ESR (where an organisation uses this to record employee relations issues) is up to date with ongoing and complete investigations into staff
    - inter-authority transfers (IATs) may reveal where there are ongoing investigations, and should be built into onboarding processes
- review chaperoning policies to ensure they empower chaperones and lead to the creation of auditable records

- engage with your EPR suppliers (including prospective providers) to monitor unusual access to patient records and ensure safeguarding oversight.

Trusts were also asked to complete the Sexual Misconduct Policy Framework audit which LCHG undertook in September 2025.

At this time in August 2025, NHS England also published a refreshed sexual safety assurance framework, enabling boards to assess progress against the Sexual Safety Charter. They advised an audit of this will take place in the autumn to review progress on the implementation of the Charter, as well as the actions outlined in the NHS letter. To date, further information on this audit is awaited from NHS England.

LCHG first completed the self-assessment framework in November 2024, following its publication by NHS England in October 2024. The self-assessment has now been completed again during October 2025 based on the refreshed assurance framework and progress is reviewed by the Sexual Safety Working Group. This group contains representatives from staff networks, staff side and FTSUG, Safeguarding, HR, Occupational Health and Wellbeing, EDI, Operational leads including from theatres and medical staff, together with the Executive sponsors, and meets on a monthly basis. The actions from the self-assessment will be monitored by the Culture and Leadership Group and will be upwardly reported to the People Committee.

Staff Networks - all Staff Network Leads (one representative per meeting from each is requested); Staffside ULTH and LCHS (3 representatives in total); Group Director of Safeguarding; Head of Divisional HR (one per meeting) and HR Advisor; Freedom to Speak Up Guardians ULTH and LCHS; Occupational Health & Wellbeing for both; Theatres (Louth - Nursing) and Theatres/ICU Pilgrim and Grantham (Consultant/College Tutor and Consultant/MAC); EDI Lead, Project Manager and Assistant; Group Medical Director's Business Manager; Executive Sponsors - Karen Dunderdale and Kathryn Helley; you
The self-assessment covers the 10 principles of the NHS Sexual Safety Charter, with a RAG rating against each area and the associated evidence for each area, together with the outcomes. The full self-assessment details for the audit completed in October 2025 are contained within appendix one.

A summary of the self-assessment shows the following key actions and progress:

- The majority of areas are now fully completed and embedded.
- Currently the organisation's approach to Sexual Safety is as part of the LCHG Dignity at Work Policy, however this is being expanded into a stand-alone policy, based on the national policy for this area.
- The stand-alone Sexual Safety At Work Policy has been developed in draft and is going through stakeholder engagement with the Sexual Safety Working Group on 5th November 2025. Following this it will then go to the appropriate policy committees for sign-off in quarter 3, ahead of publication in quarter 4.
- The e-learning module "Sexual Misconduct at Work" has been implemented and is mandatory for all, with completion rates monitored. Current completion rates for both ULTH and LCHS are 89%.
- There are seven named and specially trained sexual safety support ambassadors in place.

- Further communications and awareness-raising have taken place, including the Sexual Safety Live Launch with the Group CEO, Chief People Officer, Chief Clinical Governance Officer, and staff network leads.
- Implementation of the EPR system (NerveCentre) will assist ULTH in monitoring unusual patterns of patient record access as it will allow the complete record to be held electronically.
- Key awareness questions have been included in the National Quarterly Pulse Survey (NQPS) and National Staff Survey (NSS) and will be reported on.
- The quarterly and annual reporting arrangements have been agreed, and are now being enacted, with the first annual sexual safety "deep dive" due to take place when the NSS 2025 results are available to LCHG in early 2026.
- The final step will be to agree thresholds for escalating of sexual misconduct cases to Executive and Board level leads – to be agreed by the end of November 2025.

It is anticipated that the remaining actions will be completed as soon as possible, with the stand-alone Sexual Safety policy to go to the Group Policy Committee in quarter 3 with publication in quarter 4. The quarterly reporting will commence in quarter 3 and the first annual deep dive will be carried out in early 2026 once the full national staff survey results have been received and analysed.

A key aspect of the self-assessment framework is the associated monitoring and upward reporting as described in the actions above and the self-assessment framework document. It was agreed at October's People Committee that this reporting would be via the Culture and Leadership Group with an upward report to People Committee and then Board – unless issues needed escalation by exception.

In addition, to the quarterly and annual deep dive reporting the Board Assurance Framework is currently being reviewed to ensure that the relevant controls and sources of assurance are updated accordingly to reflect the arrangements that have been agreed.

**Conclusion**

The Sexual Safety Charter within LCHG is an important organisational commitment and outlines the associated mechanisms in how we support our people with what behaviour is and is not acceptable in creating a safe working environment.

Following the launch of this Charter, there needs to remain a focus on this, together with embedding it across LCHG and ensuring people behave in an appropriate way.

The recent review of the self-assessment against the refreshed framework demonstrates that LCHG have made good progress against the majority of areas. Once the stand-alone policy has been through the appropriate governance process and is published this will further strengthen a number of key actions, together with the embedding of the agreed reporting schedule. This self-assessment and outstanding actions will be monitored by the Culture and Leadership Group, with upward reporting into People Committee.

## APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework

**Key**

| | |
|---|---|
| Action underway | |
| Action fully completed | |

### NHS Sexual Safety Charter principles 1 to 10: implementation assurance

**Principle 1: we will actively work to eradicate sexual harassment and abuse in the workplace**

**Principle 2: we will promote a culture that fosters openness and transparency and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours**

| Action & RAG Status | Evidence |
|---|---|
| **Have clear plans to focus the organisation on prevention & culture change** | • Delivery Plan<br>• Working Group in place – membership details and notes of monthly meetings |
| **Set clear standards of behaviour in policies and enforce them** | • Group Disciplinary policy – published<br>• Group Dignity at Work policy - published<br>• Group Sexual Safety at Work policy (Draft – out for stakeholder engagement)<br>• Group Sexual Safety Charter – launched & published<br>• Cases – anonymised and tracked by investigated, gone to hearing, summary of action taken |
| **Core training for all staff and specialist training for those who need it** | • eLearning For Health Sexual Misconduct at Work eLearning is mandatory for all and the completion rate is tracked quarterly (reported at organisation-wide and Care Group level) |

**APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework**

| | |
|---|---|
| | • Specialist training for Seven Sexual Safety Support Ambassadors completed, through The Survivors' Trust/Employers Against Abuse. This group of colleagues includes: Freedom to Speak Up Guardians and Champions; EDI and OD colleagues; Staff Network Leads (Women's Network) and an Independent Domestic Violence Advisor. Other Staff Network Leads have expressed an interest and a further cohort of training is planned<br>• HR colleagues to be invited to express an interest in completing the support ambassador training too<br>• HR and Staffside briefings to take place through Sexual Safety Policy approval and launch process<br>• Workshops led by the GMC on Sexual Harassment and Discrimination offered at three acute sites in 2025 for all members of the Medical & Dental Workforce, arranged by the Deputy Medical Director (Professional Standards) |
| **Communications campaign shared with all staff** | • Evidence from bulletins, Live Launch, and copy of Comms plan – ongoing updates to intranet in progress and launch of leaflets (funding secured) and scrolling screensaver message to follow |
| **Establish a structured risk management and escalation process for sexual misconduct, including defined risk thresholds for escalation to executive and board levels.** | • Draft Sexual Safety policy out with stakeholders for review and feedback<br>• Escalation process in place via senior HR and Safeguarding for potential criminal acts, serious misconduct and gross misconduct<br>• Incidents are escalated to HR SLT level and Board, **however further work is necessary to define the thresholds for escalation to executive & board levels, for consistency, support & accountability.** |
| **Board-level ownership and accountability for cultural issues, prevention strategies and oversight** | • Named Executive Director Leads: Prof. Karen Dunderdale, Group CEO; Claire Low, Group Chief People Officer and Kathryn Helley, Group Chief Clinical Governance Officer. |

**APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework**

| | |
|---|---|
| | • Quarterly reporting of agreed metrics via Culture & Leadership Group, People Committee and Board<br>• Cultural issues – thematic trend data to be collated and reported anonymously as per bullet point above |
| **Embed tackling sexual misconduct and protecting the sexual safety of our workforce into all relevant business as usual areas – for example, training, contracts, induction and equality, diversity and inclusion (EDI) improvement plans** | • Induction – referred to during induction, included in induction handbook, and eLearning is completed.<br>• Core Sexual Misconduct at Work eLearning – mandatory for all<br>• General reference to misconduct and disciplinary rules in LCHS and ULTH contracts – **not specific to sexual misconduct**<br>• EDI improvement plan – included |
| **Clear signposting to policies and support services, which are easily accessible to all staff** | • Intranet page, QR code on LCHG Sexual Safety Charter, leaflets (to be printed), policy, Support Ambassadors to talk to and gain information.<br>• Information on external support organisations available too. |
| **Visible senior leadership** | • Executive Leads: Prof. Karen Dunderdale, Claire Low, Kathryn Helley<br>• Visible through Internal Communications, Live launch and in-person through walkabouts. Visible and present in their support of the Sexual Safety Working Group. |
| **Appoint Domestic Abuse and Sexual Violence Lead** | • Executive Leads: Prof. Karen Dunderdale, Claire Low, Kathryn Helley<br>• Senior Operational Lead and Advisor: Craig Ferris, Group Director of Safeguarding and Patient Experience<br>• Implementation Lead: Alison Marriott, EDI Project Manager |

## Outcomes

- sexual misconduct, its prevalence, impact and how to eradicate it is discussed openly and appropriately within the organisation

**APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework**

- the executive board has agreed a suitable governance process to understand prevalence rates, staff experience and the outcomes of cases in their organisation
- data about prevalence, actions taken and learning from cases is shared across the organisation
- reduction in cases (recognising likely to be an initial increase due to increased confidence in reporting)
- reduction in staff saying in annual staff survey they have experienced sexual misconduct in the workplace
- the Board proactively governs and escalates emerging sexual misconduct risks, ensuring accountability, oversight, and early intervention across the organisation
- increased confidence in the organisation at tackling sexual misconduct and improving safety for all staff

## APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework

**Principle 3: we will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate. For example, women, black, ethnic minority, disabled and LGBTQ+ groups**

| Action & RAG Status | Evidence |
|---|---|
| **Complete equality impact assessment of sexual safety and misconduct work (including policies)** | • EIA completed for Sexual Safety Policy, and being reviewed by stakeholders representing the staff networks<br>• LCHG Sexual Safety Charter developed with Staffside and Staff Networks, to be inclusive of all and using accessible language – including an easy read version. |
| **Engage through staff networks, EDI officials and experts by experience to ensure all cohorts of our staff are represented appropriately and robustly as part of this work** | • All Staff Network leads are members of the Sexual Safety Working Group, along with three EDI colleagues. This ensures representation from male and female colleagues, LGBTQ+ colleagues, Black and Asian colleagues and those with visible and non-visible disabilities. The Agenda for Change and Medical & Dental workforce are represented, including a link to Medical Education.<br>• Staffside representatives are also members of the Sexual Safety Working Group |
| **Use data from NHS staff surveys, cut by EDI metrics, to understand staff experience and inform iterative development of key products** | • Initial analysis has been undertaken by an OD Manager who is a member of the working group, and this has informed the development of the support ambassador role (in particular, ensuring representation across the staff networks), and also the follow-up of uptake of mandatory Sexual Misconduct at Work eLearning.<br>• As part of regular reporting, **an annual "deep dive" into the two sexual safety questions in the National Staff Survey is planned, by protected characteristic as well as care group and business unit, and professional grouping.** This will form part of the regular reporting to Culture & Leadership Group, People Committee and Board. |

**APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework**

| | |
|---|---|
| | • It will inform a review of the current sexual safety charter "products" e.g. support/how to report an incident/response to incident/training and ongoing communications & awareness plan. |
| **Tailor responses to ensure that they are appropriate for groups that experience sexual misconduct at a disproportionate rate** | • As above |

**Outcome**

- a clear understanding of the prevalence of sexual misconduct within different workforce groups
- support is tailored, appropriate and effective in tackling intersectional experience of sexual misconduct

## APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework

### Principle 4: we will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours

| Action & RAG Status | Evidence |
|---|---|
| **Confidential information and resources are available on the intranet and staff are signposted to them regularly** | • A Sexual Safety Intranet page with a range of internal and external information and support has been in place since late 2024 and has been reviewed recently. Staff are signposted to the page through the LCHG Sexual Safety Charter itself, and through internal communications repeated at regular intervals throughout the year. |
| **Staff support structures, like the Employee Assistance Programme, have guidance on sexual misconduct processes and pathways to specialist support** | • The EAP is confirmed as able to support staff experiencing sexual misconduct at work, and domestic and sexual violence outside of work – both local and national sources of support, recognising that staff have different needs.<br>• In addition, LCHG has seven trained support ambassadors in place, named on the intranet, for staff to approach in confidence and gain support & information<br>• The LCHG Occupational Health team has trauma-informed counselling services, and links into specialist services such as Rape Crisis Lincs, the ISVA service and Sexual Assault Referral Centre at Spring Lodge (provided by LPFT). Two members of the Occupational Health team are trained support ambassadors and members of the Sexual Safety Working Group.<br>• Specialist safeguarding support is kindly provided to the working group and support ambassadors by Craig Ferris and team, recognising the importance of supporting the listeners and sign-posters. |

## APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework

| | |
|---|---|
| **The support offer is monitored to inform continuous improvement and ensure appropriateness. Offsite support can be offered** | • The support offer is monitored through the quarterly reporting mechanism and feedback from the support ambassadors and other ad-hoc sources.<br>• Offsite and virtual support can be offered, including independent support through the ISVA and IDVA roles in Lincolnshire, which the working group has met and confirmed their support. |
| **Relevant policies are evidence-based and informed by data and subject matter expertise** | • The draft Sexual Safety policy is based very closely on the national NHS Sexual Safety policy framework, co-produced by subject matter experts and based on the best evidence available from national subject matter experts in supporting victim-survivors and data on the prevalence of sexual harassment, abuse and assault.<br>• This is further assured by the working group, who will confirm if it is workable in practice locally, ensure that the local version of the policy is reflective of not only local data in the completed Equality Impact Assessment, but also their lived experience, and alignment with safeguarding procedures and support services locally. |

**Outcome**

- staff have knowledge of and access to a range of support tools and mechanisms that are iteratively reviewed and based on a growing evidence base
- specific and specialist support for those who experience sexual misconduct is embedded into organisational staff support structures

## APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework

### Principle 5: we will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour

| Action & RAG Status | Evidence |
|---|---|
| **The Sexual Misconduct policy is clear on standards of behaviour, the role of those who witness inappropriate behaviour, and any interactions with other relevant policies** | • The draft Sexual Safety policy is clear on standards of behaviour and the roles of witnesses and others, and how this interacts with other policies such as safeguarding, domestic abuse, dignity at work, disciplinary/MHPS and grievance. |
| **Roll out communications campaign to all staff** | • An ongoing communications campaign began in late 2024 when the Worker Protection Act (amendment to Equality Act 2010) came into force and has continued during 2025. There is a Senior Communications Officer who is a member of the working group and proactively supports this work |
| **Sexual safety and misconduct are comprehensively addressed in induction and all staff training** | • Addressed comprehensively through core learning and written information (handbook) and signposting to the LCHG charter at induction<br>• Mandatory eLearning in place for all staff and completion rates are monitored.<br>• People Management Essentials includes reference to the Sexual Safety Charter **– to be further reviewed as the new national leadership framework is embedded, to ensure this continues to be highlighted.** |

### Outcome

- staff are clear about the standards of behaviour required in the organisation
- the organisation adheres to policies and applies them consistently
- staff feel empowered to take action should they witness or experience unwanted and/or harmful sexual behaviour

## APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework

**Principle 6: we will ensure appropriate, specific, clear policies are in place. They will include appropriate and timely action against alleged perpetrators**

| Action & RAG Status | Evidence |
|---|---|
| **Publish a policy on sexual misconduct in line with the NHS national policy framework** | • The draft Sexual Safety policy is based very closely on the national NHS Sexual Safety policy framework<br>• **This will be further assured by the working group, who will confirm if it is workable in practice locally**<br>• **This will then proceed through the usual policy approval route (including JNF & JCNC), anticipated to be in quarter 3, ready for publication in quarter 4** |
| **Sexual misconduct policy is supported by a flowchart and easy-read version and is easily accessible to all staff** | • The easy-read and condensed LCHG Sexual Safety Charter, our main staff-facing document, already meets this requirement, as this was the founding goal and first action of the working group. A printed version as well as the electronic version is now in progress, with funding in place.<br>• Further easy-read and condensed documents are part of the policy draft, with an overall flowchart and one-page guides which match the orange branding of the LCHG Sexual Safety Charter, providing further easy-to-access information on how to gain support, report a concern, and respond if witnessing a concern. |
| **Conduct/competence policies should take of complexities where it may initially be unclear whether behaviours and actions should be considered as conduct or capability** | • A Just Culture approach is already included in the Group conduct and capability policies, including a robust preliminary assessment framework which considers these questions. |
| **Policies set out roles and responsibilities of people in the organisation, for example, HR and people professionals,** | • The draft policy sets these out by each role |

**APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework**

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| **safeguarding teams, freedom to speak up guardians, mental health first aiders (or equivalent), leadership, line managers** | |
| **Provide tools and support for line managers to understand their responsibilities and how to follow escalation processes consistently** | • Support is available via the Care Group HR Managers and Advisors, with senior HR support available for escalation<br>• Further easy-read and condensed documents are part of the policy draft, with an overall flowchart and one-page guides which match the orange branding of the LCHG Sexual Safety Charter. **Once published**, these will provide further easy-to-access information on how to gain support, report a concern, and respond if witnessing a concern or a line manager receiving information about a concern<br>• Sexual Safety Support Ambassadors are also available to support managers with their understanding of situations and responsibilities, as specified in the draft policy and their intranet page will need to be updated to include this when the policy is published |
| **Policies are clear about action that needs to be taken against perpetrators, by whom, when and how**<br><br>**Policies are clear about investigation processes and standards** | • This is contained within the current LCHG Dignity at Work policy<br>• The draft Sexual Safety policy sets this out further, and cross-refers to the Group Disciplinary Policy which set out further the steps to be taken - when, how and by whom, and investigation processes and standards |
| **Policies are clear about the circumstances in which complaints and investigations about staff should be shared with future employers and police** | • The police requirements are clear in the draft policy and the safeguarding policy<br>• Following the August 2025 letter from NHS England outlining the future employers' requirement, this has been incorporated into the draft Sexual Safety policy. It will need further review with HR stakeholders to ensure it is workable and embedded in practice<br>• This will also include consideration of investigation findings, relevant DBS information, and reflect cumulative patterns of behaviour, and how these are recorded on ESR and |

## APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework

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| | equivalent ER trackers and the use of Inter-authority transfers (IATs). |

### Outcome

- action is always taken against perpetrators, and in line with policies
- clear, evidence-based and trauma-informed processes are documented in policies
- all staff are clear on roles and responsibilities
- line managers are clear on their responsibility to escalate potential sexual misconduct issues and the processes for doing so
- HR and people professionals are clear on the necessary steps required to take timely action against alleged perpetrators and this is part of their induction and ongoing training
- HR and people professionals are clear about when information needs to be shared with future employers relating to sexual misconduct complaints and investigations

## APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework

### Principle 7: we will ensure appropriate, specific, clear training is in place

| Action & RAG Status | Evidence |
|---|---|
| **Training is available for all staff to recognise and report sexual misconduct and to understand how to support colleagues (victims and witnesses)** | • The national eLearning is available and mandatory for all staff |
| **Specialist training is available for those who need it to ensure effective support, reporting and investigations (for case managers, investigators and responsible officers)** | • Specialist training can be made available, however further work is necessary to embed it into Just Culture-related training, which is linked to the new Group Disciplinary policy<br>• Sexual Safety Support Ambassadors and the safeguarding team are trained and available in the meantime, to support case managers, investigators and responsible officers |
| **Training is developed for managers to support culture change** | • People Management Essentials includes reference to the Sexual Safety Charter **– to be further reviewed as the new national leadership framework is embedded, to ensure this continues to be highlighted** |
| **All staff have undertaken national eLearning on sexual misconduct** | • Completion rates are monitored quarterly<br>• The working group has identified a need for support to be offered to those who have not yet completed it. In some cases, it is "triggering" because of their experiences and support and signposting is offered in confidence by trained Sexual Safety Support Ambassadors<br>• Also, Sexual Safety Support Ambassadors can have constructive discussions with those who are reluctant to complete it for other reasons – NB: to date there has been no overt resistance, and uptake of the eLearning was swift and high when it launched in February 2025, and rates have |

| | |
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| | steadily improved since then. ULTH and LCHS current completion rates are both at 89% |

**Outcome**

- training on sexual misconduct and sexual safety is accessible to all staff
- specialist training is accessible to those who need it
- staff knowledge and awareness of issues relating to sexual misconduct increases

## APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework

### Principle 8: we will ensure appropriate reporting mechanisms are in place

| Action & RAG Status | Evidence |
|---|---|
| **Policy outlines sexual misconduct reporting mechanisms, including anonymous reporting** | • The policy outlines these, including the anonymous reporting function through the turquoise "United against Discrimination" posters with a QR code which goes in confidence to the Equality, Diversity & Inclusion team. It allows a report to be made without adding any identifying information.<br>• This information is also on the Sexual Safety Intranet page and is summarised on the LCHG Sexual Safety Charter itself. |
| **Reporting mechanisms are widely communicated to ensure awareness** | • Reporting mechanisms are widely communicated, on the LCHG Sexual Safety Charter itself, through the United against Discrimination posters and on the Sexual Safety intranet page. This information is re-shared regularly as part of the communication plan. |
| **Freedom to Speak Up infrastructure and training for guardians updated to include sexual misconduct** | • Freedom to Speak Up Guardians have completed the specialised support ambassador training<br>• A Sexual Safety Charter briefing has been held for their Freedom to Speak Up champions<br>• Some of the FTSU champions have also completed the specialised training – this is done on a voluntary basis. |
| **There is a clear safeguarding process for identifying unusual patters of patient record access (where an electronic patient record is in place)** | • This is monitored already, however at ULTH, the patient record is still partially electronic, and partially paper based.<br>• When anomalies are identified, they are acted on appropriately, including use of the disciplinary procedure where there is a case to answer<br>• The EPR & EDMS implementation programme has begun at ULTH. The EPR, NerveCentre, has greater capability to |

**APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework**

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| | identify unusual patterns of patient record access earlier and the EDMS will allow a complete record to be held electronically. |

**Outcome**

- staff can report an instance of alleged sexual misconduct through multiple routes, including anonymously
- staff have confidence their disclosure will be treated confidentially (and understand where it might need to be shared for safeguarding reasons) and escalated appropriately
- disproportionate and inappropriate use of patient records is picked up earlier

## APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework

### Principle 9: we will take all reports of sexual misconduct seriously, and appropriate and timely action will be taken in all cases

| Action & RAG Status | Evidence |
|---|---|
| **Clear actions and action-owners set out in the sexual misconduct policy** | • The draft policy meets this requirement |
| **Timeframes for action are set out in the sexual misconduct policy** | • Broad timeframes – e.g. "as quickly as possible", "ensure immediate safety" – are set out in the sexual misconduct policy<br>• Further timeframes are set out in the relevant related policies, such as the disciplinary policy, dignity at work policy, safeguarding policy. |
| **Ensure access to external investigators** | • Provision is made for this possibility, within the relevant related policies |
| **Ensure access to external subject matter experts** | • Provision is made for this, within the Sexual Safety policy. |
| **Executive/board reporting, including on relevant data and learning from surveys, reports and investigations of sexual misconduct, FTSU and complaints** | • Quarterly reporting plan and annual deep dive in place, to be reported via the Culture and Leadership Group, upwards to People Committee and Board<br>• This will now be enacted as business as usual |
| **Establish a governance and risk oversight process for serious and complex sexual misconduct cases, with defined escalation thresholds for executive and Board review** | • Serious and complex sexual misconduct cases are overseen by senior executives (executive directors)<br>• However, as per Principles 1 and 2, **further work is necessary to define the thresholds for escalation to executive and board levels, for consistency, support and accountability.** |
| **There are timely routes to share with HR concerns raised through professional and clinical avenues that could have a** | • The draft policy is clear that concerns with a sexual component should be discussed with HR without delay, |

**APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework**

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| **sexual component, plus data from FTSU and sexual misconduct reporting is triangulated to support** | including those which arise through professional, training and clinical advocacy routes, as well as usual line management routes.<br>• The FTSU guardians are trained sexual safety support ambassadors<br>• As part of the quarterly reporting plan, the data from all sources of reporting will be triangulated, appropriately anonymised and in confidence.<br>• For more urgent matters, the FTSU guardians, EDI team, and sexual safety support ambassadors all have timely access to HR and Safeguarding support for advice and escalation of reports which they receive – including HR SLT and senior/expert Safeguarding support. |

**Outcome**

- sexual misconduct is identified in a timely way, all reports are actioned following organisational policies, and incidents are escalated appropriately
- staff have increased confidence to report concerns
- complex cases have Board and executive scrutiny, aiding the identification of systemic and organisation-wide issues

## APPENDIX ONE – Self-Assessment Completed October 2025 against refreshed national framework

### Principle 10: we will transparently capture and share data on the prevalence of sexual misconduct and staff experience of sexual misconduct

| Action & RAG Status | Evidence |
|---|---|
| **Staff survey results are published and shared, with actions taken/to be taken to address issues and risks raised in the results** | • We have begun to do this, starting from the 2024 NSS results and as part of the launch communications for the NSS 2025<br>• However, with the enacting of the reporting plan (quarterly including Pulse question and annual deep dive) this will be more robust from the 2025 NSS results onwards, and will include breakdown by protected characteristic, work area and professional/occupational group.<br>• The quarterly and annual report will be published to the whole organisation, to enable all staff to have access to it. |
| **Executive/Board reporting on cases, including relevant data and learning** | • This has begun, however with the enacting of the reporting plan for sexual safety, and the establishing of thresholds for Board escalation and oversight, this will become more robust. |

### Outcome

- executive board understands prevalence rates, staff experience and the outcomes of cases in their organisation, including impacts and any differences between different groups of staff and required actions
- staff have access to data on sexual misconduct prevalence in their organisation

NHS
Lincolnshire Community and Hospitals NHS Group

# People Committee Upward Report

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *9.1* |

# *People Committee Upward Report of the meeting held on 9 December 2025*

| | |
|---|---|
| Accountable Director | *Claire Low, Group Chief People Officer* |
| Presented by | *Vicki Wells, Non-Executive Director* |
| Author(s) | *Karen Willey, Deputy Trust Secretary, ULTH* |
| Recommendations / decision required | *The Group Board is asked to:*<br>• *note the discussions and assurance received by the People Committee;* |

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

**Board Committee Upward Report to the Group Board**

| | |
|---|---|
| **Report for meeting of the Group Board to be held on:** | 6 January 2026 |
| **Report from:** | People Committee |
| **Report from meeting held on:** | 9 December 2025 |
| **Quoracy requirements met:** | Yes |

## 1.0 Purpose of the report

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

## 2.0 Matters considered by the committee

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

Assurances in respect of Objectives 2a:

a) Education Oversight Group Upward Report
b) Safer Staffing Nursing to inc AHP compliance
c) Safer Staffing Medical
d) 10 Point Plan – Resident Doctors
e) Emergency Department Lincoln – OD Interventions, Engagement and output 2024
f) Volunteer Workforce update

The Education Oversight Group offered assurance to the Committee with a positive position noted for both Continuing Professional Development and use of the apprenticeship levy. Updates on the band 2 to band 3 uplift were noted with a detailed report due to be received by the group in January.

Discussions were held in respect of medical education including the enhanced induction for staff to ensure a clear understanding of the Group values. Feedback had been received from the University of Lincoln following a 6-month review, the outcome of this had been positive.

The Committee received the safer staffing reports for nursing and medical noting that the position for both staffing groups remained relatively static despite the operational pressures being seen. The Nursing Team had launched the Be Kind initiative to support staff being redeployed.

The bi-annual maternity staffing report was received and noted, which would also be considered by the Quality Committee, with recognition that the business case for maternity staff, in line with staffing requirements, had been rejected by the ICB.

The Committee received the 10 Point Plan for Resident Doctors noting the ongoing work to address the areas identified and the reassessment of the baseline, which required submission on the 10 December. There was recognition that the well-being actions required for those working out of hours would be applied to all of the workforce working these hours.

The OD intervention in ED and volunteer workforce reports were received.

Assurances in respect of Objectives 2b:

a) Workforce Strategy Group Upward Report
b) Workforce Hub Upward Report

The sickness position across the Group was noted to be in line with national trends with recognition of the NHS Planning Guidance indicating a 4% absence rate. There was recognition of the work required nationally to achieve this position.

The Managing Attendance Policy had been approved and would provide a consistent approach across the Group, and the Sickness Manager had been appointed and was due to commence in January.

The significant number of change programmes were noted with a need to ensure support was in place for staff, taking significant resource of the HR teams. The Committee recognised the volume of work being undertaken by the People Directorate and supported a review of the work being undertaken to ensure priorities were met.

The workforce hub position was noted with support continuing to be offered to staff.

Post Meeting Note – confirmation that the Group continues to have in place enhanced vacancy controls through the executive led vacancy control process, this is informed by the Quality Impact Assessment. In additional, in December, the Group introduced a 3-month deferment on start dates to support the year end position. Non-pay discretionary spend is also being targeted, with enhanced approvals also required for spend on specific categories.

Assurances in respect of Objectives 2c:

a) Culture and Leadership Group Upward Report
b) Equality, Diversity and Inclusion Group Upward Report
c) Employee Relations Activity
d) Employee Exclusions

The Committee noted the approval of the Group Absence Management Policy which was due to go live in April 2026. There had been a pause to the Behaviour Framework, request by ELT, in recognition of winter pressures and the impact of ongoing consultation processes.

Progress was noted in respect of the National Staff Survey (NSS) completion of actions plan for the previous year, despite some variation in progress. Overall response rates for the 2025 NSS were noted as positive with a 12% increase noted for both ULTH and LCHS compared to the previous year.

A positive position was also noted in respect of flu vaccinations and the uptake position across the Group with LCHS reported third regionally and ULTH first at week 10 of the campaign.

Health and wellbeing support was noted for those staff currently in consultations as well as the positive impact of the menopause service. The group had also focused on the sexual safety charter self-assessment during the meeting.

The Equality, Diversity and Inclusion Group had considered the gender and ethnicity pay gap report which would be offered in detail to the next meeting with ethnicity noted as a new requirement.

The group received the NHS Racism and Antisemitism letter and would provide oversight of this. Progress was noted in respect of the Workforce Race and Workforce Disability Equality Standards, with action plans continuing to be delivered.

Employee relation activity was noted with the Committee commending the work that had been undertaken to reduce the open cases, and the time period cases were open. The report would be further developed to include professional registration data of all professional regulators.

The Committee noted employee exclusions with 3 reported for ULTH, 1 closed in month and 1 exclusion at LCHS.

Assurances in respect of Objectives 2d:

a) None

Whilst the Committee did not receive any formal reports for Objective 2d, it was recognised that the staff story had supported the objective.

Assurances in respect of other areas:

a) Staff story
b) Board Assurance Framework 2025/26
c) Topical, Legal and Regulatory Update
d) Risk Report

e) Policy Position Update
f) Internal audit Recommendations

The Committee noted the staff story demonstrating the support put in place by the recruitment and onboarding team to ensure successful international recruitment.

The risk register was received with the Committee noting the revised format which would develop to ensure greater oversight of risks, aligned to risk appetite.

The policy position was noted with recognition of the work undertaken to review the overdue policies and agreement with Staff Side that these would be extended for 6-months to support the development of Group policy documents.

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

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

a) None

## 4.0 Matters for reporting / escalation to the Group Board

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

a) None

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

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

## 6.0 Group Board Action Required

6.1 The Group Board is asked to:

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

***Vicki Wells, People Committee Chair***

***9 December 2025***

NHS
Lincolnshire Community and Hospitals NHS Group

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

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *9.1* |
| Report title | *Resident Doctors 10 Point Plan Update (pertaining to NHSE 10 Point Plan to Improve Resident Doctors' Working Lives)* |
| Report purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | • *Discussion*<br>• *Approval*<br>• *Assurance* |
| Accountable Director | *Professor Colin Farquharson, Group Chief Medical Officer, LCHG* |
| Author(s) | *Professor Colin Farquharson, Group Chief Medical Officer and Senior Lead for Resident Doctors Experience, LCHG*<br><br>*Dr Arunpreet Sahota, Resident Doctors Peer Representative, LCHG*<br><br>*Clare Frank, Business Manager to the Group Chief Medical Officer, LCHG* |
| Assurance rating:<br>• Substantial assurance<br>• Reasonable assurance<br>• Limited or no assurance | • *Reasonable Assurance* |
| Prior approval process, if applicable | |
| Financial implications, if applicable | *TBC* |
| Action / decision required | *The board / committee is asked to:*<br><br>• *Note the paper for awareness* |

*Assurance Rating Key:*

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

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

## Executive Summary

On 28 August 2025, NHSE / DHSC sent a letter to all acute provider Trusts setting out a “10-Point Plan” to improve the working lives of resident doctors and initial actions to be taken over the next 12 weeks, with further milestones to be achieved into 2026. This letter and the required actions have previously been referenced and discussed at ELT, Group People Committee and the Group Board.

The document was circulated to key stakeholders within the Trust and a baseline compliance / gap analysis assessment undertaken which supported the organisational submission to NHSE on 12 September 2025.

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

As part of the ongoing work, a 12-week progress survey was undertaken in December 2025, and the response back from NHSE has confirmed significant improvement (of 19 percentage points) in the organisational compliance with the 10 Point Plan, which now sits at 81%.

Further work will continue (or is planned) to improve ongoing compliance with the 10 Point Plan to improve the working lives of resident doctors.

## Introduction / Background

On 28 August 2025, Sir Jim Mackey and Professor Meghana Pandit on behalf of NHS England (NHSE) wrote to all organisations to launch the national Getting the Basics Right for Resident Doctors programme. The initiative has now become colloquially known as the “Resident Doctor 10 Point Plan” and further details related to the components of the plan can be found in the subsequent document circulated from NHSE called “10 Point Plan to improve resident doctors’ working lives”.

As per the asks laid down in these documents from NHSE, this paper summarises the steps already carried out by ULTH to date (on behalf of the Group).

## Timeline of General Actions taken by ULTH since end August 2025

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

- Carried out a full baseline assessment / gap analysis as requested by NHSE and submitted this to NHSE on 12 September 2025.
- Formed a focused 10 Point Plan Task and Finish group meeting weekly that includes Postgraduate Medical Education (PGME), Medical Workforce, Guardian of Safe Working, Estates and Facilities, and Group Chief Medical Officer (GCMO) representatives. This group directly reports to the GCMO.
- Appointed a “Senior Lead for Resident Doctor Experience” (SLRDE) for the Group (the GCMO).
- Undertaken a competitive process to appoint a Resident Doctor Peer Representative to work closely alongside the SLRDE, and subsequent to this process, Dr Arunpreet Sahota has been appointed into that Peer Representative role. In addition, as a result of the strength of the field of prospective candidates, there has also been the appointment of two Associate Peer Representatives to work alongside Dr Sahota.
- The CEO and GCMO have met with the Resident Doctor Peer Representative on 15 October 2025 following on from his appointment
- GCMO (as SLRDE) and Peer Representative meet on a weekly basis one-to-one, separate to the Task and Finish Group.
- The SLRDE and the Resident Doctor Peer Representative attended a face-to-face East Midlands launch event for the “Resident Doctor 10 Point Plan” on 6th November 2025 at Queens Medical Centre in Nottingham.
- The CEO, SLRDE and other Executive colleagues attended the LCHG Resident Doctor Forum on 12th November 2025, where the various elements of the 10 Point Plan, the actions already undertaken / completed, and those actions still outstanding were discussed with the Resident Doctors within that forum.
- LCHG received notification on 26 November 2025 of a further follow up survey that will be conducted between 1-10 December 2025 and as part of

the ask and this round of assurance, a repeat assessment / gap analysis was undertaken and then submitted to NHSE on 10th December 2025.

- GCMO had a scheduled individualised discussion with the regional NHSE representative as part of routine process to assess delivery of 10 Point Plan on 10th December 2025 – verbal feedback at that meeting was very positive on the progress made by ULTH since the 10 Point Plan work has started.
- Following on from the submission of the gap analysis 12-week progress re-survey submission, the CEO, SLRDE and Resident Doctor Peer Representative met on 19th December 2025 to discuss the survey and outstanding actions.
- The validated re-survey feedback was received from NHS England on 29th December 2025, which confirmed 81% compliance on the 12-week progress survey, which is an improvement of 19% from the initial baseline survey.

For further detail, the document in Appendix A describes the organisational responses submitted to NHSE on 10th December 2025, the table attached within Appendix B shows these survey questions asked by NHSE mapped against the RAG ratings on the organisational responses from the submission of 12 September 2025 and 10 December 2025 on attainment / achievement. Appendix C contains the Midlands Overview received from NHS England of the 12-week Progress Survey responses, with the validated ULTH responses / assessment summarised on slide 10.

## Brief Summary of the Current Progress against the specific 10 Points of the Plan

**POINT 1:**

**1. Improve workplace wellbeing for our resident doctors**

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

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

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

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

**Progress:**

- Baseline self-assessment carried out and submitted to NHSE 12 Sept 2025
- Reporting schedule to Group People Committee / Board defined
- Task and Finish Group established to maintain pace of delivery of outstanding actions
- Awaiting some further national updates / reporting requirements
- Re-assessment undertaken and submitted to NHSE on 10 December 2025 – results show significant improvement in compliance with the 10 Point Plan as compared to the original baseline.

**POINT 2:**

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

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

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

**Progress:**

Completed – information received from NHSE, and all asks have been actioned.

**POINT 3**:

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

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

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

**Progress:**

Ongoing – as information from NHSE still awaited. However, LCHG has a Leave Policy that specifically covers resident doctor leave, so organisation likely to be compliant with the awaited NHSE guidance.

**POINT 4:**

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

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

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

**Progress:**

Completed – SLRDE / Peer Representative (and two additional Associate Peer Representatives) appointed within the initial 6-week window.

**POINT 5:**

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

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

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

**Progress:**

Ongoing - LPFT Payroll team is participating in current national payroll improvement plan. The Medical Workforce team is to be the single point of contact for the Group.

**POINT 6:**

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

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

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

**Progress:**

Completed – this process is now in place as per MOU.

The revised framework from NHSE is to be confirmed by April 2026.

**POINT 7:**

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

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

**Progress:**

Ongoing – the task and finish group is currently awaiting further guidance / clarity from NHSE regarding the implementation of the new processes (to be implemented by 4 Feb 2026)

**POINT 8:**

**8. Resident doctors should receive reimbursement for course-related expenses within 4 to 6 weeks of submitting their claims**
We will transition nationally from an approach where expenses for approved study leave are reimbursed only after a resident doctor has attended a course/activity, to one where reimbursement is provided as soon as possible after the expense is incurred.

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

**Progress:**

Completed – the review of the course-related expense process has been carried out, and reimbursement will now occur upon submission of valid receipts.

**POINT 9:**

**9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery**
A review of how rotations are managed is now underway and is being led by the Department for Health and Social Care (DHSC) in conjunction with the British Medical Association (BMA). NHS England is working closely with the BMA to fully understand trainees' concerns and to find constructive and workable solutions to address their needs as a matter of priority.

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

**Progress:**

Currently awaiting (to date) on further information from NHSE / DHSC.

**POINT 10:**

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

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

**Progress:**

The road map from NHSE regarding Local Employer extension is currently awaited (to date).

## Further Actions / Immediate Priorities

- Peer representative / SLRDE will continue to maintain ongoing engagement with resident doctors on behalf of organisation – and report to Board via agreed mechanisms.
- To await the further outstanding information from NHSE / DHSC pertaining to some of the nationally driven points on the 10 Point Plan.
- Continue with local T&F Group to help deliver the outstanding actions required.
- Further attendance of key finance-related individuals at National Payroll Webinars.

## Conclusion / Recommendations

ULTH has already completed a number of the DHSC / NHSE asks, and other actions are also in place to enable the implementation of the other outstanding elements of the 10 Point Plan. This has been objectively evidenced by the significant improvement (of 19 percentage points) between the NHSE baseline and 12-week progress surveys.

There is an ongoing commitment from all relevant stakeholder groups involved to meet weekly within the Task and Finish group, in order to maintain pace of delivery on the outstanding actions.

The Group Board are therefore asked to note the contents of this paper and the attached Appendices for awareness on the progress related to the 10 Point Plan work. It would be anticipated that the Board will continue to receive further information from the SLRDE / Resident Doctor Peer Representative, either via People Committee upward reporting which will update on the progress on actions, or directly reported to the Board.

# Measuring the Impact of the Improving Doctors' Working Lives Programme

This form requests that you provide information in respect of the actions your Trust has taking to improve the Working Lives of Resident Doctors over the last 12 weeks. The Survey should be completed by one person and **should be assured by your Senior Accountable Resident Doctor Lead and your Resident Doctor Peer Lead prior to submitting**. All answers will be treated in line with General Data Protection Regulations requirements. Please direct any queries about the survey to england.10pp@nhs.net **PLEASE PROVIDE YOUR RESPONSE BY 5pm Wednesday 10 December 2025**

## Trust Details

1. Please provide the name of your Trust (IN FULL) *

   United Lincolnshire Teaching Hospitals NHS Trust

2. Please provide the name of the person responding to this survey on behalf of your Trust. *

   Prof Colin Farquharson

3. Their role *

   Group Chief Medical Officer / SLRDE

4. Their e-mail address *

   colinfarquharson@nhs.net

5. The region the trust is in *

   NHS Midlands

## Improve workplace wellbeing for our Resident Doctors.

**Trusts are expected to take meaningful steps to improve the working environment for Resident Doctors**. We are keen to see the activities you have undertaken in the last 12 weeks to improve workplace wellbeing for Resident Doctors.

6. Which of the following facilities and support levels do you offer to Resident Doctors *

| | YES, for ALL | YES PARTIALLY (available but to more than 50% of Resident Doctors) | YES, PARTIALLY (available but to less than 50% of Resident Doctors | Planning to Introduce in the next 3 months | NO |
|---|---|---|---|---|---|
| Access to Lockers | ○ | ◉ | ○ | ○ | ○ |
| Designated on-call car parking access. e.g. access to safe / secure car parking near the hospital for RDs' on call. | ◉ | ○ | ○ | ○ | ○ |
| Rest facilities. | ○ | ◉ | ○ | ○ | ○ |
| Access to hot and cold food 24/7. e.g. a microwave / fridge? | ○ | ○ | ◉ | ○ | ○ |
| Access to cold food 24/7. | ◉ | ○ | ○ | ○ | ○ |
| Access to inductions specifically designed to meet the needs of Resident Doctors. | ◉ | ○ | ○ | ○ | ○ |
| Offer beds or sleeping pods free of charge, to allow for rest post duty periods for staff who feel too tired to drive home. | ◉ | ○ | ○ | ○ | ○ |
| Ability for Resident Doctors to work from home for portfolio and self-directed learning where possible. | ◉ | ○ | ○ | ○ | ○ |
| Access to free psychological support and treatment. | ◉ | ○ | ○ | ○ | ○ |

| | YES, for ALL | YES PARTIALLY (available but to more than 50% of Resident Doctors) | YES, PARTIALLY (available but to less than 50% of Resident Doctors | Planning to Introduce in the next 3 months | NO |
|---|---|---|---|---|---|
| Positive feedback mechanisms to reward and promote staff for excellence (e.g. Greatix or Patient Safety 2) | ◉ | ○ | ○ | ○ | ○ |
| Protected Breaks | ○ | ○ | ○ | ◉ | ○ |
| Promotion of the Safe Learning Environment Charter | ○ | ◉ | ○ | ○ | ○ |
| Sexual safety /harassment training and awareness | ○ | ◉ | ○ | ○ | ○ |

7. Please give examples of the improvements you have made, particularly if you have moved towards offering a service to more than 50%. If you have been unable to make improvements please describe why including the findings, challenges and barriers you encountered. *

Actions have been taken forward by a weekly dedicated task and finish group. Current improvements include: Lockers - developed a map of lockers where lockers are currently available and can be used by Resident Doctors. Car parking spaces - RDs are able to park on-site in hospital staff spaces as opposed to e.g. off-site residential areas. Rest facilities - improved space utilisation including off ward areas that have freed up areas for RDs to rest. Access to hot food - improved on one hospital site and currently undergoing procurement process to enhance cross-site availability for all staff members including RDs. Beds / Sleeping pods offer - now available to all RDs. Positive feedback mechanism - values award process launched 01 Oct 2025. Promotion of SLEC charter - now on RD induction and in-year refresher sessions for both RDs / other medical staff. Sexual safety charter / harassment training - now on RD induction and in-year refresher sessions / workshops for both RDs / other medical staff (run in collaboration with GMC).

## Resident Doctors must be able to take annual leave in a fair and equitable manner

**It is vital that leave is allocated in a way that helps look after individual's needs and well being while maintaining service delivery.**

8. Do you have a local policy to encourage good annual leave management which explicitly includes reference to resident doctors? *

- ◉ Yes
- ○ No

- ( ) Not yet. Planning to introduce in the next 3 months

9. Is good annual leave practice covered at resident doctor induction? *

- (•) Yes
- ( ) No
- ( ) Not yet. Planning to introduce in the next 3 months

10. Do you allow resident doctors to carry over annual leave between rotations? *

- (•) Yes but only for internal rotations
- ( ) Yes both for internal and external rotations
- ( ) No

11. Please use this space to give examples of the activity undertaken in the last 12 weeks to improve annual leave management and any future plans: *

Developed SOP and policy that explicitly articulates annual leave management for resident doctors.

12. Do your rostering systems for Resident Doctors allow for self/preferential rostering? *

- ( ) Yes our rostering system for Resident Doctors allows for self/preferential rostering
- (•) No our rostering system for Resident Doctors do not allow for self/preferential rostering

13. Please use this space to give examples of the activity undertaken in the last 12 weeks to improve self/preferential rostering and any future plans: *

Exploring different mechanisms to allow preferential rostering in the future through e.g. self reporting of shift preferences via MS Forms etc - but this being feasible is likely to be dependent on expanding the Medical Workforce team numbers.

14. If you have answered 'No' to any of the questions in this section, please explain why. For example, the RDs asked for a different solution or it wasn't possible because of a specific issue. *

As above - enacting the functionality of preferential rostering is likely to require an increase in Medical Workforce team headcount, which is challenging in the current financial / workforce climate within the NHS.

## Appointing senior leads to take action on Resident Doctor issues

**All NHS Trust Boards must appoint two named leads**: One senior leader responsible for Resident Doctor issues, and one peer representative who is a Resident Doctor. Both should report to the Board.

15. Has your Trust Board appointed a **Senior Accountable Resident Doctor Lead?** *

- (●) Yes
- ( ) No

16. Has your Trust Board appointed a **Resident Doctor Peer Lead?** *

- (●) Yes
- ( ) No
- ( ) Recruitment Underway

17. Has your Resident Doctor Peer Lead been invited to attend Board level discussions on issues which specifically relate to improving doctors working lives. *

- ( ) Yes
- ( ) No
- (●) Invited but not yet attended

18. At what levels of your organisation have you reviewed and discussed the following surveys? *

| | Executive Team | People Committee | Trust Board | All | None | Two of the Three |
|---|---|---|---|---|---|---|
| GMC Trainee Survey | ( ) | ( ) | ( ) | (●) | ( ) | ( ) |
| NETS Survey | ( ) | ( ) | ( ) | (●) | ( ) | ( ) |
| National Staff Survey | ( ) | ( ) | ( ) | (●) | ( ) | ( ) |

| | Executive Team | People Committee | Trust Board | All | None | Two of the Three |
|---|---|---|---|---|---|---|
| National Student Survey | ○ | ○ | ○ | ◉ | ○ | ○ |

19. If you report GMC/NETS survey results to any of the groups above, does the report contain a quality improvement plan with individuals assigned as responsible for actions? *

- ◉ Yes
- ○ No

20. How else do you try to understand and act on issues specific to Resident Doctors? (Please tick ALL that apply) *

- ☑ Meet regularly with a local representative body of Resident Doctors e.g. LNC, JCC
- ☑ Have some other regular similar meeting?
- ☑ Meet regularly with BMA representatives?
- ☑ Resident Doctors' Forum
- ☑ Staff survey results specifically for Resident Doctors
- ☑ Other Methods

21. How are you engaging on improvement activities with your Resident Doctor Peer Lead and Senior Accountable Resident Doctor Lead. Has a plan been developed to understand local working conditions and priorities. Please use this space to describe the activity which has been undertaken in the last 12 weeks and any future plans?

Weekly meetings between PR / SLRDE. PR is a core member of the weekly 10 Point Plan Task and Finish Group, and is already bring issues and concerns to be addressed in a timely fashion via that Group. Trust has also appointed two associate Peer Representatives to support the PR / SLRDE. PR is actively engaging with the Resident Doctors via multiple approaches to gauge opinion on future directions.

22. If you have answered 'No' to any of the questions in this section, please explain why. For example, the RDs asked for a different solution or it wasn't possible because of of a specific issue. *

N/A - no responses were No.

## Resident Doctors should never experience payroll errors due to rotations.

What are you doing to ensure that payroll errors as a result of rotations are reduced by a minimum of 90% by March 2026. All organisations are required to attend a payroll.

23. Have you implemented local SLAs and introduced board-level governance for tracking and reporting payroll errors *

- ( ) Yes
- ( ) No
- (•) No, but planning to in the next 3 months

24. Did you undertake any of the following actions within the 12 week period? *

- [x] Attended a Payroll Webinar (Inc through Lead Employer)
- [ ] Introduced a Board-level governance framework
- [ ] Other activities (e.g. Payroll drop in sessions)
- [ ] None of the above

25. Have you seen any changes in payroll errors over the last 12 months? *

- ( ) Yes, we have seen a DECREASE in errors
- ( ) Yes, we have seen an INCREASE in errors
- ( ) No material change
- (•) We do not monitor

26. Please describe the any improvements you have made to reduce Payroll errors.

Enter your answer

27. If you have answered 'No' to any of the questions in this section, please explain why. For example, the RDs asked for a different solution or it wasn't possible because of of a specific issue.

Payroll services are provided by a third party (LPFT), who are engaging with the national payroll improvement plan. Local KPIs are being developed, which will then enable robust reporting on payroll errors thereafter. The Trust Medical Workforce team will be the single point of contact for all medical staff payroll enquiries (including Resident Doctors).

## Course related expenses must be reimbursed when expenses occur

**Resident Doctors should receive reimbursement of course related expenses within 4-6 weeks after expenses are submitted.** We will transition nationally from an approach where expenses for approved study leave are reimbursed only after a Resident Doctor has attended a course/activity, to one where reimbursement is provided as soon as possible after the expense is incurred. If your Trust works with a Lead Employer Organisation, please qualify your responses with them prior to submitting.

28. In relation to course fee reimbursement, do you: *

- ○ Process and pay reimbursement at the point the course is booked/expense is incurred.
- ○ Only after attendance on a course.
- ◉ Only after attendance on a course, but planning on changing this approach within the next 3 months.

29. Have you reviewed current processes to ensure Resident Doctors can be reimbursed upon submission of valid receipts for all approved study leave-related expenses, including travel and subsidence. *

- ◉ Yes
- ○ No
- ○ No, planning on changing within the next 3 months

30. Are you reimbursing within 6 weeks of submitting expense? *

- ◉ Yes
- ○ No
- ○ Plan to in next 3 months

31. Please use this space to give examples of the activity undertaken in the last 12 weeks to improve reimbursement of course fees and expenses and any future plans: *

Currently actively changing process through governance mechanisms to allow reimbursement upon submission of claims / receipts, with a quality control mechanism to check that RDs have attended the course activities claimed for after the event.

32. If you have answered 'No' to any of the questions in this section, please explain why. For example, the RDs asked for a different solution or it wasn't possible because of of a specific issue. *

Not applicable

## No resident doctor should unnecessarily repeat mandatory training when rotating

**Within the next 12 weeks if they are not already doing so, every trust should:** Comply with agreements set out in MoU signed by all trusts in May 2025 by ensuring acceptance of prior training. By April 2026 we will reform the entire approach to stat/man with a revised framework as outlined in the 10 Year Plan.

33. Do you accept mandatory training completed by resident doctors elsewhere, in line with the Recognition of Statutory and Mandatory Training Memorandum of Training **AND** do you adhere to the People Policy Framework for Mandatory Learning agreed on 1 May 2025? *

- ○ Yes, MOU only
- ◉ Yes, both
- ○ Yes, People Policy Framework only
- ○ No
- ○ No, but planning to within the next 6 months

34. Please describe the implementation actions you have undertaken to improve Statutory and Mandatory Training for Resident Doctors and any future plans: *

Was already doing this before the proposal of the 10 Point Plan in August 2025.

35. If you have answered 'No' to any of the questions in this section, please explain why. For example, the RDs asked for a different solution or it wasn't possible because of of a specific issue. *

Not applicable.

Once you have completed this section please submit using the button below. Thank you.

36. Who has assured this survey prior to submitting: *

- [x] Senior Accountable Resident Doctor Lead
- [x] Resident Doctor Peer Lead
- [ ] Other
- [ ] Chief People Officer
- [x] Medical Director

37. For completion by the Resident Doctor Peer Lead, do you: *

- (•) Fully support the findings as set out in this survey
- ( ) Partially support the findings as set out in this survey
- ( ) Do not support the findings as set out in this survey

38. Please provide a feedback statement from your Resident Doctor Peer Lead on their views of the progress over the last 12 weeks. *

Comment from Dr Arunpreet Sahota (Resident Doctor Peer Lead): described in Box 40 as unable to fit into this answer box.

39. Is the agreed post follow up survey meeting in place with your Senior Accountable Resident Doctor Board Lead and your Resident Doctor Peer Lead? *

- [ ] No, but plan to shortly
- [x] Yes
- [ ] No

40. Any other comments or feedback to help inform the next phases of the 10 Point Plan to improve resident doctors' working lives programme *

Comment from Dr Sahota (Resident Doctor Peer Lead) from box 38: "Over the last 12 weeks, I've felt that things are moving in the right direction.
The weekly Task-and-Finish meetings around the 10-point plan have been valuable.
Each week I'm also invited to bring concerns straight from the resident body to the table, and it's been good to see that these aren't just listened to but actually acted on. Having that consistent space to raise issues and check back on them has made a big difference.

My separate conversations with Prof Farquharson have also helped keep things moving. It's been useful having that direct line to the Medical Director, so I can feed back what's happening on the ground in Lincoln and make sure the bigger picture aligns with what residents are actually experiencing. He's been open and supportive, which has made it easier to push for changes that matter.
There's still plenty to do, but compared to where we started 12 weeks ago, the progress feels real. The combination of regular meetings, open discussion, and senior engagement means we're  seeing concerns turn into practical steps.
I feel positive about my contribution to this role and I am grateful for the support form my senior team and colleagues."

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| Question | RAG based on survey question responses submitted on 12.09.25 | RAG based on survey question responses submitted on 10.12.25 | Actions Undertaken |
|---|---|---|---|
| **Facilities and support to Resident Doctors** | | | |
| Access to lockers | Yes Partially but to less than 50% | Yes Partially but to more than 50% | Maps showing all lockers, communication regarding bringing a padlock to be included in induction pack for all new starters |
| Available on call parking access | Yes Partially but to less than 50% | Yes | Car Parking - after clarification nationally on question context, Resident Doctors are able to park on-site in hospital staff spaces as opposed to e.g. off site residential areas. |
| Rest Facilities | Yes Partially but to less than 50% | Yes Partially but to more than 50% | Details of all Mess facilities, Progress living and how to book on-call rooms to be communicated out and also included at induction. |
| Access to hot and cold food 24/7 | Planning to introduce in the next 3 months | Planning to introduce in the next 3 months | Procurement process currently ongoing - Resident Doctors invited to participate |
| Access to cold food 24/7 | Yes for all | Yes for all | Monitor |
| Access to inductions (Res Drs) | Yes for all | Yes for all | Monitor |
| Offer beds/pods free of charge to allow rest post duty for staff who feel to tired to drive home | Yes Partially but to less than 50% | Yes | Details of all Mess facilities, Progress living and how to book on-call rooms communicated out and also included at induction |
| Access to free psychological support and treatment | Yes for all | Yes for all | Monitor |
| Positive feedback mechanisms to reward and promote staff for excellence | | Yes for all | Values award launched on 01.10.25 and on Resident Doctor Portal. |
| Protected breaks | Planning to introduce in the next 3 months | Planning to introduce in the next 3 months | In discussion with the Care Groups |
| Promotion of safe learning environment charter | Yes Partially but to less than 50% | Yes Partially but to more than 50% | To be included at induction |
| Sexual safety/harassment training | Yes Partially but to less than 50% | Yes Partially but to more than 50% | Sexual safety charter launched |
| **Resident Doctors must be able to take annual leave in a fair and equitable manner** | | | |

| | | | |
|---|---|---|---|
| Local policy to encourage good annual leave management which explicitly includes reference to resident doctors | Planning to introduce in the next 3 months | Yes | SOP approved and published and circulated. |
| Is good annual leave practice covered at resident doctor induction | Yes | Yes | Monitor |
| Do you allow resident doctors to carry over annual leave between rotations | Yes but for only internal rotations | Yes but for only internal rotations | Monitor |
| If you answer Yes - how much leave do you allow | | 5 days and through mutual agreement | Monitor |
| Do your rostering systems for RD allow for self/preferential rostering | No does not allow for self/preferential rostering | Planning to introduce this | Exploring different mechanisms to allow preferential rostering in the future through e.g. self reporting of shift preferences via MS Forms etc - but this being feasible is likely to be dependent on expanding the Medical Workforce team numbers. |
| **Appointing senior leads to take action on Resident Doctor issues** | | | |
| Has your Trust Boad appointed a senior named accountable resident doctor lead | No - no available JD for role available from NHSE at time of survey | Yes | GCMO is now the appointed Senior Accountable Resident Dr Lead and there is an established Task and Finish Group which has been in meeting weekly since 02.10.25 |
| If no - why and when do you intend to appoint one | | | Appointed on 10.10.25 |
| Do you have a peer representative RD who your Board consults with on local issues relating to RD and improving working lives | No - no available JD for role available from NHSE at time of survey | Yes | Peer Representative and 2 Associate Peer Representatives appointed - draft Job Spec to be circulated |
| **At what levels of the organisation have your reviewed and discussed the following surveys** | | | |
| GMC Trainee Survey | All levels | All levels | Monitor |
| NETS survey | All levels | All levels | Monitor |

| | | | |
|---|---|---|---|
| If you report GMC/NETs survey to any of the groups in Q above does the report contain a quality improvement plan with individuals assigned as responsible for action | | Yes | Monitor |
| How else do you try to understand and act on issues specific to resident doctors | | Other actions | Meet regularly with a representative body of Resident Doctors e.g. LNC, JCC, RDF, RDC and BMA representatives and also NHSE. Staff Survey Results specifically for Resident Doctors. |
| Have you implemented local SLAs and board level governance for tracking and reporting payroll errors | No | Planning to do so | Payroll services are provided by a third party (LPFT), who are engaging with the national payroll improvement plan. Local KPIs are being developed, which will then enable robust reporting on payroll errors thereafter. The Trust Medical Workforce team will be the single point of contact for all medical staff payroll enquiries (including Resident Doctors). |
| have you seen any changes in payroll errors over the past 12 months | No - as not monitored | | See above |
| **Course related expenses must be reimbursed when expenses occur** | | | |
| In relation to course fee reimbursement, what do you do: | | | Reimbursement is done through Accent and PGME and it is now a new process that is documented on the Resident Doctor portal. Any course fee can be claimed at time of booking and then expenses usually once the course has been attended (but exceptions to paying expenses in advance of attendance can be considered on a case-by-case basis). |
| **No resident doctor should unnecessarily repeat mandatory training when rotating** | | | |

| | | | |
|---|---|---|---|
| Do you accept mandatory training completed by resident doctors elsewhere, in line with the Recognition of Statutory and Mandatory Training Memorandum of Training AND do you adhere to the People Policy Framework for Mandatory Learning agreed on 1 May 2025? | Yes | Yes | No additional action required |
| Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours | | The GoSW and GoSW officer maintain strong communication with the Resident Drs and support them in exception reporting . They have a profile created within one week on the software to ensure they are able to report on commencement with the Trust. | To await the further guidance from NHSE around Exception reporting and plan to implement any new changes ASAP. |
| Resident doctors should receive reimbursement of course related expenses as soon as possible | Yes | Yes | To remind Resident Drs to submit in a timely fashion so they can then receive reimbursement in a timely manner. |
| We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery | NHSE guidance awaited | NHSE guidance awaited | The Trust waits for the guidance from NHSE within the next 12 weeks (this was due in October 2025 and is still awaited). However, the Trust does already take into consideration requests from Resident Drs regarding external commitments which may impact on service delivery. |
| We will minimise the practical impact upon resident doctors of having to move employers when they rotate, by expanding the Lead Employer model | Await further information from NHSE regarding the Lead Employer model expansion | Await further information from NHSE regarding the Lead Employer model expansion | No further clarification from NHSE to date regarding Lead Employer expansion status. |

Department of Health & Social Care

NHS England

# 10 Point Plan to improve Resident Doctors' working lives

## Midlands Overview
## 12-week Progress Survey

# Midlands 12-Week Progress Survey Responses

## Total Organisations

* 35

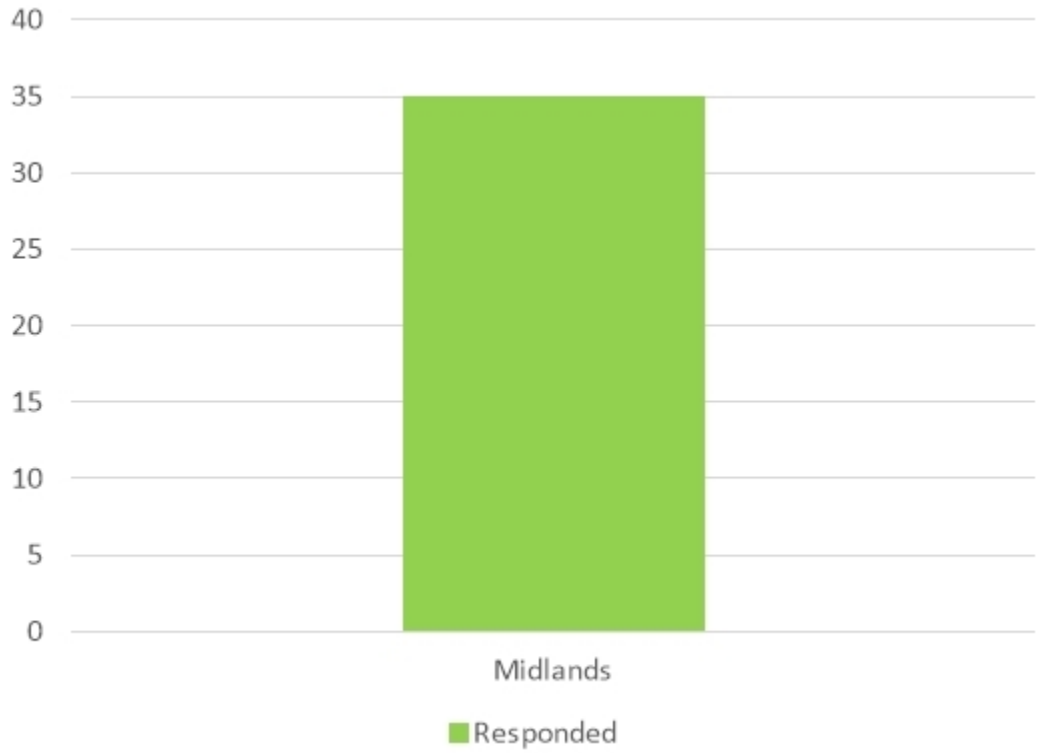
## Total Organisations Submitted

35 100%

## Organisations with no Resident Doctors (RD)

3 NB | Not included in total

Lincolnshire Community NHS Trust
Shropshire Community Health NHS Trust
Derbyshire Community Health Services NHS Foundation Trust

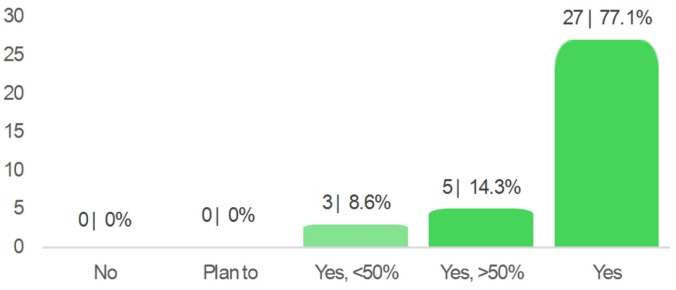



*Based on NHSE Provider Directory: 40 Trusts (2 Ambulance, 3 without resident doctors); 35 with resident doctors

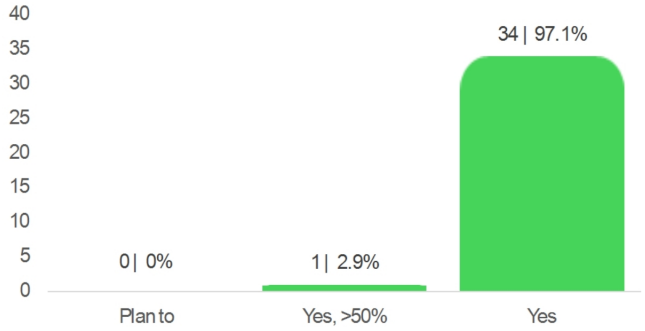
# Amenities (12-week progress survey)

## Midlands Summary | Amenities (1 of 2)

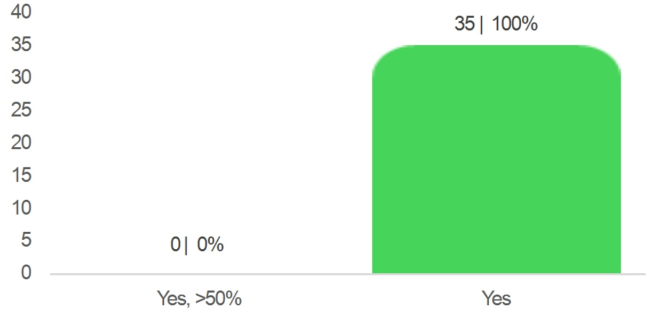
Do you offer rest facilities?



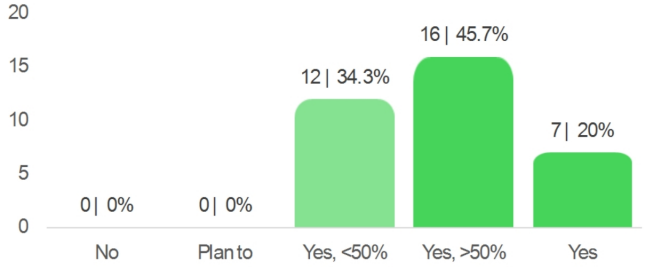

Do you offer access to inductions specifically designed to meet the needs of RDs?



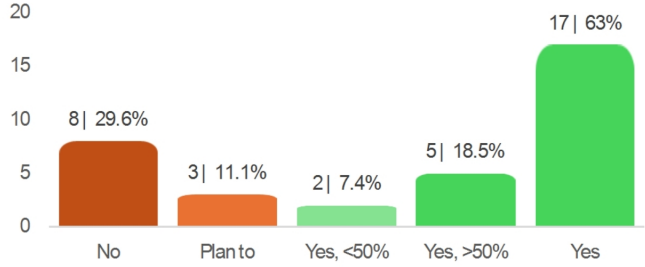

Do you offer access to free psychological support and treatment?



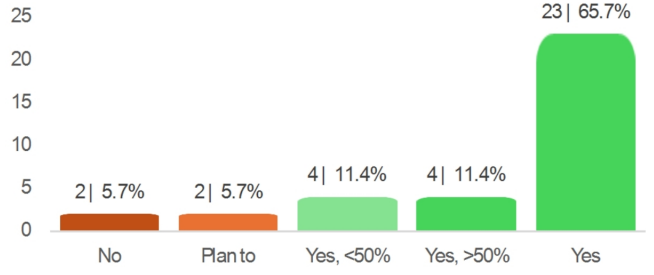

Do you offer lockers?



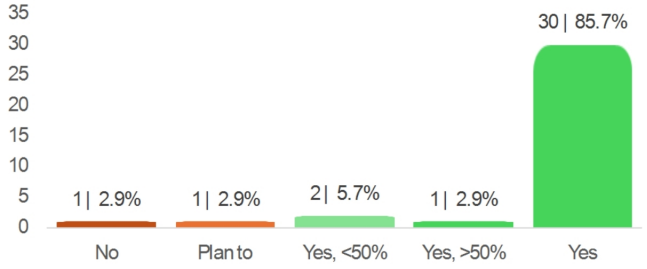

Do you offer designated on-call car parking access?



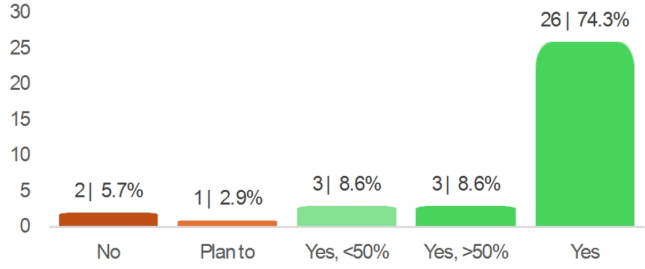

Do you offer access to hot and cold food 24/7?



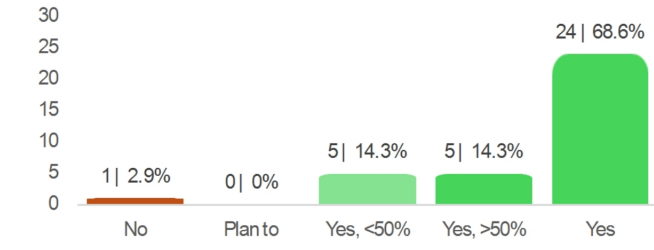

Do you offer access to cold food 24/7?




Do you offer beds or sleeping pods free of charge, to allow for rest post duty periods for staff who feel too tired to drive home?



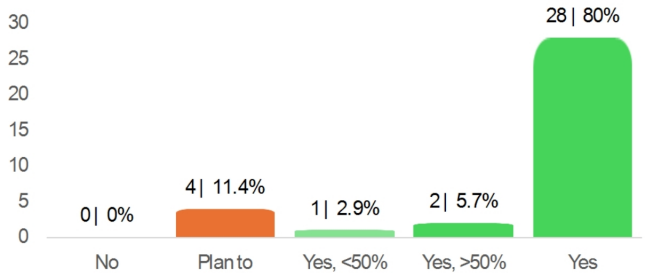

Is there an ability for RDs to work from home for portfolio and self-directed learning, where possible?



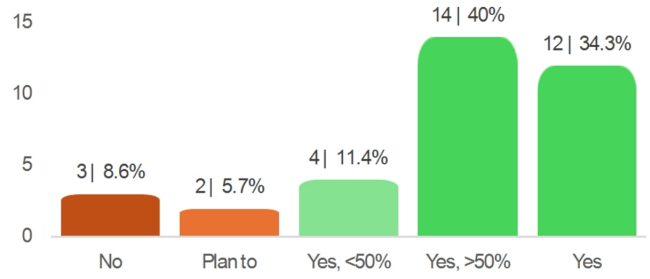
# Amenities (12-week progress survey)

## Midlands Summary | Amenities (2 of 2)

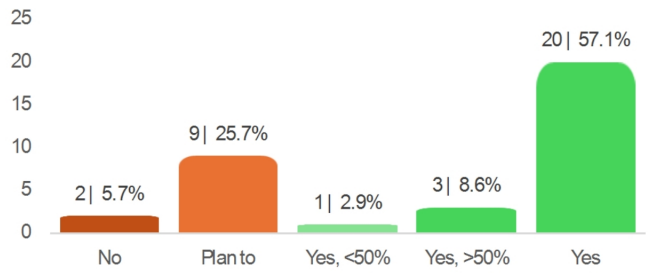
Do you offer positive feedback mechanisms to reward and promote staff for excellence? E.g, Greatix or Patient Safety 2



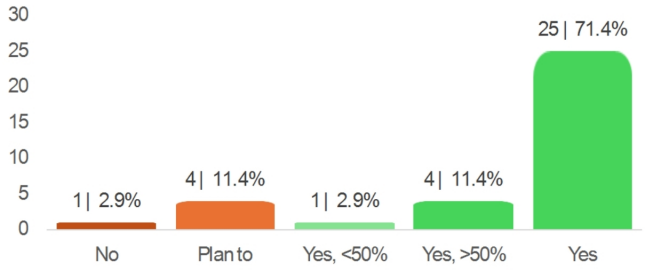

Do you offer protected breaks?




Does the organisation promote the Safe Learning Environment Charter?



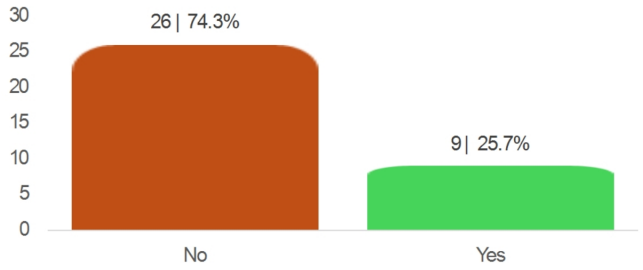

Do you offer sexual safety/harassment training and awareness?



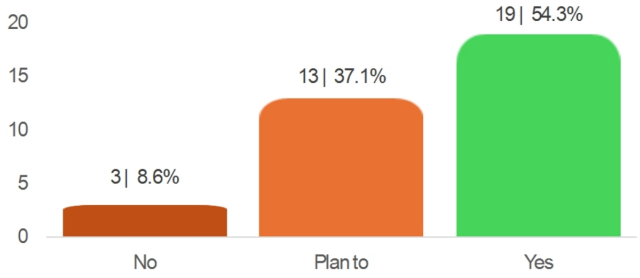
# Annual Leave (12-week progress survey)

## Midlands Summary | Annual Leave

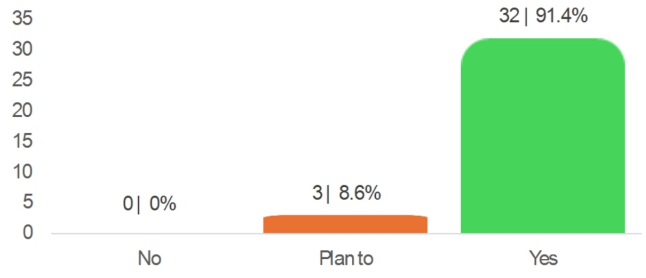
Do your rostering systems for RDs allow for self/preferential rostering?



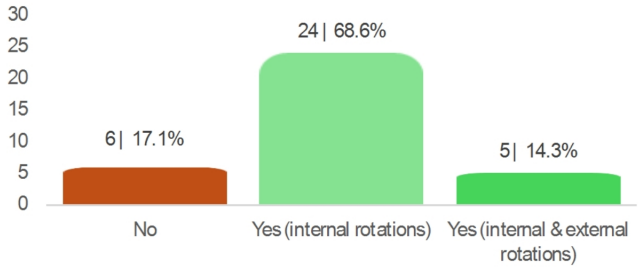

Do you have a local policy to encourage good annual leave management which explicitly includes reference to RDs?




Is good annual leave practice covered at RD induction?



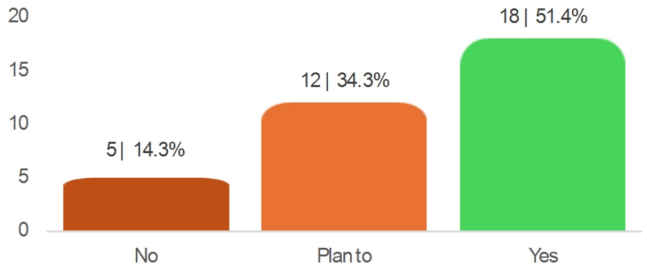

Do you allow RDs to carry over annual leave between rotations?



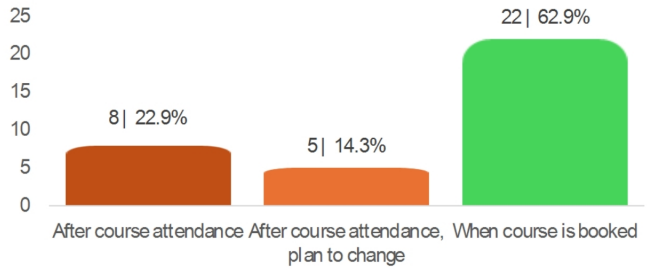
# Payroll & Expenses (12-week progress survey)

## Midlands Summary | Payroll & Expenses

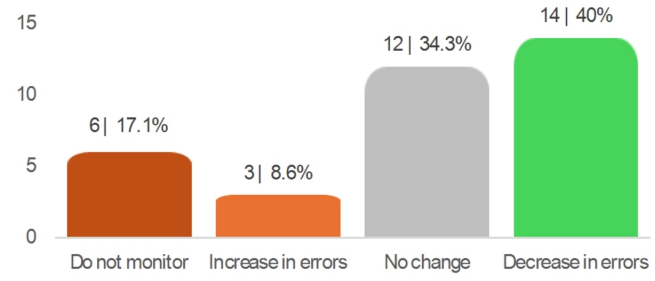
Have you implemented local SLAs and introduced board-level governance for tracking and reporting payroll errors?




In relation to course fee reimbursement, do you:



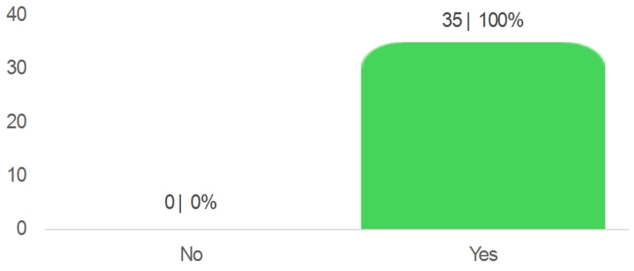

Have you seen any changes in payroll errors over the last 12 months?



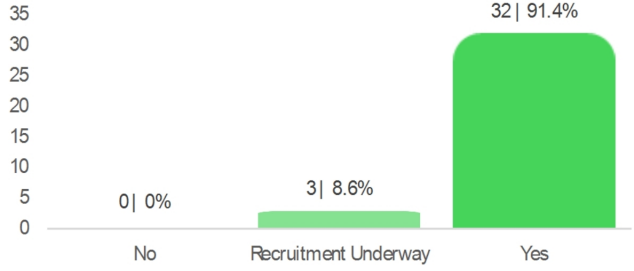
# Senior Leads & Learning (12-week progress survey)

## Midlands Summary | Senior Leads & Learning

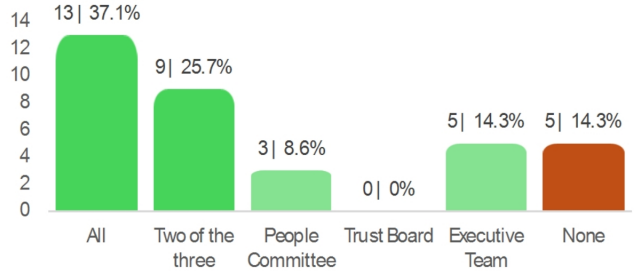
Has your trust appointed a senior named, accountable RD Lead?



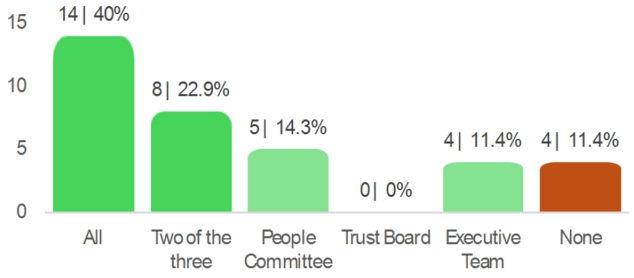

Has your Trust Board appointed a Resident Doctor Peer Lead?



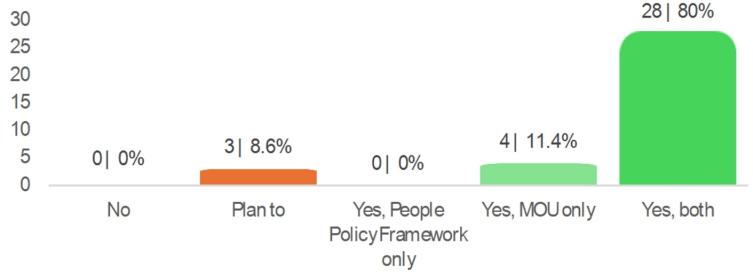

At what levels of your organisation have you reviewed and discussed the GMC Survey?



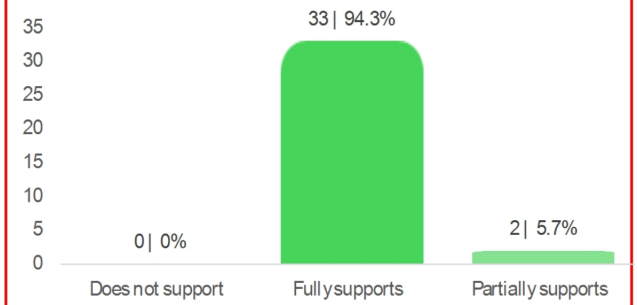

At what levels of your organisation have you reviewed and discussed the National Education and Training Survey (NETS)?




Do you accept mandatory training completed by RDs elsewhere, in line with the Recognition of Statutory and Mandatory Training Memorandum of Training AND do you adhere to the People Policy Framework for Mandatory Learning agreed on 1 May 2025?




Does the Resident Doctor Peer Lead support the findings as set out in the survey?



# Midlands Regional Improvement Progress
# Baseline Survey compared to 12-week Survey

## Amenities

| | Baseline Survey | | | | 12-week Progress Survey | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Yes | Yes, <50% | Plan to | No | Yes | Yes >50% | Yes, <50% | Plan to | No |
| Access to Lockers | 11 | 24 | 0 | 1 | 7 | 16 | 12 | 0 | 0 |
| Rest facilities | 31 | 5 | 0 | 0 | 27 | 5 | 3 | 0 | 0 |
| Designated on-call parking access | 12 | 5 | 1 | 18 | 17 | 5 | 2 | 3 | 8 |
| Access to hot and cold food 24/7 | 16 | 7 | 2 | 11 | 23 | 4 | 4 | 2 | 2 |
| Access to cold food 24/7 | 30 | 1 | 1 | 4 | 30 | 1 | 2 | 1 | 1 |
| Inductions specifically designed to meet the needs of Resident Doctors | 36 | 0 | 0 | 0 | 34 | 1 | 0 | 0 | 0 |
| Beds/sleeping pods available free of charge | 25 | 8 | 0 | 3 | 26 | 3 | 3 | 1 | 2 |
| Resident doctors able to work from home for portfolio and self-directed learning | 27 | 5 | 3 | 1 | 24 | 5 | 5 | 0 | 1 |
| Access to free psychological support treatment | 35 | 0 | 0 | 1 | 35 | 0 | 0 | 0 | 0 |
| Positive feedback mechanisms in place to reward and promote staff | 26 | 7 | 2 | 1 | 28 | 2 | 1 | 4 | 0 |
| Protected breaks | 20 | 12 | 1 | 3 | 12 | 14 | 4 | 2 | 3 |
| Promote the Safe Learning Environment Charter | 17 | 6 | 6 | 7 | 20 | 3 | 1 | 9 | 2 |
| Sexual safety/harassment training and awareness | 28 | 5 | 2 | 1 | 25 | 4 | 1 | 4 | 1 |

## Annual Leave

| | Baseline Survey | | | 12-week Progress Survey | | |
|---|---|---|---|---|---|---|
| | Yes | Plan to | No | Yes | Plan to | No |
| Is there a local policy to encourage good annual leave management which references resident doctors? | 21 | 10 | 5 | 19 | 13 | 3 |
| Good annual leave practice covered at resident doctor induction? | 33 | 3 | 0 | 32 | 3 | 0 |
| Do rostering systems for Resident Doctors allow for self/preferential rostering? | 7 | 0 | 2 | 9 | 0 | 26 |
| | Yes (internal & external rotations | Yes (internal rotations) | No | Yes (internal & external rotations | Yes (internal rotations) | No |
| Allow resident doctors to carry over annual leave between rotations? | 5 | 20 | 11 | 5 | 24 | 6 |

# Midlands Regional Improvement Progress
# Baseline Survey compared to 12-week Survey

## Appointing senior leads to take action on Resident Doctor issues

### Baseline Survey

| | Yes | | | No | | |
|---|---|---|---|---|---|---|
| Has your Trust Board appointed a senior named, accountable Resident Doctor Lead? | 23 | | | 13 | | |
| | Yes | | No, consult with LNC/equiv. bodies | | No | |
| Has your Trust Board appointed a Resident Doctor Peer Lead? | 14 | | 18 | | 4 | |
| At what levels of your organisation have you reviewed and discussed the: | All | Two out of three | Exec Team | People Committee | Trust Board | None |
| GMC training survey? | 17 | - | 10 | 8 | 10 | - |
| NETS survey? | 15 | - | 10 | 9 | 2 | - |
| National staff survey? | - | - | - | - | - | - |
| National student survey? | - | - | - | - | - | - |

### 12-week Progress Survey

| Yes | | | No | | |
|---|---|---|---|---|---|
| 35 | | | 0 | | |
| Yes | | Recruitment underway | | No | |
| 32 | | 3 | | 0 | |
| All | Two out of three | Exec Team | People Committee | Trust Board | None |
| 13 | 9 | 5 | 3 | 0 | 5 |
| 14 | 8 | 4 | 5 | 0 | 4 |
| 23 | 5 | 5 | 2 | 0 | 0 |
| 8 | 7 | 4 | 2 | 0 | 14 |

## Payroll and Expenses

### Baseline Survey

| | Yes | Plan to | | No | |
|---|---|---|---|---|---|
| Implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors. | 12 | 13 | | 11 | |
| | Yes, decrease | Yes, increase | No change | | Do not monitor |
| Changes in payroll errors over the last 12 months? | 15 | 2 | 12 | | 7 |
| | When booked | After course attendance, plan to change | | | After course attendance |
| Processing of course related expenses | 6 | 9 | | | 21 |

### 12-week Progress Survey

| Yes | Plan to | No | |
|---|---|---|---|
| 18 | 12 | 5 | |
| Yes, decrease | Yes, increase | No change | Do not monitor |
| 14 | 3 | 12 | 6 |
| When booked | After course attendance, plan to change | | After course attendance |
| 22 | 5 | | 8 |

## Mandatory Training and Learning

### Baseline Survey

| | Yes, both | Yes, MOU | Yes, People Policy | Plan to | No |
|---|---|---|---|---|---|
| Do you accept resident doctors' mandatory training from other sites and follow the People Policy Framework (May 2025)? | 31 | 0 | 1 | 4 | 0 |

### 12-week Progress Survey

| Yes, both | Yes, MOU | Yes, People Policy | Plan to | No |
|---|---|---|---|---|
| 28 | 4 | 0 | 3 | 0 |

# Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: United Lincolnshire Teaching Hospitals NHS Trust

| Amenities | Baseline survey | 12-week progress |
|---|---|---|
| Access to Lockers | Yes, <50% | Yes, >50% |
| Rest facilities | Yes, <50% | Yes, >50% |
| Designated on-call parking access | Yes, <50% | Yes |
| Access to hot and cold food 24/7 | Plan to | Yes, <50% |
| Access to cold food 24/7 | Yes | Yes |
| Inductions specifically designed to meet the needs of Resident Doctors | Yes | Yes |
| Beds/sleeping pods available free of charge | Yes, <50% | Yes |
| Are Resident doctors able to work from home for portfolio and self-directed learning? | Yes | Yes |
| Access to free psychological support treatment? | Yes | Yes |
| Positive feedback mechanisms in place to reward and promote staff? | Yes, <50% | Yes |
| Protected breaks? | Plan to | Plan to |
| Do you promote the Safe Learning Environment Charter? | Yes, <50% | Yes, >50% |
| Sexual safety/harassment training and awareness? | Yes, <50% | Yes, >50% |

| Appointing senior leads to take action on Resident Doctor issues | Baseline survey | 12-week progress |
|---|---|---|
| Has your Trust Board appointed a senior named, accountable Resident Doctor Lead? | No | Yes |
| Has your Trust Board appointed a Resident Doctor Peer Lead? | No (consult with LNC/ equiv. bodies) | Yes |
| At what levels of your organisation have you reviewed and discussed the following surveys? (None, Executive team, Trust Board, People Committee, Two out of Three, or All) | | |
| GMC Training survey | All | All |
| NETS survey | All | All |
| National Staff Survey | | All |
| National Student Survey | | All |

| Annual Leave | Baseline survey | 12-week progress |
|---|---|---|
| Is there a local policy to encourage good annual leave management which references resident doctors? | Plan to | Yes |
| Good annual leave practice covered at resident doctor induction? | Yes | Yes |
| Allow resident doctors to carry over annual leave between rotations? | Yes (internal rotations) | Yes (internal rotations) |
| Do rostering systems for Resident Doctors allow for self/preferential rostering? | No | No |

| Payroll and Expenses | Baseline survey | 12-week progress |
|---|---|---|
| Implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors? | No | Plan to |
| Changes in payroll errors over the last 12 months? | Do not monitor | Do not monitor |
| Processing of course related expenses? | After attendance, plan to change | After course attendance, plan to change |

| Mandatory Training & Learning | Baseline survey | 12-week progress |
|---|---|---|
| Do you accept resident doctors' mandatory training from other sites and follow the People Policy Framework (May 2025)? | Yes, both | Yes, both |

| | |
|---|---|
| **Does the Resident Doctor Peer Lead support the findings as set out in this survey?** | Fully supports |

* 12-week progress survey **81%** (Improvement of 19pp)

* The survey score is calculated by averaging the percentage scores of each scored question. . Please refer to the points scheme for specific scoring criteria.

# 12-Week Progress Survey Points Scheme

*These questions follow the flow of the survey but not the clustering as outlined in the Trust level breakdown.*

| Question | Answers | Maximum Point | Minimum Point |
|---|---|---|---|
| Q1 – Provide name of organisation | Question not scored | | |
| Q2 – Provide name of person responding | Question not scored | | |
| Q3 – Role of person responding | Question not scored | | |
| Q4 – Email address of person responding | Question not scored | | |
| Q5 – Region | Question not scored | | |
| Q6 – Do you offer access to lockers | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q6 – Do you offer designated on-call parking access. | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q6 – Offer rest facilities | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q6 – Do you offer access to hot and cold food 24/7 | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q6 – Do you offer access to cold food 24/7 | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q6 – Do you offer access to inductions specifically designed to meet the needs of Resident Doctors. | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q6 – Offer beds or sleeping pods free of charge, to allow for rest post duty periods for staff who feel too tired to drive home. | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q6 – Ability for Resident Doctors to work from home for portfolio and self-directed learning where possible. | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q6 – Access to free psychological support and treatment. | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q6 – Positive feedback mechanisms to reward and promote staff for excellence (e.g. Greatix or Patient Safety 2) | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |

## Improving Doctors Working Lives – 12-Week Progress Survey Points Scheme cont'd

| Question | Answers | Maximum Point | Minimum Point |
|---|---|---|---|
| Q6 – Offer protected breaks | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q6 – Promotion of the Safe Learning Environment Charter | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q6 – Offer sexual safety /harassment training and awareness | Yes for all – 3 points, Yes partially (available to more than 50% of Resident Doctors) – 3 points, Yes, partially (available but to less than 50% of Resident Doctors) – 2 points, Planning to introduce in 3 months – 1 point, No – 0 points. | 3 | 0 |
| Q7 – Please give examples of the improvements you have made, particularly if you have moved towards offering a service to more than 50%. If you have been unable to make improvements please describe why including the findings, challenges and barriers you encountered. | Question not scored. | | |
| Q8 – Do you have a local policy to encourage good annual leave management which explicitly includes reference to resident doctors? | Yes – 2 points, Not yet. Planning to introduce in the next 3 months – 1 point, No – 0 points | 2 | 0 |
| Q9 – Is good annual leave practice covered at resident doctor induction? | Yes – 2 points, Not yet. Planning to introduce in the next 3 months – 1 point, No – 0 points | 2 | 0 |
| Q10 – Do you allow resident doctors to carry over annual leave between rotations? | Yes both for internal and external rotations – 2 points, Yes but only for internal rotations – 1 point, No – 0 points. | 2 | 0 |
| Q11 – Please use this space to give examples of the activity undertaken in the last 12 weeks to improve annual leave management and any future plans. | Question not scored | | |
| Q12 – Do your rostering systems for Resident Doctors allow for self/preferential rostering? | Yes – 1 point, No – 0 points | 1 | 0 |
| Q13 – Please use this space to give examples of the activity undertaken in the last 12 weeks to improve self/preferential rostering and any future plans. | Question not scored | | |
| Q14 – If you have answered 'No' to any of the questions in this section, please explain why. For example, the RDs asked for a different solution or it wasn't possible because of a specific issue. | Question not scored | | |
| Q15 – Has your Trust Board appointed a senior named, accountable Resident Doctor Lead? | Yes – 1 point, No – 0 points | 1 | 0 |
| Q16 – Has your Trust Board appointed a Resident Doctor Peer Lead? | Yes – 2 points, Recruitment Underway – 1 point, No – 0 points | 2 | 0 |
| Q17 – Has your Resident Doctor Peer Lead been invited to attend Board level discussions on issues which specifically relate to improving doctors working lives. | Question not scored | | |
| Q18 – At what levels of your organisation have you reviewed and discussed the GMC Survey? | All – 2 points, Two out of Three – 2 points, Executive Team – 1 point, People Committee – 1 point, Trust board – 1 point | 2 | 1 |
| Q18 – At what levels of your organisation have you reviewed and discussed the NETS Survey? | All – 2 points, Two out of Three – 2 points, Executive Team – 1 point, People Committee – 1 point, Trust board – 1 point | 2 | 1 |
| Q18 – At what levels of your organisation have you reviewed and discussed the National Staff Survey? | Question not scored | | |
| Q18 – At what levels of your organisation have you reviewed and discussed the National Student Survey? | Question not scored | | |
| Q19 – If you report GMC/NETS survey results to any of the groups in Q6 above, does the report contain a quality improvement plan with individuals assigned as responsible for actions? | Question not scored | | |

## Improving Doctors Working Lives – 12-Week Progress Survey Points Scheme cont'd

| Question | Answers | Maximum Point | Minimum Point |
|---|---|---|---|
| Q20 – How else do you try to understand and act on issues specific to Resident Doctors? | Question not scored | | |
| Q21 – How are you engaging on improvement activities with your Resident Doctor Peer Lead and Senior Accountable Resident Doctor Lead. Has a plan been developed to understand local working conditions and priorities. Please use this space to describe the activity which has been undertaken in the last 12 weeks and any future plans? | Question not scored | | |
| Q22 – If you have answered 'No' to any of the questions in this section, please explain why. For example, the RDs asked for a different solution or it wasn't possible because of of a specific issue. | Question not scored | | |
| Q23 – Have you implemented local SLAs and introduced board-level governance for tracking and reporting payroll errors? | Yes – 2 points, Planning to in next 3 months – 1point, No – 0 points | 2 | 0 |
| Q24 – Did you undertake any of the following actions within the 12 week period? Attended payroll webinar, introduced board level governance framework, other activities, none of above. | Question not scored | | |
| Q25 – Have you seen any changes in payroll errors over the last 12 months? | Yes, decrease in errors – 2 points, Yes, increase in errors – 1point, No change – 1 point, We do not monitor – 0 points | 2 | 0 |
| Q26 – Please describe the any improvements you have made to reduce Payroll errors. | Question not scored | | |
| Q27 – If you have answered 'No' to any of the questions in this section, please explain why. For example, the RDs asked for a different solution or it wasn't possible because of a specific issue. | Question not scored | | |
| Q28 – In relation to course fee reimbursement, do you: | Process and pay reimbursement at the point the course is booked/expense is incurred – 2 points, Only after attendance on a course, but planning on changing this in the next 3 months – 1 point, Only after attendance on a course – 0 points | 2 | 0 |
| Q29 – Have you reviewed current processes to ensure Resident Doctors can be reimbursed upon submission of valid receipts for all approved study leave-related expenses, including travel and subsidence. | Question not scored | | |
| Q30 – Are you reimbursing within 6 weeks of submitting expense? | Question not scored | | |
| Q31 – Please use this space to give examples of the activity undertaken in the last 12 weeks to improve reimbursement of course fees and expenses and any future plans. | Question not scored | | |
| Q32 – If you have answered 'No' to any of the questions in this section, please explain why. For example, the RDs asked for a different solution or it wasn't possible because of a specific issue. | Question not scored | | |
| Q33 – Do you accept mandatory training completed by resident doctors elsewhere, in line with the Recognition of Statutory and Mandatory Training Memorandum of Training AND do you adhere to the People Policy Framework for Mandatory Learning agreed on 1 May 2025? | Yes, both – 3 points, Yes, MOU only – 2 point, Yes, People Policy Framework only – 2 point, No, but planning to in next 6 months – 1 point, No – 0 points | 3 | 0 |
| Q34 – Please describe the implementation actions you have undertaken to improve Statutory and Mandatory Training for Resident Doctors and any future plans. | Question not scored | | |
| Q35 – If you have answered 'No' to any of the questions in this section, please explain why. For example, the RDs asked for a different solution or it wasn't possible because of a specific issue | Question not scored | | |
| Q36 – Who has assured this survey prior to submitting: | Question not scored | | |
| Q37 - For completion by the Resident Doctor Peer Lead, do you: Fully support findings, partially support or do not support. | Question not scored | | |
| Q38 – Please provide a feedback statement from your Resident Doctor Peer Lead on their views of the progress over the last 12 weeks. | Question not scored | | |
| Q39 – Is the agreed post follow up survey meeting in place with your Senior Accountable Resident Doctor Board Lead and your Resident Doctor Peer Lead? | Question not scored | | |
| Q40 – Any other comments or feedback to help inform the next phases of the 10 Point Plan to improve resident doctors' working lives programme | Question not scored | | |

# 12-Week Progress Survey Methodology

The 12-week progress survey score is calculated by averaging the percentage scores of each scored question. Using the following calculations.

**Percentage score per response/question**

Percentage score = ((response points – minimum points) x 100) / (maximum points – minimum points)

For Example  - Question 5

“Yes” Answer Percentage Score  ((3-0)x100) / (3-0)  = 100
“Yes, under 50%” Answer Percentage Score  ((2-0)x100) / (3-0)  = 67

**Final aggregated survey score**

Aggregated survey score = (sum of all percentage scores / number of scored questions)

**Improvement Scoring**
Yes = Yes offered to all
No = not at all
Yes >50% = Yes offered to between 50% and 99%
Yes <50% = Yes offered to between 1 and 49%

NHS
Lincolnshire Community and Hospitals NHS Group

# Integration Committee Upward Report

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *10.1* |

# *Integration Committee Upward Report of the meeting held on 25 November 2025*

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

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

**Board Committee Upward Report to the Group Board**

| | |
|---|---|
| **Report for meeting of the Group Board to be held on:** | 6 January 2026 |
| **Report from:** | Integration Committee |
| **Report from meeting held on:** | 25 November 2025 |
| **Quoracy requirements met:** | Yes |

## 1.0 Purpose of the report

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

## 2.0 Matters considered by the committee

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

Assurances in respect of Objective 3a:

a) Estates and Facilities Update

Progress in respect of open space bookings was noted, with the hope that the impact of this would be seen the following month, should this not be achieved a further review would be undertaken.

The volume of capital works was noted with significant progress commended on the Lincoln Endoscopy build, which continued to move at pace. Progress was also noted in respect of the Community Diagnostic Centres and car park at Pilgrim.

Assurances in respect of Objective 3b:

a) Alliance Steering Group Upward Report

Work continued in respect of the development of the Integrated Neighbourhood Teams (INT) with a workshop due to take place to support further progress and agreement for a matrix approach.

Significant progress was noted in respect of the left-shift work and the Neighbourhood Board had convened, however challenges were noted due to staff changes resulting from the ICB cluster arrangements.

The outcome of the Newton diagnostic work had been received and would flow through governance with the Committee noting the indicative position that was offered in respect of INT working, reduction of duplication and improvement in patient experience.

Assurances in respect of Objective 3c:

a) EPR Stage 3.5 Assessment Report
b) Research and Innovation Group Upward Report

The Committee noted the report in respect of the EPR programme, which formed part of the national programme post investment assessment, recognising a number of gateways were required to be met. Positive progress was noted with the recognition that this would support a third line of assurance within the BAF.

Changes were noted in respect of the structure of the National Institute for Health and Care Research (NIHR), with the budget now values based, split 50% baseline, 20% performance and 30% activity. This was noted to be a positive change for ULTH as funding was no longer based on historical performance.

The Committee was delighted to hear of the achievement of the Group Deputy Chief Medical Officer in opening the first phase 2, Lincolnshire-based, clinical trial for the MIST programme. This was noted to be an international study, attracting $1m of funding, with future funding bid opportunities available.

Assurances in respect of Objective 3d:

a) Productivity, Improvement and Transformation Oversight Group Forum Upward Report

The Committee noted the breadth of areas being covered and noted that all programmes remained on track, or on track with issues being managed. A total of 12 programmes and 375 schemes were noted with a comply and explain approach in place for a number of areas where underperformance we being seen.

Assurances in respect of other areas:

The Committee undertook a workshop for horizon scanning and to review the Board Assurance Framework (BAF) in detail as the Committee had been in place for a year. The session allowed the Committee to undertake reflections on progress over the past year and to focus on the development of the Committee and content of the BAF moving forward.

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

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

a) A referral would be made to the Quality Committee in respect of the clinical risk associated with the high number of ungraded referrals within the neurology service.

## 4.0 Matters for reporting / escalation to the Group Board

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

a) None

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

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

## 6.0 Group Board Action Required

6.1 The Group Board is asked to:

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

***Rebecca Brown, Non-Executive Director/Deputy Chair***

***25 November 2025***

NHS
Lincolnshire Community and Hospitals NHS Group

# Integration Committee Upward Report

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *10.1* |

# *Integration Committee Upward Report of the meeting held on 19 December 2025*

| | |
|---|---|
| Accountable Director | *Daren Fradgley, Group Chief Integration Officer* |
| Presented by | *Rebecca Brown, Non-Executive Director/Deputy Chair* |
| Author(s) | *Kwame Mensa-Bonsu, Deputy Director of Corporate Affairs* |
| Recommendations / decision required | *The Group Board is asked to:*<br>• *note the discussions and assurance received by the Integration Committee;* |

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

**Board Committee Upward Report to the Group Board**

| | |
|---|---|
| **Report for meeting of the Group Board to be held on:** | 6 January 2026 |
| **Report from:** | Integration Committee |
| **Report from meeting held on:** | 19 December 2025 |
| **Quoracy requirements met:** | Yes |

## 1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Integration Committee at its meeting held on 19 December 2025 including assurances received and those matters which the Committee wish to escalate to the Group Board.

## 2.0 Matters considered by the Committee

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

Assurances in respect of Objective 3a:

a) Estates and Facilities Upward Report
b) Continuous Planning Update (Transformation)
c) Newton Diagnostic/Improvement Plan

A new booking process for Open Space utilisation commenced in November 2025 in ULTH and there had been a clear reduction in space wastage since. Though more steps needed to be implemented to make the booking process fully effective, the Committee was assured that the new process was in place. The Estates team was planning to implement the same process in LCHS as well.

The Committee was comprehensively updated on the draft annual plan, which was submitted to NHS England on 17 December 2025, with the Group Board due to receive it for review on 6 January 2026. The Committee was informed that the draft annual plan was focused on delivering objectives that were broadly compliant with national expectations (except for finance whilst we undertake modelling to understand the real impact of changing commissioning intentions). The plan highlighted operational areas of challenge and associated risks for delivery. Work would continue to refine these risks and identify the appropriate mitigations.

The Committee received an update on the Phase 1 Newton Diagnostic Flow work undertaken between July and October 2025. The areas of focus for the

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diagnostic flow work were - acute hospitals, intermediate care (including community services provided by the group) and integrated neighbourhood teams. The Committee noted the diagnostic flow work's outputs and the identified opportunities which could be utilised so that Lincolnshire's healthcare system can move sustainably towards ensuring people were supported to be as independent and as healthy as possible.

Assurances in respect of Objective 3b:

a) Alliance Steering Group Upward Report
b) Partnership Strategy

The Committee noted the Alliance Steering Group's upward report, which provided moderate assurance on the work being undertaken across 4 workstreams to deliver integrated, community-focused care, with the aim of improving population health, and reducing reliance on acute services.

The Committee was updated on the steps being undertaken to sustainably embed the actions from the Health Inequalities Plan in the Group's care groups. The Committee was also informed of the good progress achieved under the 'left shift' workstream, and the steps being implemented to improve upon the care groups' engagement with the 'left shift' agenda.

The upward report informed the Committee of the output from a Neighbourhood Health Board workshop in November 2025 at which the Group and its system partners agreed to develop a 'Partnership Agreement' and align boundaries based on Primary Care Networks.

In terms of the work being undertaken to ensure the Partnership Plan was fit for the Group's significantly changed operating environment, the Committee supported a proposal that LCHG should:

- Close down the 2024-27 Partnership Plan and Delivery Plan rather than continuing with the Year 3 Refresh.
- Develop a new Partnership Plan and Delivery Plan for 2026-30 bringing it back into alignment with the LCHG 5-year Strategy.
- Refresh the Delivery Plan in each of the four years to allow us to develop the detail and respond to what is likely to be continued volatility and uncertainty.
- Incorporate the updated stakeholder mapping work requested by the Group Board.
- Better align with some of the new enabling plans in development for 2026/27.
- Clarify the accountability for delivering partnerships within the Group performance management and accountability framework and executive portfolios.
- Better align the Plan to the outputs of the annual planning round which was still in train.

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The Committee also supported the proposed approach to the delivery of the Partnership Plan 2026-30. The proposal was that during the remainder of 2025/6, the Strategy, Improvement and Redesign Team (SIRT) would undertake a full review of the Partnership Plan and Delivery Plan to create a new suite of documents for 2026-30. This will include engagement with LCHG enabling functions, key external stakeholders, Integration Committee and Group Board.

The LCHG Refreshed Partnership Plan and Delivery Plan Update, which included the proposals, would be submitted to the Group Board in January 2026 for further review and discussion.

Assurances in respect of Objective 3c:

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

The Committee was informed of steps being implemented by the Digital Oversight Group to ensure that all business continuity plans in the Group were updated so that they were robust and fit for the purposes of the organisation.

The Committee noted that the Electronic Patient Record (EPR) Programme (Acute) was rated 'red' due to the programme having entered a reset phase. During the reset phase the organisation of knowledge transfer for staff to gain a full understanding of the workings of the EPR product would be enhanced to ensure that the transfer process was successfully concluded.

Assurances in respect of Objective 3d:

a) Productivity, Improvement and Transformation Oversight Forum Group Upward Report

The Committee received the report which noted that the Group's 2025/26 Cost Improvement Programme (CIP) had achieved a delivery of £41.9 against a plan of £42.6m. There were significant risks associated with the Group's ability to achieve its 2025/26 CIP target of £79.3m. Though all CIP schemes were reporting good progress to delivery, there was the need for the accelerated delivery of planned schemes and the identification of additional schemes to ensure that the 2025/26 target was achieved.

The Committee was assured that the progress of the CIP programme was being monitored by the Group Board's Finance and Performance Committee.

Assurances in respect of other areas:

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

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e) Policy Position

The Committee received the performance dashboard noting the performance data being reported, the detail of which was aligned to the National Oversight Framework (NOF).

The risk register was received with the Committee noting the movement in risks presented.

The policy position was received and noted in respect of research policy documents.

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

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

a) None

## 4.0 Matters for reporting / escalation to the Group Board

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

a) None

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

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

## 6.0 Group Board Action Required

6.1 The Group Board is asked to:

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

***Rebecca Brown, Non-Executive Director/Deputy Chair***

***19 December 2025***

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# LCHG Partnership Plan Update

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals NHS Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *10.2* |
| Report title | *LCHG Partnership Plan Update* |
| Report purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | • *Information* |
| Accountable Director | *Daren Fradgley, Group Deputy CEO, Group CIO* |
| Author(s) | *Sameedha Rich-Mahadkar, Group Director of Strategy, Improvement and Redesign*<br>*Vicky Holden, Group Deputy Director of Strategic Partnerships*<br>*Angela Sharp, Group Associate Director of Strategic Partnerships* |
| Assurance rating:<br>• Substantial assurance<br>• Reasonable assurance<br>• Limited or no assurance | *Reasonable* |
| Prior approval process, if applicable | *Integration Committee December 2025* |
| Financial implications, if applicable | *Positive – partnerships create opportunities for new income and efficiency and productivity.* |
| Action / decision required | *The board / committee is asked to:*<br>• *Note the update and support the proposed approach to the Partnership Plan.* |

*Assurance Rating Key:*

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

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

**Purpose of the report**

This report provides an update on the work to ensure the LCHG Partnership Plan keeps pace with and helps us to respond effectively to our changing operating environment for our people, patients and population.

It also provides an update on some of the partnership activities that have helped us to deliver our Strategic Aims and Objectives in 2025/26 (Appendix 1).

**Background**

In March 2024, the LCHG Board approved the Group's first 3-year Partnership Plan 2024-27. Since the Plan was developed in late 2023, the LCHG Group officially formed, a new board team has been created, LCHG has developed a new 5-year strategy with new strategic aims, objectives and values. Externally, the 10-year Health Plan has been published, NHSE has been abolished, and ICBs are subject to cost reductions and clustering with a new operating blueprint.

A Year 3 refresh has been undertaken over Q3, led by the Strategy, Improvement and Redesign Team (SIRT), to update the Plan for 2026-27. In completing this refresh, it has become clear that the Plan is no longer fully fit for purpose to support the Group to deliver its ambitions in such a changed operating environment.

Given the degree of change in the internal and external operating environment since the Partnership Plan, it is proposed that LCHG should:

- **Close down** the 2024-27 Partnership Plan and Delivery Plan rather than continuing with the Year 3 Refresh.
- Develop a new Partnership Plan and Delivery Plan for 2026-30 bringing it back into **alignment with the LCHG 5-year Strategy.**
- Refresh the Delivery Plan in each of the four years to allow us to **develop the detail** and respond to what is likely to be continued volatility and uncertainty.
- Incorporate the updated **stakeholder mapping** work requested by LCHG Board.
- Better align with some of the **new enabling plans** in development for 2026/27.
- Clarify the accountability for delivering partnerships within the Group **performance management and accountability** framework and executive portfolios.
- Better align the Plan to the outputs of the **annual planning** round which is still in train.

**Proposed approach to delivery of the Partnership Plan 2026-30**

During the remainder of 2025/6 it is proposed that the SIRT team undertakes a full review of the Partnership Plan and Delivery Plan to create a new suite of documents for 2026-30. This will include engagement with LCHG enabling functions, key external stakeholders, Integration Committee and Board.

## LCHG Partnership Plan Update

### 1. Background

In March 2024, the LCHG Board approved the Group's first 3-year Partnership Plan 2024-27. The Plan focused on six key priorities:

- **Priority 1:** Provide resilience and support for Primary Care and General Practice, maximising the interface and our CPP opportunities.
- **Priority 2:** Support our fragile services, working with partners to improve patient outcomes.
- **Priority 3:** Working with partners to grow and develop our workforce through education, research and innovation capacity and capability).
- **Priority 4:** Build our commercial partnerships and sponsorship opportunities.
- **Priority 5:** Deliver on our Anchor and Green responsibilities through partnership and collaboration.
- **Priority 6:** Maximise and deliver opportunities via East Midlands Acute Provider (EMAP) – to improve the delivery of care to our patients.

Appendix 1 below highlights some of the partnership activities undertaken that have helped LCHG to deliver its strategic aims and objectives in 2025-26.

### 2. Why do we need a Partnership Plan?

While there is no specific strategic aim or objective that explicitly focuses on partnership, we know that partnerships are a key enabler of how we will deliver for our patients, people and populations.

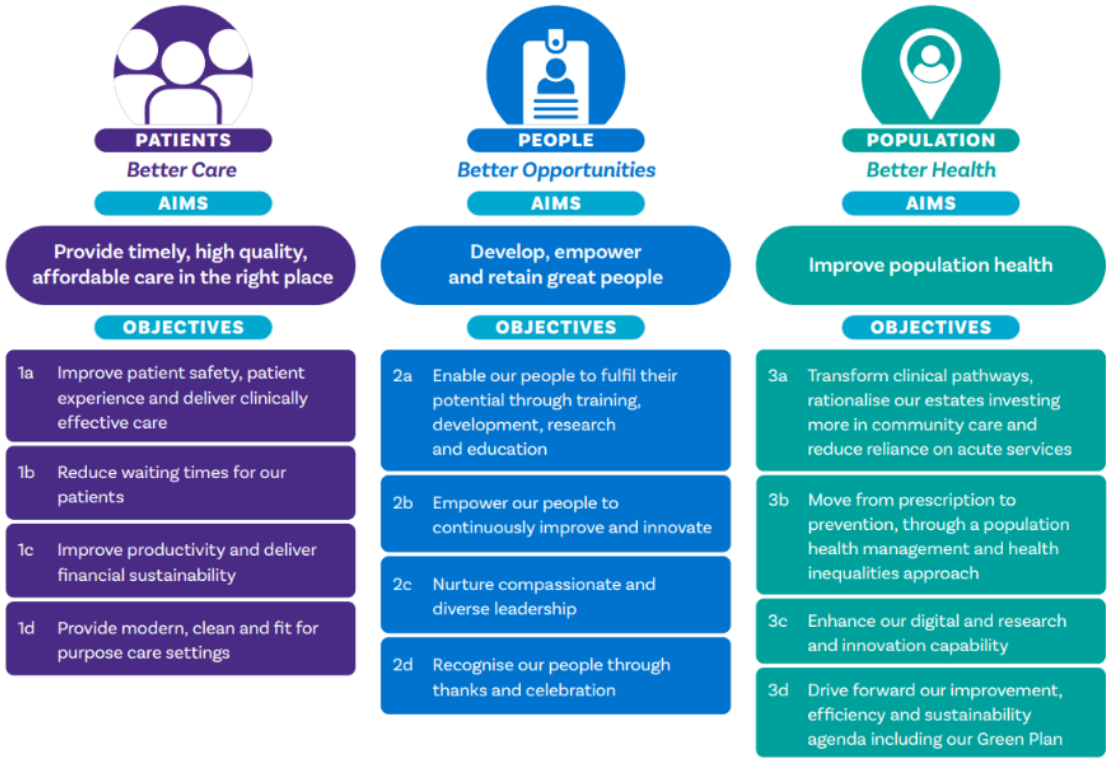



*Figure 1: LCHG Strategic Aims and Objectives*

Partnership is a golden thread that runs through our LCHG 5-Year Strategy, our clinical operating model, and our enabling plans including People, Research and Innovation, Digital, and Estates. Plus, collaboration is one of our three LCHG values.

## 3. Risks and Assurance

The Partnership Plan is identified as a control in the Board Assurance Framework (BAF) for Objective 3a. It also provides mitigation for a risk raised on the Corporate Risk Register in September 2025 related to partnership:

*Risk to our transformation programme due to changes within the ICB* (5711, Initial risk score = 20, Target risk score = 12).

The actions identified to reduce the likelihood and/or the severity of the risk are:

- **Action 1:** Map critical relationships and dependencies to ensure they are actively maintained and not lost during leadership changes.
- **Action 2:** Ensure new cluster executives are quickly brought up to speed with local context, priorities, and strategic goals.
- **Action 3:** Enhance joint system governance reporting through improved visibility and alignment across forums such as BLLET, LLG, TOM, and the Group Board.
- **Action 4:** Oversee continuity and coordination during the reorganisation period to maintain strategic momentum.

Assurance against the controls and risks is provided through the Alliance Steering Group and the Integration Committee.

## 4. Our current Partnership Plan and Delivery Plan 2024-27

Since the Plan was developed in late 2023, the LCHG Group officially formed, a new board team has been created, LCHG has developed a new 5-year strategy with new strategic aims, objectives and values. Externally, the 10-year Health Plan has been published, NHSE has been abolished, and ICBs are subject to cost reductions and clustering with a new operating blueprint.

A Year 3 refresh has been undertaken over Q3, led by the Strategy, Improvement and Redesign Team (SIRT), to update the Plan for 2026-27. In completing this refresh, it has become clear that the Plan is *not fully fit for purpose to support the Group to deliver its current strategic ambitions* in such a changed operating environment and that a refresh of the final year would be a missed opportunity to build resilience and realignment with the overarching group strategy.

## 5. A new Partnership Plan 2026-30

Given the degree of change in the internal and external operating environment since the Partnership Plan 2024-27 was developed, it is proposed that LCHG should closedown the 2024-27 Partnership Plan and Delivery Plan rather than continue with the Year 3 Refresh.

- Focus our resources on developing a new Partnership Plan and Delivery Plan for 2026-30, bringing it back into **alignment with the LCHG 5-year Strategy.**
- Refresh the Plan in each of the next four years to allow us to **develop the detail,** particularly relevant for Y3 and 4, and respond to what is likely to be continued volatility and uncertainty.
- Incorporate the updated **stakeholder mapping** work requested by LCHG Board in Q4.
- Better align the Partnership Plan with LCHG **enabling plans** including those in development for 2026/27 (see table 1 below).
- Clarify the accountability for delivering partnerships within the Group's **performance management and accountability** framework and executive portfolios.
- Better align the Plan to the outputs of the **annual planning** round which is still in train.

*Table 1 Alignment with LCHG enabling functions*

| Area/function | Status | Timescale |
|---|---|---|
| Group Strategy | Published (2025) | - |
| Clinical Operating Framework | In Development | April 2026 |
| NMAHP Strategy | In Development | April 2026 |
| Digital Strategy | Published (2025) | - |
| Finance Strategy | Published (2025) | - |
| Estates Strategy | In Development | 2026/27 |
| People Strategy | Not Started | - |
| Quality Strategy | Not Started | - |
| R&I Plan | In Development | TBC |
| Partnerships Plan | In Development | April 2026 |
| Green Plan | Published (2025) | - |
| Procurement Plan | In Development | TBC |
| QI Plan | Published (2025) | - |
| Communications Plan | In Development | TBC |
| Health & Safety Plan | Published (2025) | - |
| Library & Knowledge Plan | Not Started | |
| Operational Plans | In Development | April 2026 |

## 6. Proposed approach and timeline

During the remainder of 2025/6 it is proposed that the SIRT team develops a new Partnership Plan and Delivery Plan 2026-30. An overview of the key steps is below:

| Action | Forum | Proposed date |
|---|---|---|
| Engagement with key lead for enabling plans | Individual meetings | Jan-Feb |
| Engagement with key enablers and care groups | GLT/Alliance Steering Group | Jan-Feb 2026 |
| Key external stakeholders | EMAP Working Group, HI Working Group, individual meetings | Jan-Feb 2026 |
| Stakeholder Mapping | Board Development | Feb 2026 |
| Partnership Plan and Delivery Plan | Integration Committee | Mar 2026 |

## 7. What will the Partnership Plan and Delivery Plan 2026-30 include?

The focus of the Partnership Plan 2026-30 will include:

- Why we need partnerships and how they help us deliver our strategic direction.
- The overarching framework (including our partnership principles and partnership aims and objectives) through which partnerships can be effectively deployed.
- The partnership activities in each of our main business areas (partnership intent and accountability for each area*) that will help the Group to deliver its 5-year Strategy and its strategic Aims and Objectives.
- The support that will be provided by the SIRT Partnership Team, including building capability across the Group to develop, maintain, and evaluate effective partnerships.
- Measures of success.
- A methodology for assessing the effectiveness of our partnerships.

* The Partnership Plan and Delivery Plan do not attempt to capture all partnership activities to be undertaken across the Group. This is because partnerships are a method of delivering our objectives rather than being an end in themselves. The partnership activities that will support business areas to deliver their strategic and operational priorities should be captured within their own individual enabling strategies and plans. Progress toward delivery should be monitored by the relevant groups and committees aligned to the strategic objectives.

## 8. Board Action Required:

The Board is asked to note the update and support the proposed approach to the Partnership Plan and Delivery Plan.

**Appendix 1: Partnership Plan 2024-25 – partnership activities in 2025/26**

This section showcases a small proportion of the partnership activity undertaken by LCHG against the 6 priority areas in the 2024-27 Partnership Plan and Delivery Plan. It is intended to provide the committee with a flavour of the breadth and depth of our strategic partnerships that helped us to deliver our Strategic Aims and Objectives in Year 2.

| Partnership priority 2024-27 plan | Name of partnership | Description of partnership | What it has delivered | Strategic Objective |
|---|---|---|---|---|
| **Priority 1:**<br><br>**Provide resilience and support for Primary Care and General Practice, maximising the interface and our CPP opportunities** | Left Shift – Women's Health initiative | A partnership between PCN and Family Health is aiming to reduce unnecessary 2ww referrals to the unscheduled bleeding pathway by improving shared understanding of the HRT pathway and alternatives to a consultant referral. Metrics are in development, but it is anticipated that GP referrals could be reduced by c.40%, improving waiting times, experience, and outcomes. | • Workshop with PCNs, LMC and ICB as key partners, to improve understanding of the HRT pathway including alternatives to 2ww referrals.<br>• Once evaluated, the model will be scaled up.<br>• Work currently underway with East Lindsay PCN to identify a patient cohort for roll out. | 3a |
| | Primary Care/ Acute/ Community Interface Group (Lincolnshire Interface Collaborative) | The collaborative has 12 key priorities including: Onward Referrals, Fit Notes, Clear points of contacts, Call and Recall, Discharge Letters. ULTH has improved/ maintained on all these areas in the recent national self-assessment. LCHS completed the assessment for the first time in late 2025. | • Details and guidance for Onward Referrals and Fit Notes added to induction packs for all medical staff and on the medical staff intranet pages.<br>• Interface Group agreed Discharge Letter template for use in EPR.<br>• Dedicated intranet page established, providing clear points of direct contact within Primary Care, Acute, Community and Mental Health, for clinician-clinician discussion.<br>• Regular presentations to the Resident Doctors Forum. | 1a, 3a, 3b |

| Partnership priority 2024-27 plan | Name of partnership | Description of partnership | What it has delivered | Strategic Objective |
|---|---|---|---|---|
| | | | • LCHG Interface Liaison role agreed with Clinical Governance to be embedded within PALS. | |
| | Neighbourhood Operating Model | In October 2025, a Neighbourhood Health Board was established for the key health and care decision makers to set the strategic direction for neighbourhoods. | • Members agreed a 3-tier Neighbourhood Operating Model (Unplanned Care, Planned Care, Resilient Communities) and PCNs as the 'lowest common denominator' for neighbourhoods.<br>• Commitment to try to align managerial as well as operational boundaries.<br>• Partnership Agreement in development to define how partners will work together e.g. PEOL lead provider model. | 3b |
| **Priority 2:**<br><br>**Support fragile services – work with partners to improve patient outcomes** | Partnership with family hubs to transform pre-school Children's Speech and Language Therapy | The Children's SLT service changed its model of delivery within the existing financial envelope by wrapping speech and language therapy around local authority family hubs for all pre-school provision. | • Before the change, children waited 52 weeks to see a therapist. Working in partnership with LCC family hubs, they will get a drop-in session the same day or same week. | 1a, 1b, 3a |
| **Priority 3:**<br><br>**Work with partners to grow and develop our workforce through education, research and** | Research and Innovation | The team has facilitated numerous opportunities to develop its principal investigator pipeline including through NIHR and various Higher Education Institutions which is essential to LCHGs' ability to undertake research delivery. The team has benchmarked LCHS and ULTH against national research activity | • Achieved Teaching Hospital status<br>• Draft model and priority list agreed for initial Medical Workforce Clinical Academic recruitment<br>• Engagement workshops with Care Groups to develop a new 3-year R&I Strategy from 2026. | 3c |

| Partnership priority 2024-27 plan | Name of partnership | Description of partnership | What it has delivered | Strategic Objective |
|---|---|---|---|---|
| **innovation capacity and capability** | | and, as part of the process to develop a new 3-year R&I Strategy, it has started to define its approach to research development and research delivery. This includes scoping potential commercial partnerships e.g. in CVD and Haematology, both of which are strong prospects. | • ULHT & LCHS participated in 50 research studies with 920 participants (by Nov 2025).<br>• 85 conferences and journal articles on a variety of topics including AI & Robotics, Oncology, Cardiology, Diabetes, Gastroenterology, and Obstetrics (by Nov 2025). | |
| **Priority 4:**<br><br>**Build our commercial partnerships and sponsorship opportunities** | Commercial Advertising Initiative | Following a successful procurement process, ULTH secured national advertising concession partnerships with Pulse Media and Fendix Media, facilitating streamlined campaign management, and expanding income streams. | • Governance framework has ensured responsible campaign approval and risk mitigation.<br>• Advertising media displayed reaches 42% of the approved public-facing locations across ULTH sites with plans to increase uptake including LCHS estate.<br>• First local marketplace partnership with Lincolnshire Co-op<br>• Delivered £15K income in H1 of 2025/26. Ambition to grow passive advertising income to £100K pa by Y3. | 1c, 3d |
| | Commercial partnership to benefit our people | In summer 2025, a partnership with Amazon and InPost saw lockers installed across our three main acute hospitals. | • Annual income of £4.8K to date with a plan for growth in coming years including community hospital sites. | 3c |
| | Private Patients Services | Identified key areas for private patient services (women's health, endoscopy, fertility, ophthalmology) in collaboration with the COO. | • Clear preferred model to manage the existing private patient fertility service to improve financial sustainability.<br>• Potential private patient income could range from £50k to £250k, depending | 3c |

| Partnership priority 2024-27 plan | Name of partnership | Description of partnership | What it has delivered | Strategic Objective |
|---|---|---|---|---|
| | | | on appetite, procedures, and market—currently being worked through with specialties. | |
| | Wheelshare | Completed a Case of Need for a charity-funded outpatient wheelchair pilot with a commercial partner to enhance patient experience and reduce risk. If successful, long-term funding could be secured through estates or expanded advertising/sponsorship | • Pending final approval from GLT but if agreed will deliver improved patient experience and improve compliance with regulatory requirements. | 1a |
| **Priority 5:**<br><br>**Deliver on our Anchor and Green responsibilities** | Green Plan | In May 2025, Pilgrim Hospital was awarded £23M for energy infrastructure improvements and clean power upgrades to support decarbonisation. The bid was developed with the Carbon and Energy Fund, and the scheme will be delivered by Salix on behalf of the Department for Energy Security and Net Zero. | • The funding will be used for a range of measures including an electrically powered heating and hot water system across the site.<br>• The impact will reduced reliance on fossil fuels for energy and significantly improve critical infrastructure across the site.<br>• CEF noted the Groups innovative carbon reduction project “would benefit the whole community”. | 3d |
| | System sustainability partnership | LCHG is a member of the Lincolnshire Sustainability Officers group which includes all public sector partners. One of the key areas of focus for the group where progress is being made is adaptations – how we deliver care in the wake of climate care/build and secure our buildings for the future. | • LCC have completed an adaptation risk assessment for Lincolnshire which links to HI, digital inequalities, public transport etc.<br>• The responsibilities for health partners are being taken forward through our Green Plans 2025-28 including adaptation assessments and plans. | 3d |

| Partnership priority 2024-27 plan | Name of partnership | Description of partnership | What it has delivered | Strategic Objective |
|---|---|---|---|---|
| | Digital transformation | During 2025/26, ULHT progressed key digital initiatives in partnership with IT providers including an Electronic Document Management Systems (EDMS) and expanded video consultations. | • These initiatives enabled reduced physical records and remote care pathways, minimise both patient travel and postal paper waste. | 3c |
| | Health Inequalities Working Group (HIWG) | HIWG was established in October 2024. Chaired by LCHG, the other partners are LCC, LPFT and ICB. Its early focus was building on findings of the Maturity Matrix assessment (an ICB requirement) e.g. access, community engagement, use of data, and monitoring and evaluation. | • LCHG improved in all Maturity Matrix areas (now completed as a Group).<br>• First HI audit in October 2025 received second highest rating of 'Reasonable Assurance'.<br>• HI is being integrated into Care Group plans through the planning process. | 3b |
| **Priority 6:**<br><br>**Maximise and deliver opportunities via East Midlands Acute Provider (EMAP) – to improve the delivery of care to our patients** | East Midlands Acute Provider Collaborative (EMAP) | EMAP is a collaborative of 8 acute providers across the East Midlands. It aims to support greater clinical stewardship and leadership and to develop a shared understanding of population need, agree pathways to meet population need and provide necessary oversight to ensure expected outcomes are being achieved.<br><br>An EMAP approach was agreed in relation to the assessment of service sustainability where priority areas of focus were agreed as part of the EMAP work programme. | • A team led by 3 EMAP partners (ULTH, ULT, UHN) and wider regional partners have produced a joint business case in response to an opportunity to retender national Phase 1 PET/CT services from March 2026.<br>• Financial model shows potential £11M profit over 7 years for the partnership (subject to capital investment).<br>• Consistent methodology for the assessment of service sustainability before and after EMAP intervention – in use in oncology, stroke and haematology programmes of work.<br>• Identification of high impact procurement opportunities via supply chain and independent routes to | 3a, 3c |

| Partnership priority 2024-27 plan | Name of partnership | Description of partnership | What it has delivered | Strategic Objective |
|---|---|---|---|---|
| | | EMAP Procurement Workstream established to maximise opportunities to leverage regional buying power | deliver financial benefits for EMAP partners. | |

NHS
Lincolnshire Community and Hospitals NHS Group

# Integrated Performance Report

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *11* |
| Report title | *Integrated Performance Report* |
| Report purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | • *Assurance* |
| Accountable Director | *Daren Fradgley, Group Chief Integration Officer* |
| Author(s) | *Shaun Caig, Associate Director of Performance & Information* |
| Assurance rating:<br>• Substantial assurance<br>• Reasonable assurance<br>• Limited or no assurance | • *Reasonable* |
| Prior approval process, if applicable | *Sub-Committees* |
| Financial implications, if applicable | *Not applicable* |
| Action / decision required | *The Board is asked to:*<br>• *Note the current performance* |

*Assurance Rating Key:*

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

| How the report supports the delivery of the LCHG strategic aims & objectives: | |
|---|---|
| *Patients: Better Care – Timely, affordable, high quality care in the right place:* | |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | *X* |
| 1b: Reduce waiting times for our patients | *X* |
| 1c: Improve productivity and deliver financial sustainability | *X* |
| 1d: Provide modern, clean and fit for purpose care settings | *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* |

| Range | Colour | Description |
|---|---|---|
| 1.00 - 2.00 | Green | Performing Well/On Track |
| 2.01 - 2.99 | Warm Amber | Slightly Below Expectations |
| 3.00 | Burnt Orange | Performance Concern |
| 3.01 - 4.00 | Red | Underperforming |

# Group Board M8

Lincolnshire Community and Hospitals NHS Group

## Overall Summary

| FPC | Integration Committee Scorecard | People Committee Dashboard | Quality Committee Report |
|---|---|---|---|
| 2.05 | 2.13 | 2.03 | 2.11 |

## Finance & Performance

| Community - Unplanned | Community - Front Door | Acute - Front Door | Acute - Planned | Acute - Unplanned | Community - Planned |
|---|---|---|---|---|---|
| 2.00 | 2.00 | 2.30 | 2.22 | 2.20 | 1.85 |

## Integration

| Community - Unplanned | Acute - Front Door | Acute - In Hospital | Community - Planned |
|---|---|---|---|
| 1.90 | 2.42 | 2.14 | 2.17 |

## People

| Vacancies | Staffing Levels | Staff Training & Development | Staff Health & Wellbeing | Job Planning | Policies & Procedures | Recruitment | International Recruitment | Employee Relations | Sickness Absence |
|---|---|---|---|---|---|---|---|---|---|
| 2.08 | 2.25 | 1.83 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 |

## Quality

| Clinical Effectiveness | Patient Safety | Patient Experience |
|---|---|---|
| 2.42 | 2.10 | 1.93 |

| Range | Colour | Description |
|---|---|---|
| 1.00 - 2.00 | Green | Performing Well/On Track |
| 2.01 - 2.99 | Warm Amber | Slightly Below Expectations |
| 3.00 | Burnt Orange | Performance Concern |
| 3.01 - 4.00 | Red | Underperforming |

# Group Board M8

Lincolnshire Community and Hospitals NHS Group

| Acute - Quality | Community - Quality | Acute - Workforce | Community - Workforce | Community - Unplanned | Acute - Front Door | Acute - Planned | Acute - Unplanned | Community - Planned |
|---|---|---|---|---|---|---|---|---|
| 2.20 | 2.00 | 2.20 | 2.50 | 1.75 | 2.07 | 2.35 | 1.50 | 2.50 |

## Metrics Out of Range

| Section Name | Org Name | Metric Name | Value | Target | LCHG Score |
|---|---|---|---|---|---|
| Acute - Quality | United Lincolnshire Teaching Hospitals | Acute - Summary Hospital Mortality Indicator (SHMI) (rolling year data 5 month time lag) | 106.69 | | 3.00 |
| Community - Quality | Lincolnshire Community Health Services | Quality - Pressure Ulcers Category 3 | 108 | | 3.00 |
| Acute - Workforce | United Lincolnshire Teaching Hospitals | Acute - Overall percentage of completed mandatory training | 93.39% | | 3.00 |
| Community - Workforce | Lincolnshire Community Health Services | Workforce - Sickness Rate | 7.50% | 4.81% | 3.50 |
| Community - Workforce | Lincolnshire Community Health Services | Workforce - Vacancy Rate | 8.29% | 6.99% | 3.50 |
| Acute - Planned | United Lincolnshire Teaching Hospitals | Acute - 104+ Day Waiters | 105 | | 3.00 |
| Acute - Planned | United Lincolnshire Teaching Hospitals | Acute - Hospital Average LoS (Elective) | 3.52 | 2.80 | 3.50 |
| Acute - Planned | United Lincolnshire Teaching Hospitals | Acute - Partial Booking Waiting List | 46242 | | 3.00 |
| Community - Planned | Lincolnshire Community Health Services | 52 Week Waits % | 99.75% | 100.00% | 3.50 |

Information on Scoring Methodology

# Report Summary Page

Lincolnshire Community and Hospitals NHS Group

## Metrics for Awareness

| Section Name | Org Name | Metric Name | Value | Target | LCHG Score |
|---|---|---|---|---|---|
| Community - Workforce | Lincolnshire Community Health Services | Workforce - Overall Compliance | 91.94% | 90.00% | 2.50 |
| Acute - Front Door | United Lincolnshire Teaching Hospitals | Acute - >12hr Trolley Waits | 932 | 0 | 2.50 |
| Acute - Front Door | United Lincolnshire Teaching Hospitals | Acute - Under 4 hour performance | 76.28% | 78.00% | 2.50 |
| Acute - Front Door | Lincolnshire Community Health Services | UTC - Monthly 4 Hour Waits | 96.28% | 98.00% | 2.50 |

Information on Scoring Methodology

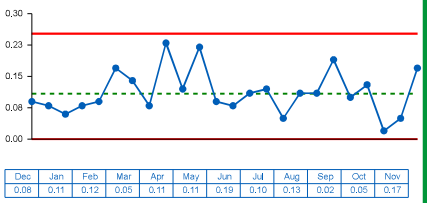
# Report Performance Dashboard

Lincolnshire Community and Hospitals NHS Group

## Acute - Quality

### Acute - Falls per 1000 bed days resulting in moderate, severe

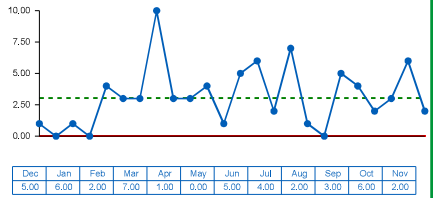
United Lincolnshire Teaching Hospitals




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 0.08 | 0.11 | 0.12 | 0.05 | 0.11 | 0.11 | 0.19 | 0.10 | 0.13 | 0.02 | 0.05 | 0.17 |

### Acute - Pressure Ulcers category 3

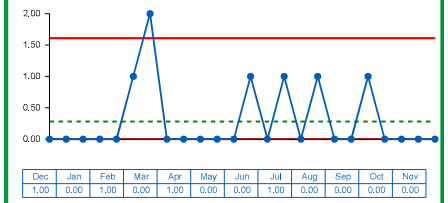
United Lincolnshire Teaching Hospitals




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 5.00 | 6.00 | 2.00 | 7.00 | 1.00 | 0.00 | 5.00 | 4.00 | 2.00 | 3.00 | 6.00 | 2.00 |

### Acute - Pressure Ulcers category 4

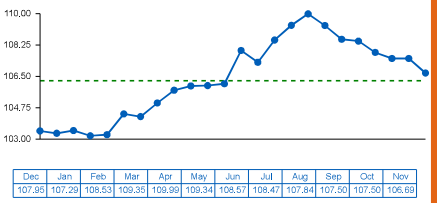
United Lincolnshire Teaching Hospitals




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.00 | 0.00 | 1.00 | 0.00 | 1.00 | 0.00 | 0.00 | 1.00 | 0.00 | 0.00 | 0.00 | 0.00 |

### Acute - Summary Hospital Mortality Indicator (SHMI) (rolling y

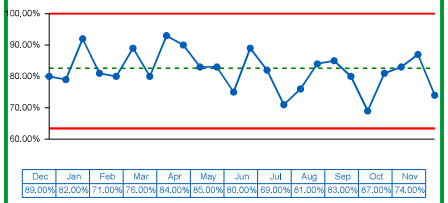
United Lincolnshire Teaching Hospitals




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 107.95 | 107.29 | 108.53 | 109.35 | 109.99 | 109.34 | 108.57 | 108.47 | 107.84 | 107.50 | 107.50 | 106.69 |

### Acute - Complaints investigated and responded to within agre

United Lincolnshire Teaching Hospitals



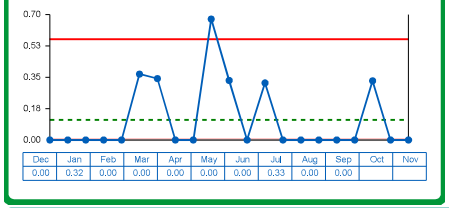

| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 89.00% | 82.00% | 71.00% | 76.00% | 84.00% | 85.00% | 80.00% | 89.00% | 81.00% | 83.00% | 87.00% | 74.00% |

## Community - Quality

### Community Hospital Injurious Falls per 1000 OBDs

Lincolnshire Community Health Services — Target: 1.38

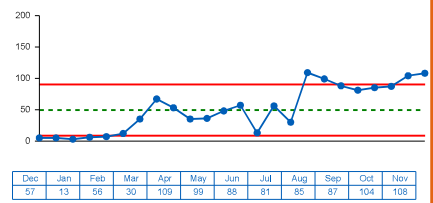
Activity Volume




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 0.00 | 0.32 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.33 | 0.00 | 0.00 | | |

### Quality - Pressure Ulcers Category 3

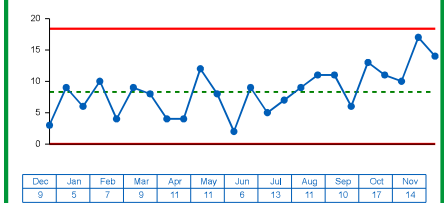
Lincolnshire Community Health Services




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 57 | 13 | 56 | 30 | 109 | 99 | 88 | 81 | 85 | 87 | 104 | 108 |

### Quality - Pressure Ulcers Category 4

Lincolnshire Community Health Services

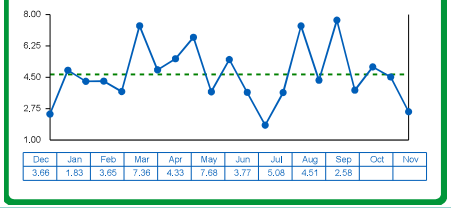



| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 9 | 5 | 7 | 9 | 11 | 11 | 6 | 13 | 11 | 10 | 17 | 14 |

### Complaints - Rate per 1000 WTE

Lincolnshire Community Health Services — Target: 2.62

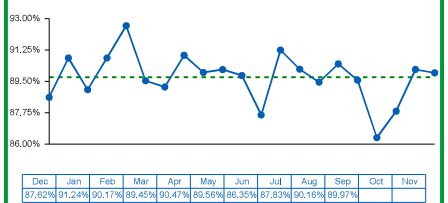
Activity Volume




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.66 | 1.83 | 3.65 | 7.36 | 4.33 | 7.68 | 3.77 | 5.08 | 4.51 | 2.58 | | |

### Friends & Family Test

Lincolnshire Community Health Services

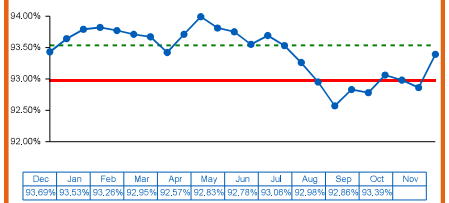



| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 87.62% | 91.24% | 90.17% | 89.45% | 90.47% | 89.56% | 86.35% | 87.83% | 90.16% | 89.97% | | |

## Acute - Workforce

### Acute - Overall percentage of completed mandatory training

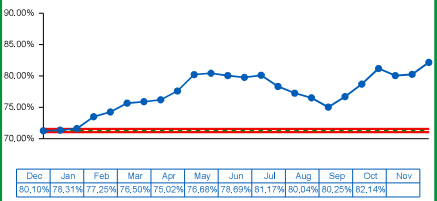
United Lincolnshire Teaching Hospitals




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 93.69% | 93.53% | 93.26% | 92.95% | 92.57% | 92.83% | 92.78% | 93.06% | 92.98% | 92.86% | 93.39% | |

### Acute - Staff Appraisals

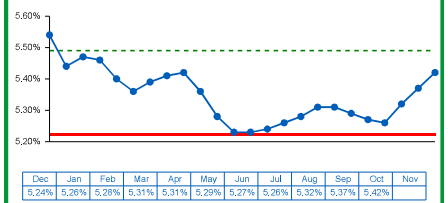
United Lincolnshire Teaching Hospitals




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 80.10% | 78.31% | 77.25% | 76.50% | 75.02% | 76.68% | 78.69% | 81.17% | 80.04% | 80.25% | 82.14% | |

### Acute - Sickness Absence

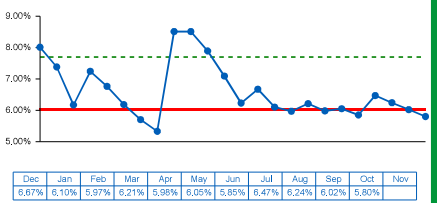
United Lincolnshire Teaching Hospitals




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 5.24% | 5.26% | 5.28% | 5.31% | 5.31% | 5.29% | 5.27% | 5.26% | 5.32% | 5.37% | 5.42% | |

### Acute - Number of Vacancies

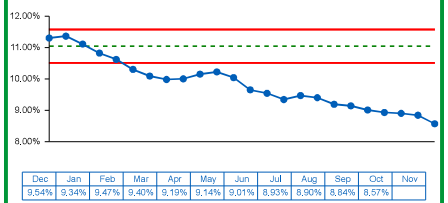
United Lincolnshire Teaching Hospitals




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 6.67% | 6.10% | 5.97% | 6.21% | 5.98% | 6.05% | 5.85% | 6.47% | 6.24% | 6.02% | 5.80% | |

### Acute - Staff Turnover

United Lincolnshire Teaching Hospitals



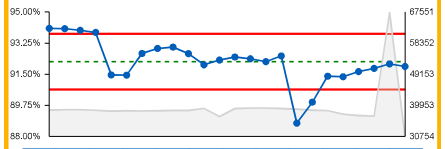

| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 9.54% | 9.34% | 9.47% | 9.40% | 9.19% | 9.14% | 9.01% | 8.93% | 8.90% | 8.84% | 8.57% | |

## Community - Workforce

### Workforce - Overall Compliance

**Lincolnshire Community Health Services** — **Target: 90.00%**

Activity Volume

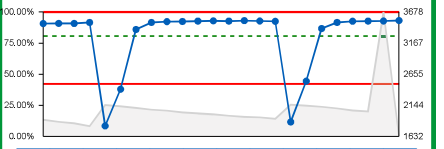



| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 92.47% | 92.37% | 92.21% | 92.53% | 88.75% | 89.93% | 91.39% | 91.36% | 91.65% | 91.83% | 92.08% | 91.94% |

### Workforce - Appraisals

**Lincolnshire Community Health Services** — **Target: 80.00%**

Activity Volume

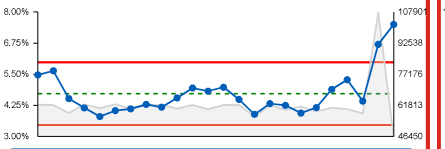



| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 92.71% | 93.04% | 92.81% | 92.47% | 11.75% | 44.45% | 86.70% | 91.65% | 92.57% | 92.72% | 92.79% | 93.14% |

### Workforce - Sickness Rate

**Lincolnshire Community Health Services** — **Target: 4.81%**

Activity Volume

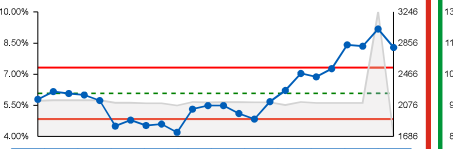



| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.98% | 4.49% | 3.89% | 4.32% | 4.25% | 3.94% | 4.16% | 4.89% | 5.28% | 4.42% | 6.70% | 7.50% |

### Workforce - Vacancy Rate

**Lincolnshire Community Health Services** — **Target: 6.99%**

Activity Volume

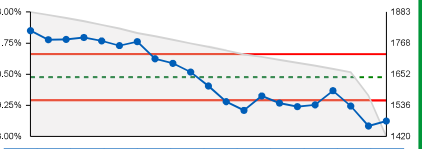



| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 5.49% | 5.11% | 4.84% | 5.68% | 6.22% | 7.04% | 6.87% | 7.27% | 8.42% | 8.35% | 9.18% | 8.29% |

### Workforce - Turnover

**Lincolnshire Community Health Services** — **Target: 15.00%**

Activity Volume



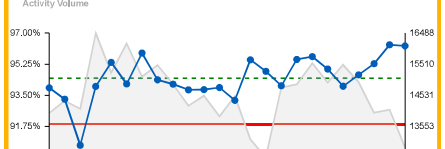

| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10.59% | 10.03% | 9.40% | 9.05% | 9.63% | 9.34% | 9.20% | 9.27% | 9.84% | 9.22% | 8.42% | 8.62% |

## Acute - Front Door

### UTC - Monthly 4 Hour Waits

**Lincolnshire Community Health Services** — **Target: 98.00%**

Activity Volume

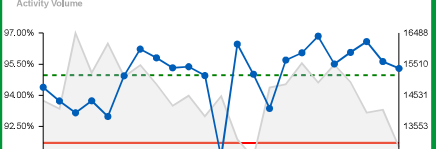



| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 93.22% | 95.50% | 94.85% | 94.04% | 95.52% | 95.68% | 94.98% | 94.01% | 94.65% | 95.28% | 96.34% | 96.28% |

### UTC - 15 Minute Triage Compliance

**Lincolnshire Community Health Services** — **Target: 95.00%**

Activity Volume

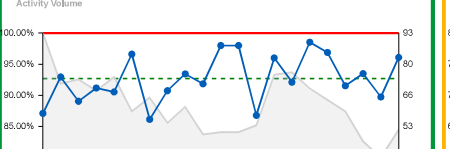



| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 91.03% | 96.47% | 95.02% | 93.37% | 95.70% | 96.05% | 96.85% | 95.51% | 96.07% | 96.59% | 95.63% | 95.30% |

### UTC - 15 Minute Ambulance Handover

**Lincolnshire Community Health Services** — **Target: 95.00%**

Activity Volume

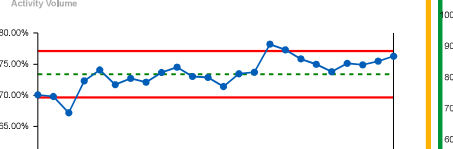



| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 91.84% | 98.00% | 98.00% | 86.79% | 96.00% | 92.11% | 98.55% | 96.88% | 91.53% | 93.48% | 89.74% | 96.08% |

### Acute - Under 4 hour performance

**United Lincolnshire Teaching Hospitals** — **Target: 78.00%**

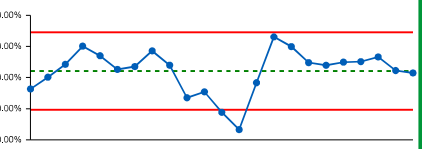
Activity Volume




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 71.41% | 73.47% | 73.72% | 78.21% | 77.32% | 75.86% | 74.98% | 73.78% | 75.13% | 74.90% | 75.48% | 76.28% |

### Acute - % EMAS Conveyance Delayed <45 mins

**United Lincolnshire Teaching Hospitals**

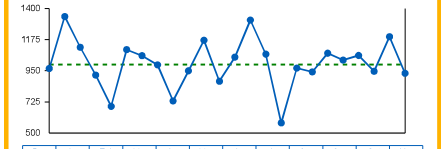



| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 68.87% | 63.26% | 78.35% | 93.07% | 86.94% | 84.80% | 83.93% | 84.94% | 85.11% | 86.64% | 82.27% | 81.46% |

### Acute - >12hr Trolley Waits

**United Lincolnshire Teaching Hospitals** — **Target: 0**

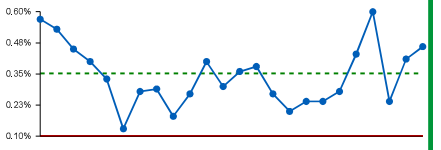
Activity Volume




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1049 | 1317 | 1070 | 573 | 969 | 942 | 1077 | 1027 | 1061 | 946 | 1196 | 932 |

### Acute - % Triage Data Not Recorded

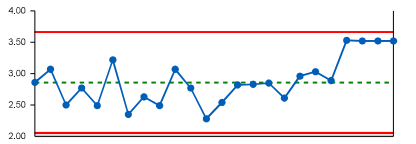
**United Lincolnshire Teaching Hospitals**




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 0.36% | 0.38% | 0.27% | 0.20% | 0.24% | 0.24% | 0.28% | 0.43% | 0.60% | 0.24% | 0.41% | 0.46% |

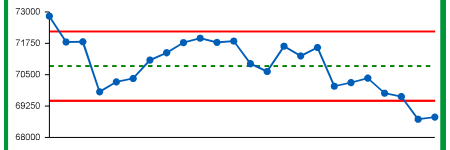
## Acute - Planned

### Acute - Hospital Average LoS (Elective)
United Lincolnshire Teaching Hospitals — Target: 2.80
Activity Volume



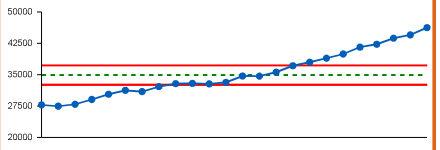

| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2,54 | 2,82 | 2,83 | 2,85 | 2,61 | 2,96 | 3,03 | 2,89 | 3,53 | 3,52 | 3,52 | 3,52 |

### Acute - Waiting List Size
United Lincolnshire Teaching Hospitals



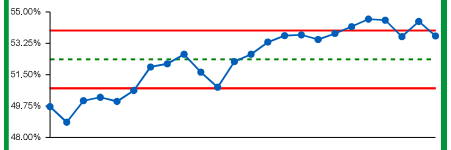

| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 70628 | 71636 | 71248 | 71582 | 70044 | 70185 | 70366 | 69763 | 69630 | 68724 | 68810 | |

### Acute - Partial Booking Waiting List
United Lincolnshire Teaching Hospitals



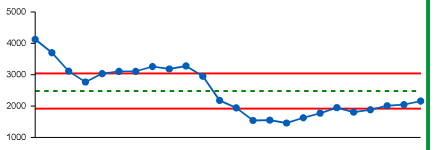

| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 34684 | 34661 | 35622 | 37147 | 37969 | 38948 | 39943 | 41605 | 42275 | 43727 | 44519 | 46242 |

### Acute - 18 week incompletes
United Lincolnshire Teaching Hospitals



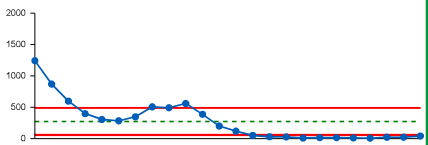

| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 53,32% | 53,68% | 53,72% | 53,46% | 53,80% | 54,18% | 54,60% | 54,54% | 53,62% | 54,47% | 53,66% | |

### Acute - 52 Week Waiters
United Lincolnshire Teaching Hospitals



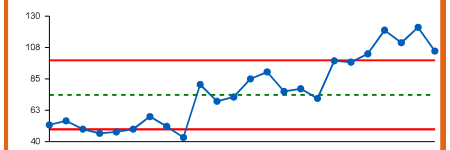

| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1543 | 1552 | 1461 | 1629 | 1775 | 1951 | 1805 | 1882 | 2012 | 2046 | 2159 | |

### Acute - 65 Week Waiters
United Lincolnshire Teaching Hospitals



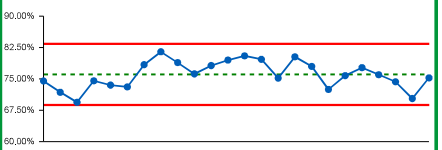

| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 53 | 30 | 29 | 10 | 17 | 16 | 13 | 9 | 23 | 24 | 43 | |

### Acute - 104+ Day Waiters
United Lincolnshire Teaching Hospitals



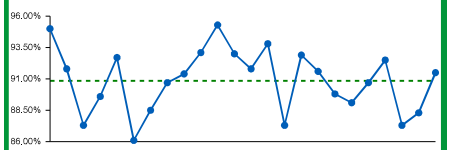

| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 85 | 90 | 76 | 78 | 71 | 96 | 97 | 103 | 120 | 111 | 122 | 105 |

### Acute - 28 days faster diagnosis
United Lincolnshire Teaching Hospitals



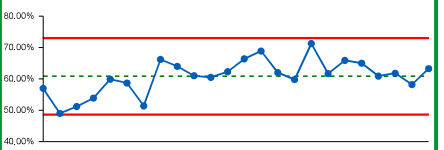

| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 79,70% | 75,20% | 80,30% | 78,00% | 72,50% | 75,80% | 77,70% | 76,00% | 74,32% | 70,30% | 75,25% | |

### Acute - 31 day first treatment
United Lincolnshire Teaching Hospitals




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 93,80% | 87,30% | 92,90% | 91,60% | 89,80% | 89,10% | 90,70% | 92,50% | 87,30% | 88,30% | 91,50% | |

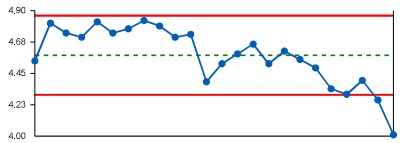
### Acute - 62 day classic
United Lincolnshire Teaching Hospitals




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 68,90% | 62,00% | 59,80% | 71,30% | 61,70% | 65,90% | 65,00% | 60,90% | 61,80% | 58,20% | 63,30% | |

## Acute - Unplanned

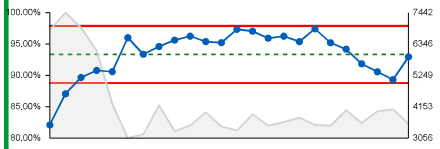
### Acute - Average LoS (Non Elective)
United Lincolnshire Teaching Hospitals — Target: 4.50
Activity Volume




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.52 | 4.59 | 4.66 | 4.52 | 4.61 | 4.55 | 4.49 | 4.34 | 4.30 | 4.40 | 4.26 | 4.01 |

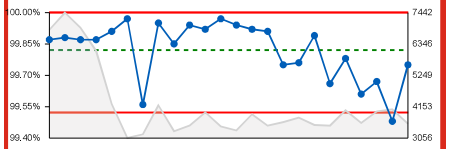
## Community - Planned

### 18 Week Wait
Lincolnshire Community Health Services — Target: 65.00%
Activity Volume




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 97.32% | 97.01% | 95.92% | 96.23% | 95.36% | 97.41% | 95.19% | 94.16% | 91.83% | 90.56% | 89.28% | 92.95% |

### 52 Week Waits %
Lincolnshire Community Health Services — Target: 100.00%
Activity Volume




| Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 99.94% | 99.92% | 99.91% | 99.75% | 99.76% | 99.89% | 99.66% | 99.78% | 99.61% | 99.67% | 99.48% | 99.75% |

# LCHG Scoring

Lincolnshire Community and Hospitals NHS Group

## LCHG Score

### 1. Field Scoring

Each metric is scored based on 3 criteria as per the table below

| Score | Target | Trajectory | Plan |
|---|---|---|---|
| 0 | Above Target | Stable or Improving | Above Plan |
| 0.5 | No Target Set | - | No Plan Set |
| 1 | Below Target | Deteriorating | Below Plan |

### 2. Total Metric Score

The total score is the sum of the 3 criteria, uplifted to fit a range of 1 - 4

### 3. Colour Bandings

| Range | Colour | Description |
|---|---|---|
| 1.00 - 2.00 | Green | Performing Well/On Track |
| 2.01 - 2.99 | Warm Amber | Slightly Below Expectations |
| 3.00 | Burnt Orange | Performance Concern |
| 3.01 - 4.00 | Red | Underperforming |

### 4. Aggregation

Section scores are calculated based on the average score of all metrics in that section. With the section score being rated using the same logic above

# Metric Scoring Example

Lincolnshire Community and Hospitals NHS Group

| Metric Name | Value | Target | LCHG Score |
|---|---|---|---|
| Acute - #NOF 48 hrs | 29.41% | 90.00% | 3.50 |
| Acute - #NOF 36 hrs | 11.76% | | 3.00 |
| Acute - eDD issued within 24 hours | 91.42% | 95.00% | 2.50 |
| Acute - Actions from National clinical audits have been or will be completed within agreed timescale | 100.00% | 100.00% | 1.50 |

Above is an example of 4 metrics with different scores

Acute - #NOF 48 hrs is flagged as red due to the metric being below target and having a deteriorating trajectory

Similarly #NOF 36 hrs is below trajectory but due to the lack of target scores slightly lower but would still be flagged within reporting

Acute - EDD scores 2.5 because whilst the metric is below target, it has a consistent trajectory with no signs of deteriorating

Acute - Actions from clinical audits is flagged as green as the metric is above target and does not have a deteriorating trajectory

NHS
Lincolnshire Community and Hospitals NHS Group

# LCHG Strategy Delivery Q2 Assurance Report (2025/26)

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *11.1* |
| Report title | *LCHG Strategy delivery Q2 assurance report* |
| Report purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | *Assurance* |
| Accountable Director | *Daren Fradgley – Group Deputy CEO / Group Chief Integration Officer* |
| Author(s) | *Dr. Sameedha Rich-Mahadkar Group Director of Strategy, Improvement and Redesign*<br>*Pauline Bazett, Planning and Business Frameworks Support Lead* |
| Assurance rating:<br>• Substantial assurance<br>• Reasonable assurance<br>• Limited or no assurance | *Substantial* |
| Prior approval process, if applicable | *Daren Fradgley – Group Deputy CEO / Group Chief Integration Officer* |
| Financial implications, if applicable | *N/A* |
| Action/decision required | *Trust Board is asked to note progress against delivery of the LCHG 5-year strategy* |

*Assurance Rating Key:*

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

| How the report supports the delivery of the LCHG strategic aims & objectives: | |
|---|---|
| *Patients: Better Care – Timely, affordable, high quality care in the right place:* | *X* |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | *X* |
| 1b: Reduce waiting times for our patients | *X* |
| 1c: Improve productivity and deliver financial sustainability | *X* |
| 1d: Provide modern, clean and fit for purpose care settings | *X* |
| *People: Better Opportunities – Develop, empower and retain great people:* | *X* |

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

## Executive Summary

This Q2 report provides assurance against the delivery of the Trust Strategy. The overall assurance rating for Q2 is substantial, indicating effective controls and appropriate assurances are in place.

**Strategic Pillar 1: Our Patients – Better Care**

Key progress includes improvements in infection control, and patient experience. FFT scores are high (ULTH 88%, LCHS 89.97%). Operational challenges persist in A&E (74.9% performance) and RTT (53.62%), with cancer pathway delays and diagnostics capacity issues. Financially, £22.3m in CIP savings were achieved. Estates and facilities show progress in safety, sustainability and maintenance.

Key actions include enhancing flow programmes, expanding diagnostics, streamlining cancer pathways, and accelerating estates compliance.

**Strategic Pillar 2: Our People – Better Opportunities**

Training compliance exceeds 90%, and appraisal rates are near target at ULTH and exceeding target at LCHS. The medical workforce has increased by 30 WTE over the last 3 months. Leadership programmes and Just Culture initiatives are progressing. Staff recognition is high, with long service celebrations for 98 staff and LCHG was awarded the overall winner – employer champion, at the Greater Lincolnshire 2025 Apprenticeship Awards.

Risks include rising vacancy rates, high sickness absence, and WRES/WDES disparities.

Actions focus on recruitment, mandatory training support and inclusive leadership.

**Strategic Pillar 3: Our Populations – Better Health**

Transformation efforts include successful left-shift models and pathway redesigns; progress made on endoscopy build at Lincoln; and new framework for evaluating service sustainability in place. Digital innovation is advancing with EPR, EDMS, and OPTICA pilots. Sustainability efforts include a Green Plan approved by Board on 1st September. Increase in local research activity is on track to achieve the target for recruits to trials.

Challenges include continuing momentum on the productivity work, estates delays, and digital resource constraints.

Actions include recruitment prioritisation and planning acceleration.

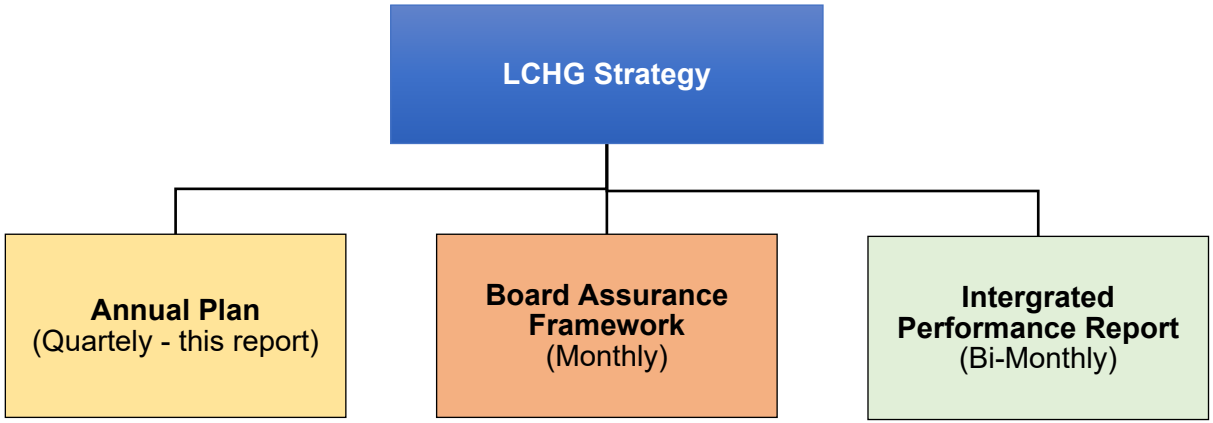
**Conclusion**

We are making meaningful progress in delivering against our strategic aims, particularly in infection control, patient experience, mandatory training compliance and EPR implementation. Continued focus is required on urgent care performance, diagnostics, cancer pathway recovery and estates compliance to maintain momentum across all strategic pillars. Clear action plans are in place to address these challenges and maintain momentum on strategic delivery

# LCHG Strategy Delivery – Q2 Assurance Report (2025/26)

**Background:**

We separately monitor progress against the Annual Plan goals, Board Assurance Framework risks and Key Performance Indicators to report whether expected progress is being made within that quarter. There are already established mechanisms that the Trust Board utilises to receive updates on how the Trust is progressing against the requirements of the strategy. These are set out in the diagram below which also shows the frequency of reporting.




The report provides a holistic assessment of progress against the delivery of the LCHG strategy whilst considering information from the Board Assurance Framework (BAF), annual plan progress update and associated KPIs from the Integrated performance reports. The following sections describe our strategic aims, what we set out to achieve in 2025/26, our key strategic risks, followed by a summary of key highlights against each strategic aim and key areas of improvements and associated actions.

# Pillar 1 (Our Patients) – Q2 Strategic Assessment against delivery of ambitions set for 2025/26

| Strategic Aim | Strategic Objective | What we will achieve in 2025/26? | Board Assurance Framework Strategic Risks |
|---|---|---|---|
| Patients: Timely, high quality and affordable care in the right place | 1a: Improve patient safety, patient experience and deliver clinically effective care | Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm, improved IPC practices and reviewing external reports and assessments of our services<br><br>Identify areas where services do not meet best practice requirements and deliver demonstratable improvement in those areas.<br><br>Focus on improving the top three patient feedback themes: Communication, appointments and clinical practice | If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny |
| | 1b: Reduce waiting times for our patients | Utilise best practice from HVLC/GIRFT, deliver a number of planned care improvement programmes to maximise patient experience and flow to support elimination of 52 week wait and 18-week RTT<br><br>Deliver a number of improvement programmes and projects focussed on unplanned care pathways, that deliver a reduction in A&E waiting times, and improve category 2 ambulance response times<br><br>Better utilise our Community Diagnostics Centres and increase % of patients receiving diagnostic test within six weeks to support plans to address elective/ cancer backlogs and diagnostic waiting time | If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm |
| | 1c: Improve productivity and deliver financial sustainability | Robust CIP and productivity monitored through our LCHG Productivity, Improvement and Transformation Forum (PITOF)<br><br>Embed a culture of Quality Improvement | If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients |
| | 1d: Provide modern, clean and fit for purpose care settings | Manage our backlog maintenance liability and deliver our capital programme<br>Optimise property and space utilisation and improve functionality<br>Improve our internal resilience across all services | If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives |

| | | | |
|---|---|---|---|
| | | Fully integrate group working across acute, community, private and system where possible | or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny |

## Key Highlights

### 1. Clinical Safety

Clinical safety remains a key priority for the Trust. Medication safety continues to be a concern, particularly regarding the omission of time-critical drugs. This is being addressed through the Patient Safety Incident Response Framework (PSIRF), with harm reduction identified as a priority workstream. Performance against the paediatric sepsis pathway remains below standard. In August, 69% of children attending ED received IV antibiotics within the recommended one-hour window (target: 90%). Thematic analysis identified barriers such as difficult cannulation and significant ward transfer delays. Harm reviews have been completed for the affected case, with no harm identified.

### 2. Infection Prevention and Control (IPC)

- Challenges continue in respect of antimicrobial prescribing with a focussed discussion to take place at Quality Committee to strengthen oversight.
- CQC Report following inspections at Lincoln County Hospital ED highlighted significant improvements in infection prevention.

### 3. Safeguarding

- **Adults**: Pressure ulcers and discharge planning remain recurring themes. In respect of Discharge Planning, a focused piece of work to start to look to increase this over next 3 months (Community Hospitals) and deep dive taking place into hotspots of Louth UTC and Skegness UTC.

### 4. Patient Experience

Patient experience metrics remain broadly positive.

- **Friends & Family Test**: ULTH reported 88% positive responses; LCHS 89.97%.
- **Complaints**: investigated and responded to within agreed timescales (ULTH 83% against a target of 100%) (LCHS 2.58 against a target of 2.62 (Rate per 1000 WTE budgeted staff)). Patient stories are actively used in governance forums to support learning.
- **Duty of Candour**: DoC compliance decreased in August; verbal was 86% and written was 76% however this position was fully recovered and compliance for both verbal and written DoC is at 100% for both Q1 and Q2. Dedicated members of the Incident Team are aligned to Care Groups to support with compliance. There were no Patient Safety Alerts with a deadline for completion in September, however, despite fluctuations in compliance the overall position remains positive.

## 5. Clinical Effectiveness

Both Trusts maintained 100% participation in national clinical audits.

## 6. Operational Performance

### Urgent and Emergency Care

- Operational pressures across urgent and emergency care pathways remain significant. In September, the Trust recorded an overall A&E 4-hour performance of 74.9%, below the trajectory of 76.5%. Type 1 performance was particularly challenged with an average daily patient volume of 553, reflecting a 3.68% increase from 533 patients in August, with delays in ward discharges and late identification of long-stay patients impacting flow and capacity.
- Despite these pressures, there was an improvement in 12-hour trolley breaches, which reduced to 946 from 1,061 in August. All breaches have undergone harm reviews, with no significant harm identified. Discharge lounges at Lincoln and Pilgrim continue to operate 24/7, supporting ED flow and timely transfers. 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.
- Ambulance handover delays remain a concern, with 86.64% handovers delayed under 45 minutes. Late afternoon and evening surges continue to contribute to crowding. Performance against the Fractured Neck of Femur (NOF) 48-hour theatre target declined to 29.41%, with theatre and staffing constraints the main factors.
- The non-elective length of stay (LOS) increased to 4.4 days, but below the target of 4.5 days.

## 7. Elective and Cancer Pathways

- Referral to Treatment (RTT) performance remains below national expectations, with 53.62% of patients treated within 18 weeks in August. However, the Trust reported 111 patients waiting over 104 in September, a slight decrease from August's 120, against a target of 10 and zero patients waiting over 78 weeks, and 23 patients over 65 weeks, an increase of 14 from July's 9. The number of patients waiting over 52 weeks stood at 2,012, an increase of 130 from July's 1,882.
- The total waiting list stood at 69,630 at the end of August, a decrease of 133 from July, with sustained pressure in ENT, Trauma & Orthopaedics, Gynaecology, Ophthalmology, and Gastroenterology. These specialties remain the focus of targeted recovery and transformation efforts.
- Diagnostics (DM01) performance was 68.84% (target: 99%), with Ultrasound and Audiology identified as the most challenged modalities. Recovery plans and additional capacity are being explored. Cancelled operations on the day improved slightly to 1.68%, though 28 patients breached the 28-day rebooking standard in September, a significant decrease from 51 in August, due to scheduling pressures.

## 8. Cancer pathway performance remains variable:

- Faster Diagnosis Standard (28-day): 74.3% in August, showing a deterioration from July and is below plan.

- 31-day first treatment: 87.3% (target: 96%).
- 31-day subsequent surgery: 80.6% (target: 94%), impacted by theatre and pre-op delays.
- 62-day classic pathway: 61.8% (target: 85.39%).
- 104+ day waiters: Increased to 111 patients, with colorectal, upper GI, head & neck, and lung pathways most affected.

To support recovery, the Trust continues to hold Intensive Support Meetings across tumour sites and has implemented additional theatre slots and pathway reviews.

## 9. Financial Performance and Productivity

The Group has a planned breakeven position for 2025/26 inclusive of a £79.3m Cost Improvement Programme (CIP).

At Month 6, ULTH reported a £12.0m deficit, in line with plan, and delivered £22.3m in CIP savings, below target by £0.5m. LCHS reported a £2.3m deficit, £0.1m favourable to plan, with £2.6m in CIP savings, exceeding target by £0.4m. Group-wide, £24.9m in savings have been achieved, £0.2m behind plan. The Group's cash position has deteriorated and stands at £26.9m, £8.0m lower than forecast.
Financial position delivery is being driven through three key areas of focus:

- **Workforce Controls**: Level of reduction is below our workforce plan with a key driver being our temporary workforce. Workforce colleagues are working with our nursing and medical teams on addressing this position at pace.
- **Operational Efficiency**: Efficiency plan is slightly (£0.2m) behind plan as some schemes have not delivered as intended and mitigations are being developed.
- **Variable Income**: In Month 6 ULTH saw a step up in income driven by the productivity improvements in theatres and further improvements are focused on our outpatient care setting. It is forecast that we will fully deliver our activity plan for the year.

## 10. Estates and Facilities

The Trust continues to invest in estate safety and sustainability.

- Carbon Energy Project with chosen supplier now mobilising
- Fire safety improvements noted across Group and Group Fire Safety Policy approved
- Authorised engineers now in place across Group and reports due to be received in the coming months
- Statutory maintenance and Planned Preventative Maintenance (PPM) improvements have been made with an external review due to be undertaken to support further improvement
- Escalation of recent RIDDOR reportable incidents and issues with lifts at Pilgrim Hospital being addressed with the maintenance supplier.

**Strategic Aim 1 (Patients) Summary**

The Trust is managing ongoing pressures across clinical safety, urgent care, and elective pathways while maintaining positive patient experience and audit participation. Key challenges include medication safety, paediatric sepsis response times, ambulance handover delays, and long waits in cancer and elective care. Financial performance is broadly on track, though cash flow and workforce costs need closer control. Group delivered £13.2m deficit (vs breakeven plan); CIP savings on track (£33.8m) but £13m risk remains. Estates improvements are progressing, with safety and sustainability initiatives underway. Overall, while there are areas requiring focused recovery, the Trust is actively implementing measures to address performance gaps and improve service delivery.

**Areas for Improvement & Actions:**

**Clinical & Patient Safety**

- Implement targeted training for time-critical medication administration.
- Streamline paediatric sepsis pathway with rapid access to IV antibiotics and improved cannulation support.

**IPC & Safeguarding**

- Enhance antimicrobial stewardship via Quality Committee oversight.
- Launch discharge planning initiative in Community Hospitals and conduct hotspot analysis.

**Patient Experience**

- Continue to monitor Duty of Candour compliance and support Care Groups with the ongoing provision of DoC training and process audits.
- Continue leveraging patient stories for learning and improvement.

**Operational & Cancer Pathways**

- 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. 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.
- Increase theatre availability and streamline pre-op processes for cancer surgeries.

- Strengthen cancer pathway governance with regular reviews and escalation protocols. Priority remains focused on clinically urgent and Cancer patients. National focus is now on patients that are waiting 52 weeks and over. with resource targeted at patients who have the potential to be >52 weeks. Schemes to address the backlog include;
    - Outpatient utilisation
    - Tertiary capacity
    - Outsourcing/Insourcing
    - Use of ISPs
    - Reducing missing outcomes

- Diagnostics: Secure extra ultrasound/audiology capacity, explore AQP alternatives, prioritise backlog clearance.
- UCR 2: Brought 2 legacy teams together and doubled the volume in addition to the data quality errors we had
- Community Waiting List >52 weeks: waits resolved in 2 services in LCHS ( predicted 0/52 in Dec) Redesign of community peads pathway in ULTH aligning with LCHS team to recover

**Financial & Estates**

- Deliver CIP recovery:
    - Accelerate productivity & transformation schemes (Theatres and Booking Centre)
    - Implement non-recurrent mitigations and technical efficiencies.
    - Additional workforce controls including vacancy pause
- Monitor cash flow closely and adjust forecasts.
- Continue estate safety upgrades and ensure timely resolution of lift issues.

# Pillar 2 (Our People) – Q2 Strategic Assessment against delivery of ambitions set for 2025/26

| Strategic Aim | Strategic Objective | What we will achieve in 2025/26? | Board Assurance Framework Strategic Risks |
|---|---|---|---|
| People: Develop, empower and retain great people | 2a: Enable our people to fulfil their potential through training, development and education | Support our Divisions to provide all staff with an appraisal, clear objectives and clear relevant statutory and mandatory training<br><br>Increase the number of staff involved with research activity across LCHG<br><br>Harness new roles, integrated roles and rotational roles where there is further opportunity for productivity or integration through a 'grow our own' approach and maximising the apprenticeship levy<br><br>Ensure all staff have the correct training and support available to them to fulfil their role as a leader | If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable, less efficient services and the inability to attract and retain staff |
| | 2b: Empower our people to continuously improve and innovate | Actively listen to our staff experience through the National Staff Survey and Quarterly Pulse Surveys and have clear action plans in place at a Group and Divisional Level. In addition, the 'Free text' elements of the staff survey need to be factored into the action plans<br><br>Ensure Medical and Dental staff have a fully agreed job plan agreed with the Division.<br><br>Improve consultant and middle tier stabilisation and succession planning<br><br>Create a culture of research and innovation | 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 | Continue our focus on upskilling leaders by strengthening their leadership knowledge, training and awareness of their responsibilities through active engagement with the 'basics brilliantly' and 'leading functional teams' training<br><br>Work to be an employer of choice by developing our one desired culture of Civility and Respect through:<br>a. Embedding the 'Just Culture' principals and developing an inclusive culture across the Trust.<br>b. Actively listening to our staff experience through the National Staff Survey.<br>c. Working closely with our Staff Networks<br><br>Creation of a 'Hot Spot' Dashboard which includes cultural elements including turnover, vacancies, complaints, datix, HR cases, FTSU concerns, sickness which will highlight cultural positions | If we do not **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement |

| | | | |
|---|---|---|---|
| | 2c: Nurture compassionate and diverse leadership | Continue our focus on upskilling leaders by strengthening their leadership knowledge, training and awareness of their responsibilities through active engagement with the 'basics brilliantly' and 'leading functional teams' training<br><br>Work to be an employer of choice by developing our one desired culture of Civility and Respect through:<br>a. Embedding the 'Just Culture' principals and developing an inclusive culture across the Trust.<br>b. Actively listening to our staff experience through the National Staff Survey.<br>c. Working closely with our Staff Networks<br><br>Creation of a 'Hot Spot' Dashboard which includes cultural elements including turnover, vacancies, complaints, datix, HR cases, FTSU concerns, sickness which will highlight cultural positions | If we do not **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement |
| | 2d: Recognising our people through thanks and celebration | Hold celebratory events through our awards programme and long service programmes to say thank you to our staff and celebrate their achievements and service to the NHS. | If we do not continue to **recognise our people through thanks and celebration,** then we will be unable to attract and retain staff of the required calibre and experience resulting in services becoming unsustainable / fragile |

## Key Highlights

### 11. Training, Development and Education

- **The Mandatory training Core Learning Rate of 92.86% (ULTH) and 95.38% (LCHS)** is **exceeding our overall target of 90.00%**. Compliance will continue to be monitored to ensure that we remain in line with our overall trajectory. The biggest challenge is ensuring staff have protected time to complete role specific mandatory training. **Targeted support is being provided to staff with ≤50% compliance**.
- **Appraisal rates for September 2025 against a Q2 target of 85% were 80.87% (ULTH) and 92.23% (LCHS)**. At ULTH the Agenda for Change appraisals require focus. The move in 2025/26 to an appraisal window in Q1 is expected to support attaining the target and sustaining in year.

### 12. Continuously Improve and Innovate

- **The National Staff Survey and Quarterly Pulse Survey** are reviewed quarterly alongside the free text comments post thematic review. Divisional action plans are formulated to support closing the feedback loop.

- Over the last three months we've **increased our Medical Workforce by 30 WTE** which includes an **increase in our Consultant Workforce of 5 WTE**.

**13. Nurture Compassionate and Diverse Leadership**

- Culture and Leadership Programmes are in place across the group.
- Embedding the 'Just Culture' principals and developing an inclusive culture across the Trust.
- Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) - 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.
- In September sickness absence is outside of the Q2 targets (ULTH 5.37% against Q2 target of 4.78%) and (LCHS 5.50% against Q2 target of 4.35%). Additional resource is being put in place to support the active and robust management of absence over the next 12 months.
- Turnover rate for September 2025 is 8.84% against a target of 9.00% (ULTH) and 8.89% against a target* of 15.00% (LCHS). *The "target" level of 15% represents a ceiling to stay within. Additional platforms are in place where retention of staff can be considered through various workforce lenses.
- Vacancy rate for September 2025 is 6.02% against a target of 6.81% (ULTH). Monitoring will continue in 2025/26 to ensure recruitment to roles/services directly impacting patient care. Vacancy rate is 8.35% (LCHS) against a target of 8%. This has decreased from a high in August, mainly due to the MARS scheme taking effect with successful applicants leaving and corresponding budgets still to be adjusted.

**14. Thanks, and Celebration**

- **Long Service Awards** celebrated 98 LCHG clinical and support staff receiving certificates for 20, 30, 40 or 50 years of NHS service.
- Following a recent nomination to the **Greater Lincolnshire 2025 Apprenticeship Awards**, LCHG was awarded the **overall winner – employer champion**.

**Strategic Aim 2 (People) Summary**
The Trust continues to perform well in training and development, with mandatory training compliance exceeding targets across both ULTH and LCHS. Appraisal rates are improving, with further gains expected through a revised appraisal window. Staff feedback is actively used to drive improvement, and medical workforce capacity has increased. Leadership and culture programmes are in place, with efforts to embed inclusive practices and improve equality data reporting. Sickness absence remains above target, but turnover and vacancy rates are within acceptable limits and trending positively. Finally, staff recognition is strong, with long service awards and external accolades celebrating workforce contributions.

**Areas for Improvement & Actions:**
**Training, Development and Education**
- Ensure protected time for staff to complete mandatory training.
- Improve appraisal rates, particularly for Agenda for Change roles at ULTH.
- Implement Q1 appraisal window to support sustained compliance.

**Continuously Improve and Innovate**
- Strengthen feedback loops from staff surveys.
- Maintain thematic reviews and develop divisional action plans.
- Monitor impact of medical workforce growth on service delivery.

**Nurture Compassionate and Diverse Leadership**
- Address high sickness absence rates with additional support.
- Enhance reporting for WRES/WDES to improve inclusion data.
- Continue embedding inclusive leadership and ‘Just Culture’ principles.
- Monitor and manage vacancy rates, prioritising roles impacting patient care.
- Use retention platforms to support workforce stability.

# Pillar 3 (Our Populations) – Q2 Strategic Assessment against delivery of ambitions set for 2025/26

| Strategic Aim | Strategic Objective | What we will achieve in 2025/26? | Board Assurance Framework Strategic Risks |
|---|---|---|---|
| **Population: Improve our population health** | 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | Deliver left shift transformation through the Alliance Care Group, focussed on key specialties OPAT/IV Therapies, Stroke, Dermatology, Weight Management, Respiratory, Rheumatology, Therapies Rehab, Paediatrics, cataract surgery, ENT surgery, Neurology<br>Transform acute wards to community wards to improve pathways of care<br>Strengthen integrated working with Primary Care/GPs/PCNAs and provider partners through collaboration in the Alliance Division<br>Develop our estates strategy for rationalisation and develop business cases for maternity and theatres | If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience |
| | 3b: Move from prescription to prevention, through a population health management & health inequalities approach | Embed a BAU population health-based approach to service change and transformation that supports a reduction in health inequalities across our population<br>Deliver the LCHG Health Inequalities Action plan<br>Embed CDC pathways into primary care<br>Deploy neighbourhood health model | If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes |
| | 3c: Enhance our digital, research and innovation capability | Become a paperlite digital Group, deliver our Digital Strategy and Implement an Electronic Prescribing system<br>Upgrade our technological infrastructure and provide our people with real-time data to support high quality care delivery<br>Enhance our organisational digital capability and skills through training<br>Develop a new LCHG Research Strategy which will support additional research opportunities and improvements in patient care<br>Attract and increase number of clinical academics and principle investigator opportunities across our workforce to build a strong R&I culture within LCHG and with the University of Lincoln<br>Host system wide provision of Digital and Business Intelligence | If we do not **enhance our digital, research and innovation** capability then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale |

| | | | |
|---|---|---|---|
| | 3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan | Robust CIP and transformation delivery monitored through our LCHG Productivity, Improvement and Transformation Oversight Forum<br><br>New Board-approved Green Plan for LCHG which provides a clear roadmap toward the net zero 2024 target, increasing staff understanding and awareness of the green agenda<br><br>Develop a sustainability dashboard to provide clear baseline carbon footprint measure and track progress<br><br>Produce Adaptation Risk Assessments for both ULTH and LCHS | If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable |

**Key Highlights**

**15. Transform Clinical Pathways and Rationalise our Estates**

- **Estates and Facilities** progress made with space utilisation continuing to support cost reduction and increase utilisation.
- Major building works continuing with **some delays experienced with the Pilgrim ED build phase 1b** which was **due to complete in October**. **Endoscopy build at Lincoln progressing well** with **anticipated completion of May 2026**.
- **New framework in place for evaluating service sustainability**, based on the NHS England sustainability framework domains and adapted from successful deployments in other Trusts.

**16. Move from Prescription to Prevention**

- **Alliance Steering Group**: Key projects progressing with health inequalities having been mapped and ongoing work to produce maps for the care groups. Work progressing on rheumatology as a blueprint for left shift focusing on community delivery, clinical efficiency and workforce deployment. Anticipated mobilisation between January to March 2026 following workshops with partners to support left shift work.
- **Neighbourhood Board** terms of reference agreed by Chief Executives within the System and first meeting scheduled for October 2025. Neighbourhood Health Board held a productive workshop on 27/11. Partners agreed there is a substantive difference between how services operate on the ground (look, feel, behave day-to-day) and how it works managerially (how boundaries are set to manage services internally), and that the former is vital

**17. Enhance our Digital and Research and Innovation Capacity**

- **Electronic Patient Record (EPR) Project** approval letters received. EPR programme **officially launched at ULTH in September** and **successful engagement events with over 1,500 colleagues** were held across all sites, led by key members of the EPR Programme team and representatives from our EPR supplier, Nervecentre.

- **Research and Innovation Group** progressing development of the 5–10-year strategy. Increase in local research activity is on track to achieve the target for recruits to trials.

**18. Drive Forward our Improvement, Efficiency and Sustainability Agenda**

- **Avoidance Dashboard** first iteration produced which offered the number of beds saved and bed position for each service. Headline bed days saved, and units of activity would be included in the main dashboard moving forward.
- **Green Plans** were **approved** by Board on 1st September.

**Strategic Aim 3 (Populations) Summary**

The Group is making steady progress in transforming clinical pathways, enhancing digital capabilities, and advancing sustainability. Estates projects are moving forward despite some delays, and preventative care models are developing well, particularly in rheumatology. The EPR programme has launched successfully, and research activity is increasing. Efficiency efforts are supported by new dashboards and approved Green Plans, positioning the Trust for continued improvement.

**Areas for Improvement & Actions:**

**Clinical Pathways & Estates**

- Address delays in major build projects (e.g. Pilgrim ED).
- Continue optimising space utilisation for cost and efficiency.
- Apply new service sustainability framework consistently.

**Prevention-Focused Care**

- Mobilise rheumatology blueprint and expand community-based care models.
- Strengthen system-level collaboration through Neighbourhood Board.
    - Develop a Partnership Agreement to define how partners will deliver together focused on the 3 tiers (Resilient Communities, Planned Care, Unplanned Care) and define who leads each space.
    - Accept PCNs as the lowest common denominator in neighbourhood, and that countywide services will have a ‘managerial’ overlay that may look different.

**Digital & Innovation**

- Maintain momentum on EPR rollout and staff engagement.
- Finalise and implement long-term research and innovation strategy.

**Efficiency & Sustainability**

- EY commissioned to help trust focus on improvement of productivity. Specifically focusing on
  - RTT
  - Clinic Utilisation
  - Outpatient 6-4-2
  - Theatre 6-4-2
- The internal validation team in conjunction with the EACH have completed National validation sprint 2. A total of 3,648 clock stops were found through the sprint.
- Core CIP delivery has been challenging, productivity work and booking centre, took longer than anticipated for procurement and approval resulting in delays starting the work. Programmes are now up and running with productivity scheme delivering from September and booking centre forecast to open in December. Current forecast is to deliver our core productivity with additional FYE benefits to support underlying financial position.
- Publish Green Plans on Trust websites and monitor implementation.

NHS
Lincolnshire Community and Hospitals NHS Group

# Risk Report

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *12.1* |
| Report title | *Risk Report* |
| Report purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | • *Assurance* |
| Accountable Director | *Kathryn Helley, Group Chief Clinical Governance Officer* |
| Author(s) | *Sarah Davy, Group Risk and Datix Manager/ CAS Officer*<br>*Jeremy Daws, Associate Director Compliance and Risk* |
| Assurance rating:<br>• Substantial assurance<br>• Reasonable assurance<br>• Limited or no assurance | • *Reasonable assurance* |
| Prior approval process, if applicable | *N/A* |
| Financial implications, if applicable | *N/A* |
| Action / decision required | *The Board is asked to:*<br>• *Review the content of the report. There are no further escalations at this time.* |

*Assurance Rating Key:*

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

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

## Executive Summary

**Scope of this report:**

- The following report includes risks considered to be **high** or **very high**, scoring 15 – 25.
- This report is focussed on the risks reported to the lead Committees in December 2025, and includes risks managed across the Lincolnshire Community and Hospitals Group (LCHG), breaking these down by:
    - United Lincolnshire Teaching Hospitals NHS Trust (ULTH)
    - Lincolnshire Community Health Services NHS Trust (LCHS)

**Movement since last reported position:**

- As of the 15 December 2025, there are 743 (LCHS 118 and ULTH 625) risks in total.
- This is **an increase of 1** since the November 2025 report.
- Of the 743 risks, there are 91 (12%) risks considered to be **high** or **very high**, scoring 15 – 25. The full lists are available in **Appendix A and B.** These are broken down by organisation as follows:
- **LCHS:** Very high (20-25): 1 (same as previous report):
    - **Quality Committee (n=1):**
    - 403 - Children SLT Therapy Treatment Delays
- **ULTH:** Very high (20-25): 19 (same as previous report):
    - **Quality Committee:** (n=7; same as previous report):
    - 4731 - Reliance on paper medical records
    - 4746 - Overdue patients on Ophthalmology PBWL
    - 4879 - Recovery of planned care cancer pathways
    - 5016 - Patient flow through Emergency Departments
    - 5101 - Delivery of paediatric epilepsy pathways-across acute and community
    - 5200 - Backlog of Paediatric Cardiology clinics
    - 5450 - Risk of Gastro service not being viable due to current fragility of consultant workforce
    - **People Committee:** (n=4; same as previous report)
    - 4844 – Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service
    - 4996 - Consultant workforce capacity (Haematology)
    - 4997 – Service configuration (Haematology)
    - 5093 – Procurement service staffing levels (Pharmacy)
    - **Finance and Performance Committee:** (n=6; same as previous report)
    - 4657 - Compliance with Subject Access Requests
    - 4664 - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
    - 4839 - Lack of pharmacy capacity for Intravenous Immunoglobulin (IVIG)
    - 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
    - 5447 - Cancellation of elective lists due to lack of theatre staff
    - 5672 - Risk of failure to deliver the CIP target in full for 2025/2026
    - **Integration Committee:** (n=2; same as previous report)

- 5563 - Neurology – Service sustainability
- 5711 - Risk to our transformation programme due to changes within the ICB

**Risk profile compared to risk appetite:**

- **LCHS:** Of the 118 risks, 17 are out of the risk appetite set.
- **ULTH:** Of the 625 risks, 144 are out of the risk appetite set.

| Strategic Objective: | Defined Risk Appetite[1]: | LCHS | | ULTH | |
|---|---|---|---|---|---|
| | | Within | Out of | Within | Out of |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | **Open / Cautious:** Prepared to accept risks up to 12 and 10 respectively | 32 | 13 | 185 | 101 |
| 1b: Reduce waiting times for our patients | **Open/Cautious:** Prepared to accept risks rated to 10-12 | 6 | 1 | 14 | 3 |
| 1c: Improve productivity and deliver financial sustainability | **Open:** Prepared to accept risks rated to 12 | 10 | 1 | 66 | 7 |
| 1d: Provide modern, clean and fit for purpose care settings | **Open:** Prepared to accept risks rated to 12 | 14 | 2 | 90 | 12 |
| 2a: Enable our people to fulfil their potential through training, development and education | **Open:** Prepared to accept risks rated to 12 | 9 | 0 | 13 | 8 |
| 2b: Empower our people to continuously improve and innovate | **Hungry:** Prepared to accept risks rated as 15/16 | 5 | 0 | 13 | 3 |
| 2c: Nurture compassionate and diverse leadership | **Open:** Prepared to accept risks rated to 12 | 1 | 0 | 8 | 0 |
| 2d: Recognising our people through thanks and celebration | **Hungry:** Prepared to accept risks rated as 15/16 | 0 | 0 | 1 | 0 |
| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | **Open:** Prepared to accept risks rated to 12 | 5 | 0 | 10 | 10 |
| 3b: Move from prescription to prevention, through a population health management & health inequalities approach | **Hungry:** Prepared to accept risks rated as 15/16 | 6 | 0 | 0 | 0 |
| 3c: Enhance our digital, research and innovation capability | **Hungry:** Prepared to accept risks rated as 15/16 | 10 | 0 | 79 | 0 |
| 3d: Drive forward our efficiency and sustainability agenda through our Green Plan | **Open:** Prepared to accept risks rated to 12 | 3 | 0 | 2 | 0 |

The full list is available in **Appendix D.**

[1] For greater information on the risk appetite agreed by the Group, please refer to **Appendix C.**

## 1. Purpose

1.1 The purpose of this report is to:

- Enable the Group Board to review the management of significant risks to achievement of strategic objectives and risks
- Review those risks outside of the risk appetite set by Group Board and consider the overall extent of risk exposure within LCHG at this time.

## 2. Introduction

2.1 The Group's risk registers are recorded on the DatixWeb (LCHS) and DatixIQ (ULTH) Risk Management Systems.

2.2 This report is focussed on, both:

- Significant risks, defined as those with a current rating of Very High, scoring 20-25;
- Risks outside of the risk appetite set previously by the Group Board.

Both elements are mapped against the Group's strategic objectives and are further aligned to the lead sub-committees.

**NB:** Full details of all 'Very High' and 'High', scoring 15-25, risks please see **Appendix A (LCHS) and Appendix B (ULTH).**

**NB:** Full details of all risks outside of risk appetite are reported in **Appendix D.**

2.3 The LCHG Risk Register Confirm and Challenge Group continues to meet monthly, reviewing all High and Very High risks, as well as receiving presentations from clinical and corporate areas on a rotational basis to enable constructive feedback to be provided.

## 3. Group Risk Profile:

### 3.1: Lincolnshire Community Health Services NHS Trust

**Risk profile: This month compared to last report:**

| This month vs. last month | Number of risks | Very low (1-3) | Low (4-6) | Moderate (8-12) | High (15-16) | Very high (20-25) |
|---|---|---|---|---|---|---|
| Dec – 2025 | 118 | **4** (3%) | **37** (31%) | **65** (56%) | **11** (9%) | **1** (1%) |
| Oct – 2025 | 116 | **3** (2%) | **37** (32%) | **65** (56%) | **10** (9%) | **1** (1%) |

- The number of risks has increased by 2 compared to the previous report.
- 1 risk is scored 'Very High'. There is no change from the previous report.
- 11 risks are scored as 'High'. This is an increase of 1 from the previous report. This relates to:
  - Risk 815 – Digital Clinical Safety (16)

**Heat Map: Dispersion of risks:**

| Heatmap / Risks across Risk Matrix | | Severity | | | | | |
|---|---|---|---|---|---|---|---|
| | | Minimal (1) | Noticeable (2) | Moderate (3) | Severe (4) | Extreme (5) | Total |
| Likelihood | Extremely likely (5) >90% chance | 0 | 2 | 1 | 1 | 0 | **4** |
| | Quite likely (4) 71-90% chance | 1 | 5 | 10 | 9 | 0 | **25** |
| | Reasonably likely (3) 31-70% chance | 2 | 8 | 18 | 11 | 1 | **40** |
| | Quite unlikely (2) 10-30% chance | 0 | 5 | 21 | 13 | 6 | **45** |
| | Extremely unlikely (1) <10% chance | 0 | 0 | 2 | 1 | 1 | **4** |
| | Total | **3** | **20** | **52** | **35** | **8** | **118** |

### 3.2: United Lincolnshire Teaching Hospitals NHS Trust

**Risk profile: This month compared to last report:**

| This month vs. last month | Number of risks | Very low (1-3) | Low (4-6) | Moderate (8-12) | High (15-16) | Very high (20-25) |
|---|---|---|---|---|---|---|
| Dec – 2025 | 625 | **46** (7%) | **156** (25%) | **344** (55%) | **60** (10%) | **19** (3%) |
| Oct – 2025 | 626 | **47** (8%) | **156** (25%) | **345** (55%) | **59** (9%) | **19** (3%) |

- The number of risks has decreased by 1 this month compared to the previous report.
- 19 risks are scored as 'Very High'. There is no change from the previous report.
- 60 risks are scored as 'High'. This is an increase of 1 from the previous report. This relates to:
  - Risk 4769 – Insufficient staffing and ultrasound equipment within Vascular Lab at PBH (16)

**Heat Map: Dispersion of risks:**

| Heatmap / Risks across Risk Matrix | | Severity | | | | | |
|---|---|---|---|---|---|---|---|
| | | Minimal (1) | Noticeable (2) | Moderate (3) | Severe (4) | Extreme (5) | Total |
| Likelihood | Extremely likely (5) >90% chance | 1 | 9 | 11 | 17 | 0 | **38** |
| | Quite likely (4) 71-90% chance | 2 | 33 | 72 | 46 | 2 | **155** |
| | Reasonably likely (3) 31-70% chance | 2 | 40 | 100 | 72 | 3 | **217** |
| | Quite unlikely (2) 10-30% chance | 17 | 24 | 70 | 47 | 11 | **169** |
| | Extremely unlikely (1) <10% chance | 8 | 9 | 9 | 14 | 6 | **46** |
| | Total | **30** | **115** | **262** | **196** | **22** | **625** |

## 4. Risks by Strategic Objective:

### 4.1: Strategic objective 1a - Improve patient safety, patient experience and deliver clinically effective care

The Group's Risk Appetite is described as: 1a(i) Patient Safety 'Cautious' (accept risks up to 10) / 1a(ii) Patient Experience 'Open' (accept risks up to 12) / 1a(iii) Clinically Effective Care 'Open' (accept risks up to 12).

**Lincolnshire Community Health Services NHS Trust**

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite | Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|---|---|---|---|
| Dec – 2025 | MINIMAL Accept up to 8 | 32 (71%) | 13 (29%) | 4 | 3 (100%) | 1 (100%) |
| | | 45 | | | | |
| Nov – 2025 | | 32 (71%) | 13 (29%) | 4 | 3 (100%) | 1 (100%) |
| | | 45 | | | | |

- 71% of LCHS risks (32) are within the 'Open/Cautious' risk appetite.
- There is 1 'Very High' risk.

**United Lincolnshire Teaching Hospitals NHS Trust**

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite | Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|---|---|---|---|
| Dec – 2025 | MINIMAL Accept up to 8 | 185 (64%) | 101 (36%) | 30 | 23 (77%) | 7 (23%) |
| | | 286 | | | | |
| Nov – 2025 | | Not able to calculate retrospectively | | 29 | 22 (76%) | 7 (24%) |
| | | 288 | | | | |

- 64% of ULTH risks (185) are within the 'Open/Cautious' risk appetite.
- There are 7 'Very High' risks.

**Summary of the risks outside of the Risk Appetite (n=114):**

- Further work is underway to split the risks within strategic objective 1a into the three areas of 1a(i) Patient Safety / 1a(ii) Patient Experience and 1a(iii) Clinically Effective. This will enable fuller reporting within the February 2026 Committee and Board reporting periods.

- Given the number outside of the risk appetite set, please refer to Appendix D for the full list of risks outside of the risk appetite, grouped against the corresponding strategic objective.

**Summary of the 'Very High' risks (n=8):**
**LCHS:**

| Risk ID | Title | Risk level (current) | Care Group | Progress Update | Date of latest review |
|---|---|---|---|---|---|
| 403 | Children SLT Therapy Treatment Delays | Very high risk (20-25) | Children, Young People, and Specialist Services | Service has seen an increase in complaints relating to wait time. Therapy waits remain circa 1 year. Pilot is in its early days, with waits for initial assessment at 35 weeks, and waits for therapy at 2 years. | 01/12/2025 |

**ULTH:**

| ID | Title | Risk level (current) | Care Group | Progress update | Date of latest review |
|---|---|---|---|---|---|
| 4731 | Reliance on paper medical records | Very high risk (20-25) | Corporate | Go Live date for EDMS set for January 2026 for Neonates, Paediatrics and Community Paediatrics. There will then be a phased roll out of gradual implementation across remaining departments from Jan-Sept 2026. | 17/12/2025 |
| 4746 | Overdue patients on Ophthalmology PBWL | Very high risk (20-25) | Surgery | Paper written regarding next steps and plans and presented at the Patient Safety Group with further update to the Quality Committee in January, number of overdue patients has reduced since completing clinical and non-clinical validation. Ongoing work within CBU to define next steps. | 05/12/2025 |
| 4879 | Recovery of planned care cancer pathways | Very high risk (20-25) | Corporate | Recovery trajectory in place to reduce 62+ day breaches to 245 by March 2026, supported by an intensive specialty-level review to identify and mitigate residual risks. Weekly Care Group Intensive Support meetings have been established, with performance trajectories set at Trust and tumour site level for the 28 day FDS, 62 day and 31-day standards, aligned to national expectations and local targets for backlog reduction. Since September 2025 Head of Cancer has been appointed to provide strategic oversight and operational leadership across cancer pathway. | 19/11/2025 |
| 5016 | Patient Flow Through Emergency Departments. | Very high risk (20-25) | Medicine | Streaming project is underway with estimated completion in Dec at Lincoln then moving to Pilgrim. We are looking at replacing Manchester Triage to Acuity 1-5. | 11/11/2025 |
| 5101 | Delivery of paediatric epilepsy pathways-Acute Paediatrics & Community | Very high risk (20-25) | Family Health | Business case has been written - to be submitted for 2026/27 funding – await outcome of business case submission. Conversations ongoing with tertiary provider regarding clarity of service offer. Recent Epilepsy12 audit confirmed still non-compliant with some of the required elements of care delivery. | 10/12/2025 |
| 5200 | Backlog of Paediatric Cardiology clinics | Very high risk (20-25) | Family Health | Risk to be closed as the backlog of patients has been cleared and all patients have now been seen as required following the appointment of a consultant on a fixed term basis. Ongoing risk remains in relation to the single point of failure in this service provision – new risk to be raised, to be presented at Cabinet for agreement in December and RRC&C in January. | 10/12/2025 |
| 5450 | Risk of Gastro service not being viable due to current fragility of Consultant workforce | Very high risk (20-25) | Medicine | Work not started for moving Gastro service into community. Risk remains unchanged for now pending further recruitment as still dependent on agency - If current round of recruitment successful pending further partial retirement approved by ROAG then to explore if risk to be downgraded. | 15/12/2025 |

## 4.2: Strategic objective 1b – Reduce waiting times for our patients

The Group's Risk Appetite is described as 'Open/Cautious' which is defined as the Group is prepared to accept risks rated up to 12.

### Lincolnshire Community Health Services NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | Open/ Cautious Accept up to 12 | 6 (86%) | 1 (14%) |
| | | 7 | |
| Nov – 2025 | | | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 1 | 1 (100%) | 0 (0%) |
| 1 | 1 (100%) | 0 (0%) |

- 86% of LCHS risks (6) are within the 'Open/Cautious' risk appetite There are zero 'Very High' LCHS risks.
- There is 1 'High' LCHS risk.

### United Lincolnshire Teaching Hospitals NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | Open/ Cautious Accept up to 12 | 14 (82%) | 3 (18%) |
| | | 17 | |
| Nov – 2025 | | | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 3 | 2 (67%) | 1 (33%) |
| 3 | 2 (67%) | 1 (33%) |

- 82% of ULTH risks (14) are within the 'Open/Cautious' risk appetite.
- There is 1 'Very High' ULTH risks.
- There are 2 'High' ULTH risks.

**Summary of the risks outside of the Risk Appetite (n=4):**

- LCHS: 773 - Speech and Language Therapy – Capacity and Demand (16)
- ULTH: 5267 - Delay in processing cardiac MRIs – (16)
- ULTH: 5381 - Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands (15)
- ULTH: 5447 - Cancellation of elective lists due to lack of theatre staff (20)

**Summary of the 'Very High' risks (n=1):**
**ULTH:**

| Trust: | Risk ID | Risk Title | Risk score | Division | Progress Update | Date of latest review: |
|---|---|---|---|---|---|---|
| ULTH | 5447 | Cancellation of elective lists due to lack of theatre staff | Very high risk (20) | Surgery | Approval for 3 long-line agency scrub nurses for a period of 3 months started on 29th September. Nursing establishment has been adjusted for 9 theatres however there are still occasions where requests are made to staff additional theatres.<br>Patient Safety Group has asked for a review of the risk due to further mitigations in place and limited patient safety data being reported with the plan to reduce the scoring. | 28/11/2025 |

## 4.3: Strategic objective 1c - Improve productivity and deliver financial sustainability

The Group's Risk Appetite is described as 'Open' which is defined as the Group is prepared to accept a risk of up to 12.

**Lincolnshire Community Health Services NHS Trust**

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | **Open** Accept risks up to12 | 10 (91%) | 1 (9%) |
| | | 11 | |
| Nov – 2025 | | | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 1 | 1 (100%) | 0 (0%) |
| 1 | 1 (100%) | 0 (0%) |

- 91% of LCHS risks (10) are within the 'Open' risk appetite
- There are zero 'Very High' LCHS risks.
- There is 1 'High' LCHS risks.

**United Lincolnshire Teaching Hospitals NHS Trust**

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | **Open** Accept risks up to12 | 66 (90%) | 7 (10%) |
| | | 73 | |
| Nov – 2025 | | | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 7 | 2 (29%) | 5 (71%) |
| 7 | 2 (29%) | 5 (71%) |

- 90% of ULTH risks (66) are within the 'Open' risk appetite
- There are 5 'Very High' ULTH risks.
- There are 2 'High' ULTH risks.

**Summary of the risks outside of the Risk Appetite (n=8):**

- LCHS: 805 - CIP (Efficiency) requirement 2025/26 (16)
- ULTH: 4657 – Compliance with Subject Access Requests (20)
- ULTH: 4664 – Exceeding the agency cap due to the cost of reliance upon temporary clinical staff (20)
- ULTH: 4839 – Lack of pharmacy capacity for Intravenous Immunoglobulin (IVIG) (20)
- ULTH: 5020 – Reliance on agency / locum medical staff in Urgent & Emergency Care (20)
- ULTH: 5672 – Risk of failure to deliver the CIP target in full for 2025/2026 (20)
- ULTH: 4658 – Failure to meet national standards and best practice for record management (16)
- ULTH: 5389 – Risk of overspend due to current service provision being unfunded-Hospital at Night (16)

**Summary of the 'Very High' risks (n=5):**

**ULTH:**

| Trust: | Risk ID | Risk Title | Risk score | Division | Progress Update | Date of latest review: |
|---|---|---|---|---|---|---|
| ULTH | 4657 | Compliance with Subject Access Requests | Very high risk (20) | Corporate | Request from IGG to review score. Propose reduction in current score (decrease likelihood to 16) - whilst compliance needs to improve the position is much improved in the service and performance greatly improved, with fewer complaints to the Trust and ICO.<br>NHSE requests resolved- CPO has agreed to approve.<br>Some current concerns with staff related requests which are large and complex- resource being reallocated to support. | 17/12/2025 |
| ULTH | 4664 | Exceeding the agency cap due to the cost of reliance upon temporary clinical staff | Very high risk (20) | Corporate | The Trust's financial plan for 2025/26 includes a total agency plan of £12.7m.<br><br>Against this agency plan, expenditure of £1.2m in October 2025 was £0.3m higher than planned, and expenditure YTD of £9.4m was £1.5m more than planned; the higher than planned agency expenditure position is driven by expenditure on medical and dental agency staffing being £1.3m higher than planned.<br><br>Although YTD agency expenditure of £9.4m is £5.7m lower than spend of £15.1m in the same period 2024/25, the Trust still requires plans to address this movement from plan.<br><br>It is noted that NHSE wrote to the Trust on 8 September to offer ULTH enhanced support because the Trust has been identified as a higher risk in delivering their agency spend target. Driving concerns at a regional level is the fact that 1) the Trust had the 3rd highest agency spend of all Trusts in the Midlands in 2024/25 (£22.6m), 2) the Trust YTD continues to have the 3rd highest agency spend in the region in 2025/26 and was overspent against its YTD agency plan at month 4, and 3) the Trust has the highest level of Medical and Dental agency usage in the region.<br><br>Medical and dental agency expenditure is thus a key area of focus in our efficiency discussions and an area for further improvements. | 19/12/2025 |
| ULTH | 4839 | Lack of pharmacy capacity for Intravenous Immunoglobulin (IVIG) | Very high risk (20) | Clinical Support Services (Alliance) | Following recruitment and onboarding will be able to review risk score and reduce. Exploring if medical side covered by system prior to closure of risk. | 09/12/2025 |
| ULTH | 5020 | Reliance on agency / locum medical staff in Urgent & Emergency Care | Very high risk (20) | Medicine | Robust recruitment plan<br>International recruitment<br>Medical Workforce Management Project | 11/11/2025 |
| ULTH | 5672 | Risk of failure to deliver the CIP target in full for 2025/2026 | Very high risk (20) | Corporate | Increased CIP governance & monitoring arrangements introduced through PRM's to ensure oversight (including additional one off detailed executive review sessions with care groups).<br>Business cases submitted to NHSE for Delivery support in key areas where capacity & expertise require.<br>Development of future programme of cost improvement.<br>Additional resource supported in Financial Improvement.<br>Further pipeline opportunities being developed.<br>Discussions with system partners and regional colleagues on specific issues.<br>Further deterioration of CIP position at month 7. Medical workforce programme reinstated under CMO with targets set for each Care Group. | 20/11/2025 |

## 4.4: Strategic objective 1d - Provide modern, clean and fit for purpose care settings

The Group's Risk Appetite is described as 'Open' which is defined as the Group is prepared to accept a risk of up to 12.

### Lincolnshire Community Health Services NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | OPEN Accept up to 12 | 14 (88%) | 2 (12%) |
| | | 16 | |
| Nov – 2025 | | | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 2 | 2 (100%) | 0 (0%) |
| 2 | 2 (100%) | 0 (0%) |

- 88% of LCHS risks (14) are within the 'Open' risk appetite
- There are zero 'Very High' LCHS risks.
- There are 2 'High' LCHS risks.

### United Lincolnshire Teaching Hospitals NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | OPEN Accept up to 12 | 90 (88%) | 12 (12%) |
| | | 102 | |
| Nov – 2025 | | | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 12 | 12 (100%) | 0 (0%) |
| 12 | 12 (100%) | 0 (0%) |

- 88% of ULTH risks (90) are within the 'Open' risk appetite
- There are zero 'Very High' ULTH risks.
- There are 12 'High' ULTH risks.

**Summary of the risks outside of the Risk Appetite (n=14):**

- LCHS: 799 – Potential for a major fire (16)
- LCHS: 649 – Fire Safety Core Risk (15)
- ULTH: 4648 – Potential for a major fire (16)
- ULTH: 4725 – Prolonged Estates and infrastructure issues in Therapy & Rehab department (16)
- ULTH: 5136 – Nitrous Oxide Risk (16)
- ULTH: 5234 – No clinic space at Pilgrim affecting Neurophysiology testing (16)
- ULTH: 5272 – Risk of Cath Labs coming to end of life (16)
- ULTH: 5334 – Lack of second theatre available to use on Pilgrim Labour Ward (16)
- ULTH: 5695 – Risk of maintenance of specialist equipment was not being followed (16)
- ULTH: 4701 – Hospital environment and facilities in Maternity services (15)
- ULTH: 4830 – Pharmacy Estates at Pilgrim Hospital (15)
- ULTH: 4858 – Critical failure of the water supply-Trustwide (15)
- ULTH: 5383 – Treatment room not compliant with HBN 00-03 due to poor ventilation (15)
- ULTH: 5498 – Risk of patient delays and potential risk of accidents from Trust Helipad due to location, quality and security (15)

**Summary of the 'Very High' risks (n=0):**

- There are none.

## 4.5: Strategic objective 2a - Enable our people to fulfil their potential through training, development and education

The Group's Risk Appetite is described as 'Open' which is defined as the Group is prepared to accept risks up to 12.

**Lincolnshire Community Health Services NHS Trust**

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | **OPEN** Accept up to 12 | 9 (100%) | 0 (0%) |
| | | 9 | |
| Nov – 2025 | | 9 (100%) | 0 (0%) |
| | | 9 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 2 | 2 (100%) | 0 (0%) |
| 2 | 2 (100%) | 0 (0%) |

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.

**United Lincolnshire Teaching Hospitals NHS Trust**

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | **Open** Accept up to 12 | 13 (62%) | 8 (38%) |
| | | 21 | |
| Nov – 2025 | | 13 (62%) | 8 (38%) |
| | | 21 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 8 | 7 (87%) | 1 (13%) |
| 8 | 7 (87%) | 1 (13%) |

- 62% of ULTH risks (13) are within the 'Open' risk appetite.
- There is 1 'Very High' risk.

**Summary of the risks outside of the Risk Appetite (n=8):**

- ULTH: 4862 - Consultant staffing capacity within Respiratory Medicine (16)
- ULTH: 4996 - Consultant workforce capacity & increasing demand – Haematology (20)
- ULTH: 5142 - Continued high footfall at LCH/PHB ED overnight (16)
- ULTH: 5154 - Medicines Management training not available on ESR (16)
- ULTH: 5427 - Student training discrepancy between LCH/PHB (16)
- ULTH: 5467 - Respiratory teaching gaps at LCH (16)
- ULTH: 5469 - Failure to meet contractual requirements in Pharmacy teaching (16)
- ULTH: 5691 - Reduction of staffing levels within the PACS Team (16)

**Summary of the 'Very High' risks (n=1):**
**ULTH:**

| Trust: | Risk ID | What is the risk? | Risk rating | Risk reduction plan | Date added to register and latest review: |
|---|---|---|---|---|---|
| ULTH | 4996 | Staffing - insufficient consultant workforce to meet demand. Areas of concern:<br>1. Lymphoma tumour site cover<br>2. Haemostasis/haemophilia (single consultant Trust wide)<br>3. Pilgrim Consultant cover<br>4. Clinical governance lead<br>5. HoS/clinical lead | Very high risk (20) | Service review undertaken – progressing left shift to GP Surgeries for low grade CLL and MGUS. | **Date added to the Trust Register:** 22/08/2022<br><br>**Date of latest review:** 18/12/2025 |

## 4.6: Strategic objective 2b - Empower our people to continuously improve and innovate

The Group's Risk Appetite is described as 'Hungry' which is defined as the Group is prepared to accept a risk of 15/16.

### Lincolnshire Community Health Services NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | **Hungry** Accept risks of 15/16 | 5 (100%) | 0 (0%) |
| | | 5 | |
| Nov – 2025 | | 5 (100%) | 0 (0%) |
| | | 5 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 1 | 1 (100%) | 0 (0%) |
| 2 | 1 (100%) | 0 (0%) |

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.

### United Lincolnshire Teaching Hospitals NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | **Hungry** Accept risks of 15/16 | 13 (81%) | 3 (19%) |
| | | 16 | |
| Nov – 2025 | | 13 (81%) | 3 (19%) |
| | | 16 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 5 | 2 (40%) | 3 (60%) |
| 5 | 2 (40%) | 3 (60%) |

- 81% of ULTH risks (13) are within the 'Hungry' risk appetite.
- There are 3 'Very High' risk.

**Summary of the risks outside of the Risk Appetite (n=3):**

- ULTH: 4844 – Staffing levels requiring an increase in Pharmacy to be able to provide 7 day dispensing service (20)
- ULTH: 4997 – Service configuration – Haematology (20)
- ULTH: 5093 – Procurement service staffing levels (20)

**Summary of the 'Very High' risks (n=3):**
**ULTH:**

| Trust: | Risk ID | What is the risk? | Risk rating | Risk reduction plan | Date added to register and latest review: |
|---|---|---|---|---|---|
| ULTH | 4844 | As a result of insufficient staffing establishment there is an inability to provide a safe and effective 7 day pharmacy dispensing service at ULTH. Current funding allows for the dispensaries to open Monday to Friday 9-5 and weekends mornings only. The dispensary workloads exceed the staffing capacity. As a result of this under staffing there is a risk that patients may require critical medication and/or specialist pharmacy advice over the weekend when pharmacy is closed, there is a risk that pharmacy staff working long hours without a break could make errors, pharmacy staff could become unwell due to working conditions, patients could be discharged from hospital without vital medication and pharmacy advice. All of these risks have multiple implications such as harm to patients from omitted medicines, delayed discharge from hospital effecting the efficiency of the hospital, readmission to hospital, long term effects on pharmacy staff health and wellbeing and the pharmacy departments ability to retain staff. | Very high risk (20) | Business case on hold, workforce review undertaken and presented at GLT.<br><br>Monitoring of the change to weekend hours ongoing – no significant patient safety events reported at present. | **Date added to the Trust Register:** 19/01/2022<br><br>**Date of latest review:** 09/12/2025 |
| ULTH: | 4997 | As a result of current Consultant staffing and on-call arrangements there is a single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites which could lead to potential patient harm, delays in care/discharge. | Very high risk (20) | Risk remains the same as further investment still required. This situation will further decline in December when 2 Consultants leave the Boston site. Currently recruiting to these posts. | **Date added to the Trust Register:** 22/08/2022<br><br>**Date of latest review:** 18/12/2025 |
| ULTH: | 5093 | As a result of vacancies and long term absence within the invoicing team, purchasing and pharmacy stores team there is a risk that any further absence or leavers will mean the remaining staff don't have the capacity to do the work of all 3 sites which would impact staff wellbeing and all drug ordering across all pharmacy sites (including bulk IV fluids, medical gases, chemotherapy). Inability to complete invoices will negatively impact the Trust finance target to pay invoices within 30 days, with potential of financial penalties, and could result in suppliers putting holds on our accounts rendering us unable to order medicines, this will therefore mean that we would be unable to complete biosimilar switches and meet CIP targets (£1.4m). Payment beyond 30 days presents a risk of companies levying late payment fees and interest on outstanding amounts. | Very high risk (20) | Vacancy recruitment - QIAs completed for 0.4wte B3.<br>Staff trained and competent to fulfil roles - October 2025<br>Staff skill mix review to ensure that staff managing workload - October 2025.<br><br>Long term absence staff being reviewed for temporary redeployment. Invoicing vacancy filled. Storekeeper training and assessments being undertaken. | **Date added to the Trust Register:** 16/02/2023<br><br>**Date of latest review:** 09/12/2025 |

## 4.7: Strategic objective 2c - Nurture compassionate and diverse leadership

The Group's Risk Appetite is described as 'Open' which is defined as the Group is prepared to accept risks up to 12.

### Lincolnshire Community Health Services NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | OPEN Accept up to 12 | 1 (100%) | 0 (0%) |
| | | 1 | |
| Nov – 2025 | | 1 (100%) | 0 (0%) |
| | | 1 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 0 | 0 (0%) | 0 (0%) |
| 0 | 0 (0%) | 0 (0%) |

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.

### United Lincolnshire Teaching Hospitals NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | OPEN Accept up to 12 | 8 (100%) | 0 (0%) |
| | | 8 | |
| Nov – 2025 | | 8 (100%) | 0 (0%) |
| | | 8 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 0 | 0 (0%) | 0 (0%) |
| 0 | 0 (0%) | 0 (0%) |

- All ULTH risks are within the risk appetite established.
- There are zero 'Very High' ULTH risks.

**Summary of the risks outside of the Risk Appetite (n=0):**

- There are none.

**Summary of the 'Very High' risks (n=0):**

- There are none.

## 4.8: Strategic objective 2d - Recognising our people through thanks and celebration

The Group's Risk Appetite is described as 'Hungry' which is defined as the Group is prepared to accept a risk of 15/16.

### Lincolnshire Community Health Services NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | Hungry Accept risks of 15/16 | 0 (0%) | 0 (0%) |
| | | 0 | |
| Nov – 2025 | | 0 (0%) | 0 (0%) |
| | | 0 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 0 | 0 (0%) | 0 (0%) |
| 0 | 0 (0%) | 0 (0%) |

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.

### United Lincolnshire Teaching Hospitals NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | Hungry Accept risks of 15/16 | 1 (100%) | 0 (0%) |
| | | 1 | |
| Nov – 2025 | | 1 (100%) | 0 (0%) |
| | | 1 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 0 | 0 (0%) | 0 (0%) |
| 0 | 0 (0%) | 0 (0%) |

- All ULTH risks are within the risk appetite established.
- There are zero 'Very High' ULTH risks.

**Summary of the risks outside of the Risk Appetite (n=0):**

- There are none.

**Summary of the 'Very High' risks (n=0):**

- There are none.

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

The Group's Risk Appetite is described as 'Open' which is defined as the Group is prepared to accept risks up to 12.

**Lincolnshire Community Health Services NHS Trust**

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | OPEN Accept up to 12 | 5 (100%) | 0 (0%) |
| | | 5 | |
| Nov – 2025 | | 5 (100%) | 0 (0%) |
| | | 5 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 0 | 0 (0%) | 0 (0%) |
| 0 | 0 (0%) | 0 (0%) |

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.
- There are zero 'High' LCHS risks.

**United Lincolnshire Teaching Hospitals NHS Trust**

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | Open Accept up to 12 | 10 (50%) | 10 (50%) |
| | | 20 | |
| Nov – 2025 | | 10 (50%) | 10 (50%) |
| | | 20 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 10 | 8 (80%) | 2 (20%) |
| 10 | 8 (80%) | 2 (20%) |

- 50% of ULTH risks (10) are within the 'Open' risk appetite.
- There are 2 'Very High' ULTH risks.
- There are 8 'High' ULTH risks.

**Summary of the risks outside of the Risk Appetite (n=10):**

- ULTH: 4778 - Risk of failure to meet best practice standards for stroke patients due to lack of access to community rehabilitation service (16)
- ULTH: 4780 - Significant deficit in stroke consultant staffing (16)
- ULTH: 5169 - Stroke outlier causing delays to stroke rehabilitation therapy (15)
- ULTH: 5480 - Risk of depleted workforce in diabetes-DSN (15)
- ULTH: 5535 - No Stroke Patient access to Clinical Psychology in line with current guidelines (15)
- ULTH: 5563 - Neurology – Service sustainability (20)
- ULTH: 5564 – Risk of operational pressures to Hospital Out of Hours due to staffing and increase of wards (16)
- ULTH: 5598 - Risk of HASU overspill (16)
- ULTH: 5710 – Risk of unsuccessful delivery of transformation programme (16)
- ULTH: 5711 - Risk to our transformation programme due to changes within the ICB (20)

**Summary of the 'Very High' risks (n=2):**
**ULTH:**

| Trust: | Risk ID | Risk Title | Risk score | Division | Progress Update | Date of latest review: |
|---|---|---|---|---|---|---|
| ULTH | 5563 | Neurology – Service sustainability | Very high risk (20) | Medicine | Neurology has the largest PBWL and is a small service. There are currently 9000 on the services PBWL, 5900 of which are overdue with no plan to mitigate and no capacity to clinically audit. At present no route to improve operational RTT performance or meet Trust objectives. At this time service will likely see 65-week breaches in circa Q3. Outsourcing companies contacted and working up pathways. Working back towards establishment but still significant gaps in provision (e.g. botox and significant backlogs). Insourcing now in place to meet elective targets at cost. No significant change to risk, service remains unsustainable. | **Date of latest review:** 15/12/2025 |
| ULTH | 5711 | Risk to our transformation programme due to changes within the ICB | Very high risk (20) | Corporate | The current position is monitored and mitigated through the following strategic and leadership engagement forums:<br>BLET; LLG; System exec to exe; ICB Board (include partner chief execs; -Group Board; weekly chief executive meetings; target operated model board (TOM); Executive one to one's<br><br>Given the pace of change and the current vagueness of the ICB cluster operating model it is difficult to quantify the future controls possible until the cluster executive team is in place. | 15/10/2025 |

## 4.10: Strategic objective 3b - Move from prescription to prevention, through a population health management & health inequalities approach

The Group's Risk Appetite is described as 'Hungry' which is defined as the Group is prepared to accept a risk of up to 15/16.

**Lincolnshire Community Health Services NHS Trust**

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | Hungry Accept risks up to15/16 | 6 (100%) | 0 (0%) |
| | | 6 | |
| Nov – 2025 | | 6 (100%) | 0 (0%) |
| | | 6 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 0 | 0 (0%) | 0 (0%) |
| 0 | 0 (0%) | 0 (0%) |

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.
- There are zero 'High' LCHS risks.

**United Lincolnshire Teaching Hospitals NHS Trust**

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | Hungry Accept risks up to 15/16 | 0 (0%) | 0 (0%) |
| | | 0 | |
| Nov – 2025 | | 0 (0%) | 0 (0%) |
| | | 0 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 0 | 0 (0%) | 0 (0%) |
| 0 | 0 (0%) | 0 (0%) |

- There are zero ULTH risks aligned to this objective.

**Summary of the risks outside of the Risk Appetite (n=0):**

- There are none.

**Summary of the 'Very High' risks (n=0):**

- There are none.

## 4.11: Strategic objective 3c - Enhance our digital, research and innovation capability

The Group's Risk Appetite is described as 'Hungry' which is defined as the Group is prepared to accept a risk of up to 15/16

### Lincolnshire Community Health Services NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | HUNGRY Accept up to 15/16 | 10 (100%) | 0 (0%) |
| | | 10 | |
| Nov – 2025 | | 9 (100%) | 0 (0%) |
| | | 9 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 1 | 1 (10%) | 0 (0%) |
| 0 | 0 (0%) | 0 (0%) |

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.
- There is 1 'High' LCHS risk. This is an increase of 1 from the previous report. This relates to:
  - Risk 815 – Digital Clinical Safety (16)

### United Lincolnshire Teaching Hospitals NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | HUNGRY Accept up to 15/16 | 79 (100%) | 0 (0%) |
| | | 79 | |
| Nov – 2025 | | 79 (100%) | 0 (0%) |
| | | 79 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 4 | 4 (5%) | 0 (0%) |
| 4 | 4 (5%) | 0 (0%) |

- All ULTH risks are within the risk appetite established.
- There are zero 'Very High' ULTH risks.
- There are 4 'High' ULTH risks.

**Summary of the risks outside of the Risk Appetite (n=0):**

- There are none.

**Summary of the 'Very High' risks (n=0):**

- There are none.

## 4.12: Strategic objective 3d - Drive forward our efficiency and sustainability agenda through our Green Plan

The Group's Risk Appetite is described as 'Open' which is defined as the Group is prepared to accept a risk of up to 12.

### Lincolnshire Community Health Services NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | OPEN Accept up to 12 | 3 (100%) | 0 (0%) |
| | | 3 | |
| Nov – 2025 | | 3 (100%) | 0 (0%) |
| | | 3 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 0 | 0 (0%) | 0 (0%) |
| 0 | 0 (0%) | 0 (0%) |

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.
- There are zero 'High' LCHS risks.

### United Lincolnshire Teaching Hospitals NHS Trust

**Risk appetite and number of risks rated as 'High' or 'Very High':**

| This month vs. last month | Risk Appetite | Within Risk Appetite | Outside of Risk Appetite |
|---|---|---|---|
| Dec – 2025 | OPEN Accept up to 12 | 2 (100%) | 0 (0%) |
| | | 2 | |
| Nov – 2025 | | 2 (100%) | 0 (0%) |
| | | 2 | |

| Number of risks 15-25 | High (15-16) | Very high (20-25) |
|---|---|---|
| 0 | 0 (0%) | 0 (0%) |
| 0 | 0 (0%) | 0 (0%) |

- All ULTH risks are within the risk appetite established.
- There are zero 'Very High' ULTH risks.
- There are zero 'High' ULTH risks.

**Summary of the risks outside of the Risk Appetite (n=0):**

- There are none.

**Summary of the 'Very High' risks (n=0):**

- There are none.

**Appendices**

- Appendix A – LCHS Quality Committee Very High and High Risks Dec 2025.
- Appendix B – ULTH Quality Committee Very High and High Risks Dec 2025.
- Appendix C – Further detail of the risk appetite agreed by the Group.
- Appendix D – Full list of risks outside of Risk Appetite by Strategic Objective.

| Strategic Objective | ID | Group Risk Type | Risk Lead | Committee Responsible | Opened | Rating (initial) | Division | Service | Risk Description | Controls in place | Date of last review | Likelihood (current) | Consequence (current) | Risk level (current) | Rating (current) | Updates by reviewers | Risk level (Target) | Next review date | Movement of risk |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1a (i) Improve patient safety | 403 | Physical or Psychological Harm | Farbrace, Kylie for) | | 13/09/2022 | 9 | Children, Young People, and Specialist Services | Children's Therapy | As a result of an increase in demand nationally & regionally for SLT support there is a risk that children & young people will not receive the speech and language support they require to meet their social, emotional, educational, and health needs in an appropriate timeframe for their development, resulting in poor cognitive & social outcomes increasing lifelong health inequalities. | 1. Advice and activities are given the patient's family and/or educational setting, ensuring they are safe to wait.<br>2. An appropriate skill mix is used, for example assessments are carried out by SLT and most therapy blocks completed by SLTAs.<br>3. Mix of face to face and virtual sessions<br>4. Increased the referral acceptance criteria: focused on highly complex patients only | 01/12/2025 | Extremely likely (5) >90% chance | Severe (4) | Very High Risk (20-25) | 20 | [01/12/2025 14:09:09 Daniel Thompson] No change in score. Service has seen an increase in complaints relating to wait time. Therapy waits remain circa 1 year.<br>[13/11/2025 15:30:46 Ana Morgan] Risk reviewed at CYPSS Quality SMT 13/11/25: the pilot is in its early days, with waits for initial assessment at 35 weeks, and waits for therapy at 2 years. Score remains the same.<br>[02/10/2025 15:03:22 Ana Morgan] Risk reviewed at CYPSS Quality SMT 2/10/25: too early to note any change from the pilot. No change to score.<br>[04/09/2025 15:05:54 Ana Morgan] Risk reviewed at CYPSS Quality SMT 4/09/25: pre-school pilot started with a soft launch WC 01/09/25. No change to score.<br>[15/08/2025 11:59:07 Ana Morgan] Risk reviewed at CYPSS Quality SMT 7/08/25: still aiming to start in September for the pre-school changes, although there will be a | Low Risk (4-6) | 02/01/2026 | No change |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1a (i) Improve patient safety | 681 | Regulatory Compliance | Farbrace, Kylie | (Accountable for), Patient Safety Group (Accountable for) | 05/02/2024 | 20 | Children, Young People, and Specialist Services | Children in Care | As a result of insufficient capacity within the Children in Care Service and an outdated budget that has not been reviewed for several years, there is a risk that the service will be unable to meet statutory timescales for Initial Health Assessments (IHAs) and Review Health Assessments (RHAs) for children in care, given the significant increase in demand resulting in delays in identifying and addressing health needs, reduced access to necessary care, negative impact on service user and carer experience, and reputational damage to the service. | 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.<br>An options appraisal has been completed to identify the increase in funding to meet the increased demand for IHA and RHAs, this is attached to the record. | 02/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High Risk (15-16) | 16 | [02/10/2025 15:07:06 Ana Morgan] Risk reviewed at CYPSS Quality SMT 02/10/2025: post out for recruitment for the second time as fixed term; applicants are being shortlisted. Risk score remains high. [17/09/2025 11:51:12 Sarah Davy] Reviewed at RRC&C on 17 Sept agreed to increase in score from 3x4=12 to 4x4=16 High Risk. [05/09/2025 14:02:41 Ana Morgan] Risk reviewed by DDL and CSL: The doctor provided by ULTH on an SLA basis joined the service in February and left July, working only part of that month. The service's bank capacity is variable as it's reliant on the availability of one particular clinician, who has been absent throughout most of the summer period and will continue to be so in September. ULTH are currently out to advert to recruit a permanent doctor for the service (O.75WTE). Initial health assessments are entirely reliant on doctors since they cannot be performed by any | Very Low Risk (1-3) | 08/01/2026 | No change |

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| 1c: Improve productivity and deliver financial sustainability |
| 805 |
| Finances |
| Taylor, James |
| Finance Committee (Lead assurance committee) |
| 08/08/2025 |
| 20 |
| Corporate |
| Finance |
| As a result of lack of identified efficiency plans; non-delivery of identified schemes; delays in implementing efficiency savings of increased complexity due to system implications there is a risk that the Trust will fail to deliver the efficiency requirement aspect of the financial plan, resulting in reputational damage including reduction in the SOF rating and/or lack of financial sustainability going forward, and a failure to meet statutory financial duties. |
| 1. Financial plan and budgets approved and delegated.<br>2. Financial control systems in place<br>3. Executive oversight at ELT with Executive owned targets for efficiency delivery. Cost improvement planning process overseen by ELT, PITOF and Finance Committee.<br>4. Benchmarking actively used in identifying opportunities across clinical and corporate areas including estates. |
| 20/08/2025 |
| Quite likely (4) 71-90% chance |
| Severe (4) |
| High Risk (15-16) |
| 16 |
| [20/08/2025 11:49:42 Rachael Turner] New risk presented at RRC&C meeting 20/08/25. Currently 3.7 million to be underpinned. Finance will continue to review and monitor progress around this. Risk validated at 4x4:16 High Risk. |
| Moderate Risk (8-12) |
| 20/11/2025 |
| NEW RISK |

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| 1b: Reduce waiting times for our patients |
| 773 |
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| Farbrace, Kylie |
| Finance Committee (Lead assurance committee) |
| 13/01/2025 |
| 16 |
| Children, Young People, and Specialist Services |
| Speech and language Therapy (Adult) |
| As a result of gaps in staffing, limited non-registered support, and training requirements for newly qualified staff, there is a risk that LCHS will fail to meet urgent speech and language needs for adults in Lincolnshire, resulting in delays to dysphagia and communication assessments, increased risk of aspiration and hospital admissions, reduced quality of life, breaches of statutory waiting times, and negative impact on staff morale and retention. |
| Clinical prioritisation - dysphagia as the priority due to severe impact of delays.<br>Changes to waiting list management - delay offer / opt in for any communication assessments as unable to provide the therapy intervention / assessment.<br>Prioritise training for new starters in Dysphagia and Voice assessments to manage these caseloads.<br>Provision of care home pack for all referrals.<br>Conversion to video consultations / reviews where possible.<br>Support from partners in the acute 1 day / week with dysphagia & high priority communication assessments. |
| 02/10/2025 |
| Quite likely (4) 71-90% chance |
| Severe (4) |
| High Risk (15-16) |
| 16 |
| [08/10/2025 15:24:16 Amy Evans] Additional information to support review at CYPSS Quality SMT 2/10/25 - actions to be implemented to reduce further escalation and recovery waiting lists / long waits for therapy to include: Review / update referral form, return referrals where not appropriate / outstanding actions for referrer to be completed, consider screening assessments to support prioritisation, increased provision of self management advice and guidance for P4 priority, increase telephone triage from B7 capacity, reduce planned review for care home patients: for care home staff to self-manage/ re-refer as required, increase virtual clinics / face to face clinics and reduce home visits, 1 x communication assessment day per month per clinician to reduce waits. Current longest wait - 34, with booked appointment. 282 waiting for assessment |
| Low Risk (4-6) |
| 08/01/2026 |
| No change |

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| 1a (i) Improve patient safety | |
| 714 | |
| Physical or Psychological Harm | |
| Farbrace, Kylie | |
| for) | |
| 16/05/2024 | |
| 16 | |
| Collaborative Community Care | |
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| As a result of variability in pressure ulcer care delivery, lack of consistent senior clinical case review, and variable clinical skill sets within the team, there is a risk that patients may not receive the correct level of care for pressure ulcers in community nursing settings, resulting in deterioration of ulcers, increased safeguarding referrals (S42), poor patient and carer experience, and heightened ICB/CQC scrutiny. | Daily BeSafe reviews of patient care<br>Service action plan to improve pressure ulcer care implemented<br>ICB oversight<br>Educational training plan for all community clinicians initiated<br>Assurance programme commenced<br>Monthly thematic review of pressure ulcers highlighting themes and risks in care |
| 02/12/2025 | |
| Quite likely (4) 71-90% chance | |
| Severe (4) | |
| High Risk (15-16) | |
| 16 | |
| [02/12/2025 16:15:09 Sarah Davy]<br>Bespoke meeting regarding increase in Section 42s on 28/11 agreed focus on BSafe meetings. CSLs and Safeguarding to attend. Work ongoing by AW on benchmarking data.<br>[11/11/2025 15:44:09 Zoe Wills]<br>11/11/2025 - We have seen a significant increase in S42s in October. We are reviewing these and triangulating whether there has been a delay in reporting and themes that have been identified. There are still issues with equipment provision and this links to 772.<br>[05/08/2025 15:20:40 Zoe Wills]<br>05/08/2025 - Due to challenges of equipment ordering this risk continues to be high. Ongoing work in Community Teams on PU management. Re established and focused monthly meeting for sharing learning across teams and to keep track of improvement actions. | |
| Moderate Risk (8-12) | |
| 02/03/2026 | |
| No change | |

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| 3c. Enhance our digital, research and innovation capability | 815 | | Scott, Ian | Integration Committee (Lead assurance committee) | 14/10/2025 | 20 | Corporate | Digital Health | As a result of a lack of an established (Digital) Clinical Risk Management System, processes, and resource provision, there is a risk that the Digital Clinical Safety Standards DCB0129 and DCB0160 mandated by NHSE are not met and digital systems are not implemented safely resulting in the risk of harm to patients. | In line with LCHG Group Digital:<br>•Previously no defined lead for digital clinical safety established in the Trust. The CNIO has voluntarily taken the lead on Digital Clinical Safety (Trained CSO) within their substantive role, although clinical safety responsibility not outlined in job description / role and responsibilities. However, no resource for non-project/non funded DCSO work = risk<br>•Chief Digital Clinical Information Officer in post for LCHS<br>•Clinical Safety Officer training has been completed by 9 other staff in LCHS<br>•Digital Clinical Champions in place and agreed to be funded within community from operational budgets 1 day per week<br>•Digital Clinical Safety Officer (DCSO) post recruited into May 2024, as part of ULTH 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 | 14/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High Risk (15-16) | 16 | [15/10/2025 10:09:44 Sarah Davy] Risk agreed at RRC&C on 15/10/2025 with score of 4 x 4 = 16 | Moderate Risk (8-12) | 14/01/2026 | NEW RISK |

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| 2b: Empower our people to continuously improve and innovate | 695 | Service Disruption | Farbrace, Kylie | People Committee (Lead assurance committee) | 12/03/2024 | 16 | Collaborative Community Care | | Due to lack of value placed on the DNSPQ qualification, insufficient training, failure to reimburse and retain staff, and inconsistent use of the Enhanced Practitioner role, there is a risk of reduced numbers of DNSPQ-qualified staff in community nursing teams. This may lead to poor oversight of complex cases, unsafe caseload management, increased risk of patient harm, and inadequate professional support for team development. | BSAFE initiated for daily oversight of safe care<br><br>BSAFE audits by CSL level staff<br><br>Reallocation of qualified DNSPQ staff to teams with low levels to aid safety<br><br>Identification of new assessors for DNSPQ trainees<br><br>Allocation of trainers to training places for increased trajectory of DNSPQ training<br><br>Recovery trajectory and commitment to model of care for excellence to be submitted to ELT as part of a wider strategy for service | 02/12/2025 | Quite likely (4) 71-90% chance | Severe (4) | High Risk (15-16) | 16 | [02/12/2025 15:56:52 Sarah Davy] New DNSPQ students started course in September - now only 1 team no DN qualified staff member.<br>[02/09/2025 15:42:04 Angela Wilson] No change to current position.<br>[03/06/2025 15:14:21 Zoe Wills] 03/06/2025 - Review required to look at all teams and identify specific areas that are still not meeting the QNI standard requirements.<br>[04/03/2025 15:19:06 Zoe Wills] 04/03/2025 - Risk still scoring 16. We are working towards supporting DNSPQ students. There is a risk that with the qualifications new students are gaining we will be unable to retain staff.<br>[05/11/2024 15:25:19 Zoe Wills] 05/11/2024 - Increasing DNSPQ mentors and 6 people currently going through this process.<br>[08/10/2024 15:19:26 Zoe Wills] 08/10/2024 - Update in 715 as these are linked. | Low Risk (4-6) | 02/03/2026 | No change |

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| 2a: Enable our people to fulfil their potential through training, development and education |
| 754 |
| Physical or Psychological Harm |
| Kidger, Leanne |
| (Accountable for) |
| 09/10/2024 |
| 15 |
| Corporate |
| Quality |
| As a result of poor compliance with expected standards, paused training delivery due to content re-evaluation, and review of the training model, there is a risk that clinical staff are inadequately trained in moving and handling, resulting in increased risk of injury to staff and patients, potential claims and complaints, and disruption to the planned training schedule. |
| Mutual support request to ULHT. Internal sources of alternate training support being identified. Reviewing training schedule and package. Action plan in place to increase attendance when training is reinstated. Engagement with operational colleagues to confirm appropriate staff requiring training. Training for new staff continues. |
| 15/10/2025 |
| Quite likely (4) 71-90% chance |
| Severe (4) |
| High Risk (15-16) |
| 16 |
| [15/10/2025 11:44:48 Ana Morgan] Risk reviewed with Moving and Handling Clinical Lead LK & EP Lead 15/10/25: training has been reviewed by M&H expert and appropriate training packages for each area have been developed. Delivery has commenced following a short pause, and compliance is increasing. To monitor if compliance continues to improve (currently 64.67%) and consider score reduction at next review date. [10/04/2025 13:36:35 Russell Fordham] Training is going to be run through a group model and meetings between all trainers and providers are working together. [13/02/2025 12:45:14 Russell Fordham] 18/12/2024. RF Meetings between LCHS and ULHT manual hander ling teams have been conducted, Peer review and cross party working is being implemented to embed one process and support compliance and improvements needed. |
| Very Low Risk (1-3) |
| 05/01/2026 |
| No change |

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| 1d: Provide modern, clean and fit for purpose care settings |
| 799 |
| Regulatory Compliance |
| Davey, Keiron |
| Finance Committee (Lead assurance committee), Fire Safety Group (Accountable for) |
| 04/07/2025 |
| 25 |
| Corporate |
| Estates |
| If a fire occurs in one of the Trust's work locations and is not contained due to issues with fire/smoke detection/alarm systems; compartmentation/containment or emergency lighting it may develop into a major fire resulting in physical and psychological harm, and extensive property damage with subsequent long term consequences for the continuity of services. |
| Trust Fire Safety policy<br>National Guidance including HTM, HBN,<br>British standards, ACOP<br>Trust Protocols and Policies<br>Fire Safety Training including<br>managerial role. compliance rates<br>Fire wardens<br>Fire drills<br>Governance committees, FEG, FSG, HS<br>Committee FPC.<br>Annual Fire Safety declaration including<br>PEEP awareness<br>reporting of unwanted Fire alarm<br>activations<br>reports of Fire Regulator from audits<br>conducted<br>Fire risk Assessments |
| 03/11/2025 |
| Quite likely (4) 71-90% chance |
| Severe (4) |
| High Risk (15-16) |
| 16 |
| [03/11/2025 13:01:19 Rachael Turner] New Fire Policy is now complete and available Group Wide. There is training aligned across the Group. LCHS is now integrated into FEG & FSG for compliance, governance and assurance on fire safety management.<br>[20/08/2025 11:51:57 Rachael Turner] Risk presented at RRC&C meeting 20/08/25. Risk validated at 4x4:16 High Risk.<br>[06/08/2025 14:21:20 Ana Morgan] For review at Fire Safety Group 06/08/25<br>New Risk to encompass the results if a major fire occurred |
| Moderate Risk (8-12) |
| 03/02/2026 |
| NEW RISK |

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| 2a: Enable our people to fulfil their potential through training, development and education |
| 715 |
| Physical or Psychological Harm |
| Farbrace, Kylie |
| People Committee (Lead assurance committee) |
| 16/05/2024 |
| 16 |
| Collaborative Community Care |
| |
| As a result of increased service demand, and reduced numbers of DNSPQ-qualified staff, there is a risk that the community nursing service will be unable to meet patient demand in Lincolnshire, resulting in variance in care delivery, ineffective caseload management, poor patient experience, reduced efficiency for complex cases, and task-based care with limited holistic planning. |
| Daily BSafe - escalation/oversight review<br>Twice daily matron led safety huddles<br>Re allocation of senior resource to at risk areas<br>Operational oversight of risk daily<br>Service evaluation of DNSPQ role<br>Support from UCR and CYPSS services to aid meeting unplanned demand when required |
| 02/12/2025 |
| Quite likely (4) 71-90% chance |
| Severe (4) |
| High Risk (15-16) |
| 16 |
| [02/12/2025 15:46:34 Sarah Davy] Work ongoing on Community Nursing workforce transformation. Teams still seeing high unavailability as sickness rates average 7.5% in October. 11 WTE NQ joining service in January 2026 across all teams.<br>[02/09/2025 16:06:17 Angela Wilson] No change<br>[03/06/2025 15:30:00 Zoe Wills] 03/06/2025 - Holding vacancies for apprenticeships has meant high unavailability in all teams. This has caused reduced capacity. Work ongoing to move VBV into teams helping support unavailability.<br>[04/03/2025 15:47:25 Zoe Wills] 04/03/2025 - We are currently seeing high unavailability in Sleaford, Skegness and Four Counties. Maternity and sickness rates have gone up impacting on this. Community Nursing Teams are unable to back fill people going of on maternity.<br>[05/11/2024 15:21:59 Zoe Wills] 05/11/2024 - No change currently |
| Low Risk (4-6) |
| 02/03/2026 |
| No change |

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| 1d: Provide modern, clean and fit for purpose care settings |
| 649 |
| Regulatory Compliance |
| Davey, Keiron |
| (Accountable for), Fire Safety Group (Accountable for) |
| 12/09/2023 |
| 15 |
| Corporate |
| Estates |
| As a result of inadequate fire protection measures, maintenance, training, and policies, there is a risk that the Trust cannot demonstrate statutory compliance with the Regulatory Reform (Fire Safety) Order 2005, resulting in potential regulatory action, financial penalties, service disruption including possible site closures, loss of facilities, and risk of injury to patients and staff. |
| 1. LCHS Fire Safety Operational Meeting<br>2. Planned Preventative Maintenance PPM<br>3. Fire Risk Assessments<br>4. Fire Safety Training<br>5. Fire protection system tests<br>5. Fire Emergency Plans<br>6. Yearly Fire audit<br>7. Appointed Authorising Engineer (AE) for Fire<br>8. Inpatient Fire evacuation plans and tests<br>9. Test Fire drills.<br>10. National Policy via HTM, HBN and Guidance<br>11. Policy and Protocols<br>12. Governance via FEG, FSG and trust HS Committee |
| 19/11/2025 |
| Reasonably likely (3) 31-70% chance |
| Extreme (5) |
| High Risk (15-16) |
| 15 |
| [19/11/2025 12:35:13 Rachael Turner] Risk discussed as part of the Deep Dive at Risk Register Confirm and Challenge 19/11/2025. Risk to be reviewed and then returned for possible reduction in score.<br>[03/11/2025 12:59:55 Rachael Turner] New Fire Policy is now complete and available Group Wide. There is training aligned across the Group. LCHS is now integrated into FEG & FSG for compliance, governance and assurance on fire safety management.<br>[04/07/2025 11:32:13 Keiron Davey] reviewed description of risk to include sanctions by Fire Safety Regulators and consequences. additional control measures also included to include policy protocols, and over sight by FEG, FSG and HS Committee etc<br>[14/04/2025 09:16:44 Russell Fordham] No change to the score or risks in this period and monthly and quarterly fire operational meetings are being attended by NHSPS to try |
| Low Risk (4-6) |
| 03/02/2026 |
| No change |

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| 1a (i) Improve patient safety |
| 792 |
| Physical or Psychological Harm |
| Farbrace, Kylie |
| for) |
| 13/05/2025 |
| 15 |
| Collaborative Community Care – Community Hospitals |
| Outpatients Department, Johnson Hospital |
| As a result of unrectified staffing and clinic establishment issues within the budget, leading to inability to recruit replacement staff, there is a risk that phlebotomy services will experience reduced availability, resulting in delays for routine blood appointments (currently 16-day wait), late diagnostic tests, treatment delays, increased patient safety concerns, added workload and stress for remaining staff, potential staff absence, and reputational damage to the service. |
| Highlighted risk to CSL-Discussion at QSG<br>Add to risk register |
| 08/10/2025 |
| Extremely likely (5) >90% chance |
| Moderate (3) |
| High Risk (15-16) |
| 15 |
| [16/10/2025 15:13:50 Sarah Davy]<br>Email from Zoe Wills on 14/10 requesting risk to remain open following recent developments - specifically refusal of vacancy at control panel, situation to be reviewed further before decision made to close risk.<br>[08/10/2025 12:44:42 Zoe Wills]<br>08/10/2025 - Clinic has increased capacity and staff in post and trained. This has resulted in waiting list down to routine - 1 day. and urgent - 0 days<br>[11/07/2025 17:19:24 Lisa Jennings]<br>Update from Divisional risk meeting provided by CSL EG: Recruitment of x2 HCSWs approved. Recruitment process in progress. New recruits to be in post by end of August 2025. Bank staff covering gaps at present. Waiting time for both routine and emergency phlebotomy appointments much improved.<br>[06/06/2025 10:10:25 Ana Morgan]<br>New risk agreed at RRCC 04/06/25. |
| Very Low Risk (1-3) |
| 08/01/2026 |
| No change |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5200 | 283 | Physical or psychological harm | Caroline Landon | Coghill, Piper | Shuck, Joanne | Children & Young Persons Oversight Group | 30/06/2023 | 8 | Family Health | Children and Young Persons CBU | Paediatric Cardiology | | As a result of a backlog Paediatric Cardiology clinic appointments patients are at risk of undiagnosed cardiac conditions, lack of follow up within appropriate timeframes and subsequent delay in treatment, which could lead to life limiting outcomes or death.<br><br>RTT Target is 18 weeks, best practice is to be seen within 6-8 weeks to ensure the risk of life limiting conditions and death is significantly reduced and treatment can be undertaken when necessary by appropriate clinician. | -All new referrals are triaged by Leicester but scanning is then requested locally.<br>-Manage clinics follow up and new patients based on demand with flexibility to swap between either based on waiting times and outcomes<br>-Additional clinics at Boston and Lincoln<br>-Escalated to ELT regarding waiting list<br>-Cardiology meetings monthly with Leicester<br>-Cancellation list in place to ensure clinic is filled and prioritise patients who are overdue and chasing an appointment<br>-Continuing to support Paediatric Consultant undertaking PEC training to gain Cardiology experience<br>-Recruited additional Paediatrician at PHB, support being given to upskill to deliver Cardiology clinics | -Number of patients awaiting an appointment<br>-Audits<br>-Staff feedback<br>-Next of kin feedback<br>-Incidents<br>-Complaints/PALS | 10/12/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | None - all actions have been completed. | [15/12/2025 12:37:55 Nicola Cornish] Risk to remain at current grading, despite improvement in waiting list due to provision of additional clinics, in order to support business case.<br>[01/12/2025 14:39:58 Nicola Cornish] After further discussion it has been agreed that this risk should be closed as the backlog of patients has been cleared and all patients have now been seen as required following the appointment of a consultant on a fixed term basis. However, there is still an ongoing risk in relation to the single point of failure in this service provision. It was agreed that a new risk should be raised in relation to this rather than simply updating the narrative of this risk. These changes will go to cabinet for agreement in December and then to RRC&C in January.<br>[13/11/2025 10:57:13 Nicola Cornish] This will be discussed at Cabinet meeting in November to agree a reduction in score, before presenting to RRC&C in December for approval. Whilst the backlog has decreased and a cardiology consultant is in post, a risk still remains as this represents a single point of failure and the consultant post is only fixed term for a year.<br>[09/10/2025 09:53:58 Nicola Cornish] Awaiting agreement of cabinet for decrease in risk score to reflect the significant reduction in backlog. Once agreed, this will be listed for RRC&C meeting to confirm approval of the score decrease.<br>[22/09/2025 09:39:09 Nicola Cornish] 19/09/2025 - KR<br>The cardiology service is delivering additional Saturday clinics throughout September and October 2025 to increase capacity to complete clinic reviews. This has resulted in a decrease in the backlog of clinics and it is hoped that reverting to 'Business as Usual' once this has been completed will be sufficient to maintain the clinic backlog at an acceptable level.<br><br>Added the need to review risk the current score to next Specialty Governance | 8 | 30/06/2024 | 30/06/2025 | 10/01/2026 |
| 1b: Reduce waiting times for our patients | 5447 | 691 | Service disruption | Caroline Landon | Capon, Mrs Catherine | Rojas, Mrs Wendy | Workforce Strategy Group | 05/06/2024 | 16 | Surgery | Theatres, Anaesthesia and Critical Care CBU | Theatres | | Nurse staffing in theatres does not support current activity, resulting in patient cancellations and delays. There is a risk of elective lists being cancelled due to lack of theatre staff. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill. | AFPP guidelines for staffing in perioperative setting in place.<br>Daily review of staffing/lists and prioritisation of patients within available capacity.<br>Use of agency staff where required to avoid cancellations where possible. | Incident reporting<br>Review of cancellations | 28/11/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | Business case to be submitted for increase in nursing establishment.<br>Project group at Lincoln to introduce activity manager to try to support planning and management of deficits. | [28/11/2025 14:35:58 Nicola Cornish] Risk reviewed, no change.<br>[09/10/2025 14:11:52 Nicola Cornish] Discussed at Anaesthetics speciality governance meeting on 3rd October. Sam Goy provided an update confirming that the Director of Nursing has given approval for 3 long-line agency scrub nurses for a period of 3 months and they started on 29th September. Nursing establishment had been adjusted for 9 theatres however there are still occasions where requests are made to staff additional theatres.<br>[15/09/2025 15:11:19 Nicola Cornish] Sam Goy reviewed this risk and confirmed there is no change.<br>[29/08/2025 14:16:56 Nicola Cornish] Risk reviewed by Wendy Rojas, no change.<br>[10/07/2025 14:02:42 Nicola Cornish] Risk reviewed by Wendy Rojas, no further update.<br>[04/06/2025 14:03:55 Nicola Cornish] Discussed at RRC&C meeting on 4th June. Reduction of theatre floor plan is progressing and it is expected that this will be completed in the next couple of months. Following this, the current nursing establishment will be sufficient and this risk can be closed.<br>[14/05/2025 13:09:52 Nicola Cornish] Floor plans to reduce to 9 theatres are now being finalised by the division. Once this reduction has been completed, it is expected that the existing staffing establishment will be able to meet the demand and the likelihood of list cancellations will reduce.<br>[29/04/2025 11:00:58 Nicola Cornish] Risk reviewed, no further update.<br>[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.<br>[21/02/2025 12:57:19 Nicola Cornish] Risk reviewed, no change.<br>[07/01/2025 10:42:07 Nicola Cornish] Risk reviewed by Wendy Rojas - no further | 8 | 30/06/2025 | | 28/12/2025 |
| 1c: Improve productivity and deliver financial sustainability | 4657 | 7 | Reputation | Jayne Warner | Warner, Jayne | Hobday, Fiona | Digital Hospital Group | 10/01/2022 | 12 | Corporate | Trust Headquarters | Information Governance | Trust-wide | If the Trust does not comply with Subject Access Requests (SARs) and Access to Health Records provisions in accordance with statutory requirements specified legislation, could lead to complaints to the Trust and Information Commissioner's Office (ICO). This has resulted in regulatory action and could possibly have financial penalties.<br><br>Inconsistent levels of expertise outside IG team regarding SAR requirements.<br>Lack of technical tools to carry out a search of emails / systems to identify personal information held.<br>Implementation of digital systems which don't include a disclosure process. | ULHT policy in place.<br>Monitoring through IGG and at exec level.<br>Temporary additional resource has been agreed to be put in place to support admin parts of role.<br>Proposal made to ELT and IGG regarding process which has removed reliance on clinical staff to review all cases.<br>Increased training provided to team.<br>18/11/24- Procured new solution to better manage requests. Went live 1/12/25 and fully rolled out. | Monthly reporting completed.<br>Compliance rate is monitored by the Supervisor and reports taken to IGG in our KPI report.<br>Volume of ICO complaints and Trust complaints received. | 19/11/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | Current active communications with ICO-regulator.<br>Changes to processes are being constantly discussed and implemented.<br>Resource needs being discussed and temporarily increased to support.<br>Monitored through the IGG in DP KPI report.<br>Head of IG leading on work to review and improve.<br>Working in a more digital way where feasible.<br>Workforce change is required which will be a much longer process.<br>Early identifications of chasers and urgent requests to reduce the likelihood of complaints. | [19/11/2025 10:04:55 Fiona Hobday] Request from IGG to review score- Propose slight reduction in current score through moving likelihood score down- would take from a red 20 to orange 16. This is on the basis that whilst compliance needs to improve the position is much improved in the service and performance greatly improved, with fewer complaints to the Trust and ICO.<br><br>*NHSE requests resolved- CPO has agreed to approve.<br>*Some current concerns with staff related requests which are large and complex- resource being reallocated to support.<br>[21/10/2025 16:50:45 Fiona Hobday] STAFF- Ongoing challenges with getting data from NHSE as won't accept authorisation. Awaiting discussion with Chief People Officer.<br><br>PATIENT- Position is much improved to last year and whilst compliance remains lower than needed, the seriousness of breaches is very low with the majority being completed within 60 days. Corestream enables better monitoring of the position and processes are being tweaked as needed based on capacity levels, volumes etc...<br>Current concern relates to when temp resource is no longer available and ability to maintain position and improvement.<br>[01/09/2025 13:11:21 Fiona Hobday] PATIENT- Additional resource in team to copy/ support from LCHS staff following departure of team supervisor.<br><br>STAFF- Work ongoing re new process with NHSE to obtain data.<br>[15/07/2025 13:00:21 Fiona Hobday] PATIENT:<br>New temp staff in post and currently being trained.<br>DATIX backlog has been reduced to x2 requests. | 6 | 31/12/2025 | 31/12/2025 | 19/12/2025 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 2a: Enable our people to fulfil their potential through training, development and education | 4996 | 39 | Physical or psychological harm | Caroline Landon | Lynch, Diane | Chester-Buckley, Sarah | Outpatient Improvement Group | 22/08/2022 | 16 | Clinical Support Services | Cancer Services CBU | Haematology (Cancer Services) | Trust-wide | As a result of lack of investment for Haematology workforce historically there is insufficient workforce and to meet increasing demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave and the service to collapse which would also lead to significant patient harm. Patients would need to be referred to other neighbouring Trusts which in turn would cause other Trusts to collapse.<br>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<br>(Clinical Governance Lead to commence post in April 2025)<br>Introduction of nurse-led clinics to manage demand.<br>Fixed term Locum Consultants / High cost agency above budget to support service.<br>Ad-hoc additional clinics outside of consultant job plan<br>Workforce review completed<br>Refresher of Fragile Services Paper completed (NB there is a National shortage of Haematology consultants)<br>Additional unfunded ST3+ for Haematologist started in August 2022 | New referrals and PBWL show ongoing capacity issues.<br>RTT and cancer performance below target.<br>Increased PA's for substantive consultants.<br>Outcome from Staff Survey results<br>Financial constraints of group<br>Monitoring of outpatient appointments<br>Datix incidents / Clinical Harm reviews / Complaints / PALS | 20/11/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | Recruitment of further substantive consultants - Sarah Chester-Buckley April 2026<br>Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026 | [20/11/2025 09:39:48 Gemma Staples] Risk reviewed and remains the same as further investment is still required. This situation will further decline in December when 2 Consultants leave the Boston site. Currently recruiting to these posts.<br>[20/10/2025 11:06:28 Gemma Staples] Risk reviewed and remains the same.<br>[18/09/2025 11:15:16 Gemma Staples] Meeting taken place with Stakeholders progressing left shift to GP Surgery's for low grade CLL and MGUS.<br>[19/08/2025 08:20:43 Gemma Staples] All services are currently under review to establish if there is opportunity to left shift activity to the CDC's. The first services to be reviewed are Low Grade CLL and MGUS Blood monitoring.<br>[18/07/2025 11:01:57 Gemma Staples] Vacancy control now in force within the Trust, CRIG not excepting Business Cases which are not funded by charitable funds therefore unable to proceed at present therefore risk remains the same.<br>[18/06/2025 10:08:43 Gemma Staples] 20 at risk posts now to be put into the run rate and therefore will be added to Cancer Services budget lines. Further investment will be required, business case written, awaiting CRIG to reopen.<br>[16/05/2025 10:38:24 Gemma Staples] Risk reviewed and remains the same.<br>[16/04/2025 10:06:19 Gemma Staples] Vacancy control now in force within the Trust, CRIG not excepting Business Cases which are not funded by charitable funds therefore unable to proceed at present.<br>[18/03/2025 11:35:42 Gemma Staples] Business case submitted due to financial situation no further update.<br>[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.<br>[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.<br>[19/12/2024 11:38:08 Gemma Staples] Cancer Services paper written awaiting CRIG invitation | 8 | 30/09/2023 | 01/04/2025 | 19/12/2025 |
| 1a (i) Improve patient safety | 5101 | 487 | Physical or psychological harm | Caroline Landon | Rivett, Kate | Herath, Dr Durga | Clinical Effectiveness Group | 14/03/2023 | 20 | Family Health | Children and Young Persons CBU | Children's Community Services | Trust-wide | As a result of insufficient staffing to meet the level of demand, there is a risk that we will may be unable to deliver epilepsy pathways within both Community & Acute Paediatrics that meet national standards. This may result in patient harm, regulatory action and reputational damage. | 1. Single Consultant Paediatrician (DH) is currently managing all children with Epilepsy alongside a single specialist epilepsy nurse;<br>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;<br>3.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition;<br>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; | 10/12/2025 | 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<br>2. Agreement for spending has been obtained, moving forward.<br>3. Appointing 2 x epilepsy nurses.<br>4. Epilepsy workshop with ICB<br>5. Multi-professional working group tasked with delivering improvements that will support achievement of audit compliance. | [15/12/2025 12:41:44 Nicola Cornish] Risk remains inadequately mitigated with Deep Dive presentation due to Quality Committee on 15/12/2025 to further raise service concerns regarding fragility. Risk reduction is potentially only solvable via investment (business case presented and declined on numerous occasions). Current grading to remain.<br>[18/11/2025 13:18:02 Nicola Cornish] No update for this risk as absence of funding means that we are unable to expand the service to mitigate the risk.<br>[21/10/2025 13:29:56 Nicola Cornish] Risk reviewed, no change. The recent Epilepsy12 audit confirmed that we are still non-compliant with some of the required elements of care delivery.<br>[24/09/2025 09:21:48 Nicola Cornish] Risk reviewed, no change. Await outcome of business case submission.<br>[21/08/2025 14:03:34 Sarah Davy] Business case has been written - to be submitted for 2026/27 funding. Conversations ongoing with tertiary provider regarding clarity of service offer.<br><br>[15/07/2025 13:14:03 Nicola Cornish] No further progress, team are working to make improvements within current service but this does not address the risk and further mitigation is dependent on the business case being approved.<br>[18/06/2025 11:50:34 Rachael Turner] Email confirmation for risk score to remain added to documents.<br>[18/06/2025 11:47:28 Rachael Turner] Epilepsy risk was reviewed recently, and it remains high at 20.<br>This is partly due to the business case to expand the workforce has been suspended<br><br>[17/06/2025 14:43:50 Nicola Cornish] Risk reviewed with Debbie Flatman, no | 8 | 14/03/2024 | 16/02/2024 | 10/01/2026 |
| 1c: Improve productivity and deliver financial sustainability | 4664 | 5 | Finances | Paul Antunes Goncalves | Antunes Goncalves, Paul | Picken, David | | 11/01/2022 | 20 | Corporate | Finance and Performance | Finance | Trust-wide | The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services. | ULHT policy:<br>- Financial plan set out the Trust limits in respect of temporary staffing spend<br>- 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<br>- 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.<br>- Key financial controls for the use of the break glass agency usage are in place.<br>- Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups.<br>- Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing.<br>- Plan for every post information has been embedded to support temporary staff usage forecasts<br><br>ULHT governance:<br>- The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes<br>- Board assurance through Finance, Performance and Estates Committee (FPEC) | The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I<br>The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group<br>The cross Trust workstreams are reported to the Improvement Steering Group<br>The Divisional workstreams are reported to the relevant Finance, People & Activity Meeting (FPAM) | 20/11/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | Financial Recovery Plan schemes:<br>- recruitment improvement;<br>- medical job planning;<br>- agency cost reduction;<br>- workforce alignment | [20/11/2025 08:47:08 Rachael Turner] The Trust's financial plan for 2025/26 includes a total agency plan of £12.7m.<br><br>Against this agency plan, expenditure of £1.2m in October 2025 was £0.3m higher than planned, and expenditure YTD of £9.4m was £1.5m more than planned; the higher than planned agency expenditure position is driven by expenditure on medical and dental agency staffing being £1.3m higher than planned.<br><br>Although YTD agency expenditure of £9.4m is £5.7m lower than spend of £15.1m in the same period 2024/25, the Trust still requires plans to address this movement from plan.<br><br>It is noted that NHSE wrote to the Trust on 8 September to offer ULTH enhanced support because the Trust has been identified as a higher risk in delivering their agency spend target. Driving concerns at a regional level is the fact that 1) the Trust had the 3rd highest agency spend of all Trusts in the Midlands in 2024/25 (£22.6m), 2) the Trust YTD continues to have the 3rd highest agency spend in the region in 2025/26 and was overspent against its YTD agency plan at month 4, and 3) the Trust has the highest level of Medical and Dental agency usage in the region.<br><br>Medical and dental agency expenditure is thus a key area of focus in our efficiency discussions and an area for further improvements.<br><br>[20/10/2025 09:12:04 Rachael Turner] The Trust's financial plan for 2025/26 includes a total agency plan of £12.7m. | 8 | 31/03/2023 | 31/03/2024 | 20/12/2025 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 1c: Improve productivity and deliver financial sustainability | 4839 | 328 | Finances | Caroline Landon | Bassi, Sangeeta | Moore, Lisa-Marie | | 19/01/2022 | 20 | Clinical Support Services | Pharmacy CBU | Pharmacy | Trust-wide | As a result of not having pharmacy capacity to support NHSE Intravevenous Immunoglobulin (IVIG) framework switch, there is a financial risk that the Trust will not be able to deliver to expected CIP £1.8 million and unable to support to system HCD risk which sits at £2.8 million. Missed opportunity of savings of Circa £3,200 through the NHSE financial enabler scheme. There is also a reputational risk, due to litigations if patients perceive that they have not had the correct management. There is a risk of financial loss of income (£2.7 million) if not compliant with the switch. NHSE will not reimburse drug costs and introduce financial penalties on top of this. There is also a risk that the Trust will not meet monthly KPI's. | NHSE IVIG Framework<br>NHSE Immunoglobulin Clinical Commissioning Policy<br>Governance arrangement in place:<br>- Local Immunoglobulin Panel (IAP) and Subregional Immunoglobulin Panel (SRIAP) | National framework switch being completed/not completed in time by September 2025)<br><br>Financial enabler scheme/CIP targets being met/not met by December 2025<br><br>Monthly contract challenges from NHSE (challenge value and non-payment accrued)<br><br>Monthly KPIs monitored by subregional IVIg panel (SRIAP)<br><br>Monthly KPIs monitored by local IVIg panel (ULTH IAP)<br><br>Financial reporting (Pharmacy, Finance and CSS)<br><br>Prescribing data indicating the use of non-framework products | 09/12/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | Once staff fully up to speed, review need for risk Nov 2025 LMM | [09/12/2025 15:20:42 Gemma Staples] Reason for closure is that all staff are in post and fully trained therefore risk can be closed.<br>[09/12/2025 14:01:23 Lisa Hansford] Approved to close at Pharmacy governance meeting 9th December 2025. To go to Alliance cabinet Jan 2026<br>[19/11/2025 09:40:43 Lisa Hansford] Potential to close this risk. Exploring whether or not medical side is covered by system risk before closing.<br>[21/10/2025 10:05:39 Lisa Hansford] Posts recruited to now and onboarding commenced this month. If progressed will view to close risk next month.<br><br>[22/09/2025 15:19:19 Gemma Staples] Interview and successful appointment for B7 Pharmacy Technician – planned start date mid October<br>Interview for 8b 26th September<br>Interview for 8a 29th September<br><br>Following recruitment and onboarding will be able to review risk score and reduce. Once team embedded will be looking to close risk<br><br>[20/08/2025 10:01:13 Rachael Turner] Risk discussed as part of the Deep Dive at RRC&C, as soon as posts are filled we will be looking at closing risk. This will continue to be monitored.<br>[19/08/2025 13:39:37 Lisa Hansford] Vacancies going through Trac. Once staff in place. Risk can be reduced.<br>[06/08/2025 09:03:46 Lisa Hansford] Trust agreement to support utilisation of NHSE funding for 0.5wte 8b, 1wte 8a and 0.5wte 7. QIAs approved and jobs placed on trac w/c 4th August. Retrospective case on a page to be submitted to CSS cabinet August<br>[23/07/2025 14:38:57 Gemma Staples] Amendment: below should state 5x4(20) | 4 | 01/10/2021 | 31/03/2023 | 09/01/2026 |
| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | 5563 | 782 | Physical or psychological harm | Caroline Landon | Mooney, Mrs Katy | Smith, Charles | | 19/12/2024 | 16 | Medicine | Specialty Medicine CBU | Neurology | Trust-wide | As a result of the retirement of 50% of the substantive workforce in Apr 2025 and a challenging national recruitment environment; there is a risk that the trust's Neurology service will cease to function sustainably. This would lead to a risk of harm to patients via delayed outpatient appointments, delayed inpatient reviews and an inability of the service to meet it's demands.<br><br>Prior to the impending retirement, the Neurology service is already in a situation whereby substantive capacity does not meet recurrent demands on the service<br><br>At present Neurology has 5900 overdue patients on its PBWL, 44% of which (2415) are overdue by more than 1 year. At this time there is no clinical capacity (for all the reasons highlighted in this report) for any clinical validation of this backlog and no available administrative resource for a data cleanse. It may be some of these patients no longer require follow-up, are now under the care of other centres or represent duplicates. Upon review of current demand and the loss of capacity approaching in the service, it has been estimated that if no additional capacity or mitigations are possible the PBWL could approach 12000 patients by the end of the 2025/26 financial year with roughly 8500 of these being overdue. | Agency workforce already in place to supplement establishment that is not right-sized to service demands<br><br>1x new consultant starting 01/09/25<br><br>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<br>-Size of PBWL<br>-NEW backlog/Booking timeframes | 15/12/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | Action 1. Working group convened to discuss plans for service as current model not appropriate. Have met twice as of 19/12.<br><br>Action 2. Discussions to take place with contracting team/ICB re: discussion of service model for Lincolnshire.<br><br>Action 3. Meetings taken place with NUH to discuss interim measures for balancing workload/pt cohorts.<br><br>Action 4-Multiple papers drafted for GLT updating on situation. Most recent has requested permission for insourcing. | [15/12/2025 09:20:11 Charles Smith] Working back at establishment via agency but significant backlog, unmanageable PBWL and severely under-resourced sub-specialty teams. Unable to meet elective care targets without continued insourcing at cost, YMS in place a/w extension into January.<br>[17/11/2025 10:00:23 Charles Smith] Working back towards establishment but still significant gaps in provision (e.g. botox and significant backlogs). Insourcing now in place to meet elective targets at cost. No significant change to risk, service remains unsustainable.<br>[17/10/2025 15:51:24 Charles Smith] Risk remains the same. Establishment returning and agency in support in place but significant risk in backlog of long-waiting pts, grading backlog and PBWL. Insourcing contract signed w/c 13/10/25, will allow improvement by early 2026 although not currently sustainable.<br>[22/09/2025 09:39:46 Charles Smith] Risk remains the same. Now significant 65wk cohort challenges with breaches likely in September.<br>Outsourcing companies contacted and working up pathways.<br>Team will be back to x4 consultants by October however significant backlogs and PBWL risk remains<br>[19/08/2025 14:37:04 Rachael Turner] Risk currently remains the same, we have recruited to one of the vacancies who start of the 1st September but still carrying 1 vacancy and we have continued issues that even at full establishment working is too small for the influx that we get in.<br>[28/07/2025 11:50:09 Gemma Staples] Agreed increase in score at RRC&C on 23/7/25 to 5x4=20 (not a 4x5 as previously stated)<br>[23/07/2025 15:38:40 Gemma Staples] Agreed increase in score at RRC&C on 23/7/25 to 4x5=20<br>[13/06/2025 14:13:57 Rachael Turner] Neurology has the largest PBWL and is a small service. There are currently 9000 on the services PBWL, 5900 of which are | 8 | 19/12/2025 | | 19/01/2026 |
| 1a (i) Improve patient safety | 4746 | 121 | Physical or psychological harm | Caroline Landon | Lacey, Mark | Knapp, Chris | Outpatient Improvement Group, Patient Safety Group | 14/01/2022 | 20 | Surgery | Urology, Trauma and Orthopaedics, and Ophthalmology CBU | Ophthalmology | | As a result of a backlog of patients on the Trust-wide Ophthalmology Partial Booking Waiting List, patients are waiting longer for follow up than timescale specified by clinician. There is a risk of undetected deterioration of their eye condition whilst waiting to be seen which may result in permanent sight loss. | Ophthalmology / Surgery Division clinical governance arrangements<br>Outpatient / PBWL management processes<br>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.<br>Both clinical and non-clinical validation undertaken to prioritise according to urgency and verify that patients are accurately recorded and still require an appointment.<br>Ophthalmology pathway prioritisation project plan led by project management team following peer review visit to Exeter. | Monitoring Ophthalmology PBWL<br>Clinical harm reviews / reported incidents due to appointment delays | 05/12/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | Need to ensure future sustainability once recovered. | [05/12/2025 11:03:28 Nicola Cornish] A new SOP has been agreed, which requires clinicians to complete 3 validations per clinic, and define a clear outcome for each patient which will then be actioned by the Failsafe team, including creation of a letter to the patient informing them of the outcome.<br>[24/11/2025 15:49:01 Nicola Cornish] Risk reviewed, no change. Ongoing work within CBU to define next steps.<br>[17/10/2025 13:30:43 Nicola Cornish] Paper currently being written regarding next steps and plans, number has reduced since completing clinical and non clinical validation<br>[06/10/2025 14:43:22 Rachael Turner] process remains ongoing with updates through PSG<br>[20/08/2025 10:39:00 Rachael Turner] Risk presented at RRC&C for increase in score. Increases are occurring in incidents, this is being seen weekly, which demonstrates that the risk is rising, this is reflected in Datix. Risk validated for increase in score to 5x4:20 Very High Risk.<br>[25/07/2025 12:17:39 Nicola Cornish] Risk reviewed with Leanne Chamberlain. There has been an increase of severe harm incidents being reported and the PSRPM suggested that the scoring this risk should be reviewed for a potential increase. Proposal is to increase from 4x4 to 5x4 to reflect the increase in likelihood and Cabinet has agreed this. To be listed for RRC&C in August for final approval.<br>[04/06/2025 14:07:03 Nicola Cornish] 21/05/25 - Leanne Chamberlain - no new update, continue to work through action as previous<br>[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.<br>[08/10/2024 12:59:55 Nicola Cornish] 07/10/2024 - Leanne Chamberlain no | 4 | 31/07/2021 | 30/06/2022 | 05/01/2026 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 1a (i) Improve patient safety | 5016 | 22 | Physical or psychological harm | Caroline Landon | Mooney, Mrs Katy | Mooney, Mrs Katy | Workforce Strategy Group | 02/09/2022 | 25 | Medicine | Urgent and Emergency Care CBU | Accident and Emergency | Trust-wide | If there is not sufficient flow through the Trusts Emergency Departments, due to demand outstripping capacity and insufficient availability of beds in the hospitals leading to overcrowding; this may result in increased likelihood of long waits in the departments for patients, and an increase in the potential for patient harm, delays in care, poor patient and staff experience and impact on the reputation of the Trust . | Medical SDEC currently working 08:00 - 20:00<br>24 hour UTC co-located with ED at Pilgrim and Lincoln<br>'Are you sitting comfortably' scheme<br>4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00)<br>Clinical Operational Flow Policy<br>Full Capacity Protocol<br>National Criterial 2 Admit flowchart embedded in the ED's<br>Introduction of "Pit stop" model.<br>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<br>Capacity Meetings to dynamically risk assess<br>Monthly scorecard to track performance from both harm and constitutional standards<br>Matrons Dashboard<br>Datix<br>Number of harm reviews | 11/11/2025 | 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.<br>Safer Programme in place and SOP is being delivered for Operational meetings in the aim to process discharges and improve flow.<br>Ongoing Care and Comfort project in place to mitigate both harm and risks. | [11/11/2025 11:14:17 Rachael Turner] Risk reviewed, the streaming project is underway with estimated completion in Dec at Lincoln then moving to Pilgrim. We are looking at replacing Manchester Triage to Acuity 1-5. Risk remains at current score.<br>[13/10/2025 08:53:02 Rachael Turner] Risk reviewed, no change to current risk, mitigation remains in place.<br>[15/09/2025 09:11:23 Rachael Turner] Risk reviewed, no change currently. Risk score remains accurate<br>[15/08/2025 09:34:38 Rachael Turner] New national navigation process to be instigated at the front door to signpost to patient specific pathways to reduce pressures in ED and for ED to be moving towards life and limb only.<br>[14/07/2025 08:53:18 Rachael Turner] Risk reviewed, risk remains at current level with no new update from last month.<br>[16/06/2025 09:08:37 Rachael Turner] Risk reviewed.The risk is not ready for reduction as we still come into many DTA pts on a morning, flow is still fairly slow and the speciality pathways are not 24/7 – we have some mitigations currently needs to stay at risk score of 20.<br>[28/05/2025 11:44:10 Rachael Turner] Risk reviewed, no current change to risk scoring at this time.<br>[07/05/2025 12:54:09 Rachael Turner] Risk reviewed, no change to current flow | 10 | 02/09/2023 | 02/09/2023 | 31/03/2024 | 11/12/2025 |
| 2b: Empower our people to continuously improve and innovate | 5093 | 40 | Service disruption | Caroline Landon | Bassi, Sangeeta | Baines, Andrew | Workforce Strategy Group | 16/02/2023 | 20 | Clinical Support Services | Pharmacy CBU | Pharmacy | Trust-wide | As a result of vacancies and long term absence within the invoicing team, purchasing and pharmacy stores team there is a risk that any further absence or leavers will mean the remaining staff don't have the capacity to do the work of all 3 sites which would impact staff wellbeing and all drug ordering across all pharmacy sites (including bulk IV fluids, medical gases, chemotherapy). Inability to complete invoices will negatively impact the Trust finance target to pay invoices within 30 days, with potential of financial penalties, and could result in suppliers putting holds on our accounts rendering us unable to order medicines, this will therefore mean that we would be unable to complete biosimilar switches and meet CIP targets (£1.4m). Recruitment has been further delayed due to VCP to improve the current financial status. Payment beyond 30 days presents a risk of companies levying late payment fees and interest on outstanding amounts. | Currently no controls in place | Staff Survey<br>Staff Feedback<br>Staff sickness<br>Finance performance on invoice payment<br>Workload<br>CIP tracking<br>Biosimilar switching targets | 09/12/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | Vacancy fulfillment - QIAs for 0.4 band 3 submitted; jobs offered in progress to agree start dates - Andrew Baines - March 2026 (dependant on funding)<br><br>Staff trained and competent to fulfil roles - Colin Bell - Jan 2026<br><br>Staff skill mix review and time and motion study to ensure that staff managing workload Andrew Baines - January 2026<br><br>Training of new store keeper post - Andrew Baines Jan 2026<br><br>Procurement staffing review - Fran Martinez Jan 2026 | [09/12/2025 14:06:47 Lisa Hansford] Sore keeper due to start 22nd December. Staffing review drafted. To be finalised and circulated for comments before Christmas.<br>[09/12/2025 13:59:00 Lisa Hansford] QIA Band 3 submitted to Alliance but need to confirm funding as was at risk posts<br>[17/11/2025 11:39:39 Lisa Hansford] QIA for 0.4WTE B3 will be submitted. Store keeper training and assessments underway. Report from procurement staffing review in progress. Date collection for the time and motion study under way.<br>[20/10/2025 18:59:48 Gemma Staples] Pharmacy update: our view is we don't support a risk reduction given the ongoing invoicing sickness absence and the unfunded band 3 gap which means I can't do a QIA as I don't have the funding for those 2 days.<br>Division said they were challenging the two days we lost due to MARRS, but no update received on that yet... so pending outcome of Fran's review I think we want the risk to remain as it is.<br>[20/10/2025 16:09:44 Lisa Hansford] Staff training and assessment not yet complete this is affecting storekeepers and purchasers at LCH. Time and motion study underway.<br>Pilgrim storekeeper post, interviews w/c 27th Oct; this post will also require training and assessment.<br>Current vacancy situation is 0.4WTE band 3 (unfunded).<br><br>[22/09/2025 15:21:15 Gemma Staples] MARS scheme approved for 0.4wte staff member. Thus reduction in procurement clerk staffing as a result. This affects resilience of team due to part time flexible working of staff members remaining. Further notice received 18th September.<br>Long term absence staff being reviewed for temporary redeployment. Invoicing | 4 | 16/02/2024 | 16/02/2024 | 09/01/2026 |
| 1a (i) Improve patient safety | 4879 | 28 | Physical or psychological harm | Caroline Landon | Carter, Mr Damian | Hobson, Louise | | 28/03/2022 | 20 | Corporate | Operations | Cancer Centre | Trust-wide | As a result of National long waits there may be significant delays within the cancer pathway and as a consequence patients may experience extended waits for diagnosis and surgery which would lead to a failure in meeting national standards and potentially reducing the likelihood of a positive clinical outcome for many patients. | National policy:<br>- NHS standards for planned care (cancer)<br><br>ULHT policy:<br>- Cancer care pathway & booking systems / processes<br>- Clinical Harm Review (CHR) processes<br><br>ULHT governance:<br>- Lincolnshire System Elective Recovery meeting – Monthly<br>- Lincolnshire system RTT Cancer and Diagnostic- Weekly<br>- ULHT Cancer Recovery and Delivery – Weekly<br>- ULHT Clinical Business unit meetings – Weekly<br>- Integrated Performance Report (IPR) to Trust Board - Monthly<br>- Divisional Performance Review Meeting (PRM) process<br>- Clinical Harm Oversight Group<br>Intensive support meetings in association with the ICB - 2/52<br>Cancer Delivery and recovery - 2/52<br>Cancer Board - Monthly | -% of patients breaching cancer standards (FDS, 62-Day, 31-Day, 104-Day)<br>-Median wait times for diagnostics and surgery<br>-Number of patients waiting >62 days without a treatment plan<br>-Clinical harm reviews linked to delays | 19/11/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | -Recovery trajectory in place to reduce 62+ day breaches to 245 by the end of March 2026<br>-Weekly Care Group Intensive Support Meetings are established at the tumour site level to monitor progress and to identify and mitigate specific risks not addressed by the trajectory<br>-Trust-wide and tumour-specific trajectories have been set for FDS, 62-Day and 31-Day standards, aligned with national expectations and local targets<br>-Local targets established to reduce the number of patients breaching 62 days with prioritisation of high-risk patients | [19/11/2025 12:30:18 Rachael Turner] Risk reviewed, no further update from previous reported in October.<br>[30/10/2025 09:05:39 Rachael Turner] A recovery trajectory is in place to reduce 62+ day breaches to 245 by March 2026, supported by an intensive specialty-level review to identify and mitigate residual risks. Weekly Care Group Intensive Support Meetings have been established, with performance trajectories now set at Trust and tumour site level for the 28-Day FDS, 62-Day, and 31-Day standards, aligned to national expectations and local targets for backlog reduction. Since 9 September 2025, a Head of Cancer has been appointed to provide strategic oversight and operational leadership across the cancer pathway. This role ensures focused attention on performance delivery and leads the coordination of Care Group support and escalation processes.<br>[29/10/2025 15:40:25 Rachael Turner] The Cancer Centre has been moved to corporate service to provide a more robust governance structure and promote closer working with the tumour sites. As part of this change, a new Head of Cancer role has been implemented to focus on Cancer delivery, improve performance and ultimately improve outcomes for patients.<br>A redesign in the management of Cancer services is underway to create a better working flow between departments, reduce duplication and reduce waiting times<br><br>[29/10/2025 15:39:44 Rachael Turner] Risk to remain under Ops but with Louise Hobson as Handler<br>[29/10/2025 15:14:44 Rachael Turner] At request of Louise Hobson, Head of Cancer, Risk realigned to Cancer Services with Louise as Handler.<br>[11/07/2025 12:10:11 Rachael Turner] Risk transferred to Operations.<br>[23/06/2025 09:20:38 Gemma Staples] 14 wte of the 20 wte posts approved at risk by the previous CEO / COO have now been included in 25/6 funded | 8 | 31/03/2026 | 31/03/2023 | 19/12/2025 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 1c: Improve productivity and deliver financial sustainability | 5020 | 6 | Finances | Caroline Landon | Hamer, Fiona | Lentz, Blanche | WORK | 02/09/2022 | 20 | Medicine | Urgent and Emergency Care CBU | | | If there is a continued reliance on bank and agency staff for medical workforce in Urgent & Emergency Care there is a risk that there is not sufficient fill rate for medical rotas both ward / department fill and on call shifts which will impact on patient safety and have a negative impact on the CBU budget | Robust medical plan for every post meetings<br>Close working with temporary medical staffing team<br>Daily management of any gaps to support minimum staffing levels<br>Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels.<br>Introduction of BMA rate cards<br><br>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<br>Budget reports | 11/11/2025 | Quite likely (4) 71-90% chance | Extreme (5) | Very high risk (20-25) | 20 | Robust recruitment plan<br>International recruitment<br>Medical Workforce Management Project | [11/11/2025 11:15:07 Rachael Turner] Tier 2 remains ongoing, no current change to risk.<br>[20/10/2025 14:07:06 Rachael Turner] All posts for Tier 2 and residents advertised for LCH and PHB ED. x2 consultants at PHB, await VCP approval. LCH consultant awaits AAC panel date. UTC GDH x1 tier2 doctor advertised due to DIS and interviews for x2 residents booked. 6 months most vacancies should be recruited too<br>[13/10/2025 08:55:37 Rachael Turner] Risk reviewed, no change currently, mitigation remain sin place.<br>[15/09/2025 09:10:31 Rachael Turner] Risk reviewed, no change currently. Risk score remains accurate<br>[15/08/2025 09:38:45 Rachael Turner] Job planning process instigated, current position for first level formal meeting 3rd September with Chief of Service.<br>[14/07/2025 12:03:57 Rachael Turner] Risk reviewed.no current change to risk scoring.<br>[17/06/2025 14:54:45 Rachael Turner] Risk reviewed, remains at current position<br>[28/05/2025 11:35:37 Rachael Turner] Approval provided for job planning for tier 2 rota. Job planning cycle will be the next step.<br>[07/05/2025 12:51:56 Rachael Turner] Risk reviewed and remains at current level, Tier2 rota is being worked on.<br>[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.<br>[04/03/2025 15:09:11 Rachael Turner] Conversations around tier 2 have failed so this has been escalated to executive level.<br>[04/03/2025 15:05:36 Rachael Turner] Risk reviewed, conversations are currently taking place around tier 2 rotas.<br>[04/02/2025 15:39:31 Rachael Turner] Risk currently remains, we still haven't | 10 | 02/09/2023 | | 11/12/2025 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 4731 | 33 | Physical or psychological harm | Caroline Landon | Landon, Caroline | Landon, Caroline | Patient Safety Group | 13/01/2022 | 20 | Corporate | Operations | Operations | Trust-wide | If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome. | - Clinical Records Management Policy (approved June 2021, due for review December 2023)<br>- 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.<br>Reported incidents involving availability of patient records issues. | 21/11/2025 | 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. | [21/11/2025 12:40:25 Rachael Turner] Go Live date for EDMS set for January 2026 for Neonates, Paediatrics and Community Paediatrics. There will then be a phased roll out of gradual implementation across remaining departments from Jan-September 2026.<br>[13/10/2025 11:23:43 Rachael Turner] Request made by digital for this risk to remain open from ops perspective.<br>[22/09/2025 09:24:09 Rachael Turner] Presenter not available for RRC&C, this will now be deferred to October meeting for closure.<br>[13/08/2025 14:37:26 Rachael Turner] Risk to be presented at RRC&C in September for closure as this risk will be included in risk ID 5680.<br>[09/07/2025 09:59:53 Rachael Turner] Risk meeting booked to add this record to 5680. Risk currently remains at current level with no change to scoring.<br>[17/06/2025 10:59:46 Rachael Turner] Risk reviewed, remains at current level. This risk will be included as part of the actions in risk 5680-Risk of paper based records and standalone digital systems, currently waiting to set up meeting with Digital to go through all risks relating to this topic area as 5680 will be an overarching risk. Once complete this risk will be closed.<br>[29/05/2025 09:16:48 Rachael Turner] Risk remains on current level-no change.<br>[19/05/2025 09:45:29 Rachael Turner] Risk reviewed, no change from last months update. Risk remains at current level.<br>[08/04/2025 10:30:22 Rachael Turner] The ULTH Electronic Patient Record (EPR) programme has now reached the final stages of contract and funding. The contract with our new supplier, Nervecentre, is due to be agreed and finalised in the next few weeks and ministerial approval for the programme has also been received.<br>Once the contract has been finalised the Digital Services Team will submit the full business case and contract to the Cabinet Office who will then agree the | 4 | 30/06/2018<br>31/03/2025 | | 21/12/2025 |
| 1c: Improve productivity and deliver financial sustainability | 5672 | 883 | Finances | Paul Antunes Goncalves | Antunes Goncalves, Paul | Sargeant, Paula | | 17/06/2025 | 25 | Corporate | Finance and Performance | Finance | Trust-wide | The Trust has a £69.8m Financial improvement target for 25/26. If the Trust fails to deliver the CIP Plan, this will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to deliver its breakeven financial plan for the year.<br><br>This represents a 6% target of £48m plus the impact from systemwide schemes of £21.8m, totalling £69.8m to breakeven.<br><br>This is greater than any financial improvement the trust has delivered in previous years. This requires delivery at the same time that the organisation is going through vast amounts of transformation, both as a Group and as part of the Lincolnshire system.<br><br>This target represents a significant reduction in headcount, and needs to be delivered either without invest to save options or with additional CIP delivered over and above target to support additional resource.<br><br>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:<br>- NHS annual budget setting and monitoring processes<br>- Breakeven Plan<br>- Acute to Community, Analogue to digital.<br><br>ULHT policy:<br>- Detailed Financial plan inclusive of the headcount reductions has been submitted and ownership is in place for delivery.<br>- Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial recovery plan aligned to CIP.<br>- Development of Care Group level Schemes assured through PRM's and GLT (Transactional)<br>- Establishment of future looking programme to develop schemes for a sustainable cost improvement programme for the future. This incorporates Acute to Community pathways across the group (Transformational)<br>- Establishment of a suite of cross cutting schemes aligned to the Group Improvement Strategy supported by the transformational team resource. (Targeted)<br>- Divisional CIP targets allocated as part of the budget setting process and removed from budgets.<br><br>ULHT governance: | The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE and through ICB.<br><br>For 2025/26 the Trust continues to be monitored weekly on the status of the CIP programmes and their level of maturity.<br><br>The Trust monitors internally against its CIP targets inclusive of specific Care Group and Transformational scheme targets through the PRM's, GLT and PITOF.<br><br>Scrutiny & oversight is increased as all committees | 20/11/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | - Support offered to all Care Groups.<br><br>- Increased CIP governance & monitoring arrangements introduced through PRM's to ensure oversight (including additional one off detailed executive review sessions with care groups).<br><br>Business cases submitted to NHSE for Delivery support in key areas where capacity & expertise require.<br><br>- Alignment with the Group Strategy for Acute to Community, Digital To Analogue.<br><br>- CIP is embedded across the group and resources shared and is not seen as a separate annual work stream.<br><br>- Development of future programme of cost improvement. | [20/11/2025 08:52:49 Rachael Turner] Further deterioration of CIP position reported at month 7.<br>Further confirm & challenge in month being taken to understand what the impact is on the forecast.<br>Care Group PRM's & CIP Reviews – frequency stepped up where needed and focus on delivery of plan.<br>Medical workforce programme reignited under CMO with targets set for each care group.<br>[30/10/2025 08:40:32 Rachael Turner] Trust wide lock in of month 5 likely CIP forecast and monitoring against that going forwards. £13.4m deficit at month 5 ; Actions being undertaken to close the gap.<br>•Non recurrent mitigations - currently being explored to target £3m.<br>•Winter bed capacity discussions underway with ICB<br>•WOS – Following guidance change, discussions with local trust to align working<br>•External support being sought<br>•Care Groups being targeted for improvements.<br>•Weekly meetings with Care group & COO put in place to monitor CIP progress.<br>•Medical Workforce review.<br>Following Care Group PRMs risks highlighted against further deterioration from the month 5 forecast of £13.4m. Care groups remain in escalation. | 4 | 01/04/2026 | | 20/12/2025 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5450 | 659 | Physical or psychological harm | Caroline Landon | Mooney, Mrs Katy | Highfield, Kimmi | | 05/06/2024 | 12 | Medicine | Specialty Medicine CBU | Gastroenterology | Trust-wide | The capacity of the Gastroenterology Consultant workforce is reducing due to individuals wishing to take resign, retire or partially retire and return with reduce job planned activity. This is impacting the inpatient and outpatient activities of the service. However, as the drive to resign/retire/reduce job planned activity focuses on removal of all inpatient and on-call activity as a 'must' the primary impact is being felt in these area's.<br><br>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.<br><br>-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.<br><br>-Management of UGI Guidelines policy.<br><br>-Guidelines on Management of Upper Gastro-Intestinal Bleeding (UGIB) | Workforce gaps<br>Capacity of the service<br>Cover of rota's (inpatient ward cover and on-call bleed cover) | 15/12/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | Explore recruiting to Hepatology specialist posts with ERCP and EUS included.<br>-Robust recruitment plan to cover establishment gaps, including non substantive workforce.<br>-Single site on-call cover in place-currently covering both sites to mitigate for gaps.<br>-Development of clinical service strategy for Gastroenterology by end of 2024/25 financial year.<br>-Paper to go to executive detailing short fall and asking for support with further mitigation by close of play September 2024. | [15/12/2025 09:26:10 Charles Smith] Risk remains at current level with no change for now.<br>[17/11/2025 10:02:16 Charles Smith] Risk remains at current level after discussion with consultant body. Not comfortable to reduce risk as gaps remain on core rotas etc.<br>[17/10/2025 15:52:01 Charles Smith] Risk remains at current level with no change for now.<br>[22/09/2025 09:49:51 Charles Smith] Risk remains at current level with no change for now.<br>[19/08/2025 17:01:38 Rachael Turner] Risk remains at current level with no change to risk scoring.<br>[14/07/2025 19:07:26 Rachael Turner] Risk reviewed, no change to risk score at this current time.<br>[16/06/2025 09:12:31 Rachael Turner] Work hasn't started for moving Gastro service into community. There has been slight improvement but Division would like to wait until August review time to look at possibly reducing score.<br>[04/06/2025 11:52:28 Charles Smith] Risk remains unchanged for now pending further recruitment as still dependent on agency - if current round of recruitment successful pending further partial retirement approved by ROAG then to explore if risk to be downgraded.<br>[29/04/2025 14:47:41 Rachael Turner] We have recruited a substantive consultant. Rotas: bleed gaps covered at Lincoln. We have had consultants returned from sickness.<br>[01/04/2025 14:38:14 Rachael Turner] Risk remains in current position but with further update to be provided around current recruitment.<br>[05/03/2025 09:18:37 Rachael Turner] Risk reviewed, risk remains in current position at the same risk score. | 8 | 05/06/2025 | | 19/01/2026 |
| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | 5711 | 915 | Finances | Daren Fradgley | Fradgley, Daren | Fradgley, Daren | | 03/10/2025 | 20 | Corporate | Integration and Improvement | | Trust-wide | As a result of the ICB's reorganisation into a three county cluster, with fewer senior leaders covering a bigger area there is a risk for the Group that a loss of corporate memory and diluted focus disrupts our ability to deliver our strategy. This could lead to failed delivery of our 25/26 operational plan and loss of progress or regression in our strategic partnerships | The current position is monitored and mitigated through the following strategic and leadership engagement forums:<br>-BLET<br>-LLG<br>-System exec to exec<br>-ICB Board (include partner chief execs<br>-Group Board<br>- weekly chief executive meetings<br>- target operated model board (TOM)<br>- Executive one to one's<br><br>Given the pace of change and the current vagueness of the ICB cluster operating model it is difficult to quantify the future controls possible until the cluster executive team is in place. It is anticipated the announcement will be made during October on these roles and then formalised next steps planning can take place. | 1)The system boards including the ICB Board, the Group Board and the formal joint committees at a system level.<br>2)Measuring progress and impact at exec to exec monthly meetings. | 15/10/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | Action 1. Map critical relationships and dependencies to ensure they are actively maintained and not lost during leadership changes.<br>Lead: Director of Strategy, Improvement & Redesign<br>Completion date: 3 months<br><br>Action 2. Ensure new cluster executives are quickly brought up to speed with local context, priorities, and strategic goals.<br>Lead:Chief Integration Officer<br>Completion date: 3 months<br><br>Action 3. Enhance joint system governance reporting through improved visibility and alignment across forums such as BLET, LLG, TOM, and the Group Board.<br>Lead: Chief Integration Officer<br>Completion date: 3 months<br><br>Action 4. Oversee continuity and coordination during the reorganisation period to maintain strategic momentum<br>Lead: Chief Integration Officer<br>Completion date:3 months | [15/10/2025 10:41:00 Rachael Turner] Risk presented at RRC&C 15/10/25, risk validated as 5x4:20 Very High Risk. | 12 | 31/03/2026 | | 15/11/2025 |
| 2b: Empower our people to continuously improve and innovate | 4997 | 41 | Service disruption | Caroline Landon | Lynch, Diane | Chester-Buckley, Sarah | Patient Safety Group | 22/08/2022 | 16 | Clinical Support Services | Cancer Services CBU | Haematology (Cancer Services) | Trust-wide | As a result of current Consultant staffing and on-call arrangements there is a single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites which could lead to potential patient harm, delays in care/discharge. | Middle Grade cover in Oncology & Haematology over and above budget therefore using high cost agency.<br>VC ward rounds are taking place if face to face ward rounds are not possible.<br>Workforce review completed<br>Refresher of Fragile Services Paper completed (NB there is a National shortage of Haematology consultants)<br>Additional unfunded ST3+ for Haematologist started in August 2022 | Datix incidents<br>Complaints and PALS<br>Outcome from Staff Survey results<br>Financial constraints of group | 20/11/2025 | Extremely likely (5) >90% chance | Severe (4) | Very high risk (20-25) | 20 | Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026<br>Recruitment of further substantive consultants - Sarah Chester-Buckley - April 2026 | [20/11/2025 09:39:17 Gemma Staples] Risk reviewed and remains the same as further investment is still required. This situation will further decline in December when 2 Consultants leave the Boston site. Currently recruiting to these posts.<br>[20/10/2025 11:05:38 Gemma Staples] Risk reviewed and remains the same.<br>[18/09/2025 11:16:17 Gemma Staples] Further investment is still required to remedy this risk.<br>[19/08/2025 08:21:39 Gemma Staples] Until there is further investment in the team the risk will remain as we are unable to staff two on call teams to cover both sites appropriately.<br>[18/07/2025 11:02:15 Gemma Staples] Vacancy control now in force within the Trust, CRIG not excepting Business Cases which are not funded by charitable funds therefore unable to proceed at present therefore risk remains the same.<br>[18/06/2025 10:09:12 Gemma Staples] 20 at risk posts now to be put into the run rate and therefore will be added to Cancer Services budget lines. Further investment will be required, business case written, awaiting CRIG to reopen.<br>[16/05/2025 10:39:50 Gemma Staples] Risk reviewed and remains the same.<br>[16/04/2025 10:05:53 Gemma Staples] Vacancy control now in force within the Trust, CRIG not excepting Business Cases which are not funded by charitable funds therefore unable to proceed at present.<br>[18/03/2025 11:35:18 Gemma Staples] Business case submitted due to financial situation no further update.<br>[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.<br>[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.<br>[19/12/2024 11:34:12 Gemma Staples] Cancer Services paper written, awaiting CRIG invitation | 8 | 01/04/2023 | 01/04/2023 | 19/12/2025 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 2b: Empower our people to continuously improve and innovate | 4844 | 38 | Service disruption | Caroline Landon | Bassi, Sangeeta | Saddick, Ahtisham | Medicines Quality Group | 19/01/2022 | 20 | Clinical Support Services | Pharmacy CBU | Pharmacy | Trust-wide | As a result of insufficient staffing establishment there is an inability to provide a safe and effective 7 day pharmacy service at ULTH. Current funding allows for the dispensaries to open Monday to Friday 9-5 and weekends mornings only and clinical cover Monday to Friday 9-5. As a result of this under staffing there is a risk that patients may require critical medication and/or specialist pharmacy advice over the weekend when pharmacy is closed. The Trust is failing to meet NICE NG5 Medicines Reconciliation targets and there is no pharmacy capacity to review eDDs or provide specialist pharmacy advice. All of these risks have multiple implications such as harm to patients from omitted medicines, delayed discharge from hospital effecting the efficiency of the hospital, readmission to hospital, cost pressures from use of FP10s. | Provision of an emergency supply only service on weekends between 9am and 12:30<br><br>On call pharmacy service outside of pharmacy working hours<br><br>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.<br><br>Reported medication incidents occurring out of hours.<br><br>Monitor sickness rates following weekend working<br><br>Staff Survey results<br><br>Staff exit interviews | 09/12/2025 | 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 on completion of workforce review Jan 2026 | [09/12/2025 14:10:10 Lisa Hansford] Weekend working change impact being monitored through QIA panel and to be presented to GLT<br>[19/11/2025 09:35:50 Lisa Hansford] Workforce review presented to GLT. Work ongoing<br>[21/10/2025 10:41:15 Lisa Hansford] Business case on hold until pharmacy workforce review has been completed.<br>[22/09/2025 15:23:07 Gemma Staples] Reports for the ED and Discharge Lounge Pharmacy Pilots complete and sharing reports with CSS, ED and also MQSG. Further actions to be developed from this including opportunity for winter pressure funds<br>Monitoring of the change to weekend working hours ongoing – no patient harms reported to date. Presented to QIA panel 10/9. To continue monitoring and review if any significant events<br>[19/08/2025 13:35:21 Lisa Hansford] Weekend working change in practice effective as of 9th August which was approved through QIA and approved by QIA panel. Effects of are being monitored.<br>[22/07/2025 11:43:44 Lisa Hansford] Awaiting outcome of pharmacy workforce review, which will inform actions to be taken.<br>[23/06/2025 09:22:45 Gemma Staples] The COO commissioned a review of Pharmacy services against local and regional benchmarking against appropriate peer trusts in May 2025. First draft output of this is available to the COO on 23/06/25. Any investment case to extend to 7 day working will potentially follow the output of the review, following improvement initiatives and considering digital development.<br>[19/06/2025 12:23:32 Gemma Staples] Work force review in progress, awaiting outcome before proceeding with business case<br>[21/05/2025 11:40:04 Lisa Hansford] Workforce review in progress and all | 4 | 29/10/2021 | 21/06/2023 | 09/01/2026 |
| 2a: Enable our people to fulfil their potential through training, development and education | 4862 | 44 | Service disruption | Caroline Landon | Mooney, Mrs Katy | Smith, Charles | WORK | 22/02/2022 | 16 | Medicine | Specialty Medicine CBU | Respiratory Medicine | Trust-wide | Consultant staffing within Respiratory Medicine at Lincoln and Boston Hospital. Currently there are only 5 Substantive consultants in place at LCH and 4 at PHB. We have a vacancy of 1 for Grantham.<br><br>It is recommended by GIRFT that we have 15 substantive consultants and at this time we continue to have 9 plus 3 locum/agency. As such we not have the recommended workforce to cover all functions of our Resp Medical Team. Inpatient risk of high acuity patients without specialist input. Outpatient risk of high activity of 2ww referrals on top of high volume OP workload, delayed pathway progress / commencing treatment such as chemotherapy. Due to lists / skillset required, there is not the ability within the organisation to cross cover between sites leading to Grantham particularly being most at risk. | Due to the severity of the risk:<br><br>Currently:<br>x 5 Consultant Gaps in Resp<br><br>The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce.<br><br>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.<br><br>The CBU continue to proactively manage workforce. Rotas are stable but continue to be challenged with gaps. | Staff Survey Results.<br><br>Data Analysis through HR around recruitment and retention.<br><br>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) | 15/12/2025 | 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.<br><br>Working with Advanta / Medical Resourcing to recruit long term and improve retention of current staff.<br><br>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.<br><br>Remote working in place to support outpatients where possible.<br><br>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. | [15/12/2025 09:17:34 Charles Smith] Risk remains unchanged. Consultant establishment fundamentally below GIRFT recommended levels since 2019 with reliance on unfunded capacity. No invitation to bring necessary workforce investment case back to CRIG as does not meet criteria. Suggestion the left-shift could support this does not address fundamental gap between secondary care core demand and capacity.<br>[17/11/2025 10:03:26 Charles Smith] Risk remain unchanged.<br>[19/08/2025 14:41:06 Rachael Turner] Risk reviewed,we have 9 cons against establishment of 10 but have asked for 15 cons previously as by GIRFT recommendation that's how many we need.<br><br>Business case written at the turn of the year to this affect but wasn't considered due to system financial constraints. Risk currently to remain open at same risk level.<br>[27/05/2025 14:50:21 Rachael Turner] Risk reviewed, risk description updated to reflect current position.<br>[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.<br>[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.<br>[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).<br>[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. | 4 | 30/12/2022 | 03/06/2024 | 19/01/2026 |
| 2a: Enable our people to fulfil their potential through training, development and education | 5142 | 65 | Physical or psychological harm | Caroline Landon | Thomson, Cheryl | Lentz, Blanche | | 12/04/2023 | 20 | Medicine | Urgent and Emergency Care CBU | Accident and Emergency | Trust-wide | Within Lincoln and Pilgrim Emergency Departments there is a risk that, given increases in demand/footfall, the current staffing template for middle grade doctors overnight may not provide assurance to maintain patient safety. | Utilisation of on-call Consultant to support dependant on holistic risk. Specialty support and signposting to other directorates and providers. Full capacity protocol and boarding. | 4 hour target/12 hour breaches. Time to first assessment. Decision to admit. | 24/09/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades.<br><br>New rota templates signed off by finance, to be implemented Q3 2023. Recruitment ongoing. | [24/09/2025 13:34:14 Rachael Turner] There is no change currently as going through consultation. Risk score to remain.<br>[26/06/2025 09:27:15 Rachael Turner] Job planning instigated on the 12th June 25. Implementation October 25.<br>[03/04/2025 14:10:48 Rachael Turner] Escalation to the execs in relation to tier 2 implementation awaiting next steps to proceed towards job planning.<br>[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.<br>[03/10/2024 09:15:45 Rachael Turner] Risk reviewed, no change.<br>[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.<br>[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.<br>[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.<br>[09/01/2024 15:09:37 Rachael Turner] Risk remains the same. Increased winter slippage funding that lets us have extra middle grade shifts. Consultation due end of Feb/ March.<br>[17/10/2023 10:11:32 Rachael Turner] This remain the same due the consultation in place. This remains to go out to bank and agency until staff are recruited.<br>[26/09/2023 14:46:05 Charles Smith] Tier 2 MG consultation extended and ongoing. Mitigation via locum/bank until then.<br>[30/08/2023 11:24:12 Carl Ratcliff] will review post meeting with exec on 30th | 9 | 31/08/2023 | 01/11/2023 | 24/12/2025 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 1b: Reduce waiting times for our patients | 5267 | 485 | Physical or psychological harm | Caroline Landon | Mooney, Mrs Katy | Marsh, David | | 26/09/2023 | 16 | Medicine | Cardiovascular CBU | Cardiology | | If there is a continued delay in processing of Cardiac MRIs, which is impacted by workforce limitations and an existing backlog of scans, then it could lead to delayed assessment and treatment for patients, resulting in potential for serious harm, a poor patient experience and a poor clinical outcomes.<br><br>Cardiac MRI backlog was recorded at 278 as of the 7th April, the oldest scan being 5th December. | 1.Paper for outsourcing option submitted to exec team for consideration for sign off ( more economical than paying substantive consultants extra contractual rates) to clear backlog.<br><br>2. Locally agreed KPI's to outline number of scans to be reported within allocated PAs.<br><br>3.Undertaking additional reporting sessions - this will help significantly with the reporting backlog but not solve causal factors. At cost.<br><br>4. We now have a Radiographer that can report Cardiac MRI's independently which is approx 8 a week.<br><br>5. Additional imaging consultant recruited (starts September 2025)-joint funding from CDC/radiology<br><br>6.Backlog monitored weekly and escalated through Divisional Governance structure. | Size of reporting backlog (number/time required)<br>Average time for reporting of scans from date of imaging<br>Locally agreed KPI's to outline number of scans to be reported within allocated PAs-This is being monitored. | 31/10/2025 | 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.<br>2. Continue to mitigate proactively at cost via current controls.<br>3. planned job planning changes to give us more capacity, this will take place October 2025 (additional device consultant starting in October 25 will enable one of our part time imaging consultants to reduce ward commitments and provide more reporting capacity)<br>4. There is a possibility of mutual aid from Sherwood Forest, ongoing negotiations are taking place.<br>6. Submitted paper to the Exec Team for £35,000 for an external company to clear 200 scans from the backlog. | [31/10/2025 14:27:15 Rachael Turner] Risk reviewed, score to remain at current time but this will be reviewed in January to review position. There are currently 42 cardiac MRI scans awaiting reporting and the oldest of these is from the 3rd October (at the time 24 days). There are also 6 Cardiac MRI scans that have been reported by Cardiology but are still awaiting co-reporting by the Radiologists. The oldest of these is from the 26th September (at the time 31 days). Radiology are utilising a company called Medica to maintain turnaround times.<br>[07/07/2025 12:07:42 Rachael Turner] Risk remains, no change to risk score.<br>[09/04/2025 10:54:58 Rachael Turner] Cardiac MRI backlog was recorded at 278 as of the 7th April, the oldest scan being 5th December. Risk controls and reduction plan updated to reflect current position.<br>[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.<br>[12/12/2024 14:49:24 Rachael Turner] As of Monday 9th December:<br>•There are 266 CMR scans awaiting reporting<br>• The oldest scan awaiting reporting is from 30.09.24 (70 days)<br><br>With regard to current reporting 'performance', the number of reports per | 3 | 01/07/2024 | | 31/01/2026 |
| 1a (i) Improve patient safety | 4855 | 207 | Physical or psychological harm | Caroline Landon | Chantry, Chris | Marshall, Lisa | | 10/02/2022 | 16 | Family Health | Women's Health and Breast CBU | Breast Services | | There is a risk of delayed diagnosis of breast cancer and increased waits for treatment of confirmed cancers as a result of insufficient staffing and clinic capacity within the Breast service, Pathology and Oncology, which could lead to increased patient harm.<br><br>This could also lead to staff fatigue through the provision of additional clinics to reduce delays. | Service level agreement with Path Links<br>Cancer MDT<br>Weekly Breast capacity meetings<br>New Cancer Remote Monitoring Administrator and tracking spreadsheet in place<br>Escalation process for converting unused oncology appointments allocated to other specialties into Breast oncology appointments where possible. | Volume of referrals and clinic capacity.<br>2ww performance / average wait time for first appointments.<br>62 day performance.<br>MDT staffing levels / absence rates. | 04/12/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Exploration of creating additional capacity through redesign of clinic facilities, etc.<br>Business case to be re-reviewed and resubmitted for investment round 2026/27. | [04/12/2025 15:42:31 Nicola Cornish] Following an external review of ways of working, a trial of an alternative was commenced at Lincoln however this ceased after a week due to a significant number of concerns that were raised. Work remains ongoing within the CBU to identify other options to increase capacity.<br>[28/11/2025 15:25:26 Nicola Cornish] No update, further review meeting scheduled for 4th December.<br>[21/08/2025 14:05:13 Sarah Davy] Breast was top of ICB cancer risk register last year. Service is essential for Trust to maintain 28 day FDS performance. Risk mitigated through 2025/26 as a result of fixed term ICB SDF investment. Case to be re-reviewed and resubmitted for investment round 2026/27.<br><br>[18/06/2025 16:07:11 Gemma Staples] Quality Committee requested that risk be reviewed and the narrative made clearer. Risk description has been updated.<br>[15/05/2025 14:57:15 Nicola Cornish] Still heavily reliant on agency radiology staff, pathway development still requires further input from pathology and oncology. Additional clinic requirement for symptomatic patients has decreased due to progress made but screening still has a fluctuating level of demand due to variations in recall rate.<br>[14/04/2025 13:35:54 Nicola Cornish] Staff still undertaking additional clinics to meet demand for diagnosis. business case to increase staffing has been completed to stabilise breast workforce, await outcome.<br>[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 | 4 | 31/12/2021<br>29/12/2023 | | 04/03/2026 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5520 | 753 | Physical or psychological harm | Caroline Landon | Landon, Caroline | Constantin, Dr Carmen | | 11/10/2024 | 16 | Medicine | Cardiovascular CBU | Stroke | Trust-wide | As a result of ULHT not having a Thrombectomy centre, we have to transport patients to Nottingham. There is a risk of transfer delays for patients with acute neurological presentation suspected to be a stroke having access to a designated thrombectomy centre for consideration of mechanical Thrombectomy. This could lead to more brain cell death, increase risk to life and ultimately poor functional outcomes/severe disability. On occasions delays have been so long the offer of intervention has been withdrawn. | Attempts to streamline pathway to hold crew bring patient to Lincoln for further transfer to Nottingham however not often successful due to pathway delays. [current acute pathway QI project] Escalating to operation centre as soon as Ambulance requested for transfer if original crew already stood down/handed over. Explored option of increasing category allocated to Stroke transfers [Currently CAT2] so far despite regional engagement Ambulance service unable to re-categorise. | Regional meetings - Integrated Stroke Delivery Network<br>M&M meetings [local & regional]<br>Datix incidents reported. | 19/11/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Action 1.<br>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]<br>Action 2.<br>Develop internal processes to escalate transfer delays more quickly. Stroke CBU/Acute team to liaise with Operations department for clear escalation process.<br>Action 3.<br>Ongoing communications/meetings with Ambulance service. Consultant stroke Practitioner liaising with ISDN & Ambulance service [Claire] ongoing<br>Action 4.<br>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? | [19/11/2025 10:36:32 Rachael Turner] Risk presented as part of Deep Dive at RRC&C, confirmed that score is appropriate at this time.<br>[12/11/2025 13:18:31 Rachael Turner] Risk remains, there is still a service in Nottingham but we experience delays with transfer.<br>[19/08/2025 12:13:00 Rachael Turner] Risk reviewed, no current changes. It has been advised that other areas are struggling more than us. We are however doing the best in performance based on Nottingham audits in the region. Risk score to remain.<br>[07/05/2025 13:05:44 Rachael Turner] Risk remains the same with no current update. We have attempted to lobby the transfer of category allocated to a 1 but this was denied by EMAS.<br>[03/02/2025 11:05:07 Rachael Turner] Risk reviewed, work remains ongoing with no change to risk scoring.<br>[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.<br>[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 | | 12/02/2026 |

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| 3c. Enhance our digital, research and innovation capability | 4641 | 18 | Service disruption | Daren Fradgley | Fradgley, Daren | Gay, Nigel | Emergency Planning Group | 23/11/2021 | 16 | Corporate | Integration and Improvement | Digital Services (ICT) | Trust-wide | If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs | National policy:<br>- NHS Digital Data Security Protection Toolkit (DSPT) and Guidance<br><br>ULHT policy:<br>- Telecoms infrastructure maintenance arrangements<br>- ICT hardware & software upgrade programme<br>- Corporate and local business continuity plans for loss of access to ICT systems & system recovery<br><br>ULHT governance:<br>- Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC)<br>- 5 year capital plan<br>- | - Network performance monitoring<br>- Digital Services reported issues / incidents<br>- Monitoring delivery of digital capital programme<br>- Horizon scanning across the global digital market / supply chain to identify availability issues | 13/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | - Prioritisation of available capital and revenue resources to essential projects through the business case approval process.<br>- Working with suppliers and application vendors to understand upgrade and support roadmaps.<br>- Assurance mechanisms in place with key suppliers for business continuity purposes<br>- Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks.<br>- Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates. | [13/10/2025 12:35:08 Rachael Turner] Following collective review the digital team determine that this overarching risk remains a 16 due to the combination of risks that contribute to this higher level risk. The individual risks that support this risk are being regularly updated and contain the detail around the specific actions and mitigations resulting in an overall reduction across a number of risk areas but due to the significance of a digital infrastructure event and the impact on Trust operations, this risk continues to be managed at current level. At this time the downward trajectory would indicate that by the end of this financial year, work will have completed to a point where this overarching risk score will begin to reduce.<br>[30/06/2025 19:05:24 Rachael Turner] Work is continuing to commission the two new locations at Lincoln and on the building of the new data centre at Pilgrim Hospital. Work is also planned this coming year 25/26 to develop new second rooms at Louth and Grantham as well as refresh the current spaces. A contract has been awarded to replace fibre cabling on Trust sites, new fibre has between the new data centre has been run and fibre work has started at Lincoln to run new fibre out to end cabinets around the site, work will follow on other sites, as the new locations come on line.<br>[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.<br>[27/01/2025 09:42:07 Rachael Turner] Work is continuing to commission the two | 4 | 31/03/2023 | 31/03/2023 | 13/01/2026 |
| 1a (i) Improve patient safety | 5651 | 871 | Physical or psychological harm | Caroline Landon | Chester-Buckley, Sarah | Rigby, Lauren | | 07/05/2025 | 16 | Clinical Support Services | Cancer Services CBU | Oncology | Trust-wide | As a result of East Midlands Cancer Alliance Centre for Psycho Social Health having temporary funding for the level 4 Psychological Oncology support service until the 31st August 2025 they currently don't have any substantive funding beyond this date. This means this service will cease as well as the delivery of level 2 psychological support to our specialist teams which would lead to an increase in Psychological distress and harm that potentially could lead to physical harm to the cancer patients of Lincolnshire so therefore having a knock on effect to patients and ULTH staff as this will increase the expectation on specialist staff who are currently only trained to level 2 psychological support and lead to moral injury and burn out due to circumstances outside of their scope of practice and no services to refer onto. | Urgent meetings are taking place between EMCA, ICB and the Mental Health Trust in Nottinghamshire.<br><br>We have Macmillan psychologists who can provide level 4 support to Bostonian and Waddington – funded until February 2026. (The Levels are the complexity of psychological support Level 4 requires specialist input from a psychologist we can only train staff up til level 2 (CNS). The Mac ones are an inreach they only have capacity for the two inpatient areas due to resource etc) | Datix<br>Complaints<br>Cancer Performance targets | 11/12/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | ICB having conversations regionally - awaiting outcome - Lauren Rigby - January 2026 | [11/12/2025 12:24:36 Gemma Staples] An update has been received from East Midlands Cancer Alliance Centre to say that patients referred 5 months ago are now getting appointments.<br>[14/11/2025 08:45:39 Gemma Staples] Risk remains the same. Ellie Sadler has informed me today that a meeting should be taking place next week which may provide further information as to next steps. Waiting list remains high at 16 weeks.<br>[04/08/2025 11:07:18 Gemma Staples] Risk reviewed and remains the same. The waiting time is currently 14 weeks for this service.<br>[06/06/2025 10:16:59 Gemma Staples] Risk approved as a 4x4 at RRC&C on the 04/06 with the request that the risk description includes that this risk has a knock on effect to our patients and staff. Risk updated and approved by Helen Shelton.<br>[07/05/2025 13:28:09 Gemma Staples] Risk approved at CSS Cabinet on 15/04/2025. Update: East Midlands Cancer Alliance (EMCA) Psychological Services provides our temporarily funded support, which finishes in August, although no Comms received, as yet. It is a big risk for Cancer patients in Lincolnshire, as they will not have access to this specific support. Psychological distress will therefore increase for this cohort of patients due to inability to refer them, if this service stops. Currently in discussion as we currently have Macmillan Psychologists but they cover the wards one day a week as their remit does not cover Outpatients, which is approximately 238 including supervision support to staff increasing this to thousands. Without this support and Level 2 training which they currently provide free of charge, this will have a knock-on effect. Will raise, as a risk at the Cancer Board but our organisation needs sight of this because of the huge impact it will have on our patients. Scored as 16: severity agreed as 4 but likelihood to be reconsidered. | 4 | 07/05/2026 | | 11/03/2026 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5533 | 754 | Physical or psychological harm | Caroline Landon | Mooney, Mrs Katy | Constantin, Dr Carmen | | 07/11/2024 | 16 | Medicine | Cardiovascular CBU | Stroke | Trust-wide | As a result of being unable to provide specialist assessment and investigation to people whom have had a suspected TIA within 24 hours [in line with guidelines] this may result in subsequent stroke due to a delay in intervention/treatment. Stroke may cause lifelong disability or death. | Reviewing patients as soon as we can in clinic and arranging investigations to coincide with clinic appointment [limited to imaging slots allocated per day]<br><br>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<br><br>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<br><br>Datix review of hospital admissions with stroke symptoms post TIA clinic referral and not yet seen | 12/11/2025 | 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.<br><br>Area to assess patients perform clinic plus access to imaging [carotid dopplers & Head imaging in a timely manner- SDEC approach]<br><br>Responsible divisional/service managers | [19/11/2025 10:42:33 Rachael Turner] Risk presented as part of Deep Dive at RRC&C, mitigations to be looked at that are currently in place to look at lowering the current score. Risk to be reviewed and brought back to Risk Confirm and Challenge.<br>[12/11/2025 13:16:51 Rachael Turner] This risk is to currently remain, there are currently ongoing discussions around admin staff as any losses may effect pathway. There has been an improvement we are currently between waiting within 3-5 days.<br>[19/08/2025 12:10:50 Rachael Turner] TIA pathway has begun last week, this is in the early stages of a new process. Risk currently to remain at same score, we will assess again in November.<br>[07/05/2025 13:03:30 Rachael Turner] Still not up and running on TIA pathway, general wait times are coming down possible due to new TIA coordinator in place. Date yet to be confirmed for TIA pathway go live.<br>[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.<br>[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 | | 12/02/2026 |

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| 2a: Enable our people to fulfil their potential through training, development and education | 5469 | 697 | Service disruption | Colin Farquharson | Rinaldi, Dr Ciro | Chablani, Manish | | 21/06/2024 | 16 | Corporate | Medical Director's Office | Medical Education | Trust-wide | As a result of Pharmacy struggling to budget and recruit into the role whilst there are budgetary provisions on the medical education side there is a risk that without adequate educators we would fail to deliver the curriculum across the entire clinical years for years 3,4 & 5 which would lead failure of our contractual requirements and this would bring into question our newly gained status as a teaching hospital. | We are currently liasing with the Pharmacy department around the appointment of a part time prescribing skills lead. This would be a 50/50 appointment shared with the pharmacy team | Meeting reviews. | 16/09/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Increase the workforce, investment into staff and education | [16/09/2025 14:14:36 Rachael Turner] Risk remains the same, no further updates. Multiple talks with LCHS, they to remain in a difficult position to recruit because of job/budget freezes. Awaiting an update from Ashok around an update with any meetings with ULTH pharmacy department.<br>[19/05/2025 12:04:21 Rachael Turner] Risk reviewed, no current change, risk remains at current level.<br>[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.<br><br>[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.<br>[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.<br>[31/07/2024 13:24:09 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk. | 8 | 21/06/2025 | | 16/12/2025 |
| 1c: Improve productivity and deliver financial sustainability | 4658 | 17 | Reputation | Jayne Warner | Warner, Jayne | Willey, Karen | Digital Hospital Group | 10/01/2022 | 20 | Corporate | Trust Headquarters | Corporate Secretary | Trust-wide | If the Trust does not have a defined records management framework/ strategy it runs the risk of not meeting national best practice and not making informed decisions in relation to Digital programmes of work.<br><br>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.<br><br>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.<br>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.<br><br>Reports of unmanaged records found in Trust locations. | 08/09/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments.<br>Needs to link into 365, ePR and EDMS Programme.<br>365 cannot be delivered with dedicated Records SME resource. | [19/11/2025 10:08:07 Fiona Hobday] Position remains the same currently.<br><br>Hope for movement in quarter 4 as part of service re-design.<br>[08/09/2025 10:56:10 Rachael Turner] Risk reviewed, mitigation remains and score is accurate<br>[28/04/2025 14:09:57 Fiona Hobday] Is a growing area of importance due to EPR, EDMS, personnel file issues etc... Lack of an SME is a challenge.<br><br>Work ongoing to look at structure and resource for a future role as part of portfolio restructures under Group. Awaiting transfer of funding from Digital projects.<br><br>Decision to procure an EDMS that can't (and won't ever) include corporate records mgmt is a missed opportunity for the Trust.<br>[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.<br>[16/01/2025 10:50:39 Rachael Turner] Risk reviewed, consideration of Records Management resource taking place through development of Executive structures.<br>[22/10/2024 09:20:44 Fiona Hobday] Still awaiting answer from Digital re money for resource.<br>Move to national tenant has began- no SME to support.<br>Project to procure scanning provider has started- no SME to support.<br>EMDS project reaching contract award- no SME for any implementation. | 4 | 28/06/2024 | 31/12/2025 | 06/03/2026 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 4741 | 42 | Service disruption | Caroline Landon | 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.<br>Oncology is considered to be a fragile service due to consultant oncologist gaps.<br>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.<br>Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung, urology, HPB<br>Clinical oncology - head and neck, skin, breast, Urology, Including testicular, upper GI (RT only).<br>Due to only consultant covering Sarcoma retiring we will no longer have consultant cover for sarcoma from July 23.<br><br>Particular areas of concern are Chemotherapy Lead.<br><br>The workload is also unmanageable for current staffing levels of Middle grade/ACP workforce therefore adding to the fragility of the Oncology Service. Currently unfunded for LCH OAU. SPA time not able to be adequately given | Medical staff recruitment processes<br>Agency / locum arrangements<br>Extra clinics offered<br>Unable to cover sarcoma due to no capacity/specialisation so this is now picked up by NUH<br>Job plans continuing to be reviewed<br>Recruited at risk over and above budget to support service<br>Support offered through on-call consultant, this is not adequate due to their workload. | Monitoring tumour site performance data<br>Datix incidents<br>Complaints and PALS<br>Outcome from Staff Survey results<br>Financial constraints of group | 18/09/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Need to undertake a fragile service review - Awaiting Trust new process for Fragile Service Review - Sarah Chester-Buckley - April 2026 | [18/09/2025 11:19:33 Gemma Staples] Further investment is still required to remedy this risk.<br>[18/07/2025 11:00:02 Gemma Staples] Vacancy control now in force within the Trust, CRIG not excepting Business Cases which are not funded by charitable funds therefore unable to proceed at present therefore risk remains the same.<br>[16/04/2025 10:05:30 Gemma Staples] Vacancy control now in force within the Trust, CRIG not excepting Business Cases which are not funded by charitable funds therefore unable to proceed at present.<br>[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.<br>[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.<br>[23/09/2024 09:58:14 Gemma Staples] Following the CSS Confirm & Challenge meeting it was agreed to combine this risk with 5180.<br>[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.<br>[23/04/2024 13:04:41 Gemma Staples] Risk reviewed and no further update<br>[05/04/2024 10:41:51 Gemma Staples] Risk reviewed. No further update<br>[05/04/2024 10:38:06 Gemma Staples] Consultant Oncologist workforce capacity<br>[18/01/2024 11:26:42 Gemma] Oncology rightsizing paper currently being written.<br>[14/09/2023 16:04:46 Rose Roberts] Ongoing<br>[28/06/2023 14:43:05 Rachael Turner] Following this risk being discussed at RRC&C meeting, the question was raised around the number of patients currently waiting to be seen (including overdue) These are as follows: | 4 | 31/03/2023 | 31/03/2023 | 18/12/2025 |

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| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5306 | 713 | Physical or psychological harm | Caroline Landon | Cooper, Mrs Anita | Rambani, Reena | Patient Safety Group | 28/08/2024 | 20 | Clinical Support Services | Path Links (Pathology) | Microbiology (Pathology) | Trust-wide | As a result of the inadequate resource of Microbiologists provided via the service contracted from NLAG, there is inadequate specialist input to ULH for complex cases or reviews on the correct use of high risk treatments used. This would lead to patient care being unsafe and can result in harm including death. It would also lead to extended hospital stays, readmissions, poor bed flow affecting access to Acute NHS care, increased morbidity and increases risk of antimicrobial resistance as a Public Health threat which harms our patients further.<br><br>There are severe restrictions to prescribers accessing Microbiologist Specialist advice as it is now limited to Registrars, Consultants, Advanced Nurse Practitioners and GP level only that can access. This is resulting in patients being managed without the specialist required input, including for complex cases. Due to lack of Microbiologist capacity there is no pro-active input either in the form of Microbiologists undertaking regular ward rounds in high risk areas, no offer of call-backs, no Microbiologists delivering educational sessions, poor input in revising antimicrobial guidelines and no Microbiologist action on anti-microbial consumption trends in a timely manner. | Currently being directed through Consultant Antimicrobial Pharmacist within own working hours and remit as and when they are able to do so.<br>Being flagged at various forums.<br>Regular communication and reminders about availability of Antimicrobial team and guidelines and any resources available.<br>Draft Business case for Microbiologist Consultant currently in progress. | Through antimicrobial consumption and surveillance<br>Audit results<br>Specialist time input from Antimicrobial Team<br>Survey Pending<br>Infection prevention & control surveillance and audits | 09/09/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Trust to review Microbiologist contracting - as a matter of urgency – Ian Fulloway – December 2025<br><br>Antimicrobial Guidelines being revised to for both ULTH and NLAG – Balwinder Bolla – March 2026 | [09/09/2025 15:18:14 Gemma Staples] Risk reworded and remains the same due to limited resources and demand remains the same.<br>[16/06/2025 11:55:54 Gemma Staples] The risk remains unchanged.<br><br>Royal college of Pathology workforce Survey suggest a median of 5.6–7.2 infection consultants per 1,000 acute beds. In our case, we have an establishment of only 6 WTE Consultant Microbiologists covering two acute NHS Trusts – NLaG and ULHT – with a combined bed base of over 2,000, in addition to diagnostic support for GP surgeries across Lincolnshire, North Lincolnshire, and North East Lincolnshire.<br><br>Currently, we have 4 substantive consultants and 2 long-term locums. Even if all posts were filled substantively, we would still fall below recommended levels.<br><br>The Microbiology service is under significant pressure due to rising demand for infection services, increasing antimicrobial resistance, and workforce shortages. Consultant microbiologists are critical for infection prevention and control (IPC), diagnostic stewardship, and antimicrobial stewardship (AMS), both in hospital and community settings. However, the current workforce is stretched beyond capacity.<br><br>Consultant microbiologists often cover multiple hospital sites, provide 24/7 support, and manage increasingly complex clinical and diagnostic workloads. This contributes to staff burnout and compromises service resilience and patient safety.<br><br>There is an urgent need to expand the consultant microbiologist workforce. | 4 | 30/11/2025 | 01/06/2025 | 09/12/2025 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 4868 | 64 | Physical or psychological harm | Caroline Landon | Bassi, Sangeeta | Martinez, Francisca | Maternity & Neonatal Oversight Group | 01/03/2022 | 16 | Clinical Support Services | Pharmacy CBU | Pharmacy | | Preparation of Drugs for Lower Segment Caesarean Section (LSCS).<br>1. Medicines at risk of tampering as prepared in advance and left unattended.<br>2. Risk of microbiological contamination of the preparations.<br>3. Risk of wrong dose/drug/patient errors.<br><br>Breach of Medicines Act:<br>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.<br>Regulation 214 permits parenteral administration of medicines by or in accordance with the directions of and appropriate practitioner.<br><br>This practice would constitute a risk to the patient and falls outside of expected governance arrangements detailed in Advice Note for Chief Pharmacists March 2017 NHS Pharmaceutical Quality Assurance Committee which defines acceptable practice as: administration immediately after (within 30 minutes) preparation and completed within 24 hours. It is noted the Trust Injectable Medicines Policy is in compliance with this expectation. | No current processes in place to minimise risk<br>Policies do not support this practice | Incidents involving advance preparation of intravenous medication in clinical areas.<br>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. | 17/11/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | 1. Use of tamper proof boxes/trays being purchased - April 2026<br>2. Risk assessment reviewing practice - LMM Feb 2026<br>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. April 2026 LMM<br>4. Safer medicines audits to be completed Dec 2025 Lisa H | [17/11/2025 11:51:43 Lisa Hansford] 3 labour theatres will be audited in Dec 2025 - LH<br>[20/08/2025 10:07:58 Rachael Turner] Risk discussed as part of the RRC&C Deep Dive, conversations have started with the anaesthetic team. Policy is being in looked at to be in line with national guidelines. Looking at closing this by end of January. Key will be monitoring compliance.<br>[19/08/2025 14:37:49 Lisa Hansford] MSO in discussion with clinical team to explore opportunities for improving safety and security of process.<br>[19/06/2025 10:46:19 Gemma Staples] Our plan is to audit current practice, complete risk assessments, confirm boxes to purchase for them, review any other mitigations that arise, agree with Chief Pharmacist the way forward and monitor through S&S - Completion date August 2025.<br>[10/04/2025 09:48:32 Lisa Hansford] Escalated to SPMM for progress update.<br>[09/01/2025 14:22:58 Lisa Hansford] No update<br>[10/10/2024 10:10:14 Lisa Hansford] No further update<br>[10/07/2024 11:13:39 Lisa Hansford] no further update<br>[04/04/2024 09:02:51 Lisa Hansford] NO FURTHER UPDATE<br>[29/12/2023 13:33:55 Lisa Hansford] No further update<br>[26/09/2023 14:17:01 Rachel Thackray] Meeting to take place to review progress<br>[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<br>[27/06/2023 09:45:38 Alex Measures] Discussed in risk register review meeting- no further updates<br>[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<br>[04/05/2023 14:26:40 Lisa Hansford] needs to go back to MQG | 4 | 30/09/2022 | 31/03/2023 | 17/02/2026 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5617 | 854 | Physical or psychological harm | Caroline Landon | Uplohn, Emma | Rayner, Gemma | Women's Health and Breast CBU | 24/03/2025 | 20 | Family Health | Obstetrics | | | As a result of insufficiencies within the current maternity services triage system, there is a risk that not all pregnant individuals will be able to access safe and timely care, which could lead to harm to the mother and baby.<br><br>A recent MNSI Escalation of Concern notification highlighted 'insufficient triage processes in place to support safe care for mothers' and 'evidence of the Trust gate keeping access to acute care'. The trust is in the process of looking to adopt the BSOTS model for triage which is the nationally recognised standard for an individualised, 24 hour service.<br><br>Despite an agreed temporary uplift in staff of 2.52 wte B6 for LCH and 2.73 wte for PHB, there is still insufficient midwifery and medical staff to fully implement BSOTS.<br><br>In addition to patient harm, there is also a financial risk to delivery of CNST year 7 due to business case for 12.1wte uplift in line with BR+ establishment review is still undecided. If 12.1wte uplift is not approved the trust will not be compliant with CNST yr 7 and risk loosing the CNST rebate monies. | • Lead midwife for triage appointed September 2024 to lead the implementation of BSOTS, action plan has already been developed to support this. Initially fixed term for 12 months due to complete in September 2025, within the Business case this has been asked to extend to a substantive position.<br>• Uplift of staff on both sites for a designated triage midwife to provide a 24 hours service. 2.75 WTE for PHB and 2.25 WTE for LCH.<br>• Maternity specific triage training is being delivered to core triage midwives and HCSW in line with BSOTS methodology to help improve the safety for women and babies. This training will then be rolled out to all maternity staff during the role out of the BSOTS pathway.<br>• Communications issued to all staff outlining a clear directive to all maternity staff emphasising that women should not be discouraged from attending triage based on criteria such as membrane rupture or the number of prior telephone calls. We are moving to Badgernet maternity IT system late Spring 2025 which has a BSOTS specific triage to be followed improving compliance.<br>• A business case has been submitted to consider a staffing uplift in line with 2024 Birthrate Plus (BR+) establishment review data which equates to 12.1 WTE midwives. | MNSI reporting<br>Audit<br>Currently women are seen in a timely manner by a midwife but the medical review is often delayed due to not having dedicated 24 hour medical cover for triage. | 04/12/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Conducting a full audit of triage cases from the past three months to identify trends and assess the impact of our interventions.<br>Implementing a patient feedback system to evaluate the effectiveness of the changes and enhance the overall maternity experience.<br>Continuing our collaboration with MNSI, ensuring that insights from the final investigation report are integrated into our maternity care strategy.<br>Progress with the triage action plan is monitored through the Maternity and Neonatal Safety Improvement Plan (MatNeoSIP) and reported through to the Maternity and Neonatal Oversight Group (MNOG) with upward reporting to the Group Quality Committee. | [04/12/2025 13:27:36 Nicola Cornish] Following approval at CRIG, the business case was put forward to the ICB however they have declined the request on 3 occasions. The short term funding for the uplift from the Trust is only until March 2026 so additional conversations are required with the ICB for service delivery plans from April onwards.<br>[05/09/2025 14:51:44 Nicola Cornish] Business case was presented to CRIG and the uplift of 12.2WTE was approved. Awaiting formal confirmation of this decision prior to commencing recruitment.<br>[03/07/2025 14:09:11 Nicola Cornish] Business case has been written and seals of approval obtained - due to be presented to CRIG on 29th July and then submitted to the ICB for values framework assessment.<br>[30/04/2025 14:25:13 Nicola Cornish] There is a continued risk due to current establishment vacancy. Additional shifts are being picked up by substantive staff to fill current templates, further recruitment is ongoing to appoint into the uplift vacancy. Expected recruitment by September 2025.<br>[30/04/2025 12:51:59 Nicola Cornish] Discussed at RRC&C meeting on 30/04. Gemma Rayner explained that we are currently not following national recommendations and this has recently been highlighted by MNSI as part of an intrapartum stillbirth investigation. Uplift of 12.1WTE midwifery staff across both sites would be needed to effectively implement BSOTS system and a business case has been submitted for this. However there will also need to an increase in medical staffing to support implementation - need to reflect that in this risk and also add in CNST implications. Risk scoring approved subject to these amendments in wording. | 4 | 30/06/2025 | | 04/03/2026 |

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| 2b: Empower our people to continuously improve and innovate | 4935 | 58 | Service disruption | Caroline Landon | Farquharson, Colin | Daniels, Mrs Samantha | Workforce Strategy Group | 26/05/2022 | 16 | Surgery | Theatres, Anaesthesia and Critical Care CBU | Critical Care | | Insufficient medical staffing in Intensive Care Units at Lincoln and Boston. Uncovered shifts may result in Unit being decompressed. Medical staff asked to work extra hours compromising workforce directive. Unsafe cover in Unit when doctors are called to attend patients in A&E. Could result in harm to both patients and staff (in terms of wellbeing/morale). | Rotas are set and monitored by a Consultant who formulates the rota and identifies gaps which cannot be covered in advance.<br>Staff are being offered paid in TOIL for any additional sessions undertaken in order to minimise additional budgetary impact.<br>Escalation to Divisional Triumvirate to request agency cover when gaps cannot be filled by existing staff.<br>Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy.<br>Business Continuity Plans are in place for both sites. | Monitoring of gaps in rotas<br>Agency spend reporting<br>Datix incidents recorded | 25/09/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Recruitment to vacant posts. | [26/09/2025 15:10:25 Nicola Cornish] Risk reviewed, no further update.<br>[04/06/2025 13:55:04 Nicola Cornish] Discussed at RRC&C meeting on 4th June. This risk has been ongoing for some time and it is recognised that there is now a need to look at alternative staffing options to mitigate the risk. As such recruitment is now underway for CESR (Certificate of Eligibility for Specialist Registration) trainees.<br>[15/05/2025 10:38:01 Nicola Cornish] Recruitment is ongoing, with interviews scheduled for July.<br>[21/02/2025 13:00:38 Nicola Cornish] Risk reviewed, no change.<br>[11/09/2024 14:27:43 Nicola Cornish] Risk reviewed, no change.<br>[14/06/2024 13:17:32 Nicola Cornish] The JD has now been approved and the consultant post is currently out to advert.<br>[28/05/2024 14:47:03 Nicola Cornish] No further update<br>[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<br>[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.<br><br>[15/06/2023 09:32:33 Wendy Rojas] No change to risk status.beds capped at x8 L3<br>[18/04/2023 13:52:46 Caroline Donaldson] No change in risk status. Bed base number remains at x8 Level 3 beds.<br>[09/01/2023 14:27:52 Caroline Donaldson] No change in status - still remains an issue. Bed base numbers remain reduced at x8 Level 3 beds.<br>[29/11/2022 15:16:01 Caroline Donaldson] 17/11/2022 Discussed at TACC CBU | 4 | 31/10/2022 | | 25/12/2025 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 4769 | 759 | Physical or psychological harm | Caroline Landon | Rojas, Mrs Wendy | Arya, Nityanand | WORK | 14/01/2022 | 15 | Surgery | Surgery CBU | Vascular Surgery | Pilgrim Hospital, Boston | As a result of insufficient staffing and ultrasound equipment within the Vascular lab at Pilgrim, there is a risk that patients may not receive time-critical scans within the expected timeframe resulting in missed diagnosis and delay in treatment. This could lead to severe patient harm such as amputation or death. | Recruited a 4th Vascular Scientist to ensure appropriate staffing levels at all times.<br>3rd ultrasound machine loaned from Clinical Engineering on a limited time basis only as it is out of warranty - must be returned in February 2026.<br>Occupational Health and EAP support available to staff in post. | Staffing levels / vacancies for Vascular Scientists<br>Incident reporting | 19/11/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Business case developed for the purchase of a 3rd ultrasound machine. | [19/11/2025 09:46:52 Rachael Turner] Risk presented at RRC&C meeting 19/11/2025 number of people being scanned and capacity has increased significantly. Scans can not be outsourced. Risk validated for increase in score 4x4:16 High Risk.<br>[06/11/2025 13:49:16 Nicola Cornish] Increase in risk score has been approved by cabinet.<br>[06/11/2025 13:48:53 Nicola Cornish] Risk description, mitigations, actions and scoring reviewed fully with Mr Arya and Justine Judd. When the risk was raised initially, this was scored in relation to service disruption and the patient harm element was not accurately reflected.<br><br>The risk description has now been updated to reflect the severity of patient harm which may result from delays in scans. Some of these patients are AAA patients awaiting follow up scans and if their scan is delayed there is a risk that deterioration is not identified and the aneurism could rupture, which is associated with a 50% in-hospital mortality and an average mortality of 90%. There are also patients with lower limb bypass that are awaiting duplex scans, and a delay in these scans could result in graft occlusion not being identified in a timely manner, leading to major amputation (above or below knee) being required.<br><br>The waiting list has now increased to 693 patients and the wait time has increased to 7 months (currently booking patients from March 2025 referrals). Additionally, one of the sonographers is due to go on maternity leave at the beginning of December so the team will be operating with 3 members of staff again. The additional machine which has been on loan from Clinical Engineering must be returned in February 2026, so there will only be two machines available | 16 | 31/08/2021 | 30/04/2023 | 19/02/2026 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5495 | 725 | Physical or psychological harm | Caroline Landon | Upjohn, Emma | Bond, Rachel | Estates Infrastructure and Environment Group, Patient Experience Group | 07/08/2024 | 16 | Family Health | Women's Health and Breast CBU | Obstetrics | Lincoln County Hospital | Lack of adequate provision for appropriate clinical care of bereaved families within Obstetrics at Lincoln County Hospital. There is a risk of psychological harm due to hearing labouring women and crying babies, and having to share facilities with mothers and their new-borns. | Have allocated a room on labour ward to care for the women, which is not within the centre of the labour ward and has its own en-suite facilities.<br>Women not to be moved to Nettleham ward at any point during their admission. | Incident reports<br>PMRT reviews<br>Patient complaints | 23/10/2025 | 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. | [23/10/2025 15:08:09 Nicola Cornish] Procurement processes are underway - we are awaiting a preferred supplier to be confirmed and it is anticipated that the refurbishment work will be able to commence soon after this.<br>[25/07/2025 10:40:46 Nicola Cornish] Charitable funds have been requested to assist with refurbishing the room currently used to make this a more comforting environment for bereaved parents to be in.<br>[12/06/2025 14:24:09 Gemma Staples] Quality Committee asked if the risk can be reviewed as they believed the work had been done. Emma Upjohn confirmed that the risk remains the same on the LCH site. The works are being planned, but not commenced yet.<br>[01/05/2025 15:26:56 Nicola Cornish] Charitable funds are working with team at Lincoln to redesign room 4, although complete sound-proofing is unlikely to be possible.<br>[24/01/2025 10:32:31 Nicola Cornish] Discussions are still ongoing with Facilities on how the room can be sound-proofed.<br>[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.<br>[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.<br>[07/08/2024 10:27:39 Nicola Cornish] Plan to enhance facilities in a designated room on labour ward to improve patient experience with current confinements. | 4 | 07/08/2025 | | 23/01/2026 |

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| 1d: Provide modern, clean and fit for purpose care settings | 5334 | 533 | Physical or psychological harm | Caroline Landon | Upjohn, Emma | Gould, Georgina | | 26/01/2024 | 15 | Family Health | Women's Health and Breast CBU | Obstetrics | Pilgrim Hospital, Boston | There is no second theatre within the confines of the labour ward within which to undertake any theatre based procedures when Theatre 8 is already in use.<br><br>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.<br><br>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.<br><br>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.<br>Out of hours – on call maternity manager available for support.<br>Dedicated theatre available in ground floor theatre.<br>Close monitoring of labour ward activity.<br>Publication of Standard Operating Procedure (SoP)<br>Labour Ward Manager / Matron / Labour Ward Obstetric Lead to have an awareness of all theatre cases.<br>Visible management and Leadership/active on call support to teams<br>PMA support | Closely monitor all cases where woman transferred to theatre before or following birth – daily Medway report for scrutiny.<br>Regular review of Incident reporting system. | | 23/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | To inform teams of the risk controls in place.<br><br>Coordinate Estates to undertake the works on Theatre 8a to minimise disruption as soon as practicably possible. | [23/10/2025 15:10:36 Nicola Cornish] Risk reviewed, no change and monitoring of impact is ongoing. Routine investigation of PPH incidents has identified areas for improvement in communication between maternity and theatre teams and steps have been taken to strengthen joint working arrangements.<br>[24/07/2025 15:43:53 Nicola Cornish] No further update, no adverse incidents being reported.<br>[01/05/2025 15:25:19 Nicola Cornish] Risk reviewed, no change.<br>[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.<br>[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.<br>[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.<br>[09/07/2024 16:09:21 Nicola Cornish] This is ongoing, it is being be picked up as part of overall refurb at Pilgrim.<br>[04/04/2024 10:33:53 Nicola Cornish] Risk reviewed, no change.<br>[31/01/2024 13:01:35 Rachael Turner] Risk discussed at RRC&C meeting 31/01/2024. Need to know frequency when this is happening. Agreed currently that this sits at a 4x4: 16 High Risk. Link to be added around regulations. | 6 | 01/01/2025 | | 23/01/2026 |
| 1a (i) Improve patient safety | 4843 | 57 | Physical or psychological harm | Colin Farquharson | Farquharson, Colin | Farquharson, Colin | Medicines Quality Group | 19/01/2022 | 20 | Corporate | Medical Director's Office | | | As a result of the ICB's non-commissioning of Senior Medical Immunology expertise within Lincolnshire, there is a risk that medication will be prescribed, supplied and administered by ULTH healthcare staff without clear senior medical input for clinical review, monitoring, and escalation, for the IVIG patients that reside within Lincolnshire. This could lead to patient harm (inappropriate treatment and risk of adverse drug reactions including when switching molecules, inappropriate treatment duration), reputational damage, and is a professional, and regulatory risk. There is also a financial risk as ULTH will be unable to switch patients in accordance with the national NHSE IVIG framework by September 2025 because the is no expert clinical review of the patients. | NHSE Immunoglobulin clinical commissioning policy<br><br>Local Immunoglobulin Panel (IAP) and Sub regional Immunoglobulin Panel (SRIAP) | Patient incidents and complaints reported through Datix<br>National framework switch being completed/not completed in time by September 2025<br><br>Financial enabler scheme/CIP targets being met/not met by December 2025<br><br>Monthly contract challenges from NHSE (challenge value and non-payment accrued)<br><br>Monthly KPIs monitored by sub regional IVIg panel (SRIAP)<br><br>Monthly KPIs monitored by local IVIg panel (ULTH IAP) | | 29/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Work with ICB to either employ an immunologist or have a local agreement with a neighbouring Trust to access senior immunologist input - Sunil Hindocha/Colin Farquharson - August 2025<br><br>Shared Care arrangements and prescribing accountabilities to be reviewed - Sunil Hindocha/Colin Farquharson - August 2025 | [29/10/2025 15:50:21 Rachael Turner] COO has reviewed and asked if this risk can please move from Group COO to Group Chief Medical Officer.<br>[19/06/2025 22:55:24 Gemma Staples] Risk reviewed and reworded.<br>[17/04/2025 10:21:23 Rachael Turner] To mitigate this risk we continue to seek advise with colleagues in Nottingham. This risk continues to be monitored<br>[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.<br>[02/09/2024 17:26:56 Gemma Staples] Risk agreed to sit under COO - now amended<br>[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.<br>[22/07/2024 12:54:39 the reporter] 22/07/2024 - Risk reviewed ad reworded with Fran. To discuss risk with Sarah Chester-Buckley.<br>[09/07/2024 09:17:09 Gemma Staples] Incident reviewed and requires review on the incident. Gemma to meet with Fran to update the risk.<br>[26/06/2024 09:36:19 Gemma Staples] Colin suggested this should still sit under CCS still under Haematology instead of Pharmacy as they are more likely to be administering the care. Now amended<br>[04/04/2024 08:50:30 Lisa Hansford] no progress<br>[29/12/2023 13:42:16 Lisa Hansford] No further update<br>[26/09/2023 14:14:06 Rachel Thackray] Progress ongoing with regard to shared | 4 | 01/10/2021<br>31/07/2023 | | 29/01/2026 |
| 3c. Enhance our digital, research and innovation capability | 5245 | 19 | Service disruption | Daren Fradgley | Fradgley, Daren | Humber, Michael | | 30/08/2023 | 20 | Corporate | Integration and Improvement | Digital Services (ICT) | Trust-wide | The Trusts disaster recovery capabilities are limited. In the event of a major incident affecting the primary data centre/site the ability to restore services elsewhere is limited. This would affect the availability and data integrity of tier 1 clinical and corporate systems, leading to extended unavailability and reliance on Business Continuity Plans. In addition there is a risk of significant data loss in the event that recent backups are unavailable or compromised. | -Business Continuity Plans which the Trust is planning to exercise of a regular basis via Emergency Response.<br>-Annual SIRO approved incident response exercise.<br>-Protections that reduce the likelihood of various disasters, including environmental and technical controls:<br>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.<br>-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.<br>-Incidents reported via Datix these are backed up via an RCA and lessons learned. | | 15/08/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Whilst some systems still need to transition fully with VLAN/IP changes we do have new systems and system upgrades migrating to the new solution.<br>Enabling Tech programme in place to improve the Trust Foundations from which the Digital Services will run. This requires completion prior to remobilisation of EPR. Trajectory for this is 2025/26. | [16/09/2025 14:21:37 Rachael Turner] Work continues to mature the Rubrik backup capability, with recovery testing now occurring on a regular basis.<br>Risk score should remain as is due to the continued targeting of backups by threat actors in malicious cyber attacks.<br>[10/06/2025 11:59:10 Rachael Turner] Development of the overall Digital Services BIA and BCP has progressed with both documents now under review by the Digital Services senior leadership.<br>Rubrik continues to be progressed along with assignment of system tiers against all servers.<br>[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.<br><br>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.<br>[19/09/2024 16:39:50 Rachael Turner] This risk is linked to risk 575. In that we have commissioned the Rubrik product that manages our backup processes and also keeps an immutable copy in the cloud which allows restoration to anywhere. This system is being refined with Operations to prioritise systems into P1, P2,etc for DR instances and provide a plan for recovery if a complete or partial lose of infrastructure is felt.<br>[14/08/2024 21:12:12 Rachael Turner] Work has been ongoing for a while to purchase and install a new backup and recovery tool. This is now in place and has been commissioned, it provides both on site and cloud capability and also immutable capability. This provides for a much more hardened and capable | 10 | 30/08/2024 | | 15/11/2025 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 2a: Enable our people to fulfil their potential through training, development and education | 5154 | 88 | Regulatory compliance | Colin Farquharson | Simpson, Mr Andrew | Hansford, Lisa | | 17/04/2023 | 16 | Corporate | | | Trust-wide | The Trust currently does not have a Medicines Management or Intravenous Drug Training package on ESR. Previous Medicines management training was removed when the ESR software was changed. Usually all new nurses will be required to complete the medicines management training as part of the mandatory training. This is to support them to be able to administer medicines to patients. Without a robust Medicines management training package staff will not have access to the r Medicines Management training that has previously been available, which is not in line with Trust standards. This could potentially lead to harm to our patients from medication incidents, we will not be adhering to CG174, NG29, SG1 and QAPPS minimising injectables risk. Risk of breaching CQC regulation 12: Safe care and treatment also | All staff will have had undertaken some level of medicines management as part of their professional qualification, however standards are inconsistent and not aligned to trust standards. National (CG174, NG29,SG1) and Local policies and guidance indicate that training should be available to staff to support in administration and safe medicines management. Additionally won't be compliant with QAPPS in relation to minimising injectable medicines risks. CQC regulation 12: Safe care and treatment all indicated training should be available. None currently in place in the Trust. | Reported incidents<br>Staff feedback on training and support available in staff surveys. Inspection feedback | 17/11/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | The Medication Safety Team have written the Medicines Management & Controlled drugs training packages. ESR team have developed the draft programmes, and these are being amended as feedback and comments are received. Plan is to then trial and take to APPG for approval before going live - Lisa Hansford July 2025 | [17/11/2025 12:52:12 Rachael Turner] Risk to be presented at December RRC&C for closure.<br>[17/11/2025 11:57:29 Lisa Hansford] IV therapy passport, medicines management training and CD training packages now live on ESR. Supporting clinical education with face to face training. Risk can now be closed<br>[19/08/2025 14:35:13 Lisa Hansford] Awaiting outcome of NMAFF approval 22nd August<br>[06/08/2025 09:36:54 Gemma Staples] The training package is not on ESR yet, hoping once been through NMAFF group at the end of August that it will be on early part of Sept.<br>[19/06/2025 10:25:39 Gemma Staples] Awaiting update from Lovelyn Ndubuisi Okoroezi by 20th June.<br>[21/05/2025 10:58:02 Lisa Hansford] ESR packages now in draft and will be going out for feedback in the next few weeks. The next step will be to get approval from APPG.<br>[10/04/2025 10:07:11 Lisa Hansford] MM package is close to completion and will be added to ESR once the draft has been circulated to clinical leads. CD package will be next to be created.<br>[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.<br>[10/10/2024 10:14:02 Lisa Hansford] Awaiting packages to be uploaded to ESR<br>[10/07/2024 11:11:57 Lisa Hansford] no further update<br>[04/04/2024 09:01:18 Lisa Hansford] Still awaiting this package to be uploaded to ESR<br>[29/12/2023 12:57:50 Lisa Hansford] Awaiting education and training team to upload to ESR | 8 | 31/03/2025 | | 17/02/2026 |
| 1d: Provide modern, clean and fit for purpose care settings | 5136 | 10 | Physical or psychological harm | Mike Parkhill | Davies, Chris | Tennison, Vincent | Health and Safety Group | 28/03/2023 | 20 | Corporate | Estates and Facilities | Estates | Trust-wide | Following monitoring for Nitrous/Entonox Oxide levels in Pilgrim and Lincoln (Theatre and Maternity Units), it was identified that in a number of locations, staff were exposed to higher levels of nitrous oxide where levels exceed the Workplace Exposure Limit (WEL) OF 100 ppm (8hr time weighted average (TWA)). | 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.<br>Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had failed and was deemed beyond economical repair and a decision had been made not to replace (no one is aware of why this was made or by whom). Estates plan to reinstate the ventilation, where feasible, which will likely include partial refurbishment and deep clean of existing systems.<br>N.B the use of sampling tubes to monitor Nitrous oxide levels can be highly time and place dependent, the person with the sampling equipment and their activities, can indicate exposure levels that are as a result of human error, not as a failing of the environment. As such G210 analysers specifically designed for highly accurate measurement and verification of the quality of piped N2O and O2 gases, are being sourced. | -COSHH assessments and training.<br>-Health Safety Environmental and Welfare Operational Audit programme.<br>-Direct involvement with Occupational Health.<br>-Datix incident reporting. | 21/11/2025 | 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.<br>Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as:<br>1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece<br>2. Staff positioning relative to exhaust N2O and the direction of ventilation flow<br>3. Turning gas and air off when not in use<br>4. Unplugging regulators from outlets when not in use<br>5. Monitoring the condition of equipment for leakages.<br>These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health.<br>ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training. The Team provide support with the Health Safety Environmental and Welfare Operational Audit programme. | [21/11/2025 12:44:40 Rachael Turner] Meetings taken place with the Chair of MGPS, Maternity and Health & Safety. Chair of MGPS has sought advice with the Head of Occupational Health, who has advised that a occupational hygienist is required to suitably and sufficiently monitor the workplace exposure to entonox. Health & Safety team are exploring potential options and shall present to the maternity team. Additional to this an e-learning training package is being explored as well with ELOD.<br>[06/10/2025 10:43:49 Rachael Turner] Risk has been re-drafted with a new Moderate scoring. Risk will be agreed at Estates Governance and then this risk will be presented at Risk Confirm and Challenge for closure and new updated risk agreed.<br>[04/07/2025 13:01:35 Rachael Turner] Work currently being undertaken to review this risk for possible closure and replacement with new risk looking at estates CBU perspective. Update to be provided.<br>[17/03/2025 12:54:09 Rachael Turner] There is a trail in place for monitoring equipment but there are current issues around acquiring data from the software. Pipes for nitrous is being removed. We have purchased a small LEV system which will support air changes in the room, if successful this will be rolled out across all maternity wards.<br>[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.<br>[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<br>[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. | 10 | 28/03/2024 | | 21/02/2026 |
| 1d: Provide modern, clean and fit for purpose care settings | 5234 | 510 | Service disruption | Caroline Landon | Lynch, Diane | Biddulph, Victoria | | 25/08/2023 | 15 | Clinical Support Services | Diagnostics CBU | Neurophysiology | Pilgrim Hospital, Boston | As result of the Emergency Department new build project, Pilgrim (PHB) H block was demolished and therefore clinical space was taken from Neurophysiology. No EEG or EMG service is provided at PHB currently. No Inpatient provision for testing at PHB. Inpatients requiring tests have to be transferred by hospital transport to Lincoln County for testing therefore there is a delay in treatment which would lead to patient harm and additional stress caused to patients having to travel to another location. | Adhoc bookings of space available within Outpatients at PHB. Booked where and when possible.<br>Inpatient being transferred to Lincoln (although this is taking staff off wards in Pilgrim) | Waiting times<br>Travel times<br>Patient Feedback<br>Datix Incident | 20/11/2025 | 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 2026 | [20/11/2025 09:29:48 Gemma Staples] Risk reviewed and remains the same.<br>[19/08/2025 16:07:52 Gemma Staples] Currently awaiting quotes from Estates so no further update.<br>[29/05/2025 16:51:00 Gemma Staples] Estates have presented specification options to the Head of Service. Once requirements agreed then estates to gather quotes for works required.<br>[25/02/2025 11:19:15 Gemma Staples] Neurophysiology had a meeting on 15/01/2025 with Capital Projects Team, awaiting further update.<br>[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.<br>[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.<br>[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<br>[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.<br>[31/01/2024 11:37:43 Rachael Turner] Risk discussed as part of the Deep Dive at RRC&C meeting 31/01/2024. Risk score reviewed and updated to 4x4:16 High risk.<br>[11/12/2023 13:05:50 Gemma] Risk reviewed. No change<br>[13/09/2023 12:20:09 Maddy Ward] From an estates point of view, there is no plan to restart the service. This has been passed to project manager in estates to review clinical space (chased today). A suitable sized, permanent room is | 4 | 26/08/2024 | | 20/02/2026 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 1a (i) Improve patient safety | 5614 | 825 | Service disruption | Caroline Landon | Fulloway, Mr Ian | Woods, Mr Michael | | 04/03/2025 | 16 | Clinical Support Services | Diagnostics CBU | Audiology | Trust-wide | As a result of Increasing demand on referrals to the service, the Paediatric Audiology Service not meeting the Paediatrics Quality Standards and the consequence of the requirement to attain UKAS IQIPS accreditation, due to insufficient staffing, capacity and lack of soundproofing rooms (the room at Boston has recently been condemned after IQUIPS benchmarking visit which has reduced capacity further) there is a risk of 1) an increase in waiting times which is a causing a delay in patients being seen and a delay in treatment which could lead to long term patient harm and risk of litigation and 2) the risk of the Trust not attaining accreditation which could lead to Audiology losing the contract for Paediatric Services in Lincolnshire. | Audiology team are undertaking work to bring the service up to this standard by updating or developing new policies, operating procedures and work instructions to meet the new Paediatric Quality Standard requirements. This is causing capacity pressures as staff are having to be taken out of clinical time due to the work involved in revising the required documents.<br><br>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.<br><br>Clinics are pausing during testing while noise levels abate.<br><br>Clinic dates have been amended to quieter clinic days.<br><br>Insert earphones used for greater attenuation of external sounds. Paediatric room layout reviewed to reduce reverberation.<br><br>Soundfield testing has been stopped at Pilgrim site for paediatric under 5's and defined complex patient group. With other children groups if ear specific information not obtained then patient transferred for testing at Lincoln site in soundproof facilities.<br><br>Development of business case to provide Gold standard soundproof facilities at Pilgrim site to reduce the need for cross site referral. The service is Investigating an | Standards met<br>Waiting times report<br>Action plan review and UKAS initial assessment report.<br>(This is relating to IQUIPS)<br>Environmental sound levels measured between patients and at times of testing.<br>Recent training identified reverberation risks which cannot be measured Facility will not meet stage C calibration standard for freefield testing hence test stopped.<br>Monitor numbers of patients being transferred and action plan for impact as data is recorded. | 15/12/2025 | 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<br><br>Development of Case of Need / Business Case to increase staffing and improve facilities to Gold Standard at all sites - Michael Woods - August 2025<br><br>Action planning from the UKAS Benchmarking visit is underway - Michael Woods - August 2025<br><br>Review of waiting list currently underway - Michael Woods + Victoria Biddulph - August 2025<br><br>Reviewing with Procurement options around temporary booth hire as an interim resolve for the CoN for refurbishment – this is not possible without significant investment in enabling works - Michael Woods + Clare Wright – September 2025 | [15/12/2025 10:11:43 Gemma Staples] Additional space identified at Lincoln site, potential room for Grantham paediatric Booth and forward movement on Boston CDC to work with Estates to look at additional facilities. Recent E&Y review identified additional paediatric team staffing required. Current Vacancy out to interview with potential for training additional paediatric post if suitable or to back fill adult service to free additional clinics for paediatrics team if facilities are funded. Risk to Quality standards and Accreditation still high due to additional impact of RTT and DM01 recovery targets on the demands of the service<br>[18/09/2025 13:21:22 Gemma Staples] No possibility of providing sound proofing to standard for Pilgrim site rooms, Grantham space identified for additional Booth, funding case to be developed, funding source required with appropriate staffing. Potential inclusion for Boston CDC to provide facilities and additional staffing for Boston area patients. Papers still in development to look at demand and capacity required for recovery. Papers going to GLT to raise awareness of the issues within Paediatric Audiology. Additional 13 long waiter children identified to be Datix'd and reviewed. Changes in QIA process slowing recruitment to B6 vacancy.<br>[24/06/2025 13:24:48 Gemma Staples] We have not been able to source a locum paediatric Audiologist, we have just appointed a temporary support post to Bank, but that's only short term for part time hours in a supporting role and will have to go through the full Trust process to appointment<br>No movement on the paperwork due to the increased clinical demands on the service.<br>Case of need still in progress + paper being written to support insourcing.<br><br>Review of waiting list on hold due to staff shortages due to the vacancy freeze.<br>Temp booth hire and installation at Pilgrim site is not possible without significant | 4 | 31/03/2026 | | 16/03/2026 |
| 1a (i) Improve patient safety | 5002 | 535 | Service disruption | Caroline Landon | Farquharson, Colin | Edwards, Mrs Jill | Palliative/End of Life Care Oversight Group, Patient Experience Group | 23/08/2022 | 16 | Clinical Support Services | Cancer Services CBU | Specialist Palliative Care | Trust-wide | As a result of the Specialist Palliative Care service being severely under resourced we are not being compliant with the Health Act, NHS England Service specification, NICE guidance and integrated care systems. There is a deficit in access and inequity to specialist palliative care for patient's, care partners and other health care professionals. This will result in patient harm including delays in assessment, increase length of stay, readmissions and dying outside of preferred place of care. | Daily caseload review and triage of caseload using PEOL OPEL reporting measures with sitrep for escalation of risks<br>Daily palliative huddle with key partners to support demand<br>Working as one team across sites to provide pan trust cover<br>Senior leadership for direct support to PEOL at ULHT by addition of deputy lead nurse for PEOL<br>Workforce plan to identify gaps in alignment with national policy and guidance completed<br>Service improvement gap analysis<br>Internal and external ask for multi disciplinary support to the SPC team.<br>Working with Clinical Education to deliver the training<br>PEOL Champions in place across the Trust and undertaken a training event with them<br>Involvement in systemwide PEOL Operational meeting to promote improvements across services<br>NACEL action plan completed | Frequency of referrals outside SPC referral criteria<br>Frequency of referrals that require more information for triage<br>Datix incident / HPF's<br>Complaints/concerns<br>Frequency of patients died/discharged before seen<br>Frequency of patients dying outside Preferred place of death<br>Frequency of first assessment (over 24hrs) from service KPI's.<br>SPC workforce review including staffing deficits and skills gap analysis<br>Daily OPEL level<br>Frequency of support needed by teams from SPC | 01/12/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Business Case written and awaiting CRIG invitation - Sarah Chester-Buckley - April 2026<br>Development of SPC SOP, job plan for CNS & business continuity plan - Jill Edwards - March 2026 | [01/12/2025 13:36:39 Gemma Staples] Locum Consultant appointed for 1 year, end date May 2026. Funding approved for 1 year. We have had 15 hours Band 7 budget repurposed to allow for 22.5 hour CNS post.<br>[08/09/2025 14:54:31 Gemma Staples] Increased absence within SPC CNS and annual leave with no headroom in budget has made staffing challenging and frequently left gaps where there is no face to face service on 1 or more sites. Concerns escalated and best contingency put in place to support most urgent need however, additional risks associated with remote cover only e.g. having to give remote advice and not review patient or have MDT approach to their care.<br>[02/06/2025 16:27:49 Gemma Staples] Education delivered to Palliative champions, Internationally educated nurses and now supporting HCSW band 2-3 training. SPC team working towards being recognised as fragile service. Awaiting new framework from Division. SOP in draft format and being circulated. Progress slow due to fragility of service and time for staff to focus on development.<br>Proposed withdrawal of Macmillan in-reach role has been noted as a risk. This risk will be monitored closely.<br>[25/02/2025 09:58:09 Gemma Staples] Business case progressing to next steps and with Business Manager<br>Fragile service documentation being completed – Target March 2025<br>SPC updating SOP and options paper to explore how best to use the resources we have available. – target April 2025<br>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<br>Palliative champions forum March 2025 to support education across organisations.<br>[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 | 4 | 30/12/2024 | | 02/03/2026 |
| 1a (i) Improve patient safety | 5095 | 59 | Physical or psychological harm | Caroline Landon | 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.<br><br>8 years ago, venous access within the Trust was classed as central lines (internal jugular insertion) and cannulas. Peripheral central catheters (PICC) were undertaken occasionally for oncology patients and portacaths and Hickman lines were done in theatre, as they still are. The vascular ACPs started to learn how to insert picc PICC lines starting from one morning clinic on a Tuesday (supported by the Consultants). The needs for PICC increased and we went to two full day clinics in a week. They were only inserting in pilgrim at that time. It was then determined that Total Parental Nutrition (TPN) needed to be given centrally and not peripherally, and the work load increased two fold. A business case was successful for a 1.0 WTE band 6 venous access nurse to take on the clinics as the work load for the ACPs was also increasing. The Royal College of Radiologists state that a PICC line should be inserted with 72 hours. However, due to the varied nature of why a line is required particulary for urgent cases this has been deemed locally as 24 hours. | At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering:<br><br>- Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients<br>- Pilgrim clinics Tuesday and Thursday, both in and outpatients<br>- 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.<br><br>Case of Need has been written with final finance input outstanding to then go to CRIG<br><br>ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable.<br><br>Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources. | Volume of requests against number of staff and time taken to acquire<br><br>IR1 submissions - started to see an increase in incidents being reported. | 27/11/2025 | 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<br><br>6 month secondment for a PICC nurse has been advertised and will require training<br><br>Give consideration to training of a wider network of clinicians associated with their individual service needs | [27/11/2025 14:02:04 Nicola Cornish] Risk remains the same. A business case is currently being written.<br>[23/09/2025 15:08:52 Nicola Cornish] No further progress, a business case is required for expanding the team.<br>[05/06/2025 14:45:39 Nicola Cornish] Discussed at specialty governance meeting on 4th June. New substantive nurse started last week and has a 3-6 development plan to learn how to insert PICCs so increased capacity will not be available until after she has been signed off for this and an additional HCA is in place to support her. Need to relook at the business case and how this can be progressed.<br>[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.<br>[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.<br>[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.<br>[29/10/2024 08:53:09 Nicola Cornish] Risk reviewed, no change.<br>[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.<br>[31/05/2024 12:07:02 Nicola Cornish] Business case needs to be reviewed before presentation to CRIG. Looking at funding sources across other divisions as it is a Trust wide service. 6 month secondment has been extended to end of March 2025.<br>[28/05/2024 14:48:51 Nicola Cornish] No further update<br>[23/10/2023 11:25:05 Nicola Cornish] Extended secondment until end of March 2024, approval and QIA for business case are ongoing<br>[03/05/2023 10:26:45 Rachael Turner] Following further quantitative data | 1 | 01/06/2023 | | 27/02/2026 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1d: Provide modern, clean and fit for purpose care settings | 4648 | 2 | Physical or psychological harm | Mike Parkhill | Parkhill, Michael | 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.<br><br>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:<br>- Regulatory Reform (Fire Safety) Order 2005<br>- NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03)<br><br>LCHG policy:<br>- Fire Policy (approved by FEG / FSG Aug 25)<br># Personal Emergency Evacuation Plans (PEEPs), reviewed 2025<br>- Fire safety training (Core Learning, annual) / Fire Warden training / Fire specialist training - protocol approved September 25 and alignment across the Group for Fire Training, TNA in complete for Fire Safety Team review<br>- Major Incident Plan<br>- Estates Planned Preventative Maintenance (PPM) programme<br><br>LCHG governance:<br>- Trust Board assurance through Finance, Performance & Estates Committee (FPC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group<br>- All areas within the Group estate are individually risk rated for fire safety (based on occupancy, dependency, height, means of escape), which informs audit / monitoring activity<br>- Local fire safety issues register (generated from local fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team, validation by Fire & Rescue Service<br>- Weekly fire safety team meetings concerning risk assessments and risk register<br>- Capital risk programme for fire<br>- Reporting of local fire safety incidents (Datix) generated through audit programme<br>- Authorising Engineer for Fire<br>- Health & Safety Committee & site-based H&S committees | Results of fire safety audits & risk assessments, currently indicate:<br>- Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements<br>- Fire risk assessments indicate lack of compartmentation within some sleeping risk areas<br>- Age of fire alarm systems across Group (beyond industry recommendations)<br>- No compartmentation reviews undertaken to provide assurance of existing compliance (across Group)<br>- Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation)<br><br>Reported fire safety incidents (including unwanted fire | 19/11/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | - Capital investment programme for Fire Safety being implemented on the basis of risk<br>- Group-wide replacement programme for fire detectors.<br>- Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection.<br>- Fire safety protocols development and publication.<br>- Fire drills and evacuation training for staff.<br>- 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<br>- Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit.<br>- Staff training including bespoke training for higher risk areas<br>- Planned preventative maintenance programme by Estates | [19/11/2025 11:04:26 Rachael Turner] Risk presented at Risk Confirm and Challenge as part of Deep Dive. Risk remains at appropriate level.<br>[03/11/2025 12:43:10 Rachael Turner] Full risk review carried out with updates to controls. Security Team are undertaking Hot Spot High Risk Fire Safety Checks across the three acute sites and we will implement at two UTC's (Skegness & Louth) once training is complete with security staff.<br>[02/09/2025 13:51:10 Rachael Turner] storage of items on corridor has been highlighted with risk from arson, task and finish group to look at challenges formed. actions from group will report to FEG/FSG and FPC. compartmentation works with capital commence this month based upon risk areas<br>[19/06/2025 10:58:29 Rachael Turner] Emergency lighting included following assurance and PPM review. new Fire group policy reviewed within FSG prior to approval. New staff training protocol reviewed in FSG with implementation of new training programme commencing June 2025<br>[17/04/2025 09:29:19 Rachael Turner] Works continue on compartmentation within capital projects on the basis of risk. surveys being undertaken for the potential new fire alarm installation at Pilgrim within capital spend.<br>[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.<br>[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 | 10 | 31/03/2026 | 31/03/2025 | 09/02/2026 |
| 1a (i) Improve patient safety | 4789 | 32 | Service disruption | Caroline Landon | Landon, Caroline | Venugopal, Mr Vinod | | 16/01/2022 | 20 | Medicine | Cardiovascular CBU | Cardiology | | As a result of ongoing pressures to clinical staffing shortages this has led to a 40% reduction in the DMO1 performance.<br>Clinical staffing shortages have been impacted by maternity leave and lack of agency staff being available for eight months. The Trust is currently unable to fund seven day echo despite this being an NHS England requirement. The Recruitment and Retention package has not been renewed which impacts ability to recruit staff. We have been unable to staff complex Echo Lists as cardiology staff are excluded from recent band 3 uplift. Length of stay for patients is increasing due to lack of cover.<br><br>In addition we have recruited four new admin posts, however it will take around 3 months until fully trained which leads to delays in processing internal and external requests. Skegness CDC opened in November, however this can only be covered by admin 5 days a week which limits capacity. | Weekly review and monitoring of OP activity /utilisation data<br><br>Monthly data provided throughout CBU to review performance; secure any additional available capacity<br><br>Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell<br><br>All referrals are triaged to ensure appropriate | DMO1 activity - monthly review<br>Backlog consistently increasing.<br>Booking Team are now part of the Cardiovascular Division. | 31/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | -Continued recruitment process, which included current recruitment and retention package. Due to be completed April 2025<br>-Lincoln CDC is online and is staffed for seven day working<br>-Business Case is currently in process, this was submitted in November in the Investment Planning Round-this will now go through Trust Process.<br>-Review of Band 2/3 uplift job description currently with HR-cardiac physiology assistant currently unwilling to support Specialist Echos due to skill required being above band 2 pay band. Currently backfilling with trained nurses at additional cost | [31/10/2025 14:20:18 Rachael Turner] ICB have funded a further 2000 scans to maintain service provision at community diagnostic centres until end of financial year. Risk score to remain due to shortage of Cardiac Physiologists and lack of seven day inpatient service as is required to maintain level three acute services and PPCI service and have an emergency department. Current outpatient demand exceeds capacity.<br>[04/08/2025 08:42:18 Gemma Staples] Below should state 4x4(16) and not 4x4(12)<br>[23/07/2025 15:33:27 Gemma Staples] Risk increase 4x4(12) presented at RRC&C 23/07 and approved.<br>[07/07/2025 11:37:01 Rachael Turner] Risk is being presented at Risk Confirm and Challenge this month for increase in score.<br>[09/04/2025 10:30:32 Rachael Turner] Risk updated to being a service disruption risk. Currently performance is 58.24%. A paper has gone to the exec team via HR requesting the continuation of a recruitment and retention premium for Cardiac Physiology staff. This is due to a nationwide shortage in this field. NHSE have only funded 3000 scans to be done in the community diagnostic centres which will mean the ULTH acute service will have to pick up the shortfall (3200 approx).This will result in an increase length of stay for inpatients and outpatient waiting list will increase causing further strain on the service and its staff. Due to this current position risk to be requested for increase in score to 4x4:16. This will be presented in May.<br>[26/02/2025 13:20:40 Rachael Turner] Risk presented at RRC&C as part of the Deep Dive 26/02/2025, risk to be reviewed looking at in as a service disruption risk and score reviewed to reflect. It can then be returned to RRC&C for re-scoring.<br>[24/02/2025 11:56:57 Rachael Turner] Risk reviewed, risk description and risk | 4 | 01/02/2024 | 31/03/2023 | 31/01/2026 |
| 1d: Provide modern, clean and fit for purpose care settings | 4725 | 466 | Reputation | Caroline Landon | Taylor, Ruth | Taylor, Ruth | Health and Safety Group | 13/01/2022 | 20 | Clinical Support Services | Therapies and Rehabilitation CBU | | Lincoln County Hospital | As a result of prolonged and unresolved estates related issues, including temporary relocation of Occupational Therapy staff into Physiotherapy Department and the decanting of the Rehabilitation Medicine Team into reduced and unsuitable space at Lincoln County Hospital, staff and patients continue to be affected by environmental and infrastructure shortcomings. These include overcrowding, poor temperature control and ventilation, inadequate clinical and patient facilities, and general deterioration of furnishings and building systems. Despite being approved as a temporary measure, the situation has remained unresolved for over 12 months. There is a risk that the ongoing substandard working and treatment environment will result in reputational damage to the organisation, stemming from negative staff and patient experiences and perceptions. | Legislation:<br>- Health & Safety at Work Act 1974<br>-Management of Health & Safety at Work Regulations 1992 associated guidance.<br><br>ULH policy:<br>- Health & Safety Policy & related guidance<br>- Health & safety training (Induction, Core Learning, Core Plus Learning and CPD)<br>- Estates Planned Preventative Maintenance (PPM) / testing<br>- Occupational Health services<br><br>ULH governance:<br>- Health & Safety Committee / site-based H&S Forums; accountable to Trust Board through Finance, Performance & Estates Committee (FPEC)<br>Frequent escalations to Estates Team for repairs<br>Increased use of flexible working policy<br>Site visits by senior Exec Team members<br>Frequent escalations through Governance processes<br>Ongoing review of space<br>Curtains in place in the clinical area which will increase clinical space, which will also reduce noise levels.<br>Staff who want to come to work in their uniform are doing so<br>Hot desking room created in the department<br>Increase in laptops provided so staff can go and work on the wards<br>New site lead office to increase space in the department<br>Bookable clinic room procedure made more robust<br>Use of onsite facilities for meetings | IPC flo scores / Monthly audits<br>Datix incidents<br>Staff surveys / leavers feedback<br>Staff concerns / complaints<br>Complaints / PALS<br>H&S audits<br>Walkaround with Estates and log jobs | 04/12/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Work with Estates to identify better facilities – Ruth Taylor – April 2026<br><br>Business Case is required to implement any service move to another space – Rebecca Johnson – April 2026 | [04/12/2025 14:36:03 Gemma Staples] Health & safety review took place 26 November 2025 as a result of rat infestation in the department. Outcome of the report is that the Estate is not fit for purpose to deliver patients clinics or for staff to work from. Currently sourcing alternative Estates with little success. Staff have been asked to hot desk and work form home. Have moved all clinics were possible to alternative space. However it is likely clinics will be required to be cancelled due to no space to deliver our services.<br>[03/11/2025 12:27:12 Gemma Staples] Therapies and rehab med service manager working with Lauren Boden from estates team and Outpatient Therapy Service Lead to review previous information sent re room size requirements and requirements for clinic requirements across all localities based on forecasted activity requirements and current resource capacity. Walk around of dept by Lauren Boden to be completed. Draft plan for therapy hub requirements document shared with Lauren. We have one rehab med consultant who is escalating his reluctance to continue to work in the current environment who is liaising with Outpatient Team in conjunction with service manager to look at solutions for his clinics. Risk remains same.<br>[24/10/2025 11:08:36 Gemma Staples] A meeting has taken place with Estates to review this risk who also have an existing risk for this, which is also being monitored and reviewed in-line with the group risk management process. Risk currently remains the same.<br>[30/07/2025 16:57:07 Gemma Staples] Following RRC&C meeting on 23/07 for an increase in scoring for risk 5428. It was asked that the risk be taken away and include the wording of the deteriorating situation and liaise with Chris Davies. We reviewed all risks and identified this risk is the same risk so have merged them both together and updated the wording of this risk to combine both risks together. A meeting is to be arranged with Estates. | 4 | 31/03/2022 | 31/03/2023 | 04/03/2026 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 1a (i) Improve patient safety | 4646 | 66 | Physical or psychological harm | Caroline Landon | Landon, Caroline | Gibbins, Donna | Patient Safety 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:<br>- NICE Guideline NG115 - COPD in Over-16s: diagnosis and management<br>- NICE Quality Standard QS10 - COPD in Adults<br>- British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV<br><br>ULHT policy:<br>- Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting<br>- NIV-trained clinical staff<br>- Dedicated NIV beds (Respiratory wards)<br><br>ULHT governance:<br>- Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine<br>- 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<br>- Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins<br>- Start time for NIV <60mins from Arterial Blood Gas (ABG)<br>- NIV progress for all patients to be reviewed (once NIV commenced) < 4hours<br>update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings | 24/09/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP):<br>1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV.<br>2. Provision of ring-fenced beds for NIV.<br>3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards.<br>4. Provision of NIV service (ED) which meets the BTS Quality Standards.<br>5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards.<br>6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt. | [24/09/2025 09:28:31 Rachael Turner] Risk continues to be monitored with accurate controls. No current change. Risk score remains at current level.<br>[12/06/2025 10:19:08 Rachael Turner] ED still not following process which is going outside of safety measures, which causes a negative effect on the NIV audit. This remains to be at both Lincoln and Pilgrim but more so at Pilgrim, Patient safety incidents continue to be reported around appropriate usage, equipment, exclusion/inclusion criteria for treatment, ongoing monitoring and usage of an already robust NIV pathway to Respiratory teams.<br>A study day was put on for ED staff, however not been able to move forward as for national standards they need to be exposed to starting off NIV and have a competency. ED are currently looking into how they can put in place this competency. In the meantime the teams need to follow the current policy which is not happening. Due to this this risk needs to remain at current High Risk score of 16.<br><br>[29/04/2025 14:38:43 Rachael Turner] Escalation has been made, we agreed that NIV & ED meetings need to be set again due to lack of engagement.The policy remains until education is delivered. Three more attempts will be made for these meetings if this fails this will be escalated again to PRM.<br>[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.<br>[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 | 4 | 31/12/2024 | 24/12/2025 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5216 | 362 | Physical or psychological harm | Caroline Landon | Cooper, Mrs Anita | Brown, Paula | Patient Safety Group | 14/07/2023 | 12 | Clinical Support Services | Cancer Services CBU | Radiotherapy | Trust-wide | As a result of various staffing issues including: Lack of engineer staff for equipment maintenance; Lack of radiotherapy physics staff for weekday and bank holiday run-ups; Lack of radiotherapy physics staff for on-call run-ups; Reduced radiographer numbers; Key staff members leaving the Trust; Increased workload in radiotherapy and radiotherapy physics. There are risks of delivering the necessary patient workload and not always being able to start treatment on time, Increased cancellations. poor morale, long term sick leave and staff leaving their post which could lead to an inability to meet cancer waiting times target, increasing waiting lists, poorer patient experience, poorer patient outcomes and impact commissioning of new equipment. | 1) Continue to pro-actively manage activity and capacity to mitigate workload; delaying patients where necessary<br>2) Review possible breaches to avoid<br>3) Train additional staff to help with pressured parts of the service where possible<br>4) Maximise use of existing technologies | Cancer Waiting Time targets<br>Datix Incidents<br>Staff sickness<br>Staff Survey<br>Cancellation of appointments<br>Activity reporting | 12/11/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | We will seek funding for some supernumerary salary support for radiation engineers in the coming years – Patrick Downes – April 2026<br><br>Business Cases will be developed to meet service needs – Patrick Downes – April 2026<br>Review duties and service needs to balance staffing against service needs. This could lead to a business to recognise the need for more staff due to service demand - Patrick Downes – 30 November 2025<br><br>Recruit to vacant posts as soon as possible - Patrick Downes - December 2025<br><br>Staffing review - Patrick Downes - November 2025 | [12/11/2025 14:31:59 Gemma Staples] New staffing guidance is due out soon the can be benchmarked against for staffing levels for radiographers, Physics staffing is still low so this risk is still appropriate with regards to that. Job matching for some roles is still ongoing<br>[26/09/2025 08:58:35 Gemma Staples] Risk reviewed and reworded.<br>[17/09/2025 13:58:27 Gemma Staples] Risk approved as a 4x4(16) at RRC&C on 17/09/2025 with the request that waiting times be included into the risk detail.<br>[09/09/2025 10:25:14 Gemma Staples] Recruitment of 3 B5 radiographer post underway, 1 starting 15th September with 2 others going through the recruitment process. Radiotherapy physics staffing still ongoing due to job matching delays<br>[19/08/2025 14:56:31 Gemma Staples] CSS Cabinet agreed to request to increase from a 3x4 to a 4x4. To be presented at RRC&C in September.<br>[01/07/2025 10:07:05 Gemma Staples] Job matching slow resulting in delays in recruitment. 2 staff members have left in radiotherapy physics. CRIG process for radiographer posts delayed resulting in reduced recruitment for other posts.<br>Capacity is being managed based on staffing numbers. Request for the risk to be increased from a 3x4 to a 4x4. To go to cabinet for agreement and then to RRC&C for approval.<br>[02/04/2025 16:17:40 Gemma Staples] Risk is still live and due to the trust recruitment restrictions is now even more of a problem due to the delays/blocks in recruiting staff.<br>[07/01/2025 12:43:34 Gemma Staples] Brachy physicist upgraded, other staffing still ongoing through strategy meetings and waiting for ICB SDF bids to be approved for some additional roles.<br>[10/10/2024 13:40:42 Gemma Staples] Review of staffing level on-going. Engaging with Ashley Broom to look at structure mapping. Upgrading of brachy physicist to | 4 | 30/09/2025 | 12/02/2026 |
| 2a: Enable our people to fulfil their potential through training, development and education | 5691 | 905 | Service disruption | Caroline Landon | Fullowlay, Mr Ian | Clapham, Mrs Sarah | | 19/08/2025 | 16 | Clinical Support Services | Diagnostics CBU | Radiology | Trust-wide | As a result of reduction in staffing levels within PACS team attributable to MARS which was 1WTE 8A (with 20+ years of experience), and unfilled vacancies.<br><br>This will have a significant adverse impact on service delivery across the Trust, affecting the delivery of safe patient care caused by the inability to deliver on vital projects such as Boston CDC, PACS / Web V and CRIS upgrades, importation of images to and from external parties, irefer, Phillips ROCC project, EPR, and the inability to produce data supporting monitoring of diagnostic Waiting times, inability to produce billing reports resulting in loss of income. (this list is a small representation and not exhaustive of the current PACS team workload)<br><br>Due to staffing issues and unsustainable workload there has not been the capacity to be able to cross train appropriately. Requiring the team to function on the basis of defaulting back to individual strengths in order to keep the service running, resulting in numerous single points of failure within the PACs team | All posts that are unaffected by MARS will be advertised as the QIA system allows. (No controls are in for the posts that have been approved by MARS as unable to replace). | Datix<br>Patient complaints<br>Patient experience<br>Waiting list<br>Staff absence<br>Patient attendance for appointments | 03/11/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Recruit into the vacant posts that have not been affected by MARS - Sarah Clapham - February 2026 | [03/11/2025 10:34:39 Gemma Staples] VCP panel finally approved posts, gone to advert looking to shortlist shortly, training will be difficult due to limited staffing. Simon has spent the last 3 months imparting as much process knowledge and detail as possible.<br>[17/09/2025 12:48:31 Gemma Staples] Risk approved at RRC&C on 17/09/2025 as a 4x4(16) with the request to include how many WTE we are short by, update risk of VCP approval and the additional updates Sarah provided.<br>[19/08/2025 12:23:03 Gemma Staples] Risk approved at CSS Cabinet as a 4x4 on 19th August 2025. | 4 | 31/08/2026 | | 03/02/2026 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 2a: Enable our people to fulfil their potential through training, development and education | 5467 | 695 | Service disruption | Paul Antunes Goncalves | Babu, Suresh | Chablani, Manish | | 21/06/2024 | 16 | Corporate | Medical Director's Office | Medical Education | Lincoln County Hospital | As a result of the respiratory teaching at Lincoln currently being delivered by a locum consultant (via bank), who has previously indicated they wish to retire and as there are no consultant job planned or capacity. This could result in the Trust failing our contractual requirements which would bring into question our newly gained status as a teaching hospital. | No controls in place at the moment. This risk has been escalated up to the head of Respiratory by Dr Babu DME as per Dr Chablani's request. | Workforce | 31/10/2025 | 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 | [31/10/2025 16:01:55 Rachael Turner] Risk reviewed, no change<br>[04/06/2025 13:49:40 Rachael Turner] Risk reviewed at RRC&C currently awaiting for confirmation until reduction, this will be monitored and be brought back for reduction<br>[28/05/2025 16:53:27 Rachael Turner] Risk proposed to be reduced to 3x4:12 Moderate Risk, the locum consultant did not leave, however still a risk as may leave. Risk to be presented as part of Deep Dive at RRC&C for reduction in score.<br>[19/05/2025 12:00:19 Rachael Turner] Risk to be presented as part of the Deep dive for RRC&C in May for reduction.<br>[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<br><br>[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.<br>[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.<br>[31/07/2024 13:21:11 Rachael Turner] Risk presented at RRC&C meeting<br>31/07/2024. Risk validated as a High risk score 4x4:16 High risk. | 8 | 21/06/2025 | | 31/01/2026 |
| 1d: Provide modern, clean and fit for purpose care settings | 5272 | 455 | Physical or psychological harm | Caroline Landon | Mooney, Mrs Katy | Miller, Mrs Sally | | 06/10/2023 | 12 | Medicine | Cardiovascular CBU | Cardiology | Lincoln County Hospital | As a result of the current Cath Labs coming to end of life and Lincoln Cardiac catheter lab not being connected to the emergency power supply at Lincoln County Hospital, power cuts and faults due to breakage may occur. This would lead to potentially being unable to offer a PPCI service (primary percutaneous cardiac intervention) and possible risk of patient harm, death or possible implications around infection if a patient is undergoing a procedure at a time of a power cut.<br>Parts not being able to be sourced may put inpatients for angioplasty and pacing procedures at risk and cause significant disruption across the service<br><br>In addition, Cardiology is trying to build a case for a 3rd lab due to lack and ability and being able to maintain emergencies and piece of work is being undertaken on lab efficiency to help inform the case for. Currently there is nowhere currently on the Lincoln site for a 3rd lab A large proportion of patients waiting for TAVI (Trans Catheter Aortic Valve Implantation) die of the waiting list, we require the 3rd lab to improve and maintain the TAVI service. Replacing a lab can take up to 3 months, which puts increasing pressure on the remaining labs in place. | Temporary electrical fix via Estates-UPS-however there have been mechanical failures which has required Estates to manually to change it over.<br><br>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.<br><br>Estates have stated they cannot provide power in the event of national grid power outage.<br><br>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.<br><br>-Maintenance of labs done by Siemens, however contract comes to an end 2027.<br><br>-Monthly testing carried out by estates on generators.<br><br>-Risk of Cath Labs has been escalated to board level.<br><br>-Project group for new Cath Lab now in place | Monthly audit internally (Cath Lab)<br>Incidents of power outage raised on Datix.<br><br>Log of jobs raised to Siemens recorded.<br><br>Financial efficiency project in progress. | 31/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | -Estates reviewing Lincoln site space.<br><br>Job has been raised around electrics with Estates-this may be tied in with Lab replacement.<br><br>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.<br><br>-Efficiency Project<br><br>-Case being developed for replacement of existing labs alongside options appraisal for the possibility of attaining a third lab. | [31/10/2025 15:01:44 Rachael Turner] Approval gained at CRIG for replacement of two Cardiac Catheter Labs with a view to exploring a third lab in the future if demand and efficiencies can be demonstrated.<br>[16/09/2025 14:35:45 Rachael Turner] Risk reviewed and remains at current level. This risk to be merged with existing Cath Lab risks on register to create one risk.<br>[13/06/2025 10:58:55 Rachael Turner] No current change, risk score remains.<br>[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.<br>[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<br>[02/12/2024 09:10:52 Rachael Turner] Both labs were tested this morning (29th November) simulating a power cut. Lab 2 worked as planned. During the simulated power cut screening was provided by the 3 phase UPS. When power was restored by estates lab2 reverted back to normal operation.<br><br>In Lab1 the simulation was repeated. Cath lab 1 did not perform as expected. During the simulated power cut the machine did not switch over to the UPS as expected. The power supply was struck in what Siemens call emergency by-pass. This is the same situation that happened during the last proper power cut where | 1 | 31/12/2023 | | 31/01/2026 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5491 | 701 | Physical or psychological harm | Mike Parkhill | Parkhill, Michael | Bailey, Karen | 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<br><br>Space Management Policy-this was approved by H&S Committee<br><br>IPC Action Plan to review all current areas that are being used inappropriately. | IPC Action Plan.<br>Datix incidents raised. | 06/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | IPC Action Plan has been developed and carried out identifying all areas where treatment rooms are being used with inadequate ventilation.<br><br>Estates Actions:<br><br>•Estates to progress a ventilation compliance review upon Trust approved Capital Funding.<br>•If mechanical ventilation is present – discuss / request Estates feasibility to increase air changes for treatment rooms found to have less than 10 air changes.<br>•Estates to progress environmental infrastructure remedial work upon Trust approved funding.<br><br>Clinical Division Actions<br><br>•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.<br>•Red rated treatment rooms to be a priority for relocation to a safer environment. | [06/10/2025 15:49:49 Rachael Turner] Risk reviewed 06.10.25, no change to risk<br>[18/07/2025 11:41:52 Gemma Staples] Risk reviewed and there is no further update, however attached to the risk are the latest action plans and reports.<br>[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.<br>[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.<br>[31/07/2024 13:53:50 Rachael Turner] Risk presented at RRC&C meeting<br>31/07/2024. Risk validated at 4x4:16 High Risk.<br>[22/07/2024 15:33:13 Rachael Turner] Treatment room action plan updated version uploaded with feedback from CSS. | 8 | 18/07/2025 | | 06/01/2026 |

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| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | 4778 | 94 | Physical or psychological harm | Caroline Landon | Mooney, Mrs Katy | Marsh, David | Patient Safety Group | 16/01/2022 | 15 | Medicine | Cardiovascular CBU | Stroke | | Risk of failure to meet best practice standards for stroke patients due to lack of timely access to community rehabilitation services.<br><br>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.<br><br>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.<br><br>-Teams Groups with LCH to facilitate handover.<br><br>-Joint email to narrow where referrals are directed and sent.<br><br>-Reviewing prioritise lists everyday to decide appropriate pathways for patients. This is carried out every morning at 08:30.<br><br>-Joint assessment with OT and PT to increase effectiveness and reduce time to decide which pathway is best for the patient.<br><br>-Pathways currently in place are HomeFirst, ABI referral pathway<br><br>--Working with CHC to create meeting of discussion for patients to trust each other within our assessments. | SNNAP data scores . Service provision not in top quartile | 19/11/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Stroke pathway development project on place.<br>Close partnership working within community to expedite discharges into the community | [19/11/2025 10:48:40 Rachael Turner] Risk presented at Risk Confirm and Challenge as part of Deep Dive. Risk remains at appropriate level.<br>[12/11/2025 13:24:02 Rachael Turner] We continue to struggle with lack of beds in community which causes long delays, from five up to thirty days. Training has been offered to communicate to educate what we offer as a stroke service.<br>[19/08/2025 12:14:43 Rachael Turner] We are planning by April 26 to adjust Navenby and move stroke there, this is ongoing work so risk to remain at current level.<br>[07/05/2025 13:07:54 Rachael Turner] We are currently undertaking a project called Clear which is looking at the whole stroke pathway (acute & community) with an aim for patients getting appropriate access-as and when needed. This is due to close in September.<br>[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.<br>[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.<br>[02/09/2024 11:21:16 Rachael Turner] Risk remains ongoing. No current change to risk score.<br>[26/06/2024 15:03:44 Rachael Turner] Risk presented at June RRC&C meeting. Risk validated at 4X4: 16 High Risk score.<br>[10/05/2024 14:02:56 Rachael Turner] Risk reviewed. Update to risk description and controls to reflect current status of the service. Risk score reviewed with a potential increase of score to 15. This will be sent to both CSS and Medicine Governance to be agreed before being presented at Risk Confirm and Challenge for validation of score change. | 6 | 31/03/2025 | 28/02/2023 | 12/02/2026 |
| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | 5598 | 853 | Physical or psychological harm | Caroline Landon | Landon, Caroline | Constantin, Dr Carmen | | 19/02/2025 | 20 | Medicine | Cardiovascular CBU | Stroke | Lincoln County Hospital | As a result of the consolidation of stroke services and acute service demands there has been occasions when patients requiring admission to the hyperacute stroke unit [HASU] have not had access due to capacity issues.<br><br>The HASU is often full and patients are stepped down when stable enough to enable new admissions. There have been occasions when no patient is suitable to step down therefore acute patients have been admitted to the ward area resulting in non-hyperacute monitoring due to differing staff levels and skill-mix/competences. This has been identified as a risk to patients as deterioration may be missed resulting in death or further disability. | •When HASU overspill happens, acute patients are cohorted in a bay area within the stroke unit, additional staffing is requested for increased patient acuity and monitoring requirements, staff with the most appropriate skills will be allocated to the additional acute cohorted patients.<br><br>•Medical staffing is reviewing and supporting to attempt the new admissions.<br><br>•Consultant on-call and/or ACP to ensure patients most at risk of deterioration/needing HASU treatments are allocated to HASU, and less acute/at risk patients will be allocated to the 2nd Bay for cohorted acute admissions unable to be cared for in HASU.<br><br>•If additional nursing staff cannot be allocated this will reduce the ability to mitigate risk. | Patient incidents<br>Datix<br>Staff reports/concerns voiced | 21/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Action 1: Improve capacity<br>Increase HASU capacity – ASR plans to increase 5 HASU beds to 7 – plan to be completed 2026<br><br>Action 2. Risk reduction<br>Ward co-ordinator/ward manager to liaise with site manager and CBU [lead nurse] to help support with additional staffing in line with acute patient acuity.<br>Increase staffing levels to ensure appropriate monitoring/treatments for acute patients admitted to the ward but not into HASU, attempting to assign those individuals with the most appropriate skills. Ensure middle grade doctor support if staffing capacity allows.<br>Extra staffing to be sort for upcoming shifts/up-lift nursing numbers whilst 2nd acute bay open – ward manager/ward co-ordinator to contact staff members<br><br>Action 3. Risk reduction<br>On-call Consultant and/or Stroke ACP to risk stratify patients liaising with ward co-ordinator/ward manager to ensure those most at risk of deterioration are moved into or stay in HASU and other acute patients | [21/10/2025 14:09:33 Rachael Turner] We are in the process of approving new 2nd nurse for the night shift in HASU. We have successfully recruited two consultants, one begins 30th October, the other in April 26. Risk controls updated to reflect current position. Risk score remains accurate.<br>[07/07/2025 11:35:34 Rachael Turner] Risk reviewed, risk remains at current level with no current change risk score.<br>[30/04/2025 13:15:22 Rachael Turner] Risk presented at RRC&C 30th April 2025. Due to current actions in place with ACPs, consultants skill mix this will take the score 4x4:16 High Risk. | 8 | 31/03/2026 | | 21/01/2026 |
| 1d: Provide modern, clean and fit for purpose care settings | 5695 | 906 | Physical or psychological harm | Colin Farquharson | Bardan, Ela | Bardan, Ela | | 19/08/2025 | 20 | Corporate | Medical Director's Office | | Trust-wide | As a result of an internal audit identifying that the Trust policy on maintenance of specialist equipment was not being followed and needed to be addressed, work has been undertaken and identified that a significant proportion of devices are beyond their stated manufacturer lifespan and require removal and replacement. There is a risk that ageing and inadequately maintained equipment may fail or malfunction which could lead to harm to patients, disruption to clinical services, and operational delays.<br><br>In addition, this poses a risk of regulatory action in response to the Trust not meeting statutory requirements in respect of regulation 12 and 15 from the Health and Social Care Act 2008 and Medical Device Regulation (MDR 2017/745) which would also lead to a reputational risk.<br>There is a financial risk in that unplanned use of resource will likely be needed to mitigate the risks to patient safety, regulatory compliance and reputational risk. This contributes to the risk of failure to deliver the Trust's CIP target in full for 2025-26. | 1.Devices deemed to be unsafe have been removed from use at audit point and portable suction devices were made available for clinical areas use, if needed. Some filters that were not fit for use were replaced then and there. This supports operational efficiency<br><br>2.24/07 Placed urgent compliant orders to support the replacement of devices at Pilgrim Hospital, Boston.<br><br>3.17/07/2025-24/07/2025 – Negotiated discount to have a cost avoidance of £48,964.76 +VAT against NHS Supply Chain, with an annual CIP saving for the next 7 years of £13,859,34 + VAT per year, giving a total of £97,015.41 saved over this period, to address the future finance risk.<br><br>4.Engagement with key stakeholders to accelerate actions while ensuring safety and considering financial implications. | Audit<br>Datix incidents<br>Patient complaints / PALs<br>Review of all equipment | 17/09/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Action 1:<br>Financial resource has been identified to purchase replacement medical devices for Boston only. This should lead to replacement of all affected devices by the w/c 25 August 2025.Completion Date – August 2025<br><br>Action 2:<br>Work is underway to raise finances needed to take mitigating action following receipt of the Lincoln audit findings. This remains a work in progress.Completion Date -March 26<br><br>Action 3:<br>Place an order for replacement devices at Lincoln and roll-out removal and replacement of deficient devices at Lincoln –Completion date- September 2025.<br><br>Action 4:<br>Clinical Engineering to submit a Quality Impact Analysis (QIA) to the Vacancy Control Panel (VCP) to secure approval for the recruitment of four Band 3 and two Band 4 Clinical Engineering Technicians. These roles are essential to manage the increased volume of medical gas equipment that Clinical Engineering is now responsible for across | [17/09/2025 13:40:26 Gemma Staples] Risk approved as a 4x4(16) risk at RRC&C on 17/09/2025. | 4 | 19/08/2026 | | 17/12/2025 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | 5564 | 783 | Physical or psychological harm | Caroline Landon | Landon, Caroline | Anderton, Kerry | | 19/12/2024 | 16 | Corporate | Operations | | Trust-wide | As a result of staffing not being uplifted for Hospital Out of Hours along with gaining more wards this has resulted in an increase in patients along with an increase in acuity. This has led to patients waiting for longer than they should do to be reviewed and for essential medications and fluids to be prescribed. This could result into an increase in patient mortality leading to increase length of stay, a reduction in bed flow and a negative effect of patient experience. This risk also has an effect on staff with reduced morale and increased levels of stress due to pressures. | -All clinical task requests are triaged by Hospital Out of Hours clinical coordinator who can advise the nurses on interim measures while they are waiting for their patient to be reviewed and give safety netting advice.<br>-Tasks are then triaged again by the clinician receiving them.<br>-Any tasks left at the end of shift are handed back to day staff.<br>- Staffing levels currently have at both Lincoln & Boston: 1 ACP, 1 Clinical Coordinator and 1 Clinical Support Worker.<br>-Medical staffing at Lincoln: 1 dedicated Hospital Out Of Hours F1 Doctor<br>-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<br>-Audit Nerve Centre<br>-Regional Hospital Out of Hours Network KPI's | 12/11/2025 | 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. | [12/11/2025 09:24:41 Rachael Turner] Hospital Out Of Hours currently has 1 FY1 Dr (from surgery) and 1 ACP, to cover the clinical needs of the patients across19 wards. We are currently working on an updated case of need for more staffing overnight, however as CRIG will not hear anything without an agreed source of funding this is very slow going and incredibly frustrating. The deputy COO, is currently trying to find funding.<br><br>With Louise's help we have created a QIA, EIA and options appraisal (QIA number 2025-585). The preferred option (for long term staffing security) would be to have a 2nd ACP on every night. However it takes 3 years to train an ACP, so we have asked medicine if they could 'lend' us a Dr while we are recruiting and training. We have had numerous meetings with Suresh Babu, Miss Varma and Jonathan Thomas Thompson and more recently with Cheryl Thompson. It is clear that medicine are staffed to the RCP safer staffing guidance and cannot give us a Dr. Also without a service review, they cannot provide us a locum Dr. My line manager, Catherine Capon was tasked with this review, but unfortunately is off work at present, with no current return date.<br><br>The QIA was due to be heard at the QIA panel on October. Unfortunately it was removed from the agenda 45 minutes prior to the meeting so another QIA could be discussed instead. I am currently waiting for another date for this to go to QIA panel.<br><br>[23/09/2025 09:11:04 Rachael Turner] We are currently working on an updated case of need for more staffing in the overnight period (and to expand into weekend days). We have been having meetings with Suresh Babu (medical lead for resident Dr education) Jonathan Thomas Thompson (clinical service manager, | 8 | 19/12/2025 | | 12/02/2026 |
| 1c: Improve productivity and deliver financial sustainability | 5389 | 559 | Finances | Caroline Landon | Landon, Caroline | Anderton, Kerry | | 19/02/2024 | 20 | Corporate | | | Hospital at night | Risk of overspend due to current service provision being unfunded. Also overspend due to increased sickness leading to a higher requirement for bank, agency and Overtime. Increased insurance due to increased litigation. Due to patient complaints and safety aspects. | Monthly budget reviews, and recognised overspend. | Datix, through finance reviews. | 03/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Case of Need to be heard by CRIG on the 26th March 2024, following which a business case to be submitted. | [03/10/2025 16:28:54 Rachael Turner] We are currently working on an updated case of need for more staffing to allow us to expand into weekend days, however as CRIG will not hear anything without an agreed source of funding this is very slow going and incredibly frustrating. The deputy COO, is currently trying to find funding.<br><br>A QIA has been created (with Louise Hobson from PMO) for the risks of stopping weekend working, as was requested by Nick Mulholland (Deputy Chief Nurse for Quality and Safety). This is going to be heard at the QIA panel meeting on October 14th (QIA number 2025-513)<br><br>[23/06/2025 17:18:27 Rachael Turner] Currently undergoing a service review of HOOH's. They are looking at everything; what we do, where we cover, reviewing our overnight staffing levels and the whole weekend service. We hope to go to CRIG in the next couple of months.<br>The first steps are a comprehensive review utilising Nerve centre's audit function, and surveying the resident Dr's on weekend working and how the team may (or may not) help them and their wellbeing.<br>[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.<br>[17/09/2024 10:24:21 Rachael Turner] Risk remains with no change at present.<br>[14/06/2024 11:12:21 Rachael Turner] Risk reviewed, no change at present. Risk score remains the same.<br>[28/02/2024 11:50:14 Rachael Turner] Risk presented at RRC&C meeting | 6 | 19/02/2025 | | 09/01/2026 |
| 3c. Enhance our digital, research and innovation capability | 5648 | 870 | Physical or psychological harm | Daren Fradgley | Fradgley, Daren | Humber, Michael | | 25/04/2025 | 20 | Corporate | Integration and Improvement | | Trust-wide | The Trust is currently carrying a significant number of risks associated with the reliance on paper-based health records (covered by Datix risk ID 4731) and legacy stand-alone digital systems. There is currently an inability to deliver the required level of patient safety that is enabled by technology and innovation, via more robust and consistent clinician decision making and access to the right information in the right place at the right time.<br><br>Without an integrated Electronic Patient Record (EPR) and Electronic Document Management System (EDMS) the Trust risks not achieving the key benefits outlined in the EPR Full Business Case (FBC). There is clear evidence in the FBC that an EPR can deliver significant benefits to an organisation which may be unrealistic to deliver with (paper-based systems and) stand-alone digital health systems. These include:<br><br>•Providing accurate, up-to-date, and complete information about patients at the point of care<br>• Enabling quick access to patient records for more coordinated, efficient care<br>• Securely sharing electronic information with patients and other clinicians<br>•Providing integrated evidence-based Clinical Decision Support (CDS), which allows clinicians to access relevant and focused medical knowledge, at the point of care<br>•Helping providers more effectively diagnose patients, reduce medical errors, and provide safer care<br>•Improving patient and provider interaction and communication, as well as health care convenience<br>•Enabling safer, more reliable prescribing via drug interaction and allergy alerts<br>• Helping promote legible, complete documentation and accurate, streamlined coding and billing. | There are many mitigations and manual workarounds in place to enable the organisation to work more efficiently with paper based health records and stand-alone digital health systems, such as digital tracking of paper based case notes and back office data integration between stand-alone digital health systems. However none of these workarounds mitigate fully against the adherent risk of relying on paper-based health records and stand-alone digital health systems. | The risk will be measured by bidirectional reference to this risk from Datix incidents, subordinate Datix risks and programme and operational digital clinical safety hazard logs. | 13/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | The implementation of an integrated EPR and EDMS systems, predominantly funded by the national Frontline Digitisation Programme. | [15/10/2025 10:05:17 Rachael Turner] Risk discussed as part of RRC&C Deep Dive, risk score remains at an appropriate level.<br>[13/10/2025 14:03:30 Rachael Turner] While there are currently many mitigations and manual workarounds in place, that enables the organisation to operate and work more efficiently with paper based health records and stand-alone digital health systems, such as digital tracking of paper based case notes and use of back office systems. The Trust EPR is moving into delivery as is the EDMS which will digitise paper records.<br>[04/06/2025 14:15:51 Rachael Turner] Risk presented at RRC&C, validated at 4x4:16.<br>All mitigations need to be included in controls. There are currently a number of active risks on the register in different service areas relating to stand alone digital systems and paper based records. A deep dive meeting will be organised to go through these risks and add as actions to this risk to make it an overarching risk for the Group. | 8 | 25/04/2026 | | 13/01/2026 |

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| 3c. Enhance our digital, research and innovation capability | 5519 | 739 | Regulatory compliance | Daren Fradgley | Fradgley, Daren | Evans, Thomas | | 08/10/2024 | 16 | Corporate | Integration and Improvement | Digital Services (ICT) | Trust-wide | As a result of the lack of an established Digital Clinical Risk Management system (Health IT system), processes and resource resulting in non-compliance with the Digital Clinical Safety Standards DCB0129 and DCB0160 (the Standards mandated by NHSE to ensure the safe manufacture, development, deployment, and use of Health IT Systems) this could lead to patient safety incidents involving digital systems, resulting in or contributing to patient harm or death.<br><br>An informal 'best endeavours' approach has previously been taken and digital clinical systems have been deployed that have not fully met the Standards. The Standards also mandate an approach to Clinical Risk Management which continues for the entire lifecycle of the Health IT system, not just prior to initial deployment. Under the standards, the CRMS must have proactive and reactive elements to effectively manage post deployment patient safety concerns / incidents and this element has also previously not existed within at the Trust in any formal way with a lack of formal governance and assurance for clinical safety. | •Previously no defined lead for digital clinical safety established in the Trust. The CNIO has voluntarily taken the lead on Digital Clinical Safety (Trained CSO) within their substantive role, although clinical safety responsibility not outlined in job description / role and responsibilities. However, no resource for non-project/non funded DCSO work = risk<br>•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.<br>•Digital Clinical Safety Policy now in the organisation (approved at DHG and Corp Gov – awaiting publication on the intranet)<br>•Draft Clinical Risk Management System developed by new DCSO and awaiting Clinical Governance review before formal approval at DHG<br>•Further development of required structures and governance standards to meet/comply with National standards and strengthen our position underway.<br>•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.<br>•Lack of digital clinical safety resource and no policy or standard within the Trust prior to recently created and published policy.<br>•Known new and upcoming digital projects are tracked, and activities aligned to new policy and the National standards.<br>•Previous deployments will require review and a post deployment safety assessment and remain subject to further clinical safety activities under the National standards and guidance | 04/12/2025 | 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.<br>Action 2. Continue to work towards meeting the National standards, all new projects will have the Digital Clinical Safety Standards applied.<br>Action 3. Further development of the new CRMS, embedding of associated processes and improved digital clinical safety literacy among digital, clinical, and operational teams.<br>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.<br>Action 5. Ensure effective application of Digital Clinical Risk Management activities through regular audits | [08/12/2025 13:27:34 Rachael Turner] Review of risk - additional roles being recruited to, however these roles are all temporary roles, so only support activities during a defined period of time, the resource to manage the systems within the Group are not sufficient and additional concerns are being raised around locally owned systems in departments that are not compliant and have not followed appropriate processes. The risk of harm with these systems is significant.<br>[15/10/2025 10:08:59 Rachael Turner] Risk discussed as part of RRC&C Deep Dive, risk score remains at an appropriate level.<br>[30/09/2025 12:03:22 Rachael Turner] Risk reviewed, score remains. Clinical safety resource remains very limited and supporting a high number of programmes.<br>[10/06/2025 12:19:29 Rachael Turner] Reviewed, meeting with Deputy Group Gov lead 23/05/2025 - for further review and return to risk confirm and challenge given new information and further identified issues with legacy systems.<br>[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.<br>[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: | 12 | 08/10/2025 | | 04/03/2026 |
| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | 5710 | 916 | Finances | Daren Fradgley | Fradgley, Daren | Fradgley, Daren | | 01/10/2025 | 20 | Corporate | Integration and Improvement | | Trust-wide | As a result of the size and complexity of our transformation programme there is a risk that we cant mitigate against unplanned delays or complexities which will result in a potential impact on multiple transformation programmes. | 1)Internal resources are coordinated by the Strategy, improvement and redesign Directorate and overseen by the productivity improvement and transformation oversight forum, which reports into and Finance and Performance and the Integration Committee.<br><br>2)Each transformation programme has a senior responsible officer who is accountable to the governance in item 1.<br><br>3)External resources are coordinated by executive sponsors (SRO) and report into the governance in item 1.<br><br>4)None transformation cost improvements or quality improvement programmes are monitored through the same governance in item 1, however if they relate specifically to care group actions they fall under the oversight of the performance review meetings. | 1)Each programme and associated projects have a delivery plan and benefits map.<br><br>2)The larger scale programmes have defined key performance indicators which relate to the expected progress and are monitored monthly.<br><br>3)Smaller change programmes including those that have cost improvement benefits are monitored through the performance review meetings. | 01/10/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Action 1. Review and strengthen governance structures to ensure consistent oversight and escalation<br>Lead:Chief Integration Officer Completion date: 3 months (Dec 2025)<br><br>Action 2. Standardise programme reporting templates to improve consistency and clarity<br>Lead: Director of Strategy, Improvement & Redesign<br>Completion date: 3 months (Dec 25)<br><br>Action 3. Align outputs from performance review meetings with strategic governance processes<br>Lead: Chief Integration Officer Completion date: 3 months (Dec 25)<br><br>Action 4. Conduct bi-annual data quality audits on delivery plans and KPIs<br>Lead:Chief Integration Officer Completion date: 3 months (Dec 25) | [15/10/2025 10:34:12 Rachael Turner] Risk presented at RRC&C 15/10/25. Risk validated as 4x4:16 High Risk | 8 | 31/03/2026 | | 01/01/2026 |
| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | 4780 | 74 | Service disruption | Caroline Landon | Mooney, Mrs Katy | Constantin, Dr Carmen | | 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.<br><br>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<br>•Consultant advert out<br>•Attended recruitment drive at medical conference November 2024<br>•Consultant ACP post<br>•Liaising with Integrated stroke delivery network [ISDN] for possible regional solutions | Datix/incidents/SJR/SI<br>Rota Gaps<br>Budget/costing | 19/11/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Action 1. Convert locum contacts to Bank where possible<br>Action 2. Continue to advertise for consultant stroke physicians<br>Action 3. Continue to liaise with Integrated stroke delivery network [ISDN] for possible regional solutions ?regional rota<br>Action 4. Further consultant stroke practitioner post & support Stroke registrars to become stroke consultants.<br>Action 5. Redesigned stroke pathway. | [19/11/2025 10:49:37 Rachael Turner] Risk presented at Risk Confirm and Challenge as part of Deep Dive. Risk remains at appropriate level.<br>[12/11/2025 13:14:05 Rachael Turner] Currently using locums whilst waiting for post to be filled and filled. We will continue to use after April but this will be at a lower number unless anything unexpected happens.<br>[09/09/2025 13:31:59 Rachael Turner] Risk transferred to Integration Committee and strategic objective updated to 3A.<br>[19/08/2025 12:25:24 Rachael Turner] Following People Committee feedback, this risk is still ongoing. Currently have two full consultants, we still have four vacant posts for full time (requiring six in total). A job was offered to an applicant but they are coming from overseas, there is potential but nothing concrete so this risk is to remain open.<br>[07/07/2025 11:39:58 Rachael Turner] Risk reviewed, recruitment still remains at issue due to national shortage. Risk remains at current level.<br>[11/04/2025 14:14:39 Rachael Turner] Stroke are now back to one full substantive Consultant which puts further pressure on the service. Stroke continue to advertise.<br>[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.<br>[09/01/2025 12:18:33 Rachael Turner] Risk being presented for increase in score at RRC&C this month.<br>[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.<br>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 | 8 | 31/03/2022 | 01/07/2024 | 12/02/2026 |

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| 2a: Enable our people to fulfil their potential through training, development and education | 5427 | 699 | Service disruption | Colin Farquharson | Babu, Suresh | Chablani, Manish | | 30/04/2024 | 16 | Corporate | Medical Director's Office | Medical Education | | Student report discrepancy in teaching between Lincoln and Boston site especially in HCOL and stroke where there is only one educator. To mitigate this , we plan to employ Teaching Fellows so they can offer similar amount of teaching on both sides. | We have appointed Teaching Fellow in Stroke and shortly will do so in HCOL. | Workforce | 25/11/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Increase the workforce, investment into staff and education | [25/11/2025 10:57:09 Rachael Turner] This risk remains the same, funding from undergraduate is still available, awaiting funding and a compatible job plan from the division.<br>[14/08/2025 15:48:30 Rachael Turner] Risk reviewed, specialty teaching fellow for HCoLL – this remains the same.<br>[19/05/2025 12:07:47 Rachael Turner] Risk remains at current position, no change to current score.<br>[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.<br>[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.<br>[10/06/2024 15:43:27 Gemma Staples] Request for the handler to be amended from Catherine Wormington to Dr Maish Chablani.<br>[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 | 25/02/2026 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5003 | 342 | Physical or psychological harm | Caroline Landon | Farquharson, Colin | Edwards, Mrs Jill | Patient Safety Group | 23/08/2022 | 16 | Clinical Support Services | Cancer Services CBU | Specialist Palliative Care | Trust-wide | As a result of the lack of staffing resource for Specialist palliative care, the Trust is not able to meet the NHS England Service specifications for specialist palliative care.<br>Resulting in lack of skilled professionals to provide specialist palliative care and negative impact on staff wellbeing. Specialist Palliative currently has absence data way above national average with a risk of poor staff retention, recruitment and impacting sustainability. Staffing deficit results in increase for Senior lead to work operationally decreasing the ability to influence, improve and innovate across the Group and partners. | Daily huddle with senior support present<br>OPEL reporting measures with sitrep for escalation of risks daily<br>Working as one team across sites increasing team support to improve wellbeing<br>Senior leadership visibility increased<br>Internal and external ask for multi disciplinary support to the SPC team as required.<br>Education training needs analysis for team completed<br>Workforce plan to identify gaps in alignment with national policy and guidance completed<br>Service improvement gap analysis completed<br>Prioritised 1:1 meetings with individuals and protected time for essential education.<br>Daily check in/out with team.<br>Clear escalation route developed for concerns/risks<br>Absence management policy followed | Gap analysis for staff education<br>Daily escalation reports with staffing levels and patient caseload numbers<br>Number of referrals to service<br>Number of referrals to assessment outside KPI target<br>Figures for nurse recruitment/retention<br>SPC absence rates<br>Staff feedback on NACEL reports<br>Staff vacancy rates and appraisal rates<br>1:1 supervision feedback on staff wellbeing | 01/12/2025 | Quite likely (4) 71-90% chance | Severe (4) | High risk (15-16) | 16 | Business Case written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026 | [01/12/2025 14:01:10 Gemma Staples] Absence rates within the team continue to be high. All current staff successfully returned to work, flexible working processes in place, absence management policy followed. Team time out sessions continue quarterly. All staff aware of the EAP offer. The SOP that is being developed will give clear guidance to staff on a day to day basis of service requirements and responsibilities.<br>[08/10/2025 12:36:54 Gemma Staples] SPCT staffing continues to be challenging we now have 0.8 WTE band 6 off LTS and band 7 has reduced their hours to 0.8 WTE and is on a phase return. This means we are working at a deficit of between 90 and 93 percent of the MINIMUM safe staffing for specialist palliative care as advised by the Association of Palliative medicine workforce review and is not sustainable or acceptable for patient care or staff wellbeing. We are submitting a datix when there is no CNS on site for the service.<br>[02/07/2025 13:38:44 Gemma Staples] RTW in progress for staff member who was on long term sick leave<br>Potential withdrawal of Macmillan In reach service could increase demand on service by approx. 200 patient/year. Still under review. Options appraisal and QIA submitted.<br>New data process in place to showcase demand on current resource.<br>Business case has not moved forward. Still awaiting invite to CRIG<br>Morning huddle and check out sessions continue<br>SOP in progress. Draft circulated to team for comment.<br>[30/04/2025 14:18:11 Gemma Staples] Agreed at RRCoC meeting on 30/04/2025 to increase scoring from 3x4 to a 4x4 and to include additional narrative.<br>[03/04/2025 13:32:48 Gemma Staples] To go to RRC&C for a request to increase the scoring from 3x4(12) to a 4x4(16) due to the additional vacancy of retirement and long term sickness absence. | 8 | 30/12/2024 | | 02/03/2026 |
| 1d: Provide modern, clean and fit for purpose care settings | 4858 | 12 | Service disruption | Mike Parkhill | Parkhill, Michael | Whitehead, Mr Stuart | Emergency Planning Group, Estates Infrastructure and Environment Group | 10/02/2022 | 25 | Corporate | Estates and Facilities | Estates | Trust-wide | If there is a critical failure of the water supply to one of the Trust's hospital sites then it could lead to unplanned closure of all or part of the hospital, resulting in significant disruption to multiple services affecting a large number of patients, visitors and staff | Estates Infrastructure and Environment Committee (EIEC).<br>Estates risk governance & compliance monitoring process.<br>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. | 11/11/2025 | 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.<br>Keeping components on site and regular contractors on stand by. Regular stock levels for emergency fixes.<br>Recently undertaken a survey that looks at the condition of infrastructure.<br>Year end capital money for SDA to carry out full site surveys to identify the current state of infrastructure-this will include high level budget costs. | [11/11/2025 11:53:37 Rachael Turner] Proposed for closure as the risk is replicated in risk IQ 789. This risk will be presented at the December Risk Confirm and Challenge meeting.<br>[15/10/2025 08:47:06 Rachael Turner] Risk Reviewed - Recommended for closure as it is replicated in Risk IQ 789. This will be discussed at the Estates Confirm & Challenge Group this week.<br>[18/07/2025 12:17:26 Gemma Staples] Risk reviewed and remains the same.<br>[18/03/2025 09:19:55 Rachael Turner] Confirmation of estimated time for survey to be carried out is 15 weeks<br>[17/03/2025 12:44:08 Rachael Turner] Year end capital money for SDA to carry out full site surveys to identify the current state of infrastructure-this will include high level budget costs. The order is the process of being placed, confirmation of estimated time for when this will be carried out to be provided. Risk score to remain at current level.<br><br>[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.<br>[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.<br>[25/06/2024 09:06:05 Rachael Turner] Survey work is ongoing, update to be provided by Paul.<br>[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 | 31/03/2026 | 31/03/2026 | 11/02/2026 |
| 1b: Reduce waiting times for our patients | 5381 | 560 | Service disruption | Caroline Landon | Landon, Caroline | Capon, Mrs Catherine | | 09/02/2024 | 15 | Corporate | Operations | Operations | | Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands. Significant RN and HCSW WTE shortfall. No B7 manager in place. B6 jnr sister post is unfunded secondment. No ward clerk. Insufficient housekeeping hours. This means that DL cannot staff each shift witihin budget and relys on temporary workforce and inpatient ward support. RNs and HCSWs act as ward clerk and Housekeeper.<br>The risks are:- service is not well led on every shift contributing to delays, failed discharges, reduced patient capacity and turnover, reduced patient flow impacting on front door, omissions in care, omissions in documentation, errors, patient safety incidents, poor staff wellbeing, Poor patient notes and careflow management, poor patient experience. Improvement to practice very challenged to implement due to temporary staffing. Unable to function within current budget. Reputational damage. Inability to meet CQC requirement from 2021 audit. | Each shift has substantive, bank or ward swap nurse in charge. Staffing issues on the day managed by ops matron. Shifts go to bank and then to agency. Dynamic risk assessment; capping capacity or refusing complex patients. Strategic on call sign off required to close discharge lounge due to staffing. Orientation of temporary staff; Induction materials. limited support and advice from operations centre. RNs and HCSWs complete meal and refreshment service. RNs and HCSWs complete cleaning required outside of 2hrs allocated Housekeeper time. RNs and HCSWs complete ward clerk duties. | Healthroster, Workforce safeguard spreadsheet, 8a lead audit, flo audit, datix, PALS feedback and complaints, e-mail feedback, monthly budget, CQC assurance summary, DL patient flow dashboard, daily delays escalation, complaints, PALS feedback, TSSG, Confirm and challenge process.<br>Sickness rates. | 31/10/2025 | Extremely likely (5) >90% chance | Moderate (3) | High risk (15-16) | 15 | 1)Recruiting RNs against potential agency savings as part of TSSG.<br><br>2)Case of need in progress to fund appropriate establishment to meet demand. | [31/10/2025 16:04:17 Rachael Turner] Risk reviewed, no current change and risk score remains at accurate level.<br>[23/06/2025 17:22:40 Rachael Turner] Risk reviewed, risk remains at current risk score<br>[24/01/2025 14:12:16 Rachael Turner] Risk reviewed, no change risk score remains at current position.<br>[25/06/2024 17:05:43 Rachael Turner] Risk reviewed, no change, risk score remains.<br>[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 | | 31/01/2026 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1d: Provide modern, clean and fit for purpose care settings | 4701 | 85 | Reputation | Caroline Landon | Chantry, Chris | Upjohn, Emma | Patient Experience Group | 13/01/2022 | 15 | Family Health | Women's Health and Breast CBU | Obstetrics | Trust-wide | Due to the poor quality and condition of the environment and facilities within Maternity services, there is a risk that patients may have a poor experience and staff morale may be reduced, resulting in loss of confidence in the Trust and damage to reputation. There is also an increased risk of infection which would lead to patient harm. | - Trust procedures for capital investment and Estates project management<br>- Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC) | Patient & staff feedback on the environment in Maternity services.<br>Audits of infection prevention & control compliance.<br>Reported health & safety and IPC incidents. | 06/11/2025 | 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.<br>Maternity shared decision council looking at simple solutions for improving working lives of staff. | [06/11/2025 14:11:47 Nicola Cornish] Lincoln site- regular meetings with estates healthcare planners. Boston, will come after Lincoln refurb.<br>[21/08/2025 14:12:43 Sarah Davy] Currently being picked up through Suzanne Nicholson and Estates work.<br><br>[24/07/2025 15:28:23 Nicola Cornish] Immediate IPC actions were undertaken as required and work continues with Estates to agree the refurb configuration.<br>[01/05/2025 15:23:40 Nicola Cornish] No change. IPC raised concerns about estate on both sites, ongoing conversations with IPC group and E&F for immediate actions to be taken.<br>[24/01/2025 12:32:05 Nicola Cornish] no change, will remain ongoing until refurb programme is complete.<br>[24/10/2024 15:12:06 Nicola Cornish] Risk reviewed, no change.<br>[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.<br>[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.<br>[04/04/2024 10:32:18 Nicola Cornish] No change, awaiting trust board decision regarding the architect plans.<br>[23/01/2024 16:04:20 Nicola Cornish] The team are continuing to work with architects to develop plans, which are expected to be submitted to the Trust board for approval by 31st March.<br>[17/10/2023 09:30:32 Nicola Cornish] Nettleham have moved to Langton, in process of issuing purchase orders for design team and healthcare planners have | 6 | 31/03/2025 | 31/03/2025 | 06/02/2026 |
| 1a (i) Improve patient safety | 5433 | 646 | Physical or psychological harm | Caroline Landon | Upjohn, Emma | Marshall, Lisa | | 08/05/2024 | 8 | Family Health | Women's Health and Breast CBU | Gynaecology | Trust-wide | As a result of insufficient EPAU scan capacity to meet the demand, there is a risk that patients may not be offered an appointment in a timely manner. National and local recommendation is that patients should be seen within 24 hours but patients are currently waiting up to 2 weeks. This increased waiting time may cause psychological harm during a very emotional and worrying time for a patient but can also result in physical harm as not all treatment options may not be open to the patient by the time they are seen. | 24 hour emergency service via GAU<br>Patient information around signs and symptoms to be aware of and who to contact for advice and help.<br>Offer scan capacity at either site.<br>Review of referral criteria along with Lead EPAU Consultant. Weekend scanning where possible if agreed within Division as overspend to support to reduce demand.<br>EPAU nurse currently undertaking sonography course to support improved scanning availability and efficiency within the service. | Complaint data<br>PALS enquiries<br>Patient and staff feedback | 05/12/2025 | Extremely likely (5) >90% chance | Moderate (3) | High risk (15-16) | 15 | Requirement for nurse-led sonography is being considered within the Gynaecology TNA currently being undertaken.<br>Need a 7 day service at each site but plan is to increase capacity by one day at first.<br>Explore utilisation of CDCs to support scan delivery - this will also assist with the separate risk of patients who are potentially losing their baby from having to access care in Maternity areas where there are heavily pregnant women and babies. | [05/12/2025 11:16:22 Nicola Cornish] The EPAU nurse has completed her sonography training and is now undergoing a preceptorship period which is due to end in March 2026. There is still only funding for 0.8WTE EPAU nurse at each site.<br>[26/09/2025 09:23:58 Nicola Cornish] The EPAU nurse is currently undertaking ultrasonography training and once completed this will provide some additional support however this will not fully address the capacity issues.<br>[30/04/2025 14:59:50 Nicola Cornish] Discussed at RRC&C meeting on 30/04. RCOG recommend patients are seen by EPAU within 24 hours of referral however our current wait time can be up to two weeks. This delay can cause permanent physical harm as well as psychological harm eg if an ectopic pregnancy is detected early, fallopian tube saving medication can be used but late diagnosis results in tube removal. Reviewing EPAU criteria to minimise when scans are essential to protect scanning capacity and perhaps have over 16 weeks patients seen within antenatal services. EPAU nurse is undertaking sonography training but this is not a quick solution.<br><br>Radiology to review their risk relating to sonography. CDCs may be an option for EPAU scans but this would require appropriately qualified radiology staff to deal with early pregnancy.<br><br>Panel agreed increase in score, subject to the risk description being updated to accurately reflect the cause/risk/impact.<br>[15/04/2025 12:16:01 Nicola Cornish] Position has worsened as the service is no longer able to offer additional clinics at weekends due to financial position. Matron reviewing referral criteria to see if anything can be done differently to protect emergency scan slot availability eg changing the timing of follow up | 4 | 31/05/2025 | | 05/03/2026 |
| 2b: Empower our people to continuously improve and innovate | 4905 | 48 | Physical or psychological harm | Caroline Landon | Cooper, Mrs Anita | Taylor, Ruth | | 22/04/2022 | 12 | Clinical Support Services | Therapies and Rehabilitation CBU | | Trust-wide | As a result of having insufficient staffing, or required level of experience and skill, the risk is patients will not receive assessment and rehabilitation leading to poor clinical outcome. Reduced flow on Ashby and the acute wards, delayed discharges, delayed referral to response times. Increase in avoidable harm i.e. deconditioning. Patient reviews delayed. Lack of specialist service area resource impacting on long term social value outcomes. Lack of consistency of provision across Lincolnshire footprint. Existing staff stretched to cover additional beds. Increased stress and sick leave on substantive staff. | Recruitment and retention strategies are being developed and implemented.<br>Comprehensive review and optimization of therapies and rehabilitation services, including CIPP and CON.<br>Strengthened collaboration with LCHS and system partners, including creation of joint system posts.<br>Defined therapies and rehabilitation strategy aligned with system priorities.<br>Collaboration with finance to review establishment and nominal roles.<br>Established plan for a sustainable medical workforce in rehabilitation medicine.<br>Development team established for therapies.<br>Neuropsychology posts successfully recruited.Substantive funding secured for therapies at front-door services.<br>Active management and review of waiting lists, including RAG rating, telephone/video consultations (TC/VC), patient-initiated follow-up (PIFU), and timely discharge.<br>Case-of-need strategy established and aligned with wider system initiatives.<br>Competency frameworks and preceptorship processes implemented.<br>Comprehensive strategy covering capacity and demand management, workforce planning, and development. | Patient complaints.<br>Monitoring of flow at front and back door.<br>Site escalation.<br>Vacancy rate monitoring.<br>Roster fill rates.<br>Waiting list numbers of frequency of follow ups.<br>Staff absence.<br>Staff survey and feedback. | 04/12/2025 | Extremely likely (5) >90% chance | Moderate (3) | High risk (15-16) | 15 | To seek agreement to be able to recruit to maximum within allocated budgets – Ruth Taylor – January 2026 | [04/12/2025 15:34:25 Gemma Staples] QIA completed to be heard at panel on 9th December. Asked to utilise Therapy budget underspend to reduce risk identified.<br>[09/10/2025 11:39:13 Gemma Staples] Risk reviewed and remains the same. Declined request for additional winter funding to increase Therapy capacity to support additional acute beds eg 7A at Pilgrim.<br>[08/08/2025 08:38:10 Gemma Staples] Following the request to review if the risk can be reduced from the People Committee deep dive. The risk owner confirmed that the rationale for not reducing is related to therapies still supporting areas where there is now increased resource allocated, this isn't likely to change as we go into winter eg escalation beds, the Lancaster ward project. We also need to complete workforce review piece of work. I would envisage that once that is done, we could then reduce the risk. I wouldn't want to reduce until we have some stability if that makes sense. We are also still trying to on board vacancies and reduce bank and agency use.<br>[30/07/2025 11:30:52 Gemma Staples] Capacity & demand delivery work ongoing. Some improvements in Therapy establishment due to vacancies being filled. Neuro Rehabilitation transformation work commenced with LCHS and relevant stakeholder partners.<br>[30/04/2025 15:21:17 Gemma Staples] Move to delivery of plans to better manage capacity and demand for outpatient and inpatient services commencing June 25. Outcome of this work to be completed by September 25.<br>[04/02/2025 11:33:00 Gemma Staples] Risk remains the same with a deteriorating picture currently on Ashby therapy and OT at PHB.<br>[04/11/2024 11:14:51 Gemma Staples] Risk reviewed and remains the same<br>[20/08/2024 09:21:14 Gemma Staples] Risk reviewed and will be reviewing progress monthly as is part of our workstream plan. | 9 | 30/09/2023 | 18/12/2023 | 04/03/2026 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
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| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | 5535 | 784 | Physical or psychological harm | Caroline Landon | Mooney, Mrs Katy | Constantin, Dr Carmen | | 07/11/2024 | 15 | Medicine | Cardiovascular CBU | Stroke | Lincoln County Hospital | Acute Stroke patients have no access to clinical psychology services in line with the National Clinical Guideline for Stroke 2023 which stipulates psychological care should be provided by stroke services across acute and community settings. Services for people with stroke should have a comprehensive approach to delivering psychological care that includes specialist clinical psychology/neuropsychology input within the multidisciplinary team and should include specialist clinical psychology/neuropsychology provision for severe or persistent symptoms of emotional disturbance, mood or cognition. This could result in patients not being able to engage fully with therapy leading to longer rehabilitation periods, increasing lengths of stay. It could also affect staff due to adverse behaviour by patients due to cognitive impairment. | There is currently no commissioned post for this service within the acute service there is limited provision in the community. | SSNAP data & Datix | 19/11/2025 | Extremely likely (5) >90% chance | Moderate (3) | High risk (15-16) | 15 | Commission post and recruit to post, currently lies with CBU<br>Proposal for additional ward space | [19/11/2025 10:53:53 Rachael Turner] Risk presented at Risk Confirm and Challenge as part of Deep Dive. Risk remains at appropriate level. Need to look at possibilities in wider stroke services looking for solutions for this risk.<br>[12/11/2025 13:19:53 Rachael Turner] Risk remains the same, the earliest appointment is beyond 12 months.<br>[21/10/2025 14:18:29 Rachael Turner] This risk remains ongoing as we do not have a clinical psychologist. We are in contact with local psychology team regularly around this and also in conversation with Leicester for guidance.<br>[07/07/2025 11:44:37 Rachael Turner] Risk reviewed, no current change. Risk score to remain at current level.<br>[11/04/2025 14:16:37 Rachael Turner] Risk reviewed, business case has been updated to include recommended staffing level of neuro psychology for acute and community services. Business case is due to go to CRIG this month.<br>[29/01/2025 13:45:12 Rachael Turner] Risk presented at RRC&C meeting 29/01/2025.Risk validated 5x3:15 High Risk.<br>[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.<br>[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 | | 12/02/2026 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5196 | 309 | Regulatory compliance | Caroline Landon | Bassi, Sangeeta | Moore, Lisa-Marie | | 20/06/2023 | 15 | Clinical Support Services | Pharmacy CBU | Pharmacy | | As a result of regular audits not being completed, the standards for medicines storage are likely to fall below the required standards. Medicines storage and temperature monitoring was raised by CQC during the last inspection, as 'must do' actions. Some of these audits have legal implications such as the controlled drugs audits and safe and secure medicines storage. As we have had the same 'must do' action since 2018 with no improvement, there is possibility without full assurance they could impose improvement notices.<br><br>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.<br><br>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.<br>Datix incidents reported indicate ongoing issues with medicines management. | 09/12/2025 | Extremely likely (5) >90% chance | Moderate (3) | High risk (15-16) | 15 | Action plan to be approved by SMIG Jan 2026<br>SB | [09/12/2025 14:21:54 Lisa Hansford] Rolling audit program in progress, action plan and audit trail established. Safer Medicines initiative Group (SMIG) established.<br>[02/10/2025 11:02:13 Lisa Hansford] SOP for ward pharmacy staff visits completed and approved at pharmacy governance.<br><br>Safe and secure audit tool has been reviewed and updated.<br>[20/08/2025 10:11:58 Rachael Turner] Risk presented as part of RRC&C Deep Dive, we are hoping to get traction on this risk and once changes embedded we will look at closing and creating a new risk around ward areas. We are making sure we are engaged with all Quality process of medicines management in place. Audits are being looked at across the Group that they are fit for purpose with support from clinical governance audit team.<br>[19/08/2025 14:32:15 Lisa Hansford] Chief pharmacist visited wards, which highlighted serious ,medicines management concerns. In addition to concerns raised by CQC visits to ED PHB and Lincoln.<br>[19/06/2025 10:31:10 Gemma Staples] Reviewing current audit tool and any other audits related to medicines with a view to closing this risk in September.<br>[02/06/2025 08:36:22 Gemma Staples] Risk removed from the RRC&C agenda due on the 4th June as Sangeeta would like some further work completing on this before considering a reduction in the scoring.<br>[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.<br>[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 | 4 | 20/06/2024 | | 09/03/2026 |
| 1d: Provide modern, clean and fit for purpose care settings | 4830 | 11 | Service disruption | Mike Parkhill | Parkhill, Michael | Savill, Allen | Estates Infrastructure and Environment Group, Medicines Quality Group | 17/01/2022 | 15 | Corporate | Estates and Facilities | Estates | Pilgrim Hospital, Boston | As a result of estates plant and pipes that are prone to blockage and overflow being located above the pharmacy at Pilgrim Hospital Boston, there is a risk that if there were to be a flood his could lead to extensive damage to medicines; computer equipment and aseptic facilities that disrupts service continuity and has serious financial implications. | ULHT policy:<br>- Estates maintenance / repair arrangements<br>- Business continuity plans<br><br>ULHT governance:<br>- Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) / Pharmacy CBU / CSS Division<br>Contingency plan in place - medicines and equipment are moved to a temporary location in the event of overflow into Pharmacy. | Reported incidents of service disruption | 09/10/2025 | Extremely likely (5) >90% chance | Moderate (3) | High risk (15-16) | 15 | Estates to identify potential solutions to the blockage / overflow issues – Estates – March 2026 | [09/10/2025 14:42:52 Rachael Turner] Risk reviewed, no current change. Mitigation remains in place and continues to be monitored.<br>[30/06/2025 14:44:45 Rachael Turner] Risk reviewed to include updates from Estates perspective of risk reduction plan. Agreed that risk score should remain as 5x3:15 High Risk.<br>[25/06/2025 09:25:24 Rachael Turner] Risk agreed to be transferred to Estates. Meeting booked Monday 30th June for full risk review.<br>[23/06/2025 09:11:45 Gemma Staples] Risk remains the same. The risk has been requested to move to Estates - awaiting a response from Estates.<br>[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.<br>[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.<br>[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:<br>[10/07/2024 11:31:17 Lisa Hansford] no further update<br>[04/04/2024 09:21:11 Lisa Hansford] No further update, all leaks reported to estates<br>[29/12/2023 12:17:18 Lisa Hansford] Leak in dispensary w/c 18th December and stock had to be moved to prevent damage.<br>[26/09/2023 14:12:47 Rachel Thackray] No further update<br>[07/09/2023 14:20:37 Lisa Hansford] 7.9.23 no further update<br>[01/08/2023 14:22:43 Rachael Turner] Risk discussed as RRC&C in July, risk approved to an increase in score to 5x3: 15 High Risk | 6 | 30/09/2021 | 31/03/2022 | 09/01/2026 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | 5480 | 683 | Service disruption | Caroline Landon | Spendlove, Mrs Clare | Bursey, Sarah | Health and Safety Group | 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.<br>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.<br>Unless patients are pregnant PUMP cannot be offered, there is currently a significant backlog.<br>This risk may lead to possible patient harm, longer waiting times, delayed discharge,service disruption, reputational risk to Trust and pressure and wellbeing to staff. | -2x secondments approved and 1x secondment to be advertised<br>-Working with Patient Safety Team looking at DKA within the ward and education.<br>-Working with cost efficiency manager for department but yet to hear feedback. | staffing levels and service provision<br>Datix incidents-list of Datix with insulin provided by Medical Safety Lead. Themes remain the same. | 08/12/2025 | Extremely likely (5) >90% chance | Moderate (3) | High risk (15-16) | 15 | Action 1: Escalated through clinical cabinet and commissioners.<br><br>Action 2: Business case was developed for increased workforce in the last workforce planning round. However, this was declined due to organisational priorities. We are actively involved in the Lincolnshire wide programme board for the redesign of diabetes service within Lincolnshire.<br><br>Action 3: Managing workload as best a possible with input from consultant team and existing specialist nurse staff. | [08/12/2025 11:40:50 Rachael Turner] Risk reviewed, currently unclear what future looks like in regards with staffing. Risk to remain at current level.<br>[09/09/2025 13:11:39 Rachael Turner] Risk transferred to Integration Committee and strategic objective updated to 3a.<br>[13/06/2025 10:55:21 Rachael Turner] Risk reviewed, some members of staff have returned from maternity. Currently risk remains at current risk score.<br>[19/03/2025 12:08:09 Rachael Turner] Confirmation received that 90% do not have access. Risk increased to 5x3:15 High Risk.<br>[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.<br>[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.<br>[28/01/2025 09:44:14 Rachael Turner] Due to current position of depleted workforce risk to be reviewed for increase in risk score. Meeting booked for 31/01/25 to review risk, following this risk to be agreed at CBU governance to then be presented at Risk Confirm and Challenge in February to validate increase in score.<br>[09/01/2025 12:44:47 Rachael Turner] Risk currently remains unchanged. No change to risk score.<br>[09/10/2024 12:14:17 Rachael Turner] This risk remains ongoing. This has been escalated to the Quad in relation for maternity cover. | 2 | 05/07/2025 | | 08/03/2026 |
| 1d: Provide modern, clean and fit for purpose care settings | 5498 | 726 | Regulatory compliance | Mike Parkhill | Parkhill, Michael | Prydderch, Andrew | Health and Safety Group | 19/08/2024 | 15 | Corporate | Estates and Facilities | Estates | Trust-wide | As a result of the poor condition of the PHB and LCH helipads they pose a risk to arriving crews (they cannot see it due to poor lighting and no demarcation) but also carry risk where they are accessible for anyone to get onto the helipad during landing.<br>The helipads fail against the CAP1264 Civil Aviation standard for NHS Helipads due to the above concerns, design and fabric.<br>There is a severe risk of harm or death to persons in the vicinity of the helipads (up to 50m) from the downwash. Issues at other NHS sites with downwash have resulted in a visitor death. LCH has also incurred incidents with people accessing the pad during landing and at other times. | Estates maintain the pads as best resources allow. Security attend the pads during landings when aware and able. | Datix,<br>ED arrival mode data, data from the air ambulance service and anecdotal information from the Lincs & Notts Air Ambulance Unit Chief Pilot | 10/09/2025 | Reasonably likely (3) 31-70% chance | Extreme (5) | High risk (15-16) | 15 | Action 1. Estates and Facilities take immediate action when notified of issues.<br>Action 2. Working with the Hospital Emergency Landing Pad (HELP) appeal and Green Deck Operations, obtaining surveys for options and developing a business case to improve conditions and become compliant. Green Deck appeal have offered to fund the works required to existing pads once the plan is developed. Currently we need to review options available at Lincoln & Boston.<br>Action 3. Once investment in place, Ops to work on Governance compliance for CAP1264 Civil Aviation standard.<br>Action 4. Meeting to be had with Lee Taylor as we need to have an accurate recorded data process for recording when a helipad lands. | [10/09/2025 12:49:06 Rachael Turner] Paper to GLT due to be represented on 19th Sept. Grant secured for 2 helipads, complete refurbishment. Funding - annual cost for staff, maintenance etc.<br><br>[23/07/2025 13:02:25 Sarah Davy] Agreed to increase in score at RRCoC 23/7/25 - 5x3 = 15 from 5x2 = 10<br>[13/06/2025 10:04:36 Rachael Turner] Risk reviewed, risk updated to be a regulatory compliance risk. We are currently not compliant as a Trust against the CAP1264 Civil Aviation standard for NHS Helipads due to the above concerns, design and fabric. Risk reduction plan updated to reflect current position. Due to change in risk type risk score proposed for increase in score to 5x3:15 High Risk. This risk will be presented at RRC&C in July for increase in score<br>[21/01/2025 12:22:03 Rachael Turner] Risk assessment has been carried out, paper was due to be presented to Execs-feedback required from Richard Townsend.<br>[25/09/2024 14:13:35 Rachael Turner] Risk presented at Risk Confirm and Challenge 25/09/2024. Risk score agreed as 2x5:10 Moderate Risk.<br>[19/08/2024 13:19:12 Rachael Turner] Risk to be presented by Richard Townsend at RRC&C for validation for score of 15 High risk at September meeting. | 3 | 31/03/2026 | | 10/12/2025 |
| 1a: Improve patient safety, patient experience and deliver clinically effective care | 5181 | 358 | Physical or psychological harm | Caroline Landon | Lynch, Diane | Rigby, Lauren | | 23/05/2023 | 16 | Clinical Support Services | Cancer Services CBU | Oncology | Trust-wide | As a result of inadequate staffing and inadequate space and an increase in available treatments particularly oral treatments, SACT capacity does not meet the demand required which would lead to the Trust being unable to meet our 31 and 62 day cancer targets, psychological distress to patients due to waiting time and staff burn out due to working conditions. Pilgrim does not have a medical day unit (MDU), our SACT services therefore have to run differently to Lincoln. Chemotherapy Suite at PHB has 18 Chairs which could all be utilised for SACT delivery however, as we do not have an MDU these are used for transfusions, picc flushes etc. | OAU used in appropriately at times, patients admitted to wards if time critical.<br>Staff work extended hours<br>Patients waiting 3 weeks or more are escalated to Matron | Datix incidents<br>Complaints / PALS<br>Staff concerns<br>Sickness absence<br>Retention figures<br>31 & 62 day targets | 26/09/2025 | Extremely likely (5) >90% chance | Moderate (3) | High risk (15-16) | 15 | SACT Pathway to be reviewed - Kate Taft - July 2025<br><br>Chairs should be return to pre covid levels - Polly Johnson and Fran Martinez - July 2025<br><br>Chemotherapy Case of need for staffing written and awaiting CRIG invitation - Sarah Chester-Buckley - April 2026<br><br>Oncology / Haematology Right Sizing paper written and awaiting CRIG invitation - Sarah Chester-Buckley - April 2026 | [29/09/2025 14:06:27 Gemma Staples] EMCA benchmarking shows Chemo Suite Needs 14 WTE RN per day and Ingham Needs 17.5 WTE RN – we currently do not have this staffing. Chemo suite Requires additional 100 clinical hours at present to deliver care and Ingham Requires additional 250 clinical hours at present to deliver care per week for what we currently are delivering.<br>[26/09/2025 13:32:45 Gemma Staples] Waiting for establishment review update, waiting for SACT room at Skegness CDC which will help.<br>[17/09/2025 14:12:35 Gemma Staples] Risk approved in the increase of scoring to a 5x3(15) at RRC&C on 17/09/2025.<br>[27/08/2025 13:10:43 Gemma Staples] Risk reviewed against the scoring matrix as a Physical & Psychological harm risk. It was agreed that the severity still sits as a Moderate (3) with the request to increase the likelihood to extremely likely (5) due to the waiting time deteriorating to 3 weeks.<br>[20/08/2025 10:33:54 Rachael Turner] Risk presented at RRC&C 20/08/25 for increase in score.The issue is lack of capacity in service, risk has been there for some time and the number of patients has increased since Covid and the types of treatments available is larger. Increase requested now as likelihood has increased and we are outside of meeting waiting time targets, so contributes to not meeting cancer targets. This is particularly an issue at Pilgrim. This risk is also included in establishment review. This needs to be updated to a patient harm risk as currently listed as regulatory which will effect the scoring. This risk will be reviewed as patient harm risk and brought back to the next meeting.<br>[06/08/2025 14:37:17 Gemma Staples] Agreed at Cabinet on 15/07 for the risk to be increased to 5x3(15). To be presented at August RRC&C meeting.<br>[04/07/2025 10:05:18 Gemma Staples] The position has deteriorated to 3 weeks waiting time so a request for the risk scoring to be increased from a 4x3(12) to a 5x3(15). To go to cabinet for agreement and the to RRC&C. | 4 | 23/05/2024 | | 26/12/2025 |

| Strategic Objective | ID | DCIQ ID | Risk Type | Exec Lead | Manager | Handler | Reportable to | Opened | Rating (inherent) | Division | Clinical Business Unit | Specialty | Hospital | What is the risk? | Controls in place | How is the risk measured? | Date of latest risk review | Likelihood (current) | Severity (currently) | Risk level (current) | Rating (current) | Risk reduction plan | Progress update | Risk level (acceptable) | Initial expected completion date | Expected completion date | Review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | 5169 | 60 | Physical or psychological harm | Caroline Landon | Constantin, Dr Carmen | Constantin, Dr Carmen | | 09/05/2023 | 15 | Medicine | Cardiovascular CBU | Stroke | Lincoln County Hospital | As a result of consolidating the acute stroke services at one site without appropriate stroke therapy staffing & bed base, many stroke inpatients reside outside the stroke unit as outliers and do not receiving the adequate level of therapy input in line with guidelines and patient-centred care, the effect is increased risk of mortality and long term disability, as well as low staff morale and poor staff retention. There is a risk of an increase of delays to patient care, causing harm and reduced functional outcomes/recovery for stroke patients.<br>Current mitigations mean patients on the Stroke Unit may also receive less therapy input in an attempt to deliver some input to outliers. | Stroke Therapy Team review all outliers at the cost of not seeing the Stroke ward patients as much. Stroke team will advise general ward based therapy team. Minimal basic Stroke assessment and treatment skills for general ward therapy staff. Proposal to implement Trusted Assessor Stroke Assessment.<br>Cohort some outlier | SSNAP data<br>Datix<br>Complaints<br>Staff retention & post vacancy | 19/11/2025 | Extremely likely (5) >90% chance | Moderate (3) | High risk (15-16) | 15 | 1) Recruit stroke therapists [PT/OT/SALT/Dietician] consistent with current service demands in line with guidelines - Ruth Taylor - December 2025<br>2) A Consultant AHP post to provide leadership and stroke pathway oversight needed across the group [this has been in development since 2024 but yet to be recruited to.] - Ruth Taylor - December 2025<br>3) Expand Stroke bed base with funded therapy posts in line with Stroke Guidelines to reduce risk, reduce length of stay and deliver the 'centre of excellence' the population of Lincolnshire were promised - Ruth Taylor - December 2025<br>4) Refurbishment and workforce development – business case to be submitted - Rebecca Johnson - March 2026 | [19/11/2025 10:56:04 Rachael Turner] Risk presented at Risk Confirm and Challenge as part of Deep Dive. Risk remains at appropriate level.<br>[12/11/2025 13:21:36 Rachael Turner] Risk remains, more disabled patients are outlines and this effects visibility of these patients as they are not receiving specialist care and it is effecting patient outcomes.<br>[06/10/2025 15:24:49 Gemma Staples] Risk reassigned to Stroke / Medicine.<br>[04/08/2025 09:23:02 Gemma Staples] The Consultant AHP post has been appointed, work continues in regards to increasing bed base and staffing levels, currently the risk continues.<br>[12/05/2025 13:29:49 Gemma Staples] I believe the Consultant AHP job has been out to advert and shortlisted, interviewing still to take place.<br>[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.]<br>[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.<br>[05/08/2024 11:15:56 Gemma Staples] We are currently involved in a review of Estates. Meeting to take regarding plans. Trying to get a Consultant / AHP job description matched to try and support the staffing issues on the Stroke Unit. We have a joint band 6 OT post with LCHS focussing on flow and discharge. Ongoing work with LCHS to enhance the pathway in order to meet standards required. Ongoing discussions with finance & ICB around additional staffing.<br>[07/05/2024 11:25:01 Gemma Staples] Increased staffing - additional full time band 6 Physio and a rotational band 6. x 2 Band 6 OT's increase. Extra x1 band 4. | 3 | 13/05/2024 | | 12/02/2026 |
| 1a (i) Improve patient safety | 5146 | 277 | Physical or psychological harm | Caroline Landon | Upjohn, Emma | Marshall, Lisa | | 13/04/2023 | 9 | Family Health | Women's Health and Breast CBU | Gynaecology | | As a result of insufficient scanning capacity, the termination of pregnancy service is currently unable to meet RCOG standards resulting in reduced patient experience and potential psychological harm. This is also a reputational risk to the trust due to non-compliance with standards. | Matron working with the ICB to look at improvements, Undertaking patient feedback requests and questionnaires to ascertain patient's voice to improve service. Home termination of pregnancy implemented, next steps to look at implementing tele medicine service which will potentially reduce the need for scanning of all patients, however reliant on patients knowing LMP and having a regular cycle. | Monitoring number of patients unable to receive service at the trust and have to be referred elsewhere. | 05/12/2025 | Extremely likely (5) >90% chance | Moderate (3) | High risk (15-16) | 15 | Full implementation of at home termination of pregnancy service including audit of services to understand if patients under 9 weeks can safely have a termination of pregnancy without a scan. Meeting with commissioners to ensure understanding of patient experience and how to improve service moving forward. | [05/12/2025 11:30:01 Nicola Cornish] We are proceeding with discussions regarding implementation of telemedicine, with guideline group due to meet today to discuss this.<br>[26/09/2025 09:24:51 Nicola Cornish] Lisa Marshall is completing the ICB weighted value framework template to request additional funding but meeting the required level to be considered at panel is challenging. The guideline for implementation of telemedicine is also being review but additional staffing would be required to deliver a robust level of service.<br>[30/04/2025 14:49:17 Nicola Cornish] Discussed at RRC&C meeting on 30/04. The referral to assessment wait is currently 3 weeks, against a standard of 5 days, with a further wait for subsequent treatment. As terminations within ULHT only done up to 12 weeks, this delay is significant as it decreases the options open to patients - prior to 10 weeks, TOP can be done in the patients own home but after this has to be done in hospital and may require surgical intervention. Working with ICB as they are currently having to commission additional service outside of ULH. The additional scan clinics that were previously being run on a weekend have now stopped due to cost pressure.<br><br>Panel agreed increase in score, subject to the risk description being updated to reflect that scanning capacity is the cause of this risk.<br>[15/04/2025 12:06:34 Nicola Cornish] Current wait at Boston is 4 weeks and at Lincoln is 2 weeks. Weekend additional lists are no longer possible due to the financial position but alternative ways of working eg telemedicine are being considered. There has been a marked increase in negative feedback received from patients regarding delays in appointments and the psychological harm with is causing. Propose to increase likelihood score to Extremely Likely which would make the overall rating High - list for RRC&C to approve. | 3 | 29/02/2024 | | 05/03/2026 |
| 1d: Provide modern, clean and fit for purpose care settings | 5383 | 615 | Regulatory compliance | Caroline Landon | Cooper, Mrs Anita | Rigby, Lauren | Estates Strategy Group, Health and Safety Group | 13/02/2024 | 15 | Clinical Support Services | Cancer Services CBU | Haematology (Cancer Services) | Pilgrim Hospital, Boston | As a result of the treatment room not being compliant with HBN 00-03 procedures are being performed in an area that is not compliant, Adhoc and urgent bone marrow biopsies and intrathecal chemotherapy will still be performed in this room which would lead to an infection risk to patients. | Room is being decluttered<br>Estates have reviewed, still awaiting if they can increase the air exchanges and how much this would cost.<br>Larger organisation piece of work being undertaken<br>Regular bone marrow biopsy clinics have been moved to outpatient department<br>Venesections have been confirmed by the lead Estates Nurse can continue<br>Risk assessment and precautions have been circulated to staff to adhere to for adhoc and urgent bone marrow biopsies and intrathecal chemo. | Datix incidents<br>Complaints / PALS<br>Assessment against regulations | 02/10/2025 | Extremely likely (5) >90% chance | Moderate (3) | High risk (15-16) | 15 | Estates job logged to see if can increase air exchange to 10 - Stuart Whitehead - December 2025<br>Wider organisational piece of work - Karen Bailey - December 2025 | [02/10/2025 09:00:42 Gemma Staples] Risk remains the same. Still awaiting a response from Estates.<br>[07/07/2025 16:27:20 Gemma Staples] We're still waiting for an update from Estates regarding whether they can carry out the work and, if so, what the cost would be. This has been escalated to Sarah Chester-Buckley.<br>[13/04/2025 18:09:12 Gemma Staples] Still waiting estates to give us a quote or if the work is possible<br>[24/01/2025 10:04:54 Gemma Staples] Risk remains the same as we are currently awaiting on Estates.<br>[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.<br>[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.<br>[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.<br>[26/03/2024 16:04:11 Gemma Staples] Risk reviewed at the RRC&C today.<br>Update: Suggested at last RRC&C meeting that Estates have one overarching risk but list each identified areas under this risk. Rachel Turner has met with Chris in Estates as this is one area of about 11 areas across all divisions where procedures are taking place without correct ventilation. Chris has a list of areas of which he is asking each area to review and look at areas to see what we can deal with now and then look at what is left. It was agreed that this risk be left on until the overarching risk has been added<br>[13/03/2024 11:15:52 Gemma] Update: We have moved the bone marrow | 3 | 13/02/2025 | 13/02/2025 | 02/01/2026 |

**Appendix C – Risk Appetite**

BOARD DEVELOPMENT

# Risk appetite and tolerance

NHS Providers

| | | How much risk is the Trust prepared to accept for each level of appetite? |
|---|---|---|
| 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 |

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| Strategic Objective | Risk Appetite Level | Risk Statement | Upper Toleran Level |
|---|---|---|---|
| 1a (i) Patient Safety | **Cautious** | If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny. | **10** |
| 1a (ii) Patient Experience | **Open** | If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny. | **12** |
| 1a (iii) Clinically Effective Care | **Open** | If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny. | **12** |
| 1b | **Open / Cautious** | If we do not improve the efficiency and effectiveness of our services then we will not improve **access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes, and increased risk of clinical harm. | **10-12** |
| 1c | **Open** | If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not return to **financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients | **12** |
| 1d | **Open** | If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny. | **12** |
| 2a | **Open** | If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable, less efficient services and the inability to attract and retain staff. | **12** |
| 2b | **Hungry** | If we do not **empower our people to continuously improve and innovate**, they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a | **15-16** |

| | | | |
|---|---|---|---|
| 2c | **Open** | If we do not nurture **compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement. | **12** |
| 2d | **Hungry** | If we do not continue to **recognise people through thanks and celebration**, then we will be unable to attract staff of the required calibre and experience resulting in services becoming unsustainable / fragile. | **15-16** |
| 3a | **Open** | If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience. | **12** |
| 3b | **Hungry** | If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners, then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes. | **15-16** |
| 3c | **Hungry** | If we do not enhance our **digital, research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale. | **15-16** |
| 3d | **Open** | If we do not drive forward our Green Plan, we will be unable to effectively transform key clinical pathways and reduce our **carbon footprint** resulting in services becoming unsustainable. | **12** |

**Appendix D**

**Strategic Objective 1a: Improve patient safety, patient experience and deliver clinically effective care >10 - ULTH**

| Risk ID | Risk Title | Risk Rating (current) |
|---|---|---|
| 4731 | Reliance on paper medical records | 20 |
| 4746 | Overdue patients on Ophthalmology PBWL | 20 |
| 4879 | Recovery of planned care cancer pathways | 20 |
| 5016 | Patient Flow Through Emergency Departments. | 20 |
| 5101 | Delivery of paediatric epilepsy pathways-Acute Paediatrics & Community | 20 |
| 5200 | Backlog of Paediatric Cardiology clinics | 20 |
| 5450 | Risk of Gastro service not being viable due to current fragility of Consultant workforce | 20 |
| 4646 | Provision of NIV treatment | 16 |
| 4741 | Fragility of Oncology services | 16 |
| 4769 | Insufficient staffing and ultrasound equipment within the Vascular Lab at Pilgrim | 16 |
| 4789 | Processing of Echocardiograms | 16 |
| 4843 | Lack of Senior Immunology expertise within Lincolnshire & resulting impact on Patient Safety and ULTH practice | 16 |
| 4855 | Delayed diagnosis of breast cancer and increased waits to treat confirmed cancers | 16 |
| 4868 | Inappropriate preparation of c-section medication | 16 |
| 5002 | Patient access to specialist palliative care | 16 |
| 5003 | Workforce deficit for Specialist Palliative Care | 16 |
| 5095 | PICC Line Service Delays | 16 |
| 5216 | Radiotherapy Staffing levels | 16 |
| 5306 | Inadequate Specialist Microbiologist input for patient care | 16 |
| 5491 | Risk of Clinical treatments being carried out in rooms that do not have the appropriate ventilation levels. | 16 |
| 5495 | Lack of adequate provision for appropriate care of bereaved families with Obstetrics | 16 |
| 5520 | Delays to mechanical Thrombectomy for patients presenting with large vessel occlusion/acute stroke | 16 |
| 5533 | Failure of adherence to NICE Guidelines – risk of life changing disability | 16 |
| 5614 | Paediatric Audiology Service not meeting the Paediatrics Quality Standards | 16 |
| 5617 | Insufficient maternity triage system | 16 |
| 5651 | East Midlands Cancer Alliance Centre for Psycho Social Health having temporary funding | 16 |
| 5146 | Termination of pregnancy service currently unable to meet RCOG standards | 15 |
| 5181 | SACT capacity does not meet demand | 15 |
| 5196 | Non-compliance with medicines storage audits | 15 |
| 5433 | Insufficient EPAU scan capacity | 15 |
| 4623 | CQC inspection outcome | 12 |
| 4624 | Patient falls resulting in serious harm | 12 |
| 4625 | Risk of Outbreak of serious infectious disease | 12 |
| 4626 | Risk of pressure ulcers | 12 |
| 4700 | Children and young people treated in clinical areas external to the Family Health division | 12 |
| 4724 | Therapies & Rehabilitation Medicine service provision | 12 |
| 4727 | Capacity gaps within individual hubs and within Outpatients | 12 |
| 4750 | Lack of emergency alarm bell system/phones/call system within Theatres | 12 |
| 4765 | Lack of therapies provision for the Head & Neck Cancer service | 12 |
| 4770 | Ageing medical and diagnostic equipment throughout the Trust is overdue for replacement | 12 |
| 4779 | Delays in Stroke Services | 12 |
| 4782 | Increasing backlog of planned care activity across the Cardiovascular CBU | 12 |
| 4842 | Storage of medicines & IV fluids across the Trust in excess of 25 degrees | 12 |
| 4877 | Planned care pathway delays | 12 |

## Appendix D

### Strategic Objective 1a: Improve patient safety, patient experience and deliver clinically effective care >10 - LCHS

| Risk ID | Risk Title | Risk Rating (current) |
|---|---|---|
| 403 | Children SLT Therapy Treatment Delays | 20 |
| 681 | Children in Care - unable to meet IHA and RHA timescales | 16 |
| 714 | Delivery of pressure ulcer care in the community | 16 |
| 792 | Reduction of Phlebotomy appointments breaching the ICB service spec | 15 |
| 402 | Medicines Management Trustwide - includes Pharmacy Staffing | 12 |
| 710 | There is a risk of a failure to safely prescribe medication within the Community Hospitals | 12 |
| 721 | CQC Compliance | 12 |
| 750 | ADOS Assessments for CYP | 12 |
| 757 | There is a risk of poor outcomes for Stroke patients in Community Hospitals | 12 |
| 772 | Lincolnshire Community Equipment Service  LCC urgent ordering changes | 12 |
| 782 | In-reach clinician Macmillan | 12 |
| 789 | Prescribing Governance | 12 |
| 793 | Contracted Pharmacy Service - Co-op Agreed KPIs | 12 |

### Strategic Objective 1b: Reduce waiting times for our patients >12 - ULTH

| Risk ID | Risk Title | Risk Rating (current) |
|---|---|---|
| 773 | Speech and Language Therapy – Capacity and Demand | 16 |

### Strategic Objective 1c: Improve productivity and deliver financial sustainability >12 - LCHS

| Risk ID | Risk Title | Risk Rating (current) |
|---|---|---|
| 805 | CIP (Efficiency) requirement 2025/26 | 16 |

### Strategic Objective 1d: Provide modern, clean and fit for purpose care settings >12 - LCHS

| Risk ID | Risk Title | Risk Rating (current) |
|---|---|---|
| 799 | Potential for a major fire | 16 |
| 649 | Fire Safety Core Risk | 15 |

### Strategic Objective 2a - Enable our people to fulfil their potential through training, development and education >12 - LCHS

All LCHS risks are within the risk appetite established.

**Strategic Objective 2b - Empower our people to continuously improve and innovate>15/16 - LCHS**

All LCHS risks are within the risk appetite established.

**Strategic Objective 2c - Nurture compassionate and diverse leadership >12 - LCHS**

All LCHS risks are within the risk appetite established.

**Strategic Objective 2d - Recognising our people through thanks and celebration >15/16 - LCHS**

All LCHS risks are within the risk appetite established.

**Strategic objective 3a - Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services >12 LCHS**

All LCHS risks are within the risk appetite established.

**Strategic objective 3b - Move from prescription to prevention, through a population health management & health inequalities approach >15/16 LCHS**

All ULTH risks are within the risk appetite established.

**Strategic objective 3c - Enhance our digital, research and innovation capability >15/16 LCHS**

All ULTH risks are within the risk appetite established.

**Strategic objective 3d - Drive forward our efficiency and sustainability agenda through our Green Plan >12 LCHS**

All ULTH risks are within the risk appetite established.

NHS
Lincolnshire Community and Hospitals NHS Group

# Group Board Assurance Framework (BAF)

Caring and building a healthier future for all

| | |
|---|---|
| Meeting | *Lincolnshire Community and Hospitals Group Board* |
| Date of meeting | *6 January 2026* |
| Agenda item number | *12.2* |
| Report title | *Group Board Assurance Framework* |
| Report purpose:<br>• Discussion<br>• Approval<br>• Assurance<br>• Information<br>• Other – please insert details | • *Assurance*<br>• *Approval* |
| Accountable Director | *Jayne Warner, Group Director of Corporate Affairs* |
| Author(s) | *Karen Willey, Deputy Trust Secretary, ULTH* |
| Assurance rating:<br>• Substantial assurance<br>• Reasonable assurance<br>• Limited or no assurance | • *Substantial assurance* |
| Prior approval process, if applicable | *Considered through Board Committees* |
| Financial implications, if applicable | *N/A* |
| Action / decision required | *The board is asked to:*<br>• *note progress with the development of the new group BAF;*<br>• *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;*<br>• *Confirm the proposal for the change to the risk rating of objective 1d, from very high (20) to high (16);*<br>• *agree the need for any additional action or assurance at this stage* |

*Assurance Rating Key*:

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

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

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

## Executive Summary

### Background & Introduction

An effective BAF should guide the agenda setting for a board and its committees and, in turn, should be used as the framework for the board committees to report assurance and / or escalate gaps in assurance to the board in respect of delivery of the group's strategic aims & objectives.

In order to reflect the move to group and to provide a more high-level and concise view of the risks to the achievement of the group's strategic aims & objectives and, in turn, the controls, sources of assurance and any gaps, the LCHG Board had agreed in January 2025 to the introduction of a revised BAF format.

Work to further refine the new style BAF – including the addition of clear timescales and leads for agreed actions – and embed its use within the board and committee cycle will continue over the coming months. Each of the board committees, in turn, will continue to review, challenge and seek assurance in respect of the areas of the BAF for which they have oversight with escalation, as required, to the Group Board.

Work is also underway as a priority to align the underpinning risks on the ULTH and LCHS risk registers to the relevant strategic risks within the BAF.

### Summary of the Report

This report provides the second iteration of the BAF in the agreed new format.

BAF entries have been populated with reference to the previous LCHG BAF and with input from relevant executive directors.

The BAF has reviewed by all Committees during November and December and narrative updates provided. During the December Finance and Performance Committee consideration of the risk rating, in respect of objective 1d was held with a view that this should be decreased from a score of 20, very high, to a score of 16, high due to the improved oversight and assurance through the development of the Estates and Facilities upward report over the last 6-9 months to include group risks, issues and mitigations, along with the development of the risk register.

### Group Board Action Required

The Group Board is asked to:

- note progress with the development of the new group BAF;
- note plans to further refine the BAF over the coming months (including the addition of clear timescales and leads for all agreed actions) with continued input from lead executives and review and challenge from the relevant board committees;
- Confirm the proposal for the change to the risk rating of objective 1d, from very high (20) to high (16);

- 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 December 2025

# The LCHG BAF

## Background & Introduction

An effective BAF should guide the agenda setting for a board and its committees and, in turn, should be used as the framework for the committees to report assurance and / or escalate gaps in assurance to the board in respect of delivery of the group's strategic aims & objectives.

In order to reflect the move to group and to provide a more high-level and concise view of the risks to the achievement of the group's strategic aims & objectives, the LCHG Group Board has agreed to the introduction of a revised BAF format. This report provides the first iteration. Work to further refine the new style BAF and embed its use within the board and committee cycle will continue over the coming months. Each of the board committees, in turn, will continue to review, challenge and seek assurance in respect of the areas of the BAF for which they have oversight.

## Scoring the BAF

### Risk Scores

The scoring methodology for BAF risks reflect the group's existing risk scoring matrix (as shown in Table 1 below) calculating the impact / severity of the identified risk should it occur by the likelihood of the risk occurring.

***Table 1:***

| | Impact / Severity score & descriptor (with examples) | | | | |
|---|---|---|---|---|---|
| **Risk type** | **1 Minimal** | **2 Noticeable** | **3 Moderate** | **4 Severe** | **5 Extreme** |
| **Physical or psychological harm** | Low level of temporary harm (no clinical attention required) affecting individual patients, staff or visitors | Relatively low level of harm (requiring first aid or psychological support) affecting multiple patients, staff or visitors | Significant, temporary harm (requiring clinical treatment but expected to make a full recovery) affecting one or more patients, staff or visitors | Significant long-term or permanent harm affecting individual patients, staff or visitors | Significant long-term or permanent harm affecting multiple patients, staff or visitors |
| **Reputation** | Small number of individual concerns raised | Small number of individual complaints raised | Multiple complaints received; negative local media / social media attention | Direct intervention from a regulator; serious complaint from one or more partner organisation; sustained negative national media / social media attention | Fundamental loss of confidence amongst the public, partner organisations and regulators |
| **Service disruption** | Manageable, temporary disruption to peripheral aspects of service provision affecting one or more service | Manageable, prolonged disruption to essential aspects of service provision reducing the efficiency & effectiveness of one or more service | Temporary, unplanned service closure affecting one or more service or significant disruption to efficiency & effectiveness across multiple services | Extended, unplanned service closure affecting one or more service; prolonged disruption to services across multiple services | Indefinite, unplanned general hospital or site closure |
| **Regulatory compliance** | Technical non-compliance with reasonable justification; no regulator attention | Recommendations for improvement for one or more service | Improvement / warning notice for one or more service; recommendation for independent review; legal action for regulatory / contract breach | Special measures; prohibition notice for one or more service; prosecution | Suspension of CQC registration; Parliamentary intervention |
| **Finances** | Some adverse financial impact (unplanned cost / reduced income / loss) but not sufficient to affect the ability of the service / department to operate within its annual budget | Noticeable adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more services / departments to operate within their annual budget | Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more business units to operate within their annual budget | Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of the organisation to achieve its annual financial control total | Significant aggregated financial impact (unplanned cost / reduced income / loss) affecting the long-term financial sustainability of the organisation |

| Likelihood score & descriptor (with examples) | | | | |
|---|---|---|---|---|
| 1<br>Extremely Unlikely | 2<br>Quite Unlikely | 3<br>Reasonably Likely | 4<br>Quite Likely | 5<br>Extremely Likely |
| Unlikely to happen except in rare circumstances<br><br>Less than 10% chance | Unlikely to happen except in specific circumstances<br><br>Between 10-30% chance | Likely to happen in a significant number of circumstances<br><br>Between 31-70% chance | Likely to happen in the majority of circumstances<br><br>Between 71-90% chance | Almost certain to happen<br><br>Greater than 90% chance |

| Risk Scoring Matrix | | | | | | |
|---|---|---|---|---|---|---|
| Impact / Severity | 5 | 5 | 10 | 15 | 20 | 25 |
| | 4 | 4 | 8 | 12 | 16 | 20 |
| | 3 | 3 | 6 | 9 | 12 | 15 |
| | 2 | 2 | 4 | 6 | 8 | 10 |
| | 1 | 1 | 2 | 3 | 4 | 5 |
| | | 1 | 2 | 3 | 4 | 5 |
| | | Likelihood | | | | |

| Risk Rating | Very Low<br>(1 – 3) | Low<br>(4 – 6) | Moderate<br>(8 – 12) | High<br>(15 – 16) | Very High<br>(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 December 2025

| Strategic Aim | Strategic Objective | Strategic Risk | Executive Lead(s) | Board Committee Oversight | Current Risk Score (as at December 2025) | Target Risk Score (March 2026) | Assurance Rating (as at December 2025) | Target Assurance Rating (March 2026) |
|---|---|---|---|---|---|---|---|---|
| **Patients: Better Care – Timely affordable, high quality care in the right place** | 1a (i): **Improve patient safety**, patient experience and deliver clinically effective care | If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny | Group Chief Nursing Officer / Group Chief Medical Officer | Quality Committee | **8 (Moderate)** | **3 (Very Low)** | **Amber** | **Green** |
| | 1a (ii): **Improve** patient safety, **patient experience** and deliver clinically effective care | | | | **9 (Moderate)** | **4 (Low)** | **Amber** | **Green** |
| | 1a (iii): Improve patient safety, patient experience and **deliver clinically effective care** | | | | **8 (Moderate)** | **3 (Very Low)** | **Amber** | **Green** |
| | 1b (i): Reduce waiting times for our patients **(Unplanned Care)** | If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm | Group Chief Operating Officer / Group Chief Integration Officer | Finance & Performance Committee | **15 (High)** | **10 (Moderate)** | **Amber** | **Green** |
| | 1b (ii): Reduce waiting times for our patients **(Planned Care)** | | | | **15 (High)** | **10 (Moderate)** | **Amber** | **Green** |
| | 1c: Improve productivity and deliver financial sustainability | If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients | Group Chief Financial Officer | Finance & Performance Committee | **12 (Moderate)** | **8 (Moderate)** | **Amber** | **Green** |
| | 1d: Provide modern, clean and fit for purpose care settings | If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny | Group Director of Estates & Facilities | Finance & Performance Committee | **~~20~~16 (~~Very~~ High)** | **16 (High)** | **Amber** | **Amber** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **People: Better Opportunities – Develop, empower and retain great people** | 2a: Enable our people to fulfil their potential through training, development and education | If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable harm, less efficient services and the inability to attract and retain staff | Group Chief People Officer | People Committee | **9 (Moderate)** | **6 (Low)** | **Green** | **Green** |
| | 2b: Empower our people to continuously improve and innovate | If we do not **empower our people to continuously improve and innovate** they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience | Group Chief People Officer | People Committee | **9 (Moderate)** | **6 (Low)** | **Amber** | **Green** |
| | 2c: Nurture compassionate and diverse leadership | If we do no **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement | Group Chief People Officer | People Committee | **9 (Moderate)** | **6 (Low)** | **Amber** | **Green** |
| | 2d: Recognising our people through thanks and celebration | If we do not continue to **recognise our people through thanks and celebration** then we will be unable to attract and retain staff of the required caliber and experience resulting in services becoming unsustainable / fragile | Group Chief People Officer | People Committee | **6 (Low)** | **3 (Very Low)** | **Amber** | **Green** |
| **Population: Better Health – Improve population health** | 3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services | If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience | Group Chief Integration Officer | Integration Committee | **12 (Moderate)** | **8 (Moderate)** | **Amber** | **Green** |
| | 3b: Move from prescription to prevention, through a population health management & health inequalities approach | If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving** | Group Chief Integration Officer | Integration Committee | **9 (Moderate)** | **8 (Moderate)** | **Amber** | **Green** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | **population health** resulting in less equitable access to services and poorer clinical outcomes | | | | | | |
| | 3c. Enhance our digital, research and innovation capability | If we do not **enhance our digital, research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale | Group Chief Integration Officer | Integration Committee | **12 (Moderate)** | **8 (Moderate)** | **Amber** | **Green** |
| | 3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan | If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable | Group Chief Integration Officer | Integration Committee | **12 (Moderate)** | **8 (Moderate)** | **Amber** | **Green** |

# Strategic Aim 1: Patients

| | |
|---|---|
| **Strategic Aim:** | Patients: Better Care – Timely, affordable, high quality care in the right place |
| **Strategic Objective:** | 1a (i): **Improve patient safety**, patient experience and deliver clinically effective care |
| **Strategic Risk:**<br>(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:** | December 2025 |
| **Lead Executive:** | Group Chief Nurse / Group Chief Medical Officer |
| **Committee Oversight:** | Quality Committee |
| **Risk Appetite:** | Minimal |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 4 | 2 | 8 (Moderate) | Amber |
| **Target** | Mar-26 | 3 | 1 | 3 (Very Low) | Green |

**Assurance Rating & Movement since last review:**

**Amber**

⇔

| **Risk Score** | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | | | |

| **Assurance Rating** | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| **Identified Controls** *(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Quality & safety priorities and KPIs agreed |
| 2 | Safety culture approach established, Patient Safety Partners appointed and human factors guidance & training in place. |
| 3 | Quality governance teams & structures, policies and processes (including robust processes to identify risks and issues) in place and refined to reflect the move to group |
| 4 | PSIRF & learning from incidents processes well embedded |
| 5 | Strong focus on maternity & neonatal safety reported through MNOG |
| 6 | Improvement plans in place to address identified risks e.g. management & use of medical devices, medicines safety, wound care management, effective practice & harm free care |
| 7 | Ward / service accreditation process in place |
| 8 | IPC team and governance framework in place across the group |
| 9 | Safeguarding team and governance framework in place across the group |

| **Gaps in Controls** *(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | Quality & safety priorities and KPIs being refreshed |
| 2 | Safety culture not yet fully embedded across all areas of the group |
| 3 | There are a significant number of policies across the group which are out of date |
| 4 | 'Just Culture principles not yet fully embedded across all areas of the group |
| 5 | Children & Young People Oversight Group to revert to reporting to Quality Committee for continued oversight of improvements within paediatric services |
| 6 | • Medicines safety across the group remains a risk although oversight is improving<br>• There has been an increase in category 3 & 4 pressure ulcers in community services |
| 7 | Ward / service accreditation programme not fully embedded in community |
| 8 | NHSE and other external reviews of the group's IPC arrangements have identified gaps |
| 9 | Low uptake of mandatory safeguarding training by operational teams |

| Actions being taken to address gaps in controls<br>*(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 | Update 08/10/25 – Safety Culture Assessment Proposal written and presented at PSG on the 16/10/25 with upward reporting to the QC.Workshop re-scheduled for the 18 November due to previous cancellation due to operational pressure. Output of workshop will identify which safety tool to be implemented / Safety Culture triggers / and annual rolling programme.Update 08/12/25 – Culture workshop held – output will be shared at the January PSG with upward reporting to the January Quality Committee. |
| 2 | Just Culture action plan covering engagement, training and new processes in place and ongoing | Group Chief Clinical Governance Officer / Group Chief People Officer | Deputy Directors – People and Clinical Governance | Ongoing | With the national launch of the Being Fair Tool which is superseding the Just Culture Tool work is being undertaken to review what this means for the workstream. |
| 3 | Aligned policy agreed on the development of policies, procedures & guidelines. Improvement trajectories to be agreed as a priority for bringing all out of date documents into compliance. Performance to be monitored through monthly PRMs with escalation to ELT / GLT as required | Group Director of Corporate Affairs | Deputy Trust Secretary | 30 September 2025 (Agreement of Improvement Trajectory)<br>31 March 2026 (Improvement Performance) | Underway – paper being submitted to ELT on Thursday, 31 July 2025. Performance also being monitored from an assurance perspective through the Audit Committee |

| | | | | | |
|---|---|---|---|---|---|
| 4 | Weekly pressure ulcer assurance meetings being held with the community nursing teams with safeguarding support. Improvement Trajectory agreed (10% reduction by the end of December 2025) | Group Chief Nurse | Deputy Chief Nurse | 31 December 2025 | Underway<br>Monthly pressure ulcer assurance meetings continue outcome themes reported to SIG. Oversight also through QA dashboards. Review of data/reporting processes in progress. Scheduled meeting 28/11 to review themes from incidents/safeguarding reports to inform improvement plan. |
| 5 | Full review of pharmacy and medicines management to be undertaken across the group / system (key priority for incoming Chief Pharmacist) | Group Chief Medical Officer | Chief Pharmacist | 30 September 2025 | Underway |
| 6 | Ward / service accreditation programme to be fully established in community | Group Chief Nurse | Deputy Chief Nurse | 31 March 2026 | Underway<br>Programme established for community hospitals and community nursing with monthly quality dashboards in place Unannounced peer review visit programme commenced. Work is underway to continue to expand and rollout to additional services during Q3/4. |
| 7 | Response to internal work and investigations and external visits of the group's infection prevention and control practice and interventions to be developed and implemented. | Group Chief Nurse | Deputy Director of Infection Prevention and Control | 31 March 2026 | Underway |
| 8 | Monthly monitoring and escalation for training noncompliance to Care Groups (CG leads / Safeguarding Operational groups and SVOG). Selective direct emails to noncompliant staff | Group Chief Nurse | Director of Safeguarding | 31 March 2026 | Ongoing |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(How we know the controls are working effectively) | |
|---|---|
| 1 | Oversight of quality & safety agenda and key risks by the Quality Committee and reporting sub-groups (e.g. Patient Safety Group, Maternity & Neonatal Oversight Group, Safeguarding & Vulnerabilities Group), with escalation to the Group Board as required |
| 2 | Reporting on quality & safety KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR) |
| 3 | QIAs reviewed by care groups and executives with Quality Committee oversight |
| 4 | Learning from incidents reported to the Patient Safety Group and disseminated across the group |
| 5 | Incident themes & trends monitored through the Patient Safety Group |
| 6 | Delivery of quality & safety KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight |
| 7 | Local level and Group Board Maternity & Neonatal Safety Champions in place with reporting to the Group Board |
| 8 | Internal & external audit, external reviews and visits provide independent assurance of the robustness of the group's quality governance arrangements |
| 9 | Internal audit review of ULTH's management of medical devices undertaken during 2024 / 25 has provided 'reasonable assurance'. Medical Devices Group in place reporting to Patient Safety Group |
| 10 | Patient Safety Group reporting groups (e.g. IPC / Skin Integrity / Care Groups etc.) |

| Gaps in Assurance | |
|---|---|
| 1 | Reporting sub-groups into Quality Committee aligned. |
| 2 | IPR not yet aligned |
| 3 | QIAs not universally used across the group |
| 4 | The occurrence of repeated or same type incidents suggests processes for learning lessons are not yet fully embedded across the group |
| 5 | None identified |
| 6 | None identified |
| 7 | None identified |
| 8 | None identified |
| 9 | Medical Devices Group to be renamed to be representative of the LCH group |
| 10 | Reporting groups into Patient Safety Group aligned however maturity of some of these groups needs further development. |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4) | Group Chair / Group Chief Executive | Group Director of Corporate Affairs | 30 June 2025 | Board and board committees have been aligned and executive governance structures agreed. Some final work to complete to align the committee reporting sub-groups. **Proposed revised deadline 31 August 2025 - CLOSED** |
| 2 | Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2) | Group Chief Integration Officer | Associate Director of Performance & Information | 30 June 2025 | Group PMAF approved and aligned PRMs in place. The agreement of final |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | metrics for 2025 / 26 and alignment of the IPR is not yet complete. **Proposed revised deadline of 31 August 2025** |
| 3 | Group level Medical Devices Group to be renamed to be representative of the LCH group | Group Chief Medical Officer | Deputy Medical Director | 30 June 2025 | Underway Update 08/10/2025 – Both Medical Devices Groups have now come together and has been renamed as the LCHG Medical Devices Safety Group. – Suggest CLOSED |
| 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) | Update 08/10/2025 – Launch of CG structure September included development of a three posts within the Compliance team that are dedicated to developing and supporting the triangulation of data and learning from all aspects of the Clinical Governance Directorate and ensure that there is a programme of learning in place across the Group. Update 13/11/2025 – Review of current process for PSII actions and learning taken place with a new process to be implemented from December. This will supplement the learning agenda across LCHG. |

| | | | | | |
|---|---|---|---|---|---|
| 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 |
| 6 | Patient Safety Group chair to meet with chairs of the groups reporting into PSG, including the Care Group leads, to refocus upward reporting / standardise reporting templates and improve risk alignment and learning. | Group Deputy Chief Clinical Governance Officer | Associate Director of Patient Safety | 31 March 2026 | UnderwayUpdate 08/12/25 – Upward reporting templates reviewed and circulated at December PSG. Meeting planned with Care Group leads for January 2026 with plan to implement improved upward reporting in February 2026. |

**Related risks on Risk Register – ULTH**

| Trust | Datix ID | Score | Summary Risk Description |
|---|---|---|---|
| ULTH | 4879 | 20 | Recovery of planned care cancer pathways |
| ULTH | 5016 | 20 | Patient flow through ED |
| ULTH | 5101 | 20 | Community and Acute paediatric epilepsy pathway |
| ULTH | 5200 | 20 | Paediatric cardiology backlog |
| ULTH | 5450 | 20 | Gastroenterology consultant workforce |
| ULTH | 4746 | 20 | Overdue patients on Ophthalmology PBWL |

**Related risks on Risk Register – LCHS**

| Trust | Datix ID | Score | Summary Risk description |
|---|---|---|---|
| LCHS | 403 | 20 | Children's SLT treatment delays |

# Strategic Aim 1: Patients

| | |
|---|---|
| **Strategic Aim:** | Patients: Better Care – Timely, affordable, high quality care in the right place |
| **Strategic Objective:** | 1a (ii): **Improve** patient safety, **patient experience** and deliver clinically effective care |
| **Strategic Risk:**<br>(How we may be prevented from meeting objective and what is the potential impact) | If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny |

**Current Risk Score & Movement since last review:**

**9 (Moderate)**

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| | |
|---|---|
| **Last Review Date:** | October 2025 |
| **Lead Executive:** | Group Chief Nurse / Group Chief Medical Officer |
| **Committee Oversight:** | Quality Committee |
| **Risk Appetite:** | Minimal |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 3 | 3 | 9 (Moderate) | Amber |
| **Target** | Mar-26 | 2 | 2 | 4 (Low) | Green |

**Assurance Rating & Movement since last review:**

**Amber**

⇔

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| **Identified Controls**<br>*(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**<br>*(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<br>• There are currently workforce gaps in the Patient Experience Team |
| 3 | None identified |
| 4 | None identified |
| 5 | Lack of staff engagement has the potential to lead to a lack of timely implementation of improvement plans |
| 6 | PLACE improvement plans in development |

| Actions being taken to address gaps in controls<br>*(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 | Completed |
| 2 | Group approach to Patient Panels to be implemented from April 2025 | Group Chief Nurse | Head of Patient Experience | 1 April 2025 | Completed |
| 3 | Ensure action plans from national patient experience surveys are SMART and translated to local action and establish a robust process / protocols for disseminating data to frontline teams | Group Chief Nurse | Head of Patient Experience | 31 December 2025 | Completed |
| 4 | Define and enforce timeframes for implementation of improvements identified during PLACE assessments | Group Chief Nurse | Head of Patient Experience | 31 March 2026 | Completed |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(How we know the controls are working effectively) | |
|---|---|
| 1 | Oversight of patient experience and key risks by the Quality Committee and its reporting sub-group: the Patient Experience & Involvement Group, with escalation to the Group Board as required |
| 2 | Reporting on quality & safety and patient experience KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR) |
| 3 | Patient Stores are heard at the Group Board |
| 4 | Patient Experience data is gathered and improvements tracked through the Patient Experience & Involvement Group |
| 5 | Delivery of patient experience KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight |
| 6 | Internal & external audit, patient surveys, PLACE reviews etc. provide independent assurance on the quality of the patient experience |

| Gaps in Assurance | |
|---|---|
| 1 | Reporting sub-groups not yet aligned |
| 2 | IPR not yet aligned |
| 3 | None identified |
| 4 | Triangulation of patient experience data with other sources of information e.g. complaints, PALS etc. requires strengthening |
| 5 | None identified |
| 6 | None identified |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4) | Group Chair / Group Chief Executive | Group Director of Corporate Affairs | 30 June 2025 | Board and board committees have been aligned and executive governance structures agreed. Some final work to complete to align the committee reporting sub-groups. **Proposed revised deadline 31 August 2025** |
| 2 | Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2) | Group Chief Integration Officer | Associate Director of Performance & Information | 30 June 2025 | Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | complete. Proposed revised deadline of 31 August 2025 |

| Related risks on Risk Register – ULTH | | | |
|---|---|---|---|
| Trust | Datix ID | Score | Summary Risk Description |
| | | | |

| Related risks on Risk Register – LCHS | | | |
|---|---|---|---|
| Trust | Datix ID | Score | Summary Risk description |
| | | | |

# Strategic Aim 1: Patients

| | |
|---|---|
| **Strategic Aim:** | Patients: Better Care – Timely, affordable, high quality care in the right place |
| **Strategic Objective:** | 1a (iii): Improve patient safety, patient experience and **deliver clinically effective care** |
| **Strategic Risk:**<br>(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:** | December 2025 |
| **Lead Executive:** | Group Chief Nurse / Group Chief Medical Officer |
| **Committee Oversight:** | Quality Committee |
| **Risk Appetite:** | Minimal |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 4 | 2 | 8 (Moderate) | Amber |
| **Target** | Mar-26 | 3 | 1 | 3 (Very Low) | Green |

**Assurance Rating & Movement since last review:**

Amber

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| **Identified Controls** *(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Quality & safety and clinical effectiveness priorities and KPIs agreed |
| 2 | Established clinical audit team in place and clinical audit plan agreed |
| 3 | NICE Policy and process in place |
| 4 | Medical Examiner Service in operation |
| 5 | Mortality review process in place and learning from deaths process wellii established |
| 6 | Getting It Right First Time (GIRFT) Programs of work |
| 7 | Subgroup reporting |
| 8 | Clinical Effectiveness Group reporting groups (e.g. HTA / MOG / Care Groups etc.) |

| **Gaps in Controls** *(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | Quality & safety and clinical effectiveness KPIs being refreshed |
| 2 | Some specialty clinical audit and governance groups require strengthening |
| 3 | ~~None identified~~ Overdue Baseline Assessments and overdue actions. |
| 4 | Non-compliance with completion of MCCD within 5 days |
| 5 | ~~None identified~~Not achieving required compliance for SJR's completion. |
| 6 | Governance not in place for GIRFT programs of work |
| 7 | None identified |
| 8 | Reporting groups into Clinical Effectiveness Group aligned however maturity of some of these groups needs further development. |

| | Actions being taken to address gaps in controls<br>*(What are we going to do, by when, to further manage and mitigate the risk?)* | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Medical Examiner – Additional workforce being recruited | Group Chief Clinical Governance Officer | Associate Director of Clinical Effectiveness and Complaints | 31 March 2026 | Recruitment underway<br>08/12/25 - Additional workforce now recruited – awaiting start dates. Compliance improved and currently achieving MCCD within 5 days. |
| 2 | GIRFT – The current GIRFT team structure is under review and a proposal is being developed to assess the team's capacity to implement effective governance | Group Chief Integration Officer | Group Director of Strategy, Improvement and Redesign | 31 March 2026 | Underway |
| 3 | Clinical Effectiveness lead to meet with chairs of the groups reporting into CEG, including the Care Group leads, to refocus upward reporting / standardise reporting templates and improve risk alignment and learning. | Group Deputy Chief Clinical Governance Officer | Associate Director of Clinical Effectiveness and Complaints | 31 March 2026 | 08/12/25 – meeting set for January 2026.~~Underway~~ |
| 4 | SJR's compliance – work underway with Care Group Leads and Clinical Governance Leads to improve compliance with oversight via the Mortality Oversight Group (MOG) and strengthening the upward reports to MOG for further assurance over process and improvement trajectories. | Group Chief Clinical Governance Officer | Associate Director of Clinical Effectiveness and Complaints | 31 March 2026 | Underway |
| 5 | Overdue Baseline Assessments and overdue actions. | Group Chief Clinical Governance Officer | Associate Director of Clinical Effectiveness and Complaints | 31 March 2026 | 08/12/25 - Clinical Governance restructure underway with recruitment to vacant posts including NICE and Best Practice Officer. |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(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 aligned.~~not yet aligned~~ |
| 2 | IPR not yet aligned |
| 3 | None identified |
| 4 | 'Outlier' status has been received for some of the National audit projects. As the Clinical Governance structure continues to develop, Clinical Audit Facilitators will work more closely with Care Groups to gain greater insight into audit processes and ensure the submission of high-quality, accurate data. |
| 5 | Overdue NICE Actions – As part of the structure, additional staff are being recruited to work more closely with Care Groups. This will strengthen oversight and support for the implementation and monitoring of NICE guidance, helping to reduce the number of overdue actions. |
| 6 | None identified |
| 7 | None identified |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4) | Group Chair / Group Chief Executive | Group Director of Corporate Affairs | 30 June 2025 | Board and board committees have been aligned and executive governance structures agreed. Some final work to complete to align the committee reporting sub-groups. **Proposed revised deadline 31 August 2025 - CLOSED** |
| 2 | Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2) | Group Chief Integration Officer | Associate Director of Performance & Information | 30 June 2025 | Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet complete. **Proposed revised deadline of 31 August 2025** |

| Related risks on Risk Register – ULTH | | | |
|---|---|---|---|
| Trust | Datix ID | Score | Summary Risk Description |
| ULTH | 4731 | 20 | Reliance on paper medical records |

| Related risks on Risk Register – LCHS | | | |
|---|---|---|---|
| Trust | Datix ID | Score | Summary Risk description |
| | | | |

# Strategic Aim 1: Patients

| | |
|---|---|
| **Strategic Aim:** | Patients: Better Care – Timely, affordable, high quality care in the right place |
| **Strategic Objective:** | 1b (i): Reduce waiting times for our patients **(Unplanned Care)** |
| **Strategic Risk:**<br>(How we may be prevented from meeting objective and what is the potential impact) | If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm |

**Current Risk Score & Movement since last review:**

**15 (High)**

| | |
|---|---|
| **Last Review Date:** | November 2025 |
| **Lead Executive:** | Group Chief Operating Officer / Group Chief Integration Officer |
| **Committee Oversight:** | Finance & Performance Committee |
| **Risk Appetite:** | Open / Cautious |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 5 | 3 | 15 (High) | Amber |
| **Target** | Mar-26 | 5 | 2 | 10 (Moderate) | Green |

**Assurance Rating & Movement since last review:**

**Amber**

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | High | High | High | High | High | High | High | High | High | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| | **Identified Controls**<br>*(What are we already doing to manage the risk?)* |
|---|---|
| 1 | Daily internal capacity meetings in place to improve discharge and flow and troubleshoot operational issues at the front door |
| 2 | Daily ICB UEC calls occur to escalate issues across the system and provide support to unblock pressure areas with the aim of reducing bed blocking and delayed discharges |
| 3 | Group Discharge Board in place with a focus on discharge & flow, SAFER principles and criterial-led discharge |
| 4 | Unplanned Care Group established to drive delivery of agreed performance & improvements |
| 5 | System Unplanned Care Partnership Board in place to have oversight of system issues and challenges and to drive delivery of agreed improvements |
| 6 | OPEL escalation triggers and actions in place |
| 7 | Winter Plan (2025) ~~in development~~ |
| 8 | 45 minute ambulance handover protocol agreed and enacted and delivered consistently |
| 9 | Power BI and daily validation, 111 CAS call back times, Ops Centre performance, UCR 2 hr performance, UTC 33 national standards inc waiting times and booked appointments, Referral to ED rate. |

| | **Gaps in Controls**<br>*(What are the gaps in control that are required to manage the risk)* |
|---|---|
| 1 | ED streaming allocation not aligned to presentation |
| 2 | Discharge across P0/1/2/3 requires improvement |
| 3 | Redesigned EPIC/NIC roles need ~~support and~~to be embedded~~ing~~ |
| 4 | Assessment chair capacity not substantially funded |
| 5 | SDEC on both sites not large enough |
| 6 | Debate regarding 'send' to assessment areas remains ongoing |
| 7 | Not all specialty teams attend ED within 30 minutes of request in line with IP standards |
| 8 | None identified |
| 9 | Alignment of systems to ensure timely and accurate reporting of community data to all stakeholders. |

| Actions being taken to address gaps in controls<br>*(What are we going to do, by when, to further manage and mitigate the risk?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Work is ongoing internally to increase SDEC / assessment centres utilisation and ensure appropriate use of SDEC pathways in support of ED | Group Chief Operating Officer | Group Deputy Chief Operating Officer | 30 September 2025 | Underway |
| 2 | Work is ongoing to address 'send' and IPR | Group Chief Operating Officer | Group Deputy Medical Director | Ongoing | Ongoing |
| 3 | Discharge task force being refreshed | Group Chief Operating Officer | Group Deputy Chief Nurse | 30 April 2025 | Completed |
| 4 | Escalation Policy & Full Capacity Protocol to be reviewed and aligned | Group Chief Operating Officer | Group Deputy Chief Operating Officer | 31 July 2025 | Underway<br>**Proposed revised deadline of 30 November 2025** |
| 9 | Requirement remains for focus on community data to ensure clarity of service delivery and meeting patient outcomes. | Group Chief Integration Officer | Group Deputy Integration Officer | 31 October 2025 | Ongoing – data needs to be consistently available |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(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~~Dedicated discharge programme |
| 2 | Assurance re daily drumbeat being embedded |
| 3 | |
| 4 | |
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| 7 | |
| 8 | |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Newtons work will support improved discharge – with proposed daily target for each ward and specialty<br>daily ED assurance meetings to discuss previous days and overnight activity and performance<br>~~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

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|---|---|
| **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:**<br>(How we may be prevented from meeting objective and what is the potential impact) | If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm |

**Current Risk Score & Movement since last review:**

**15 (High)**

| | |
|---|---|
| **Last Review Date:** | November 2025 |
| **Lead Executive:** | Group Chief Operating Officer / Group Chief Integration Officer |
| **Committee Oversight:** | Finance & Performance Committee |
| **Risk Appetite:** | Open / Cautious |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 5 | 3 | 15 (High) | Amber |
| **Target** | Mar-26 | 5 | 2 | 10 (Moderate) | Green |

**Assurance Rating & Movement since last review:**

**Amber**

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | High | High | High | High | High | High | High | High | High | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| Identified Controls<br>*(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Clinic template project initiated |
| 2 | Weekly PTL / activity meetings in place |
| 3 | Weekly 6/4/2 meetings held to support theatre utilization |
| 4 | Booking 'protocol' being developed |
| 5 | Planned Care Group established to driver delivery of agreed planned care performance & improvements |
| 6 | Forecast performance in place and used to monitor delivery |
| 7 | List brokering commenced |
| 8 | Power BI dashboard and RTT audit in place for community 52 ww. |

| Gaps in Controls<br>*(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | Lack of standardised and centralised scheduling and booking |
| 2 | Inconsistent approach to validation / validation not comprehensive. Internal validation team recruited. National validation initiative commenced |
| 3 | Opportunities exist to maximise theatre productivity & utilisation - theatre timetable not refreshed |
| 4 | Gaps in job planned and delivered activity for admitted and non-admitted |
| 5 | Workforce gaps |
| 6 | Time to first appointment delivery is high risk for 2025 / 26 |
| 7 | Delivery of cancer 62 day performance remains a risk |
| ~~8~~7 | There is no shadow booking process in place |
| 8 | Limited financial support, appropriate commissioning of high risk services. This includes SLT, TB, Lymphoedema, Community nursing & Children in Care. |

| Actions being taken to address gaps in controls<br>*(What are we going to do, by when, to further manage and mitigate the risk?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Maximise theatres & out-patient improvements (scheduling / booking / cancellations). EY commissioned to support elective producivity improvements. PWC commissioned to support scheduling / booking efficiencies | Group Chief Operating Officer | Deputy Group Chief Operating Officer | 31 October 2025 | Underway |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(How we know the controls are working effectively) | |
|---|---|
| 1 | RTT and cancer improvement trajectories agreed for all specialties |
| 2 | Theatre dashboard in place and monitored through the Planned Care Group |
| 3 | RTT & cancer performance monitored through the Planned Care Group |
| 4 | Delivery of RTT and cancer performance and improvements reviewed through the Care Group PRMs |
| 5 | Reporting on RTT and cancer performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board, as required |
| 6 | Improved performance: sustained backlog reduction |
| 7 | Internal audit review of RTT pathways within ULTH during 2025 / 26 provided 'reasonable assurance) |

| Gaps in Assurance | |
|---|---|
| 1 | IPR is not comprehensive |
| 2 | Reports to committee and ELT require improvement |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Diagnostic reporting tools in development | Group Chief Operating Officer | Deputy Group Chief Operating Officer | 30 September 2025 | Underway |
| 2 | Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2) | Group Chief Integration Officer | Associate Director of Performance & Information | 30 June 2025 | Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet complete. **Proposed revised deadline of 31 August 2025**<br><br>**The RACH system is being further developed to improve the performance scorecards and metrics that are reported to Board** |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | and Committees. These are being developed in conjunction with Non Exec and Exec leads to get sign off for metrics to be reported on and are being used alongside existing Performance reports. We are ensuring the targets & trajectories are approved and introducing a change request process for accountability. This is also being completed alongside NOF reporting and consistency in approach. |
| | Transformation of key services within envelope of money reported via Integration Committee | Group Chief Integration Officer | Group Deputy Chief Integration Officer | 31 October 2025 | Lymphodema trajectory agreed |
| | Ongoing discussion with commissioners around commissioning support for Community Management Partnership Board | Group Chief Integration Officer | Group Deputy Chief Integration Officer | 31 October 2025 | Vulnerability of ICB moving to cluster |

| Related risks on Risk Register – ULTH | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk Description** |
| ULTH | 5447 | 20 | Cancellation of elective lists due to theatre staffing |

| Related risks on Risk Register – LCHS | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk description** |
| | | | |

# Strategic Aim 1: Patients

| | |
|---|---|
| **Strategic Aim:** | Patients: Better Care – Timely, affordable, high quality care in the right place |
| **Strategic Objective:** | 1c: Improve productivity and deliver financial sustainability |
| **Strategic Risk:**<br>(How we may be prevented from meeting objective and what is the potential impact) | If we do not manage costs effectively, optimise productivity and deliver our efficiency / cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unsustainable services for patients |

**Current Risk Score & Movement since last review:**

**12 (Moderate)**

| | |
|---|---|
| **Last Review Date:** | November 2025 |
| **Lead Executive:** | Group Chief Financial Officer |
| **Committee Oversight:** | Finance & Performance Committee |
| **Risk Appetite:** | Open |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| Current | Apr-25 | 4 | 3 | 12 (Moderate) | Amber |
| Target | Mar-26 | 4 | 2 | 8 (Moderate) | Green |

**Assurance Rating & Movement since last review:**

**Amber**

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| Identified Controls<br>*(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Finance teams & structures, policies & processes in place including Standing Financial Instructions and Scheme of Delegation |
| 2 | Financial planning & budget setting processes across the group harmonised and single budget holder manual developed and implemented |
| 3 | Single operational & financial plan, planned deficit and CIP / efficiency target for the group agreed |
| 4 | Processes in place for holding Care Groups / Corporate Directors to account for budgetary control & adherence, the delivery of financial plans & activity and efficiency / cost improvements |
| 5 | Productivity, Improvement & Transformation Group in place, reporting to the Group Leadership Team, to oversee delivery of the group's financial plan (including specific deep dive sessions as required) |
| 6 | Capital, Revenue & Investment Group in place, reporting to the Group Leadership Team, to oversee the development and delivery of the group's capital, revenue and investment plan (also introduced post-investment evaluation process) |
| 7 | Pay controls in place (VCP) to support delivery of the financial and workforce plan |
| 8 | Non-pay discretionary spend controls in place to reduce spend whilst transformational plans are developed (and reviewed / amendments proposed to Audit Committee in June) |

| Gaps in Controls<br>*(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | Current financial policies are up to date but some have yet to be aligned across the group |
| 2 | Financial literacy of the organisation not fully developed |
| 3 | Finance Strategy for the group to be agreed |
| 4 | Forward assurance on efficiency delivery and activity position being developed |
| 5 | The delivery of workforce / headcount reduction, adherence to workforce controls (e.g. bank and agency spend) and activity levels are key risks. |
| 6 | Business Case development, review and approval process not yet fully harmonised - this has now been complete. Will be removed, included to show completed |
| 7 | |
| 8 | |

| | **Actions being taken to address gaps in controls**<br>*(What are we going to do, by when, to further manage and mitigate the risk?)* | **Executive Lead** | **Operational Lead** | **Due Date** | **Progress** |
|---|---|---|---|---|---|
| 1 | Harmonise the remaining financial policies across the group | Group Chief Financial Officer | Deputy Director of Finance – Financial Services | 31 December 2025 | Complete – approved in Audit Committee - October |
| 2 | Complete – approved in Audit Committee - October<br><br>Completed – version is being updated by comms team to ensure consistency. | Group Chief Financial Officer | Deputy Director of Finance - Strategy | 30 June 2025 | Completed – First Finance roadshow training event held in February 2025. Budget holder refresher training held in February & March 2025<br>Ongoing training offer available within ESR |
| 3 | Agree the Group Finance Strategy | Group Chief Financial Officer | Deputy Director of Finance - Strategy | 31 October 2025 | Completed – version is being updated by comms team to ensure consistency. |
| 4 | Approve & implement the Group Performance Management & Accountability Framework (PMAF) | Group Chief Integration Officer | Deputy Director of Finance – Financial Management | 30 June 2025 | Group PMAF approved<br>FPAM content reviewed with DMD lead, proposed finance meeting being reviewed and triangulation of other metrics concluded |
| 5 | Deliver the financial plan and maximise CIP opportunities with a focus on key high impact areas<br><br>Continue to explore and work up income generation opportunities | Group Chief Financial Officer | Care Groups / Corporate Directorates | 31 March 2026 | Underway |
| 6 | Complete the work to harmonise the business case development, review and approval process | Group Chief Financial Officer | Deputy Director of Finance – Financial Services | 31 July 2025 | Complete – documentation standardised |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(How we know the controls are working effectively) | |
|---|---|
| 1 | Oversight of finance and key risks by the Finance & Performance Committee and reporting sub-groups with escalation to the Group Board as required |
| 2 | Reporting on finance KPIs to the Finance & Performance Committee and Group Board through the Integrated Performance Report (IPR) |
| 3 | Internal & external audit arrangements in place |
| 4 | Internal audit review of performance management and data quality within ULTH during 2024 / 25 provided 'reasonable assurance' |
| 5 | Assessment of 'grip and control' undertaken by external parties including through ICB and regulator challenge |

| Gaps in Assurance | |
|---|---|
| 1 | Reporting sub-groups not yet aligned |
| 2 | IPR not yet aligned |
| 3 | Internal audit arrangements have been aligned across the group but work remains ongoing to develop a single report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability |
| 4 | Internal audit review of overseas and contracts within ULTH provided 'limited assurance' |
| 5 | None identified |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4) | Group Chair / Group Chief Executive | Group Director of Corporate Affairs | 30 June 2025 | Completed – clarity on reporting of efficiency (PITOF and PRMs) and activity (Planned and Unplanned Steering Groups), further work ongoing on other finance indicators |
| 2 | Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)<br><br>Internal Audit reports updated | Group Chief Integration Officer | Associate Director of Performance & Information | 30 June 2025 | Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet complete. **Proposed revised deadline of 31 August 2025** |
| 3 | Complete the work to develop a single internal audit report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability | Group Chief Financial Officer | Head of Internal Audit | 31 August 2025 | Internal audit reports updated |

| Related risks on Risk Register – ULTH | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk Description** |
| ULTH | 4664 | 20 | Exceeding the agency cap – temporary staff |
| ULTH | 4657 | 20 | Compliance with subject access requests |
| ULTH | 5020 | 20 | Reliance on agency / locum UEC medical staff |
| ULTH | 5672 | 20 | Risk of failure to deliver the CIP target in full for 2025/2026 |

| Related risks on Risk Register – LCHS | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk description** |
| | | | |

| | | | |
|---|---|---|---|
| ULTH | 4839 | 20 | Lack of pharmacy capacity for intravenous immunoglobulins |

# Strategic Aim 1: Patients

| | |
|---|---|
| **Strategic Aim:** | Patients: Better Care – Timely, affordable, high quality care in the right place |
| **Strategic Objective:** | 1d: Provide modern, clean and fit for purpose care settings |
| **Strategic Risk:**<br>(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:**

~~2016~~ (~~Very~~ High)

| | |
|---|---|
| **Last Review Date:** | December 2025 |
| **Lead Executive:** | Group Chief Estates & Facilities Officer |
| **Committee Oversight:** | Finance & Performance Committee |
| **Risk Appetite:** | Open |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| Current | Dec~~Apr~~-25 | 5 | 4 | ~~2016~~ (~~Very~~ High) | Amber |
| Target | Mar-26 | 5 | 3 | 15 (High) | Amber |

**Assurance Rating & Movement since last review:**

Amber

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Very High | Very High | Very High | Very High | Very High | Very High | Very High | Very High | High | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Red | Red | Red | Red | Red | Amber | Amber | Amber | Amber | | | |

| Identified Controls<br>*(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Estates & Facilities Management (EFM) leadership & professional structures in place (including Authorising Engineers (AEs), Authorised Persons (APs) and Competent Persons (CPs). The Director of Estates & Facilities is the 'Designated Person' for EFM for the group and this is now a board role |
| 2 | EFM governance structure and safety groups in place reflecting Health Technical Memorandums (HTMs), Health & Safety legislation and other statutory requirements |
| 3 | Estates Strategy, Green Plans and EFM Transformation & Improvement Plans in place |
| 4 | EFM policies, processes, work plans and risk assessments in place covering HTMs, Health & Safety legislation and other statutory requirements. Enhanced review of governance systems and structures within risk management and building CAFM (PPM's) has been completed. |
| 5 | Six-facet survey completed for ULTH in 2024: good level of understanding of the estate's 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<br>*(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | There is currently a lack of EFM capacity due to the limited EFM resource within LCHS and some senior leadership and professional roles currently remain unfilled including AEs for LCHS. Work remains ongoing to bring together the Fire Safety, Health & Safety and Emergency Planning & Business Continuity Teams |
| 2 | Continual auditing required |
| 3 | Estates Strategy and Green Plans not yet aligned for group, reports to Integration Committee |
| 4 | Fire and health & safety policies have been aligned but work remains ongoing to align the remaining EFM policies & procedures |
| 5 | There are still some unknown / unquantified risks in respect of the LCHS premises – work underway to assess |
| 6 | The backlog maintenance programme for ULTH of £123m remains a significant risk. The lack of space and the need to decompress the acute site also remains a key area of focus |
| 7 | Inability to address critical infrastructure risks with limited capital |

| Actions being taken to address gaps in controls<br>*(What are we going to do, by when, to further manage and mitigate the risk?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Appoint to directorate critical / professional roles as a priority and in line with vacancy controls process | Group Chief Estates & Facilities Officer | Deputy Directors of Estates & Facilities | Ongoing | Completed |
| 2 | Recruit to the AE roles for LCHS during Q1 2025/26 | Group Chief Estates & Facilities Officer | Deputy Directors of Estates & Facilities | 30 June 2025 | Completed |
| 3 | Transfer preventative and reactive maintenance for LCHS from NHSPS to the ULTH EFM team from 1 April 2025 | Group Chief Estates & Facilities Officer | Deputy Directors of Estates & Facilities | 1 April 2025 | Completed |
| 4 | Undertake a planned preventative maintenance (PPM) and asset register review across the group – to include the findings and response to the 2024 / 25 internal audit | Group Chief Estates & Facilities Officer | Group Chief Estates & Facilities Officer | 1 April 2026 | Audit Underway ~~Appointed specification underway~~ |
| 5 | Complete the work to bring together the Fire Safety, Health & Safety and Emergency Planning & Business Continuity Teams | Group Chief Estates & Facilities Officer | Group Chief Estates & Facilities Officer | 30 April 2025 | Completed |
| 6 | Complete the review of EFM governance structure and associated assurance processes | Group Chief Estates & Facilities Officer | Deputy Directors of Estates & Facilities | 30 September 2025 | Completed |
| 7 | Once the EFM risks in respect of LCHS are clear following the AE audits, service mapping exercise, PAM, review of leases and licences etc, complete the work to align the Estates Strategy & Green Plans. Transformation & Improvement Plans for 2025/26 already in development | Group Chief Estates & Facilities Officer | Deputy Directors of Estates & Facilities | 2 September 2025 | ~~Underway~~ **Proposed revised deadline of April 2026** |
| 8 | Complete the work to align the EFM policies & procedures across the group | Group Chief Estates & Facilities Officer | Deputy Directors of Estates and Facilities | 31 December 2025 | Underway |
| 9 | Undertake an estate rationlisation review with a focus on decompressing the acute site and agile working. A review of resources is required to understand what is needed to complete this project as current resources will not enable the completion of this work. ~~– consider 3d~~ | Group Chief Estates & Facilities Officer | Group Chief Estates & Facilities Officer | 30 June 2025 | Underway **Proposed revised deadline of April 202631 ~~December 2025~~** |
| 10 | Align and update the group business continuity plans to reflect the group infrastructure risks and challenges<br>Update:<br>• All Estates & Facilities BCP's for the acute site are in place.<br>• Fire & Security BCP's for the community sites are in place.<br>• Estates and Health & Safety BCP's to be progressed. | Group Chief Estates & Facilities Officer | EPRR Lead | 31 December 2025 | Underway |
| 11 | Continue to explore alternative sources of capital funding | Group Chief Estates & Facilities Officer | Group Chief Estates & Facilities Officer | Ongoing | Ongoing |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(How we know the controls are working effectively) | |
|---|---|
| 1 | Increased levels of compliance with EFM statutory compliance requirements as demonstrated through internal audits, external condition surveys, AE audits etc. |
| 2 | External / independent review processes in place including AE annual audits and quarterly reviews across all HTMs (ULTH) with monitoring of improvement actions through the EFM Cabinet and reporting to the Finance & Performance Committee in the monthly EFM report |
| 3 | Premises Assurance Model (PAM) utilised annually to evaluate the effectiveness of premises performance against a set of common domains / SAQs with assurance and / or key risks reported to the Finance & Performance Committee and the Group Board. Comparison of the 2023/24 & 20224/25 PAM evaluation submissions for ULTH show a year on year improvement in compliance across most domains. (A new PAM pilot will be live May 2026. A new format of 'Yes' 'No' answers). |
| 4 | Benchmarking of EFM performance is undertaken against local & national indicators and reported through the governance structure |
| 5 | Patient Led Assessment of the Care Environment (PLACE) assessments are undertaken with good levels of compliance in the areas assessed: privacy & dignity, cleanliness, food and general building maintenance and reporting to the Patient Experience & Involvement Group and Quality Committee |
| 6 | Oversight of EFM statutory compliance and key risks by the Finance & Performance Committee and relevant sub-groups (e.g. Health & Safety Committee, Infection Prevention & Control Committee, Water Safety Group) with escalation to the Group Board as required |
| 7 | Internal audit review of EFM areas provides independent assurance and / or escalation of risks. Internal audit review of the business continuity and emergency planning arrangements within ULTH during 2024 / 2025 provided 'reasonable assurance' |
| 8 | Community: AE audit programme for relevant HTMs for LCHS premises in place & progress reported via Estates & Facilities Upward Report |

| Gaps in Assurance | |
|---|---|
| 1 | EFM compliance dashboards not yet fully aligned |
| 2 | Outstanding actions continue to be progressed. |
| 3 | • Comparison of the 2023/24 & 20224/25 PAM evaluation submissions for LCHS show an improvement in compliance across the majority of domains although with good levels of compliance in the patient experience domain. The requirement for risk assessed, costed action plans for SAQs rated 'inadequate' or requiring 'moderate or minor improvements' was rated 'Inadequate' across all domains<br>• 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<br>• |
| 4 | Reliability of LCHS Estates Returns Information Collection (ERIC) scores to be improved |
| 5 | Shortfalls in housekeeping staffing levels, due to difficulties in recruiting, have the potential to impact on PLACE scores |
| 6 | There is a need for further clarity on the elements of the EFM agenda to be reported to the Finance and Performance Committee and the Integration Committee |
| 7 | Internal audit review of planned and preventative estates maintenance within ULTH during 2024 / 25 provided 'limited assurance' |
| 8 | Asbestos, Water and Lift Reports received, awaiting further reports. |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Align the EFM compliance dashboards across the group as part of the review and strengthening of the EFM governance arrangements | Group Chief Estates & Facilities Officer | Deputy Directors of Estates & Facilities | 30 September 2025 | ~~Underway~~ Completed |
| 2 | Undertake full AE audit for all LCHS properties and regular annual programme of audits and quarterly reviews to be put in place thereafter | Group Chief Estates & Facilities Officer | Deputy Directors of Estates & Facilities / AEs | 30 September 2025 | **Proposed revised deadline of April 2026** ~~Underway~~ |
| 3 | Align the process for the completion and submission of the PAM by the 30 September deadline and strengthen the process for the delivery and oversight of agreed improvement actions through the year | Group Chief Estates & Facilities Officer | Deputy Directors of Estates & Facilities | 30 September 2025 | Completed |
| 4 | As part of the review of the board committee terms of reference and work plans, ensure there is greater clarity on the elements of the EFM agenda for which the Finance & Performance Committee has oversight and which come under the remit of the Integration Committee | Group Chief Estates & Facilities Officer | Group Director of Corporate Affairs | 6 May 2025 | Complete |

| Related risks on Risk Register – ULTH | | | |
|---|---|---|---|
| Trust | Datix ID | Score | Summary Risk Description |
| | | | |

| Related risks on Risk Register – LCHS | | | |
|---|---|---|---|
| Trust | Datix ID | Score | Summary Risk description |
| | | | |

# Strategic Aim 2: People

| | |
|---|---|
| **Strategic Aim:** | People: Better Opportunities – Develop, empower and retain great people |
| **Strategic Objective:** | 2a: Enable our people to fulfil their potential through training, development and education |
| **Strategic Risk:**<br>(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:** | October 2025 |
| **Lead Executive:** | Group Chief People Officer |
| **Committee Oversight:** | People Committee |
| **Risk Appetite:** | Open |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 3 | 3 | Moderate (9) | Amber |
| **Target** | Mar-26 | 3 | 2 | Low (6) | Green |

**Assurance Rating & Movement since last review:**

**Green**

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Green | Green | Green | Green | Green | | | |

| Identified Controls<br>*(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Education, Learning & Organisational Development Team working with Care Groups to improve statutory and mandatory training compliance to 90% by 31 March 2026, with a focus on areas where compliance is <50%. ESR Hierarchy reviews planned twice per year to support accurate reporting and management of non-compliance. |
| 2 | Education, Learning & Organisational Development Team working with Care Groups to ensure that staff have the correct training and support available to fulfil their roles as leaders through upskilling, strengthening and awareness of responsibilities through active engagement with leadership and development training |
| 3 | Further opportunities being developed for improving productivity and integration through a 'grow our own' approach and use of apprenticeship levy being maximised |
| 4 | Education Oversight Group in place |
| 5 | Processes in place for holding Care Groups/Corporate Directors to account for the delivery of people KPIs and improvements to support ownership at local level |
| 6 | Lincolnshire (system) People Plan in place. Continued focus on ensuring that the People Promise themes are embedded across the group in line with the wider Lincolnshire System People Plan objectives |

| Gaps in Controls<br>*(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | Divisional/Clinical Care Group Leadership Teams awareness of areas of non-compliance to support local improvement interventions |
| 2 | Divisional/Clinical Care Group uptake of leadership and development training |
| 3 | Limited oversight of apprenticeship levy use at Clinical Care Group level |
| 4 | There is no Education Oversight Group KPI dashboard in place and assurance that Education Oversight Group agenda is in line with assurance required within People Committee, and that KPI Dashboard is in place to monitor progress against key deliverables |
| 5 | FPAM monthly reports are not aligned to the refreshed PRM packs. Divisional Leadership Teams not able to / unclear on how to access the standard reports to support oversight |
| 6 | None identified |

| | Actions being taken to address gaps in controls<br>*(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<br>There is a plan in place to now send out ESR Hierarchy Reports twice per year to the Care Groups across the Group (planned to take place March in line with readiness for new financial year, and August (post Dr rotation) for mid-year review).<br><br>Monthly reporting in place for Key Performance Indicators for the regular oversight of training, appraisal and workforce metrics to support compliance monitoring – this reports via a dashboard to Workforce Strategy Group and People Committee. | Group Chief People Officer | Head of Workforce Planning & Reporting / People Systems Manager | 30 June 2025 | Completed – embedded and added to controls and assurances |
| 2 | Monitoring uptake of leadership and development training through monthly performance meetings such as PRM, with a focus on further supporting the areas with the least uptake to release staff to be able to attend and the identification of trends and any correlation between HR / ER cases, sickness and turnover | Group Chief People Officer | Education & Learning Managers | 31 March 2026 | Underway – on track |
| 3 | Development of Education Oversight Group KPI Dashboard which reports monthly into the Education Oversight Group and upwardly into People Committee to ensure that there is oversight of apprenticeship levy use across the Group and our position against the public sector target | Group Chief People Officer | Education & Learning Managers | 31 May 2025 | Completed – continues to be embedded |
| 4 | Standardised upward report from Education Oversight Group into People Committee in place, and the current development of Education Oversight Group KPI Dashboard is ongoing | Group Chief People Officer | Education & Learning Managers | 31 May 2025 | Completed – continues to be embedded |
| 5 | Review of FPAM Packs within the acute Trust (People Section) underway to bring in line with PRM format and report by exception. This will include updated training for Divisional Head of HR and Leadership Teams on how to access core People KPI Reports to maintain regular oversight<br>ULTH has currently 'stood down' FPMA meetings so packs have not been created within 2025/26. It is not yet confirmed if these will be re-instated in year or not. Work had been done on the packs prior to cancellation of meetings and will continue once refreshed meeting are in place (as required). | Group Chief People Officer | Deputy Group Chief People Officer / Head of Workforce Planning & Reporting | 30 June 2025 | Completed – continues to be fully embedded<br>**Proposed revised deadline of 31 March 2026** |
| 6 | People Promise work streams embedded within the Reward, Recognition & Engagement Manager role within the Education, Learning & Organisational Development Team to maintain oversight of People Promise themes | Group Chief People Officer | Education & Learning Manager | 31 March 2026 | Underway – on track |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(How we know the controls are working effectively) | |
|---|---|
| 1 | Oversight of the people agenda and key risks by the People Committee and reporting sub-groups with escalation to the group board as required. Forward reporting schedule shared with People Directorate annually to able to pro-actively list agenda items in sub-groups. |
| 2 | Reporting on People KPIs to the People Committee and Group Board through the Integrated Performance Report (IPR). Mandatory training compliance continues to improve |
| 3 | Reporting on medical and non-medical education and medical revalidation to the People Committee |
| 4 | Reporting on safer staffing (including training and knowledge gaps) to the People Committee |
| 5 | Monthly FPAM and PRM meetings take place which review KPIs against targets, and this is reported at overall Trust level at People Committee within the scorecard |
| 6 | Internal audit review of the people agenda provides independent assurance and / or escalation of risks. Internal audit review of mandatory training within ULTH undertaken during 2024 / 25 provided 'reasonable assurance' |
| 7 | National and regional benchmarking data considered through the People Committee and reporting sub-groups |
| 8 | External oversight and assurance in respect of people performance is undertaken through the Lincolnshire People Board/Workforce Committee |

| Gaps in Assurance | |
|---|---|
| 1 | Sub-Groups ensuring that agenda items and upward reports are in line with People Committee annual plan |
| 2 | IPR metrics currently being confirmed – have been reviewed within People Directorate and shared, with alignment across LCHS and ULTH in line with Workforce Plans for 2025/26. |
| 3 | None identified |
| 4 | None identified |
| 5 | Alignment to PRM Packs required to ensure consistency of data and reporting by exception |
| 6 | Limited oversight of group-wide audit schedule where there is an impact on people. Audit of LCHS areas unclear |
| 7 | Oversight of benchmarking data needs to be considered and consistent across all sub-groups – currently in place in line with agenda items and discussion points within Workforce Strategy Group |
| 8 | None identified |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year. This is now in place with enhanced communication by way of agenda sharing and workplan being accessible from Trust Board papers which sets out workplan. | Group Chief People Officer | Deputy Group Chief People Officer / Head of Workforce Planning & Reporting | 31 July 2025 | Completed – embedded and added to controls and assurances |
| 2 | Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025/26 is being undertaken as part of the group development work programme (work stream 2) | Group Chief People Officer | Group Deputy Director of People / Head of Workforce Planning & Reporting | 30 June 2025 | Completed – continues to be embedded |
| 3 | Regular report into Workforce Strategy Group and upward report into People Committee – to be reviewed and refreshed in line with 2025/26 objectives (as required) | Group Chief Medical Officer / Group Chief People Officer | Business Manager to the Group Chief Medical Officer / Head of Workforce Planning & Reporting | 30 September 2025 | Completed – continues to be embedded |
| 4 | Regular report into Workforce Strategy Group and upward report into People Committee – to be reviewed and refreshed in line with 2025/26 objectives (as required) | Group Chief Nurse / Group Chief People Officer | Assistant Director of Nursing / Head of Workforce | 30 September 2025 | Completed – continues to be embedded |

| | | | | | |
|---|---|---|---|---|---|
| | | | Planning & Reporting | | |
| 5 | Review of standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms | Group Chief People Officer | Group Deputy Director of People / Head of Workforce Planning & Reporting | 30 September 2025 | Completed – continues to be embedded |
| 6 | Audit schedule to be requested and shared with key plan in place to manage audit cycles which impact People (close working between Corporate Governance and People Directorate required to deliver) | Group Chief People Officer | Head of Workforce Planning & Reporting | 31 May 2025 | Completed – continues to be embedded |
| 7 | All sub-groups to incorporate benchmarking (using as a minimum Model Hospital data) as regular agenda items in 2025/26 | Group Chief People Officer | Group Deputy Director of People | 30 June 2025 | Completed – continues to be embedded |
| 8 | Develop and embed standard reporting mechanisms into Lincolnshire People Board / Workforce Committee | Group Chief People Officer | Deputy Group Chief People Officer | 30 September 2025 | Completed – continues to be embedded |

| Related risks on Risk Register – ULTH | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk Description** |
| ULTH | 4996 | 20 | Consultant workforce capacity: Haematology |

| Related risks on Risk Register – LCHS | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk description** |
| | | | |

# Strategic Aim 2: People

| | |
|---|---|
| **Strategic Aim:** | People: Better Opportunities – Develop, empower and retain great people |
| **Strategic Objective:** | 2b: Empower our people to continuously improve and innovate |
| **Strategic Risk:**<br>(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:** | October 2025 |
| **Lead Executive:** | Group Chief People Officer |
| **Committee Oversight:** | People Committee |
| **Risk Appetite:** | Hungry |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 3 | 3 | Moderate (9) | Amber |
| **Target** | Mar-26 | 3 | 2 | Low (6) | Green |

**Assurance Rating & Movement since last review:**

**Amber**

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| **Identified Controls** *(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Education, learning and development programmes and KPIs in place |
| 2 | Engagement 'Tube Map' – 'Better Together' Programme in place and ongoing including OD support |
| 3 | Improved job planning compliance rate to 95% with supporting evidence in place, and a move towards a prospective cycle. |
| 4 | Improved Medical & Dental middle tier vacancy rate with a focus on stabilisation and succession planning through fully embedding a revised 'Plan for Every Post' process |
| 5 | Quality Improvement (QI) strategy/Quality Management System (QMS) being developed as a key enabler to support innovation/delivery of the group improvement/transformation agenda |
| 6 | Creating a culture of research and innovation recognised as a group priority |
| 7 | Workforce Planning |

| **Gaps in Controls** *(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | Delivery of action plans and improvements at operational level needs to be incorporated into the Performance Management & Accountability and PRM process |
| 2 | Staff awareness at all levels of group strategy, values and approach to innovation and continuous improvement remains ongoing |
| 3 | 2023 / 24 and 2024 / 25 job plans are still being finalised although significant improvements have been made |
| 4 | Division/Clinical Care Groups not yet fully owning the 'Plan for Every Post' process |
| 5 | Capacity of staff to engage with improvement agenda to be determined |
| 6 | Culture of research and innovation not yet embedded |
| 7 | Adverse to plan (M06) within Acute as a result of temporary staffing use, and approved substantive staff levels not included within plan |

| Actions being taken to address gaps in controls<br>*(What are we going to do, by when, to further manage and mitigate the risk?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Review the way in which Staff Survey action plans are monitored and reported through standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms | Group Chief People Officer | Education & Learning Manager / Head of Workforce Planning & Reporting | 30 September 2025 | Completed & embedded and added to controls or assurances |
| 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<br>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<br>Plan for Every Post standardised framework in development to support ownership at Divisional Care Group level with clarity on roles and responsibilities and core enablers. | Group Chief People Officer | Deputy Group Chief People Officer / Head of Workforce Planning & Reporting | 31 May 2025 | Completed & embedded and added to controls or assurances |
| 7 | Shadow Board in place since July 2025 to provide additional level of grip and control with a focus on temporary staff use, continuation of Vacancy Control Process to support risk based recruitment through a Quality Impact Assessment and weekly upward report to ELT, with forecasting included | Group Chief People Officer | Deputy Group Chief People Officer / Head of Workforce Planning & Reporting | 31 March 2026 | Underway – on track |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(How we know the controls are working effectively) | |
|---|---|
| 1<br>2 | Upward Reporting: Pulse Survey and NHS Staff Survey results are reported to the Executive Leadership Team, People Committee and Group Board and action plans are monitored through the People Committee with escalation to the Group Board as required. |
| 3<br>4 | Oversight of the people agenda and key risks by the People Committee and reporting sub-groups with escalation to the group board as required. Reporting on people KPIs to the People Committee and Group Board through the Integrated Performance Report (IPR) |
| 5 | Oversight of research & innovation has transferred to the Integration Committee |

| Gaps in Assurance | |
|---|---|
| 1<br>2 | Monitoring of action plan progress not fully embedded within sub-groups and relevant upward reporting, with priority focus being on the Divisional Clinical Care Groups monitored via PRM/FPAMs so that leaders are accountable and undertaking their actions |
| 3<br>4 | Sub-Groups ensuring that agenda items and upward reports are in line with People Committee annual plan. IPR metrics currently being refreshed |
| 5 | Regular reporting to be established |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year. | Group Chief People Officer | Deputy Group Chief People Officer / Head of Workforce Planning & Reporting | 30 June 2025 | Completed & embedded and added to controls or assurances |
| 2 | Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025/26 is being undertaken as part of the group development work programme (work stream 2) | Group Chief People Officer | Deputy Group Chief People Officer / Head of Workforce | 30 June 2025 | Completed – continues to be embedded |

| | | | | | |
|---|---|---|---|---|---|
| | | | Planning & Reporting | | |
| 3<br>4 | People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year. | Group Chief People Officer | Deputy Group Chief People Officer / Head of Workforce Planning & Reporting | 30 June 2025 | Completed – continues to be embedded |
| 5 | Reporting requirements to be agreed as part of the refresh of the board committee terms of reference and work plans | Group Director of Corporate Affairs | Deputy Trust Secretary | 30 June 2025 | Completed – continues to be embedded |

**Related risks on Risk Register – ULTH**

| Trust | Datix ID | Score | Summary Risk Description |
|---|---|---|---|
| ULTH | 4997 | 20 | Service configuration (Haematology) |
| ULTH | 5093 | 20 | Procurement service staffing levels (Pharmacy) |
| ULTH | 4844 | 20 | Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service |

**Related risks on Risk Register – LCHS**

| Trust | Datix ID | Score | Summary Risk description |
|---|---|---|---|
| | | | |

# Strategic Aim 2: People

| | |
|---|---|
| **Strategic Aim:** | People: Better Opportunities – Develop, empower and retain great people |
| **Strategic Objective:** | 2c: Nurture compassionate and diverse leadership |
| **Strategic Risk:**<br>(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:** | December 2025 |
| **Lead Executive:** | Group Chief People Officer |
| **Committee Oversight:** | People Committee |
| **Risk Appetite:** | Open |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 3 | 3 | Moderate (9) | Amber |
| **Target** | Mar-26 | 3 | 2 | Low (6) | Green |

**Assurance Rating & Movement since last review:**

**Amber**

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| Identified Controls<br>*(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 and Sexual Safety Charter. |
| 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<br>*(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 | Sexual Safety Policy to be published in Q4 2025/26; Quarterly reporting on agreed sexual safety metrics to begin by end Q3 2025-2026.~~None identified~~ |
| 6 | None identified |
| 7 | None identified |
| 8 | There is currently insufficient funding for the development of the menopause service |

| Actions being taken to address gaps in controls<br>*(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.<br>Policies have been prioritised to focus on contractual policies as the priority<br>Policy summary provided on People Committee Scorecard, with robust mechanism for oversight locally being developed to strengthen early actions and mitigate overdue dates. | 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. This will also include agreed quarterly reporting on sexual safety metrics.<br><br>Included within People Committee Scorecard to ensure oversight and ability to track changes in compliance rates. | Group Chief People Officer | Group Deputy Chief People Officer | 31 March 2026 | Underway – on track |
| 4 | People Directorate Teams (Education, Learning & OD and People, Planning & Transformation) are working together to identify improved reporting within FPAMs / PRMS. | Group Chief People Officer | Education & Learning / OD & People & Transformation Teams | 30 September 2025 | Completed – continues to be embedded |
| 5 | Review of menopause service and review of funding options to be undertaken.<br>Review completed and funding of this considered and identified as part of forthcoming People Directorate restructure to ensure embedded and appropriate continuation of the service. Service expanded across LCHG. | Group Chief People Officer | Head of Education & Learning/Occupational Health | 31 March 2026 | ~~Underway – on track~~Completed |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(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 and Sexual Safety results and actions plans are monitored through the People Committee with escalation to the Group Board as required |
| 4 | Pulse Survey and NHS Staff Survey results are reported to the Executive Leadership Team, People Committee and Group Board and action plans are monitored through the People Committee with escalation to the Group Board as required. NHS Staff Survey results are currently above average in the 'People Promise' areas. Pulse Surveys are above benchmark |
| 5 | People KPIs / metrics are reported through the IPR to the People Committee |
| 6 | There is routine reporting on employee relations activity and themes to the People Committee and Group Board |
| 7 | There is routine reporting on FTSU concerns to the People Committee and Group Board |
| 8 | Staff networks meet regularly and there is reporting from the network chairs to the People Committee |
| 9 | Staff well-being offer is monitored through discussion with staff side and through the People Committee |
| 10 | Internal audit review of the people agenda provides independent assurance and / or escalation of risks. Internal audit review of equality, diversity and inclusion undertaken within ULTH during 2024 / 2025 provided 'reasonable assurance' |

| Gaps in Assurance | |
|---|---|
| 1 | Triangulation of data sources and feedback with other relevant sources of information and where this is reported needs to be reviewed and strengthened |
| 2 | There is currently no shared platform for oversight of when policies are due for review |
| 3 | None identified |
| 4 | Monitoring of action plan progress is not fully embedded within sub-groups and relevant upward reporting |
| 5 | IPR metrics are currently being refreshed to reflect the group strategic aims & objectives and workforce plans for 2025 / 26 |
| 6 | Ability to support triangulation of HR/ER data with other key performance metrics to support wider oversight and ability to identify trends and develop action plans |
| 7 | |
| 8 | None identified |
| 9 | None identified |
| 10 | None identified |

| Actions being taken to address gaps in assurances<br>*(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. This includes agreed Sexual Safety Charter key metrics. | Group Chief People Officer | Education & Learning Managers | 30 June 2025 | Completed – continues to be embedded |
| 2 | People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the Policy report and due dates and create a dashboard which provides oversight | Group Chief People Officer | Deputy Group Chief People Officer / Head of Workforce Planning & Reporting | 30 September 2025 | Completed – continues to be embedded |
| 3 | In addition, to monitoring WRES and WDES actions through Equality, Diversity and Inclusion Group, this group will monitor incidents of sexual harassment, racism, ableism, homophobia and transphobia and other forms of discrimination, bullying, harassment and abuse, highlighting where additional actions need to be undertaken. | Group Chief People Officer | Deputy Director of People | 31 March 2026 | Underway – on track |
| 34 | 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 |
| 45 | 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 | 30 June 2025 | Completed – continues to be |

| | | | | | |
|---|---|---|---|---|---|
| | | Group Director of Corporate Affairs | Officer / Head of Workforce Planning & Reporting | | embedded |

| Related risks on Risk Register – ULTH | | | |
|---|---|---|---|
| Trust | Datix ID | Score | Summary Risk Description |
| | | | |

| Related risks on Risk Register – LCHS | | | |
|---|---|---|---|
| Trust | Datix ID | Score | Summary Risk description |
| | | | |

# Strategic Aim 2: People

| | |
|---|---|
| **Strategic Aim:** | People: Better Opportunities – Develop, empower and retain great people |
| **Strategic Objective:** | 2d: Recognising our people through thanks and celebration |
| **Strategic Risk:**<br>(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:** | December 2025 |
| **Lead Executive:** | Group Chief People Officer |
| **Committee Oversight:** | People Committee |
| **Risk Appetite:** | Hungry |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 3 | 2 | Low (6) | Amber |
| **Target** | Mar-26 | 3 | 1 | Very Low (3) | Green |

**Assurance Rating & Movement since last review:**

Amber

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Low | Low | Low | Low | Low | Low | Low | Low | Low | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| **Identified Controls**<br>*(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Reward and Recognition arrangements harmonised across the group including the development of a group Reward and Recognition Policy |
| 2 | Reward, Recognition and Engagement Manager in post to support ongoing work streams from 'People Promise' themes |
| 3 | ELT visibility and recognition of staff and teams through established communication and engagement channels |
| 4 | Annual staff awards ceremony held to recognise the contribution of individuals and teams |
| 5 | Robust review processes in place including appraisal, 1:1 meetings and feedback |

| **Gaps in Controls**<br>*(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | Policy approved but needs embedding |
| 2 | Role is in place within ULTH workforce but needs expanding to work across the group with an ability to utilise insights from this role to support wider reporting and identification of trends and development of action plans |
| 3 | None identified |
| 4 | None identified |
| 5 | Concept of group appraisals and appraisal lite process to be considered as part of review and alignment of HR policies |

| Actions being taken to address gaps in controls<br>*(What are we going to do, by when, to further manage and mitigate the risk?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Embed Group reward & Recognition Policy | Group Chief People Officer | Group Deputy Chief People Officer | 31 March 2026 | Completed – continues to be embedded |
| 2 | Review how the Reward, Recognition and Engagement Manager role aligns to wider LCHG work streams and how the role can bring insights to wider work streams, including reporting into FPAM and other key assurance meetings | Group Chief People Officer | Group Deputy Chief People Officer | 31 March 2026 | Underway – on track |
| 3 | Launch refreshed appraisal cycle as part of further harmonisation across the group | Group Chief People Officer | Education & Learning Managers | 30 June 2025 | Completed – continues to be embedded |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(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. To include but not limited to: sexual misconduct, racism, ableism, homophobia and transphobia and other forms of discrimination, bullying, harassment and abuse. |
| 2 | Monitoring of action plan progress not fully embedded within sub-groups and relevant upward reporting |
| 3 | None identified |
| 4 | None identified in respect of reward and recognition |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Develop a KPI dashboard to enable triangulation and highlighting of cultural trends and issues with reporting into the Culture and Leadership sub-group on a monthly basis with onward upward reporting to People Committee | Group Chief People Officer | Group Head of Workforce Planning & Reporting | 31 March 2026 | Completed – continues to be embedded |
| 2 | Review the way in which Staff Survey action plans are monitored and reported through standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms.<br><br>New approach introduced to both local and organisational staff survey action plan monitoring, via GLT and also Culture & Leadership Group reporting. | Group Chief People Officer | Associate Director of Culture & Wellbeing | 31 March 2026 | Underway – on track |
| 3 | To consider and develop an approach to how we identify, recognise and reward improving and exemplar pockets of culture across the Group – Just Culture; Compassionate Leadership; Equity & Inclusion, including sexual safety and other aspects of "United against Discrimination" | Group Chief People Officer | Associate Director of Culture & Wellbeing | 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:**<br>(How we may be prevented from meeting objective and what is the potential impact) | If we do not **transform key clinical pathways,** rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience |

**Current Risk Score & Movement since last review:**

**12 (Moderate)**

| | |
|---|---|
| **Last Review Date:** | December 2025 |
| **Lead Executive:** | Group Chief Integration Office |
| **Committee Oversight:** | Integration Committee |
| **Risk Appetite:** | Open |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 4 | 3 | 12 (Moderate) | Amber |
| **Target** | Mar-26 | 4 | 2 | 8 (Moderate) | Green |

**Assurance Rating & Movement since last review:**

**Amber**

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| Identified Controls<br>*(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Left Shift Transformation Plan with oversight of delivery by the Alliance Steering Group. ~~Deep dive on the programme included in ASG reporting for September.~~December ASG pack includes draft blueprint to move specialties between care groups (e.g. from Medicine to Alliance) and BI dashboard.~~Deep dive on the programme included in ASG reporting for September.~~ |
| 2 | Transformation of planned and unplanned pathways to be managed through a sub-group of the Alliance Steering Group. Alliance Steering Group sub-groups on planned / unplanned care group transformation, left shift re-design programme are all now in place and integrated neighborhood teams being scoped (HI group well-established) |
| 3 | Governance structures and QIA processes in support of the transformation programme in place. Governance and reporting being refined in support of transformation programme, with a Programme Manager allocated to support good governance and oversight of the 4 programmes. |
| 4 | Integrated Neighbourhood Working programme to be managed through the a sub-group of the Alliance Steering Group |
| 5 | Partnership Strategy in place to support transformation |
| 6 | Dedicated work stream to support collaboration at scale in place with key sub-work streams |
| 7 | Health Inequalities Working Group established to identify and address health inequalities, focusing on the use of the Health Inequalities Maturity Matrix to drive improvement |
| 8 | Estates strategy being developed, Space Group set up to support rationalisation and specific service transformation request |

| Gaps in Controls<br>*(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | Alliance Steering Group, established in June, meets monthly. Currently only with internal group representation and lacks external membership. Movement of ICB to clusters has an impact on key roles and added uncertainty. |
| 2 | Pace of change and cultural mindset of working collaboratively needs to be embedded |
| 3 | Scale of delivery while implementing a blueprint of transformation for left shift |
| 4 | Sub-groups being established with partners supported by the diagnostic by Newton's (findings being reviewed and Phase 2 being scoped including potential delivery partner support)~~commenced in August and is due to run over 8 weeks)~~ |
| 5 | Partnership Strategy needs to be refreshed in line with the Group Strategy and Alliance Model (aiming to table at December Integration Committee) |
| 6 | Spectrum of integration options to be formalised for all partners based on Partnership Strategy/Partnership Agreement |
| 7 | Embedding of HI as BAU within the Divisions. |
| 8 | No aligned Estates Strategy across the Group |

| | Actions being taken to address gaps in controls<br>*(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 TOR to be reviewed and agreed in January 2026 which will include proposals for any external stakeholder attendance.<br><br>First Neighbourhood health board took place on 21st October with external leaders – this will support the identification of the appropriate external partners to join the alliance steering sub-groups | Group Chief Integration Officer | Director of Improvement and Integration / Deputy Chief Integration Officer | 31 July 2025 | **Underway** |
| 2 | Alliance Steering Group sub-groups to be established and work streams being set up with a clear 12 month delivery plan. Focus has been on group workstreams being established across left shift to date however the EOL sub-group with external partners is due to launch in November and the Falls work being delivered with LIVES has commenced operational delivery. Review of Planned and Unplanned Care Group governance underway to remove duplication with ASG and identify any gaps. | Group Chief Integration Officer | Director of Improvement and Integration / Deputy Chief Integration Officer | 31 July 2025 | **Complete and ongoing** |
| 3 | First PITOF meeting diarised for 12 May 2025 and to take place monthly | Group Chief Integration Officer | Director of Improvement and Integration | 12 May 2025 | Complete & ongoing |
| 3. | December ASG pack includes draft blueprint to left shift specialties between care groups (e.g. from Medicine to Alliance) and BI dashboard. | Group Chief Integration Officer | Director of Improvement and Integration | End Dec 2025 | Underway |
| 3 | Partnership Strategy to be refreshed with sign off by the Integration Committee | Group Chief Integration Officer | Deputy Director of Strategic Partnership | 30 June 2025 | Underway. Will go to IC in December<br>**Proposed revised timescale 31 December 2025** |
| 4 | Work with EFM to contribute to developing the Estates Strategy. Development being informed by work on the clinical operation model and left shift work programme | Group Chief Integration Officer | Chief Estates Officer | 31 March 2026 | Underway |
| 5 | Health Inequalities plans for Care groups are in the process of being developed as part of the annual planning submission in order to ensure the embedding of the approach within BAU. | Group Chief Integration Officer | Deputy Director of Strategic Partnership | December 2025 | Underway |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(How we know the controls are working effectively) | |
|---|---|
| 1 | Oversight of transformation work streams by the Integration Committee with escalation to the Group Board as required |
| 2 | External assurance will be provided through the Alliance Steering Group updates to Lincolnshire Leaders Group and partner provider boards |
| 3 | PITOF upward reports including reporting on delivery of key KPIs and milestones to the Integration Committee |
| 4 | IPR to support demonstration of a positive shift in key metrics such as improved LOS, improved staff and patient satisfaction, improved access to services |
| 5 | New Lincolnshire Neighborhood Board now established |
| 6 | |
| 7 | |
| 8 | |

| Gaps in Assurance | |
|---|---|
| 1 | ~~identified~~Consistent representation at ASG by key leads including corporate services~~None identified~~ |
| 2 | External partners not yet meeting as part of the Alliance Steering Group but the new Neighborhood Board will be a forum for system partner discussions. |
| 3 | Work streams, KPIs and timelines still being worked up with a digital dashboard being created, to be finalised in Q3 |
| 4 | None identified |
| 5 | ~~TOR~~ No Partnership Agreement~~to be agreed in next meeting~~ in place. Currently the 'managerial' and operational boundaries differ across LCHG, LCC, LPFT and PCNA.~~TOR to be agreed in next meeting.~~ |
| 6 | |
| 7 | |
| 8 | |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Integration Committee work plan and reporting sub-groups to be established including external partners where appropriate (with support from Newton's for INW)<br><br>Newton to presented diagnostic findings to ELT November 20th and to GLT December with system leadership event to be planned in December followed by update to IC December on the proposed implementation of recommendations | Group Chief Integration Officer | Director of Improvement and Integration / Deputy Chief Integration Officer | 31 May 2025 | . Draft diagnostic being shared cross suystem leaders during November before final report is presented to ICB/The group/LCCC**Proposed revised timescale Decemberr 2025** |
| 1 | Review of the ASG ToR planned for January 2026 supported by proposed review of the agenda and operation of the meeting to make it more focused and engaging being tabled in December | Group Chief Integration Officer | Director of Improvement and Integration / Deputy Chief Integration Officer | January 2026 | Underway |
| 2 | Left shift specialties being identified, phasing model for delivery in development, relevant population health management data collated to produce evidence packs to commence service redesign with relevant partners from acute, community and wider system | Group Chief Integration Officer | Director of Improvement and Integration / Deputy Chief Integration Officer | 31 May 2025 | Complete |
| 2 | The new Neighborhood Health Board will be a forum for system partner discussions. | Group Chief Integration Officer | Director of Improvement and Integration / Deputy Chief Integration Officer | Review March 2026 | Underway |

| | | | | | |
|---|---|---|---|---|---|
| 3 | Strategy, improvement and redesign team working on pulling together programme plans for all the work streams to report through a central reporting mechanisms | Group Chief Integration Officer | Director of Improvement and Integration | 31 May 2025 | Complete |
| 4 | Integration brochure to provide options for collaborative working being developed. – is in draft and will be finalised as part of the Partnership delivery plan. | Group Chief Integration Officer | Director of Improvement and Integration | 31 May 2025 | Complete |
| 5 | Partnership Agreement to be agreed as soon as possible, and attempt to be made to map ,'managerial' and operational boundaries across LCHG, LCC, LPFT and PCNA to support neighbourhood health implementation | Group Chief Integration Officer | Director of Improvement and Integration | January 2026 | Underway |

**Related risks on Risk Register – ULTH**

| Trust | Datix ID | Score | Summary Risk Description |
|---|---|---|---|
| ULTH | 5563 | 20 | Neurology – Service sustainability |
| ULTH | 5711 | 20 | Risk to our transformation programme due to changes within the ICB |

**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:** | December 2025 |
| **Lead Executive:** | Group Chief Integration Officer |
| **Committee Oversight:** | Integration Committee |
| **Risk Appetite:** | Hungry |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 4 | 3 | 12 (Moderate) | Amber |
| **Target** | Mar-26 | 4 | 2 | 8 (Moderate) | Green |

**Assurance Rating & Movement since last review:**

**Amber**

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| Identified Controls *(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Group Strategy developed. Tackling health inequalities identified as a key organisation / system priority within the group strategy and operational and financial plan |
| 2 | The delivery of the Alliance Programme (overseen by the Alliance Steering Group) will support the work required to reduce health inequalities |
| 3 | Health Inequalities Working Group in place to oversee delivery of the plan to improve group health inequalities maturity matrix scores |
| 4 | Tackling health inequalities is a key area of focus within the board development programme |
| 5 | Consistent use of the linked data set to design, deliver and review services supported by the skills and capability to use tools and frameworks embedded as BAU within the new LCHG Transformation Framework |
| 6 | Workshops/meetings with specialties taken place ~~being scheduled~~ to identify areas of focus for transformation supported by programme managers and business partners. |

| Gaps in Controls *(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | Little focus on prevention in system strategy/lack of investment in prevention ~~None~~~~None identified~~ |
| 2 | None identifiedLittle focus on prevention in system strategy/lack of investment in prevention ~~None identified~~ |
| 3 | Embedding the data in decision making in local delivery plan. |
| 4 | None identified |
| 5 | Methodology for developing ~~D~~data packs in place~~development~~ for key left shift transformation priorities and a progrmme to address skills / knowledge gaps. Respiratory pack shared with the Integration Committee in June as an example. Work needed to embed consistent use of data in planning. ICB changes may pose a risk to sustainability of the linked data set |
| 6 | Data driven analysis to inform planning needs to be consistently applied~~packs~~packs and a ~~workshop format being developed with support from ICB business analyst as .System PHM Programme Director secondment has ended. LCHG business analysts fully supporting.~~ |

| Actions being taken to address gaps in controls<br>*(What are we going to do, by when, to further manage and mitigate the risk?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Monthly Alliance Steering Group established (complete)<br><br>ASG arrangements are subject to the outcome of a Board discussion on a proposed system Neighbourhood Board. Representation by PCNA on LCHG governance groups has been confirmed. Neighborhood established now to close the gaps | Group Chief Integration Officer | Director of Integration and Improvement / Deputy Chief Integration Officer | 31 July 2025 | Complete |
| 2 | Health Inequalities action plan is complete. Next phase incudes embedding data in decision making and BAU. | Group Chief Integration Officer | Deputy Director of Strategic Partnerships | 30 June 2025 | Complete |
| 2 | Role of Neighbourhood Health Board in prevention being scoped as part of discussions on purpose/remit (e.g. health partners as stakeholders in Resilient Communities rather than the lead) | Group Chief Integration Officer | Director of Integration and Improvement / Deputy Chief Integration Officer | Review March 2026 | Underway |
| 3 | Population Health data packs/intelligence embedded in the improvement methodology approach for left shift and wider transformation activities. | Group Chief Integration Officer | Director of Integration and Improvement / Deputy Chief Integration Officer | 31 July 2025 | Complete and ongoing |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(How we know the controls are working effectively) | |
|---|---|
| 1 | Health Inequalities Working Group upward report into the new Alliance Steering Group and Integration Committee and Group Board |
| 2 | Development of a LCHG Co-production Strategy to support the health inequalities and personalisation agenda and reduce health inequalities – being owned by Chief Nurse/Group Head of Patient Experience and Volunteer Services |
| 2 | Neighbourhood Health Board role in defining responsibilities around prevention |
| 3 | PHM and HI are golden threads through the LCHG Strategy and delivery will be monitored through upward reporting to the Integration Committee and Group Board |
| 4 | |
| 5 | |
| 6 | |

| Gaps in Assurance | |
|---|---|
| 1 | Health inequalities action plan completed, approved by Alliance Steering group and Integration Committee August 2025 – Care Group and corporate area in development ~~plans required.~~ |
| 2 | Ongoing discussion re: role of health providers in Resilient Communities e.g. stakeholder vs lead. |
| 2 | Strategy in development working with Chief Nurse/Head of Patient Experience, ICB Health Inequalities and Personalisation Teams with pilot approach in one of the left shift projects |
| 3 | Areas for improvement identified in TIAA audit – currently being reviewed and agreed before finalising and embedding into LCHG HI action plan. |
| 4 | |
| 5 | |
| 6 | |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Alliance Steering Group meeting with external partners to be held in September 2025 (ASG stood down in August due to availability of key members) ASG arrangements are subject to the outcome of a Board discussion on a proposed system Alliance Board. Representation by PCNA on LCHG governance groups has been confirmed. | Group Chief Integration Officer | Deputy Director of Strategic Partnerships | 31 August 2025 | Complete |

| | | | | | |
|---|---|---|---|---|---|
| 2 | Health Inequalities Action Plan completed and was provided to the Alliance Steering group/Integration Committee in July/August2025. Care group and corporate area plans required and are in development. | Group Chief Integration Officer | Associate Director of Partnership | 31 July 2025 | Underway |
| 2 | Neighbourhood Health Board Partnership Agreement in development that will define how partners will work together to deliver on neighbourhoods, planned and unplanned care and resilient communities (including role in prevention) | Group Chief Integration Officer | Director of Integration and Improvement | Review March 2026 | Underway |
| 3 | Communications cascade to be developed (as one of the four Health Inequalities work streams) to increase awareness of the role of the Exec Lead for Health Inequalities and Personalization | Group Chief Integration Officer | Deputy Director of Strategic Partnerships/Deputy Director of Communications and Engagement | 31 July 2025 | Complete |
| 4 | New LCHG Strategy being deployed via Roadshow and in communications cascade | Group Chief Integration Officer | Director of Integration and Improvement | 30 June 2025 | Complete |
| 5 | TIAA audit reviewed and pending exec level sign off – action to be embedded into LCHG HI Action plan | Group Chief Integration Officer | Deputy Director of Strategic Partnerships | 31 December 2025 | Underway |

| Related risks on Risk Register – ULTH | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk Description** |
| | | | |

| Related risks on Risk Register – LCHS | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk description** |
| | | | |

# Strategic Aim 3: Population

| | |
|---|---|
| **Strategic Aim:** | Population: Better Health – Improve population health |
| **Strategic Objective:** | 3c: Enhance our digital, research and innovation capability |
| **Strategic Risk:**<br>(How we may be prevented from meeting objective and what is the potential impact) | If we do not **enhance our digital, research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale |

**Current Risk Score & Movement since last review:**

**12 (Moderate)**

| | |
|---|---|
| **Last Review Date:** | November 2025 |
| **Lead Executive:** | Group Chief Integration Officer |
| **Committee Oversight:** | Integration Committee |
| **Risk Appetite:** | Hungry |

| Risk Score | | Severity | Likelihood | Overall Risk Score | Assurance Rating |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 4 | 2 | 8(Moderate) | Amber |
| **Target** | Mar-26 | 4 | 2 | 8 (Moderate) | Green |

**Assurance Rating & Movement since last review:**

**Amber**

| Risk Score | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | | | |

| Assurance Rating | Apr-25 | May-25 | June-25 | Jul-25 | Aug-25 | Sept-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| **Identified Controls** *(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Digital Strategy for the group developed with a focus on digital transformation, integration & new ways of working |
| 2 | Digital systems across the group mapped and plan developed to align. 'Enabling Technology Programme in place to deliver improved technical infrastructure |
| 3 | Transition of LCHS and GPIT Digital services from AGEM to LCHG to enable and integrated digital approach. |
| 4 | EPR and EDMS programmes under way, both strategic enablers, |
| 5 | Disaster Recovery Plans in place. Cyber security & malware processes in place and tested |
| 6 | Digital Oversight Group in place to driver delivery of digital agenda |
| 7 | Key group focus on research and innovation including Artificial Intelligence (AI) |
| 8 | Process has begun for LCHS to become a teaching trust alongside ULTH |

| **Gaps in Controls** *(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | There is a need to enhance digital capability & skills through training |
| 2 | Insufficient capital / revenue to replace ageing technology |
| 3 | Alignment and change to operating model of LCHG Digital services to scale to the combined requirement, including transition. |
| 4 | Capacity within the digital team to deliver the digital transformation |
| 5 | Effectiveness of operational business continuity plans |
| 6 | None identified |
| 7 | LCHG Research & Innovation Strategy not yet developed - delays due to stakeholder availability |
| 8 | Application paused |

| Actions being taken to address gaps in controls<br>*(What are we going to do, by when, to further manage and mitigate the risk?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Implementation Partner to be procured to provide capacity for EPR and other in scope initiatives as part of EMAP DDC collaborative. | Group Chief Integration Officer | Group Director of Digital Services | TBC to alignment with EMAP | Tactical implementation partner procured up to end March 2026 whilst longer term partner procured. EMAP Implementation Partner now in place. Also using resource via UHL |
| 2 | LCHG Research & Innovation Strategy to be developed – difficulties with stakeholder availability to support workshop 2 which will enable the content to support the strategy production. | Chief Medical Officer | Head of Research & Innovation | 30 September 2025 | Underway - First meeting held September 2025, next available date end January 2026. **Suggest new date for completion March 2026** |
| 3 | Recruitment into key project team positions, including the commencement of the EPR Programme Director position | Group Chief Integration Officer | Group Director of Digital Services | Ongoing | All roles filled for Initiation Stage and now Implementation Stage roles being filled (either tactically with implementation partner resource or strategically via fixed term contract recruitment) |
| 5 | Digital led cyber/business continuity exercise with reporting to Emergency Planning Group to support improvement and recommendations for action outside of the digital service | Group Chief Integration Officer | Group Director of Digital Services | 30 June 2025 | Complete and report went to October Digital Oversight Group and Emergency Planning Group |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(How we know the controls are working effectively) | |
|---|---|
| 1 | Oversight of digital strategy, digital transformation and key risks by the Integration Committee |
| 2 | Digital Maturity Assessment completed |
| 3 | Digital Innovations Group established to assess and accelerate safe use of AI technologies |
| 4 | Oversight of AGEM IT service transition to LCHG via upward reporting to Integration Committee to manage risk, including agreement of structures. |
| 5 | Digital led business continuity exercise to identify improvement and learning, with departments providing assurance to Emergency Planning Group. |

| Gaps in Assurance | |
|---|---|
| 1 | None identified |
| 2 | None identified |
| 3 | None identified |
| 4 | Business as usual service assurance to be aligned to support service development and alignment to standards. Responsibility to move from AGEM to LCHG |
| 5 | Output of exercise upwardly reported and actions owned |

| | Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | ULTH and LCHS Technical Digital Service Assurance reporting to transition to LCHG from AGEM as part of transition, this will support a more detailed understanding and allow further actions to be identified to align standards. | Group Chief Integration Officer | Group Director of Digital Services | 30 October 2025 | Completed |
| 2 | Report and recommendations from Exercise Subaqua to Digital Oversight Group (Digital Response) in October 2025 and to Emergency Planning Group (Operational Resilience) | Group Chief Integration Officer | Group Director of Digital Services | 30 June 2025 (Report)<br><br>31 August 2025 (Digital Oversight Group) | Completed |

| Related risks On Risk Register – ULTH | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk Description** |
| | | | |

| Related risks on Risk Register – LCHS | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk description** |
| | | | |

# Strategic Aim 3: Population

| | |
|---|---|
| **Strategic Aim:** | Population: Better Health – Improve population health |
| **Strategic Objective:** | 3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan |
| **Strategic Risk:** (How we may be prevented from meeting objective and what is the potential impact) | If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable |

**Current Risk Score & Movement since last review:**

**12 (Moderate)**

| | |
|---|---|
| **Last Review Date:** | November 2025 |
| **Lead Executive:** | Group Chief Integration Officer / Group Chief Estates and Facilities Officer |
| **Committee Oversight:** | Integration Committee |
| **Risk Appetite:** | Open |

| **Risk Score** | | **Severity** | **Likelihood** | **Overall Risk Score** | **Assurance Rating** |
|---|---|---|---|---|---|
| **Current** | Apr-25 | 4 | 3 | 12 (Moderate) | Amber |
| **Target** | Mar-26 | 4 | 2 | 8 (Moderate) | Green |

**Assurance Rating & Movement since last review:**

**Amber**

| **Risk Score** | **Apr-25** | **May-25** | **June-25** | **Jul-25** | **Aug-25** | **Sept-25** | **Oct-25** | **Nov-25** | **Dec-25** | **Jan-26** | **Feb-26** | **Mar-26** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate | | | |

| **Assurance Rating** | **Apr-25** | **May-25** | **June-25** | **Jul-25** | **Aug-25** | **Sept-25** | **Oct-25** | **Nov-25** | **Dec-25** | **Jan-26** | **Feb-26** | **Mar-26** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | Amber | | | |

| **Identified Controls** *(What are we already doing to manage the risk?)* | |
|---|---|
| 1 | Productivity & Transformation Framework developed – outline programme for 2025 / 26 agreed |
| 2 | Common PMO approach developed to monitor and drive oversight of our CIP, Care Group CIP's being monitored via PRM's and PITOF in place to oversee other transformation programmes |
| 3 | Productivity, Improvement & Transformation Group established and reports into Finance Committee |
| 4 | ULTH and LCHS Sustainability & Green Plans approved by Board in September2025, on plan to publish by 31st October 2025 – phase 1 actions complete: improvement workshops complete and areas of opportunity and risk identified. Dashboard under development to track carbon impact of improvement projects. |
| 5 | Network of Green Champions formed |
| 6 | Green Group meetings scheduled |
| 7 | Sustainability agenda embedded in new Group Strategy |
| 8 | The Group Chief Estates & Facilities Officer is the SRO for the sustainability agenda |

| **Gaps in Controls** *(What are the gaps in control that are required to manage the risk)* | |
|---|---|
| 1 | Care Group CIP's continue to be developed in order to bridge the gap |
| 2 | No single Group PMO function |
| 3 | Aspyre software contract ends 30th September 2025 – plan for alternative solution in development |
| 4 | Green Plan areas of oversight to be agreed by GLT |
| 5 | None identified |
| 6 | None identified |
| 7 | Refreshed Green Plan being drafted for board approval in September 2025. Embedding it within the strategy |
| 8 | None identified |

| Actions being taken to address gaps in controls<br>*(What are we going to do, by when, to further manage and mitigate the risk?)* | | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|---|
| 1 | Extraordinary Care Group, GLT and ELT meetings taking place to identify additional transformational/CIP's to close the gap and strengthen plans for delivery. | Group Chief Integration Officer | Group Director of Strategy, Improvement and Redesign | 30 April 2025 | **Complete**<br>**Proposed revised timescale 30 September 2025** |
| 2 | Interim solution for Aspyre agreed, longer term solution in development in collaboration with digital PMO to ensure we have a common framework across LCHG and utilize AI effectively to support project reporting | Group Chief Integration Officer | Group Director of Strategy, Improvement and Redesign | 30 April 2025 | **Underway**<br>**Proposed revised timescale end December 2025** |
| 3 | Green Plans for LCHS and ULTH approved by Board to be published and shared with NHSE | Group Director of Estates & Facilities | Group Head of Sustainability | 31 July 2025 | ~~Underway~~<br>**Complete**<br>~~**Proposed revised timescale 31 October 2025**~~**Green Plans Published and shared with NHSE**~~Underway~~<br>~~**Proposed revised timescale 31 October 2025**~~ |

| Sources of Assurance (1st, 2nd and 3rd Line)<br>(How we know the controls are working effectively) | |
|---|---|
| 1 | Oversight of productivity, improvement & transformation by the PITOF, Finance Committee and Integration Committee |
| 2 | Sustainability report to the Green Group for oversight and assurance. Upward reporting to the Integration Committee and Group Board |
| 3 | Green Plan for LCHS and ULTH approved by Board in September 2025 |
| 4 | Regular updates on PMO solution being provided at Group Leadership Team Meeting |
| 5 | |
| 6 | |
| 7 | |
| 8 | |

| Gaps in Assurance | |
|---|---|
| 1 | |
| 2 | None identified |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |

| Actions being taken to address gaps in assurances<br>*(What are we going to do, by when, to ensure the required assurances are in place?)* | Executive Lead | Operational Lead | Due Date | Progress |
|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| 1 | Sustainability sub-group (Green Group) terms of reference agreed by Integration Committee in April 2025 – first meeting to be scheduled for September 2025 | Group Director of Estates & Facilities | Group Head of Sustainability | 31 May 2025 | Completed |

| Related risks on Risk Register – ULTH | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk Description** |
| | | | |

| Related risks on Risk Register – LCHS | | | |
|---|---|---|---|
| **Trust** | **Datix ID** | **Score** | **Summary Risk description** |
| | | | |

**Lincolnshire Community and Hospitals NHS Group**
**Board Work Programme 2025/26**

| Agenda Item | Lead | Person Responsible | Committee Oversight | Mar | May | Jul | Sep | Nov | Jan | Mar | Purpose of Report | Action |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Business Items** | | | | | | | | | | | | |
| Public Questions | Group Chair | Group Director of Corporate Affairs | N/A | X | X | X | X | X | X | X | | |
| Ward Accreditation | Group Chief Nurse | | N/A | X | X | X | X | X | X | X | | Assurance |
| Declarations of Interest | Group Chair | Group Director of Corporate Affairs | N/A | X | X | X | X | X | X | X | To note any conflicts of interest on specific agenda items or any changes to Directors' Interests | Assurance |
| Annual Declaration of Board Interests | Group Chair | Group Director of Corporate Affairs | N/A | | X | | | | | | To review and note any changes to the Register of Directors' Interests | Assurance |
| Fit and Proper Person Annual Declaration | Group Chair | Group Director of Corporate Affairs | Audit & Risk Committee | | | X (def. from May) | | | | | To receive assurance that all board members remain compliant with the Fit & Proper Person requirements | Assurance |
| Minutes of the previous meeting | Group Chair | Group Director of Corporate Affairs | N/A | X | X | X | X | X | X | X | To approve and / or amend the minutes of the previous meeting ensuring an accurate corporate record of the meeting is maintained | Approval |
| Matters arising from the previous meeting/action log | Group Chair | Group Director of Corporate Affairs | N/A | X | X | X | X | X | X | X | To ensure all agreed board actions are completed | Assurance |
| Group Chief Executive Report to the Board | Group Chief Executive | Executive Business Manager | N/A | X | X | X | X | X | X | X | To brief the boards on local and national topical matters, risk issues & mitigations and good news & communication updates | |
| Group Workstreams Progress Briefing | Group Chief Executive | | N/A | X | X | X | X | X | X | X | To receive regular updates on the delivery of the expected benefits of moving to a Group model and the integration of clinical and corporate services | |
| Celebrating Group Success | Group Director of Corporate Affairs | Deputy Trust Secretary | N/A | X | X | X | X | X | X | X | To hear from Clinical Teams and give clinical teams access to the Board | |
| Patient/staff Story | Group Chief Nurse | Associate Director of Communications and Engagement | N/A | X | X | X | X | X | X | X | To receive direct feedback on the experience of both patients and staff | |
| **Patients** | | | | | | | | | | | | |
| **Strategic Aim 1 - High quality, timely care in the right place** | | | | | | | | | | | | |
| Assurance and Risk Report from the Quality Committee | Chair of Quality Committee | Deputy Trust Secretary | Quality Committee | X | X | X | X | X | X | X | To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required | Assurance |
| Quality Committee Annual Report | Chair of Quality Committee | Deputy Trust Secretary | Quality Committee | | X | | | | | | To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year | Assurance |
| Quality Committee ToR and Work Programme | Chair of Quality Committee | Deputy Trust Secretary | Quality Committee | | X | | | | | | To approve the changes to board committee terms of reference and work plans following annual review. | Approval |
| Safeguarding Annual Report | Group Chief Nurse | Group Director of Safeguarding and Patient Experience | Quality Committee | | | | X | | | | To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year | Assurance |
| Infection Prevention and Control Annual Report | Group Chief Nurse | Deputy Director of Infection Prevention and Control | Quality Committee | | | | X | | | | To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year | Assurance |
| Complaints Annual Report | Group Chief Clinical Governance Officer | Deputy Group Chief Clinical Governance Officer | Quality Committee | | | | X | | | | To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year | Assurance |
| Patient Experience Annual Report | Group Chief Nurse | Group Director of Safeguarding and Patient Experience | Quality Committee | | | | X | | | | To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year | Assurance |
| Assurance and Risk Report from the Finance Committee | Chair of Finance Committee | Deputy Trust Secretary | Finance Committee | X | X | X | X | X | X | X | To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required | Assurance |
| Finance Committee Annual Report | Chair of Finance Committee | Deputy Trust Secretary | Finance Committee | | X | | | | | | To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year | Assurance |
| Finance Committee ToR and Work Programme | Chair of Finance Committee | Deputy Trust Secretary | Finance Committee | | | | | X | | | To approve the changes to board committee terms of reference and work plans following annual review. | Approval |
| Financial Plan | Group Chief Finance Officer | | Finance Committee | | | | | | | | To approve the Financial Plan | Approval |
| Capital Plan | Group Chief Finance Officer | | Finance Committee | | | | | | | | To approve the Capital Plan | Approval |
| Contract Award Reports | Group Chief Finance Officer | Deputy Director of Procurement | Finance Committee | X | X | X | X | X | X | X | To approve relevant Contract Awards in accordance with the Trusts' Schemes of Delegation | Approval |
| Emergency Preparedness Annual Report and EPRR Core Standards | Group Chief Estates and Facilities Officer | Emergency Planning and Business Continuity Manager | Finance Committee | | | X | | | | | To receive and approve the Trusts' annual submission to NHSE on EPRR including any required improvement actions | Assurance |
| **People** | | | | | | | | | | | | |
| **Strategic Aim 2 - Attract and retain talent, build a strong culture** | | | | | | | | | | | | |
| Assurance and Risk Report from the People Committee | Chair of People Committee | Deputy Trust Secretary | People Committee | X | X | X | X | X | X | X | To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required | Assurance |
| People Committee Annual Report | Chair of People Committee | Deputy Trust Secretary | People Committee | | X | | | | | | To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year | Assurance |
| People Committee ToR and Work Programme | Chair of People Committee | Deputy Trust Secretary | People Committee | | | | | X | | | To approve the changes to board committee terms of reference and work plans following annual review. | Approval |
| Gender Pay Gap Report | Group Chief People Officer | Director of People | People Committee | X | | | | | | X | To receive the Gender Pay Gap Report | Assurance |
| Ward Establishment Review | Group Chief Nurse | Deputy Director of Nursing and Midwifery | People Committee | | | | X (def. from May) | | | X | To approve the outcome of the review of safe staffing and any recommended changes to the establishment | Approval |
| Responsible Officer Revalidation Report | Group Chief Medical Director | Deputy Medical Director | People Committee | | | | X | | | | | |
| National Staff Survey Results | Group Chief People Officer | Director of People | People Committee | | X | | | | | X | To receive the results from the annual staff survey & note the planned improvement actions and monitoring arrangements | Assurance |
| FTSU Annual Report | Group Director of Corporate Affairs | FTSU Guardians | People Committee | | | | | X | | | To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year | Assurance |
| Equality Delivery System Report | Group Chief People Officer | Director of People | People Committee | | X | | | | | X | To approve the annual EDS submission | Approval |
| Workforce Race Equality Standard (WRES) Report and Action Plan | Group Chief People Officer | Director of People | People Committee | | | | X | | | | To approve the annual WDES submission | Approval |
| Workforce Disability Equality Standard (WDES) Report and Action Plan | Group Chief People Officer | Director of People | People Committee | | | | X | | | | To approve the annual WDES submission | Approval |
| **Population Health** | | | | | | | | | | | | |
| **Strategic Aim 3 - Adapting to neighbourhood health needs** | | | | | | | | | | | | |
| Assurance and Risk Report from the Integration Committee | Chair of Integration Committee | Deputy Trust Secretary | Integration Committee | X | X | X | X | X | X | X | To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required | Assurance |
| Integration Committee Annual Report | Chair of Integration Committee | Deputy Trust Secretary | Integration Committee | | X | | | | | | To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year | Assurance |
| Integration Committee ToR and Work Programme | Chair of Integration Committee | Deputy Trust Secretary | Integration Committee | | | | | | X | | To approve the changes to board committee terms of reference and work plans following annual review. | Approval |
| **Risk and Assurance** | | | | | | | | | | | | |
| Integrated Performance Report | Group Chief Integration Officer | Associate Director of Performance and Information | Finance Committee | X | X | X | X | X | X | X | To brief the boards on key performance metrics & priorities, risks to delivery & mitigations | Assurance |
| Group Risk Management Report | Group Chief Clinical Governance Officer | Deputy Group Chief Clinical Governance Officer | Audit & Risk Committee | X | X | X | X | X | X | X | To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the Trusts' current risk profile | Assurance |
| Board Assurance Framework | Group Director of Corporate Affairs | Deputy Trust Secretary | Audit & Risk Committee | X | X | X | X | X | X | X | To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the Trusts' current risk profile | Assurance |
| Strategic Objectives | Group Chief Integration Officer | Director of Strategy and Planning | | X | | | | | | X | To approve the Group Vision, Strategy & Objectives | Approval |
| Assurance and Risk Report from the Audit Committee | Chair of Audit Committee | Group Director of Corporate Affairs | Audit & Risk Committee | X | X | | X | X | | X | To note the matters considered by the committees-in-common and the issues which the committees wish to escalate to the Trust Board and to agree any actions required | Assurance |
| Audit Committee Annual Report | Chair of Audit Committee | Group Director of Corporate Affairs | Audit & Risk Committee | | | | | X | | | To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year | Assurance |
| Audit Committee ToR and Work Programme | Chair of Audit Committee | Group Director of Corporate Affairs | Audit & Risk Committee | X | | | | | | X | To approve the changes to board committee terms of reference and work plans following annual review. | Approval |
| NHS Provider Licence Self Certification | Chair of Audit Committee | Group Director of Corporate Affairs | Audit & Risk Committee | | X | | | | | | To agree the annual Trust Board self certification of compliance with the NHS Provider Licence | Approval |
| Year End Accounts and Annual Report | Chair of Audit Committee | Group Chief Finance Officer/ Group Director of Corporate Affairs | Audit & Risk Committee | | | X | | | | | To approve and adopt the Annual Report & Accounts | Approval |
| **End of meeting** | | | | | | | | | | | | |
| Board Work Programme | Group Director of Corporate Affairs | Deputy Trust Secretary | N/A | X | X | X | X | X | X | X | To ensure the boards' consideration of all relevant items of business and, in turn, continued compliance with their statutory and regulatory requirements | Assurance |
| Any other notified items of urgent business | Group Chair | Group Director of Corporate Affairs | N/A | X | X | X | X | X | X | X | | |