Bundle LCHG Board Meeting in Public Session 5 May 2026

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

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

2 Public Questions
Group Chair

3 Staff Story - Speech and Language Therapy Service Pilot
Group Chief Nurse

4 Apologies for Absence
Group Chair

5 Declarations of Interest
Group Chair
Item 5 Register of Interests 2026

6 Minutes of the meeting held on 3rd March 2026
Group Chair
Item 6 DRAFT Public Board Minutes March 26

6.1 Matters arising from the previous meeting/action log - No open actions
Group Chair

7 Group Chief Executive Horizon Scan
Group Chief Executive
Item 7 Group CEO update Public Board -May 2026

8 BREAK

9 Strategic Aim 1 - Patients

9.1 Assurance and Risk Report from Quality Committee to include 2025/26 Annual Report, Terms of Reference and updated workplan
Chair Quality Committee
Item 9.1 Quality Committee Assurance Upward Report - March 2026
Item 9.1 Quality Committee Assurance Upward Report - April 2026
Item 9.1 Appendix 1 QC Final Annual Report 2025-26 v 2
Item 9.1 QC - Quality Committee TOR 2026-27 (Draft) v 3

9.2 Proposed Seated and Corridor Care Areas Quality and Safety Framework
Group Chief Nurse
Item 9.2 Proposed Seated and Corridor Care Report

9.3 Finance Briefing
Group Chief Finance Officer
Item 9.3 Trust Board - Finance Briefing M12

9.4 Assurance and Risk Report from Finance and Performance Committee to include 2025/26 Annual Report, Terms of Reference and updated workplan

Chair, Finance and Performance Committee

Item 9.4 Finance Committee Assurance Upward Report - March 2026
Item 9.4 Finance Committee Assurance Upward Report - April 2026
Item 9.4 Finance and Performance Committee TOR 2026-27 (Draft) v 2
Item 9.4 - 2025-26 Finance and Performance Committee Work Programme
Item 9.4 FPC Final Annual Report 2025-26 v 3dc

9.5 National Cost Collection
Group Chief Finance Officer

Item 9.5 Trust Board - National Cost Collection Pre Submission Report

10 Strategic Aim 2 - People

10.1 Assurance and Risk Report from People Committee to include 2025/26 Annual Report, Terms of Reference and updated workplan
Chair, People Committee

Item 10.1 People Committee Assurance Upward Report March 2026
Item 10.1 People Committee Assurance Upward Report April 2026 v 1
Item 10.1 PC - People Committee - Terms of Reference 26-27 (Draft) v 3
Item 10.1 PC Final Annual Report 2025-26 v 2
Item 10.1 People Committee Reporting Schedule 2026-27

10.2 2025/26 National Staff Survey Results
Deputy Group Chief People Officer

Item 10.2 Board National Staff Survey Update - 27.04.26

11 Strategic Aim 3 - Population

11.1 Assurance and Risk Report from Integration Committee to include 2025/26 Annual Report and Terms of Reference
Chair, Integration Committee

Item 11.1 Integration Committee Assurance Upward Report March 2026 v1
Item 11.1 Appendix 1 Draft Neighbourhood Plan_MASTER_v0.3_060326
Item 11.1 Integration Committee Assurance Upward Report April 2026 v1
Item 11.1 LCHG Partnership Plan Update Trust Board April 2026
Item 11.1 Partnerships Plan 2026-2030 130426 FINAL (1)
Item 11.1 Integration Committee ToR 2026-27 (Draft) v 2
Item 11.1 Appendix 1 IC Final Annual Report 2025-26 v 2

11.2 Strategy Delivery Year End Report
Group Chief Integration Officer

Item 11.2 Q4 Strategic Delivery Assurance Report_Final

11.3 2026/27 Annual Plan
Group Chief Integration Officer

Item 11.3 270426_LCHG 26_27 Annual Plan_v2

12 Integrated Performance Report
Group Chief Officers

Item 12 IPR Front sheet May Board
Item 12 Appendix 1 IPR M12

13 Risk and Assurance

13.1 Group Risk Management Report
Group Chief Clinical Governance Officer

Item 13.1 Group Board - LCHG Risk Report May 2026
Item 13.1 Appendix A - LCHS Group Board High or Very High Risks May 2026 v2
Item 13.1 Appendix B - ULTH Group Board High or Very High Risks May 2026
Item 13.1 Appendix C - Risk Appetite

13.2 Board Assurance Framework
Group Director of Corporate Affairs
Sign off 2025/26 Board Assurance Framework
2026/27 Board Assurance Framework

Item 13.2 BAF Group Board Front Sheet May 2026
Item 13.2 LCHG Group Board BAF as at March 2026
Item 13.2 Appendix Revised BAF Objectives 2026-27

13.3 Assurance and Risk Report from Audit Committee, Terms of Reference and updated workplan
Chair, Audit Committee

Item 13.3 Audit Committee Upward Report April 2026
Item 13.3 Audit and Risk Committee Revised ToR 2026-27
Item 13.3 LCHG Audit Committee forward reporting schedule 26-27

13.4 NHS Provider Licence Self Certification
Group Director of Corporate Affairs

Item 13.4 NHS Provider Licence Self Certification
Item 13.4 NHS Provider Licence G5
Item 13.4 NHS Provider Licence NHS2

13.5 Board Forward Planner
Group Director of Corporate Affairs
For information only

Item 13.5 Board Forward Planner 2026-27

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 7th July 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.

Register of Interests – Board Members

The Register of Interests is maintained in accordance with the Fit and Proper Persons requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the NHS Code of Conduct for Board Members. It supports the Trust's commitment to openness, transparency, and the highest standards of integrity and public accountability.

All Board members are required to declare any actual, potential, or perceived interests—financial or non-financial—that could influence, or be perceived to influence, the exercise of their duties. This includes personal interests and those of close family members or associates. Declarations must be made on appointment and updated promptly when circumstances change.

The Register enables the Trust to identify and appropriately manage conflicts of interest, ensuring that decisions are taken solely in the best interests of patients, staff, and the public. Board members are expected to comply fully with the agreed arrangements for identifying, declaring, and managing conflicts, including withdrawing from discussions or decisions where required.

Unless otherwise stated all Board members hold joint roles across Lincolnshire Community Health Services NHS Trust and United Lincolnshire Teaching Hospitals NHS Trust

Name of Board Member	**Role / Position**	**Type of Interest (Financial, Non-Financial, Personal, Family, Dormant)**	**Organisation / Company Name**	**Nature of Interest (e.g. shareholding, employment, hospitality)**
Mrs Rebecca Brown	Group Chair	Non - Financial	The Bridge Homelessness to Hope	Trustee
Professor Karen Dunderdale	Group Chief Executive	Non - Financial	Derbyshire, Lincolnshire and Nottinghamshire ICB Cluster	Partner Member

Mr Daren Fradgley	Group Chief Integration Officer	Financial Non-Financial Family (Partner)	Wombourne Housing Management Company CQC Birmingham Women's and Children's NHS FT	Director Executive Reviewer Deputy Director
Mr Paul Antunes Goncalves	Group Chief Finance Officer	None	None	None
Ms Nerea Odongo	Group Chief Nurse	None	None	None
Ms Claire Low	Group Chief People Officer	None	None	None
Ms Caroline Landon	Group Chief Opering Officer	None	None	None
Professor Ciro Rinaldi	Group Chief Medical Officer	Financial Non-Financial Financial Non Financial Financial Financial Financial Financial	The Park Hospital, Nottingham University of Lincoln NIHR Nottingham CRF De Montfort University, Dubai CSI medical Consultancy LTD I & A Estate LTD DocExpert BUPA, Vitality, AXA, Aviva	Private Practice Honorary Professor Director Visting Professor of Haematology Consultant Director Consultant Consultant

		Financial	TMLEP - PREMEX - SpeedMedical	Expert Opinion
Mrs Kathryn Helley	Group Chief Clinical Governance Officer	Family (daughter) Non-Financial	ULTH CQC	Bank Admin Executive Reviewer
Mr Michael Parkhill	Group Chief Estates and Facilities Officer	Financial Financial Family (wife)	Parkhill Health Estates Ltd Private Maternity Services Ltd Private Maternity Services Ltd	Director Director Director
Mrs Jayne Warner	Group Director of Corporate Affairs	Family (daughter)	ULTH	Bank Admin
Mr Jim (David) Connolly	Non-Executive Director (Deputy Chair)	Financial Financial Non Financial Family (wife)	Riverside Consultants Jim Connolly Photography Beacon CHC Nottingham University Hospitals NHS Trust	Director Owner Trustee Nurse
Ms Dani Cecchini	Non-Executive Director	Non Financial	Carer's First	Trustee
Mr Neil Herbert	Non-Executive Director	Financial Financial Financial	George Bateman and Son Limited M.I Dickson Ltd Be Greater Than Ltd	Non Executive Director Non Executive Director Director
Mrs Vicki Wells	Non-Executive Director	Non-Financial	Carers First	Trustee

		Financial Financial Family (daughter) Family (sister)	VJW Consulting NMC ULTH ULTH	Director Chair of FTPC Midwife Occupational Therapist
Professor Jamie Read	Non-Executive Director (ULTH)	Financial Non – Financial Non- Financial	University of Lincoln Academy of Medical Educators Harbour Learning Trust	Dean of Medical School Trustee Trustee
Mrs Sarah Buik	Associate Non-Executive Director	None	None	None
Mr Ian Orrell	Associate Non-Executive Director	Financial Non-Financial Non-Financial	Lincolnshire Partnership Foundation NHS Trust Futures Advice, Skills and Employment Ltd Nottingham and Nottinghamshire Youth Support Ltd	Non-Executive Director Non-Executive Director Non-Executive Director
Mr Paul Marsden	Associate Non-Executive Director	Financial	John Lewis Partnership	Director
Mr John Underwood	Associate Non-Executive Director	Financial Financial Financial	Centre for Health Communication Research Freshwater Uk Buckinghamshire New University	Director Director Visiting Professor

		Financial Financial	Joint Council for Cosmetic Practitioners Oxehealth	Trustee and Non-Executive Director Advisory Board Member
Mrs Linda Jackson	Associate Non-Executive Director	None	None	None

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

Minutes of the Joint Public Board Meeting

Held on 3 March 2026

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

Non-Voting Members:
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
Mr Paul Marsden, Associate Non-Executive Director
Mr John Underwood, Associate Non-Executive Director

In attendance:
Mrs Karen Willey, Deputy Trust Board Secretary, ULTH
Mrs Rachel Lane, Board Administration, LCHS (minutes)
Sister Sian Lynch, Ward Sister, ICU ULHT (Item 2.1)
Julie Bembridge, Consultant Midwife (Item 2.2)
Trish Tsuro, Project Manager (Item 2.2)
Emma Upjohn, Head of Midwifery, ULTH (Item 2.3)
Dr Arunpreet Sahota, Peer Doctor (Item 7)
Professor Ciro Rinaldi, Deputy Group Chief Medical Officer
Mrs Helen Shelton, Deputy Group Clinical Governance Officer
Mr Nicholas Mulholland, Deputy Group Chief Nurse

Apologies:
Mr Neil Herbert, Non-Executive Director
Mrs Nerea Odongo, Group Chief Nurse
Professor Colin Farquharson, Group Chief Medical Officer
Mrs Kathryn Helley, Group Chief Clinical Governance Officer

142/26	**Item 1 Introduction** The Group Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream.
143/26	**Item 2 Public Questions** **Question 1** The Board were in receipt of a question from the family of a patient cared for at Pilgrim Hospital, which was unable to be read within the confines of the meeting due to confidentiality issues, and the Group Chair therefore summarised the issues.
144/26	A family had raised concerns relating to the staffing ratios on the ward and how this impacted on enhanced observation and patient dignity and safety. Following receipt of the communication, the Group Chief Nurse was in contact with the family and advised that to maintain patient confidentiality this matter would be directed through the Group complaints process to allow the concerns to be fully investigated.
145/26	The family were however keen to share their gratitude for the compassion and care shown by the ward team and asked that this was acknowledged.
146/26	The Group Chair offered that following the submission, she was sad to report that this patient had subsequently passed away. All the issues raised would be investigated accordingly to understand any improvements that needed to be made.
147/26	The Board acknowledged and noted the communication and the Group Chair offered that there would be continued contact with the family and the Board would receive a further update at the appropriate time.
148/26	**Q2 Received from Vi King** First I would like to wish Elaine all the best for the future and thank you for all your help and support during your time with the Trust.
149/26	I understand that there is a piece of work being done UEC front door our new approach to Acuity Streaming. I understand that the first assessment is carried out which takes 2-4 minutes. Please can I ask if an ECG is done at this time, otherwise if the patient has to wait for the second assessment time is vital if there is a concern.
150/26	If the first assessment is being carried out in open areas of the UTC please can I ask where the privacy and confidentiality is for patients. What happens if it is a very sensitive or safeguarding issue?
151/26	I have also been informed that there are not enough chairs in the waiting room.
152/26	Please can I ask if infection control, Health & Safety and staff side have been involved in this and has it been risk assessed.

153/26	The Deputy Group Chief Medical Officer explained that a new streaming model based on acuity had been implemented with the purpose to allocate patients to correct clinical pathways from the start and not via the emergency pathway. The way in which the process had been built was either by one or two assessments, the first being a quick assessment and was usually to allocate a level of acuity with either low or high being streamed at pace, and a proportion may need additional information and observations, and an ECG would be undertaken.
154/26	The Deputy Group Chief Medical Officer also offered that the footprint within the Urgent Treatment Centre (UTC) had changed to accommodate streaming and temporary corridors had been implemented, however ECGs were conducted within private areas. Chairs were also now being utilised more productively.
155/26	The final model was still being developed, and this situation was being monitored closely to ensure it was working correctly and modifications would be made as required. Regular discussions were taking place from a health and safety and infection prevention perspective, along with Staffside colleagues in respect of the final upgraded model.
156/26	The Group Chair offered her thanks to Mrs King for her kind comments and for the questions previously submitted to the Board, during her time as Chair.
157/26	**Item 2.1 Ward Accreditation** The Group Chair was pleased to be able to commence the Board meeting with the celebration of achievement of the provision of high quality, safe care through the awarding of ward accreditation.
158/26	Sister Sian Lynch from the Intensive Care Unit at Lincoln County Hospital was welcomed to the meeting to celebrate achievements.
159/26	The Deputy Group Chief Nurse explained that the Intensive Care Unit (ICU) 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.
160/26	Sister Lynch shared some examples of outstanding work with Board members of achievements within the ICU, where the team had been empowered to make improvements and learn from incidents and staff feedback. She described the focus the Ward had on workforce, staff wellbeing and psychological safety at work, which had empowered the team to deliver improvements in patient care, including reductions in skin integrity incidents. Sister Lynch described how there was a new approach to learning from incidents, where the whole team was involved in sharing so that they could work together to prevent harm to patients, as well as integrated work which had been undertaken with maternity services in recent months.
161/26	The Group Chief Executive thanked Sister Lynch for attending the meeting and sharing these examples of good working with the Board and acknowledged the

	amount of work that would have been undertaken to achieve the award. She added that in some cases transforming painful events into powerful opportunities to redesign processes to protect patients and strengthen the culture of care, should be acknowledged.
162/26	The Deputy Group Chief Nurse offered that he was proud of what the team had achieved and acknowledged the journey the team had been on over the last few years. He added that one area which had impressed him was the integrated work that was being undertaken with maternity services and working as a strong multi-disciplinary team.
163/26	The Deputy Group Chief Clinical Governance Officer offered that it was good to show Datix was being used to make improvements and would ask a member of the Clinical Governance team to contact Sister Lynch to discuss sharing learning across the Group.
164/26	The Group Chair thanked the Ward Sister for attending the meeting and for the continued leadership, adding that the service was a credit to the organisation and commented that the team should be proud of their achievements.
165/26	**Item 2.2 Patient/Staff Story** The Deputy Group Chief Nurse welcomed Julie Bembridge, Consultant Midwife and Trish Tsuro, Project Manager to the meeting to provide the Board with an update of the work undertaken within the Black and Asian Maternal Health Group, which was a multi-professional team working across the Lincolnshire system, created as evidence demonstrated that Black and Asian women across the UK experienced inequalities in maternity care with increased mortality and morbidity among women and babies.
166/26	A comprehensive presentation was provided which detailed working together with patients with lived experience, and how the Group was working to transform care for those women.
167/26	Projects the Group had led included work around improving cultural awareness in breastfeeding, an antenatal education review and work to improve access to preferred food whilst women were maternity inpatients. The Group had also led on enhanced staff training, including sharing patient stories and feedback to improve staff awareness of the patient experience and working with student midwives to raise awareness.
168/26	The Project Manager offered that the Group was engaging with students, enforcing relationships as a Teaching Hospital NHS Trust and a piece of work would be shared more widely engaging student midwives in the learning soon. The Group had also been invited to present this work to the Health Overview Scrutiny Committee in May.
169/26	The Group Chair thanked colleagues for attending the meeting and for sharing the impressive work of the team which had been undertaken alongside the population of Lincolnshire. She added that this was an example of great innovation and leadership within the service.

170/06	Mrs Brown expressed a view that this was a wonderful network which she was extremely proud of and was pleased to hear of future plans; she commented that she would like to see articles and consultant midwife led research also being included.
171/26	Mrs Wells commented that this had been a powerful presentation. Adding that she would be interested to get into the research space and communication with the public where negative stories were often heard in respect of the experiences of women and asked if there were any plans to share something more generally in the public domain. The Consultant Midwife agreed and offered to work closely with members of the Communication team to promote the work of the Group further.
172/26	The Group Chief Integration Officer commented that health visiting in Lincolnshire sat with Lincolnshire County Council and could often get overlooked, however he expressed a view that it had been brought out well within the context of the presentation. The Group Chief Integration Officer would link the Group with the personalisation team where more inbuilt engagement may be able to be achieved. The Board: • **Received the Patient/Staff Story**
173/26	**Item 2.3 CNST Annual Board Declaration** The Head of Midwifery was welcomed to the meeting, and presented the annual CNST declaration to the Board, which outlined a proposed position of a declaration of non-compliance. The Head of Midwifery explained that there was full achievement across all elements of the ten safety standards, however during the evidence review one eligible perinatal death had been identified, which had been managed and reviewed however had not been notified within the seven day timescale. A late submission had therefore been made in respect of Safety Action one.
174/26	A non-compliance position for the Maternity Incentive Scheme (MIS) year seven was therefore proposed.
175/26	Mr Connolly advised Board members that the Quality Committee were fully sighted on this and endorsed the position.
176/26	The Group Chair offered thanks for all the work that had been undertaken in preparing for the submission and she understood the disappointment in not achieving full compliance, however she added that there was so much for the team to celebrate. The Board: • **Approved the CNST Annual Board Declaration and authorise the CEO to sign the declaration**
177/26	**Item 3 Apologies for Absence** Apologies for absence had been received from Mr Neil Herbert, Non-Executive Director, Mrs Nerea Odongo, Group Chief Nurse, Professor Colin Farquharson,

	Group Chief Medical Officer and Mrs Kathryn Helley, Group Chief Clinical Governance Officer.
178/26	**Item 4 Declarations of Interest** There were no additional Declarations of Interest made.
179/26	**Item 5 Minutes of the meetings held on 6 January 2026** The minutes of the meeting held on Tuesday 6 January 2026 were approved as an accurate record.
180/26	**Item 5.1 Matters Arising from the previous meeting/log** The Board reviewed the action log where there were no open items. The Board: • **Received the action log**
181/26 182/26	**Item 6 Group Chair Arrangements** A report was presented which outlined that this was the Group Chair's last formal Board meeting. The Group Chair would reach the end of her term of office on 31st March 2026. NHS England had agreed that Rebecca Brown, current Group Deputy Chair, would step into the role of Acting Group Chair from Wednesday 1 April 2026 for a period of six months, whilst arrangements were made to recruit into the role on a permanent basis. The Board: • **Noted the arrangements**
183/26 184/26 185/26	**Item 7 Group Chief Executive's Report to the Board** The Group Chief Executive presented the report to the Board and offered that operational colleagues continued to work under extreme pressure attending to patients with high levels of acuity. Despite this teams were continuing to demonstrate extra-ordinary levels of hard work, and she took the opportunity to formally recognise and thanked all staff members for their commitment through this period of sustained pressure. Following a major service redesign delivered through the CLEAR (Clinically led workforce and activity redesign) Programme, stroke care across Lincolnshire was undergoing significant transformation. This work would improve patient outcomes, reduce length of stay, and enhance community-based rehabilitation and support. The Group Chief Executive offered that she had attended NHS Leadership Meetings in January and February, which covered topics related to the 10 Year Health Plan and the delivery of 2025/2026 plans.

186/26	In January 2026, NHS England published the updated Maternity Care Bundle, a new national framework aimed at reducing maternal mortality and serious maternal morbidity across England. The framework sets out the minimum standards of care that all NHS maternity services are expected to implement by March 2027. Work was underway to embed this into pathways, training and governance processes by the agreed deadline.
187/26	Glen Burley, NHS Financial Reset and Accountability Director, had recently written to all Chief Executives and Medical Directors outlining the proposed additional specialty recruitment round for 2026. The initiative was designed to support delivery of the 10-Year Health Plan commitment to create an additional 1,000 postgraduate medical specialty training places. The letter requests that all trusts identify the posts and associated funding they wish to include in the expanded national training numbers. The Group Chief Medical Officer was leading the response to this request.
188/26	The British Medical Association (BMA) had written to all NHS Trusts, confirming that following the recent ballot, which closed on 2 February 2026, resident doctors had voted in favour of further strike action. The Group was awaiting additional information and guidance from national bodies to assess the potential impact and plan accordingly.
189/26	The National Cancer Plan for England had been launched in February, which provided strong national momentum for the ongoing work in the Midlands to improve cancer outcomes through earlier diagnosis, wider access to innovative treatments and more personalised, equitable care.
190/26	During January, an executive-to-executive meeting took place between the Group and St Barnabas Hospice, providing a valuable opportunity to strengthen relationships and explore areas of shared strategic interest. The discussion focused on enhancing partnership working, particularly in relation to patient experience, service integration, and future opportunities for collaborative delivery across the local system.
191/26	The Group continued to meet with the NHS England regional team as part of the monthly Provider Review Meeting cycle. Discussions had remained constructive providing a regular forum to review progress, discuss emerging pressures, and ensure alignment with regional priorities and expectations. The regional team had acknowledged the Group's improvements across operational performance. In addition, the Group's continued focus on financial discipline and delivery had been recognised, with further assurance given regarding the actions in place to support in-year and longer-term financial sustainability.
192/26	The Group had submitted its final five-year narrative plan in line with the 2026/27 national planning guidance, alongside detailed finance, workforce, activity and performance plans.
193/26	A final report had now been received following a recent Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection for ULTH undertaken by the Care Quality Commission. The findings provided strong evidence and assurance of compliance across most standards reviewed. Inspectors highlighted

	numerous areas of good practice, recognising the commitment to continuous improvement, particularly through the effective use of audit. The Group will submit its improvement action plan in accordance with the required IR(ME)R timescales.
194/26	Following a letter from NHS England issued last year to all acute provider Trusts outlining the 10-point plan to improve the working lives of resident doctors, and the subsequent baseline compliance submission by ULTH, a 12-week progress survey was completed in December 2025. The results demonstrated significant organisational improvement, with compliance now at 81%.
195/26	The Group had received full planning approval following the submission of a planning application for the new Community Diagnostic Centre (CDC) in Boston, located on the former Boston United football ground at York Street. The Group secured consent for the site purchase, and a 20-week demolition phase was scheduled to begin on 5 March 2026. This £24.9 million purpose-built facility would significantly expand diagnostic capacity for the county, providing additional X-ray, CT, MRI and general medical ultrasound services. In parallel, the extension to the Lincoln CDC remained on track, with a go-live planned for April 2026.
196/26	The Community Tuberculosis (TB) team were recently invited to attend the National Tuberculosis Summit on 26 February 2026 to showcase their improvement programme, which focused on online consultations and wider digital innovations.
197/26	ULTH had recently partnered with Wilder Doddington following the launch of The New Orchard, the first Biodiversity Net Gain (BNG) Habitat Bank in the area. This initiative would provide an accountable and transparent source of BNG Units to offset the environmental impact of the new Endoscopy Unit at Lincoln County Hospital. The Group would be planning 100 trees as part of the orchard with planting commencing towards the end of 2026.
198/26	The Group Chief Executive took the opportunity to offer her personal thanks to Professor Colin Farquharson, Group Chief Medical Officer as he stepped down from his position due to personal health reasons. She offered that Professor Farquharson had been a friend for many years, and a key member of the Executive team and wished him well for the future. The Deputy Group Chief Medical Officer would step up to Interim Chief Medical Officer from 1st April 2026 for up to twelve months whilst a recruitment process was carried out for the substantive role.
199/26	Finally, the Group Chief Executive acknowledged that the Group Chair, would conclude her term of office at the end of March 2026, having reached the maximum tenure permitted under the relevant national governance frameworks.
200/26	The Group Chief Executive Offered that the Group Chair had played a pivotal role in the leadership and development of the Lincolnshire Community and Hospitals NHS Group. As Group Chair since its establishment, and previously as Chair of both Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT), continuous and steadfast leadership had been provided across more than a decade of significant organisational change.

201/26	Throughout her tenure, the Group Chair had demonstrated exceptional leadership, professionalism and integrity and provided clear strategic oversight during periods of complexity and challenge, promoting a culture of accountability, compassion, and continuous improvement. Under her stewardship, the Group had benefited from a strong and consistent focus on quality, safety, and the improvement of services for the people of Lincolnshire. Her visible leadership, commitment to strengthening governance, enhancing organisational resilience, and supporting the maturation of Group arrangements had been widely recognised and valued by colleagues across the organisation and the wider system.
202/26	On behalf of the Board, the Group Chief Executive wished to formally record sincere thanks to the Group Chair for her distinguished service, exemplary leadership, and unwavering dedication to the population of Lincolnshire. She added that her legacy would continue to shape the organisation's development and provide a strong foundation for future progress.
203/26	The Deputy Group Chief Medical Officer then introduced Dr Arunpreet Sahota, Peer Doctor for the Resident Doctor 10 Point Plan to the Board and he provided a comprehensive update on the progress made on each of the points with the majority now rated green or amber.
204/26	The Group Chair thanked the Deputy Group Chief Medical Officer for providing reassurance and an understanding of where improvements were required.
205/26	The Peer Doctor was grateful for the opportunity, which had given him exposure to senior colleagues and had provided a platform for colleagues to raise their concerns.
206/26	The Group Chair thanked the Peer Doctor for attending noting the requirement to attend future Board meetings going forward. The governance relating to the 10 Point Plan would remain with the People Committee and escalations and updates would be provided to the Board as this work progressed. The Board: • **Received the report and noted the significant assurance provided**
207/26	**Item 7.1 Group Model Workstream Report** The Group Chief Executive presented the closedown report which was taken as read and offered that this marked an important transition to move into full business as usual and over the lifetime of the programme, substantial progress had been made across all ten workstreams.
208/26	Key achievements included, establishment of the Group Model, with leadership fully recruited to and operating effectively. Implementation of a performance management and accountability framework, including regular Performance Review Meetings with Care Groups and Corporate areas. Strengthening of governance and decision making, with a unified Board Assurance Framework (BAF) now live and a standardised approach to risk management in place. Harmonisation of reporting, information and digital systems across the organisation, including progress against

	the digital strategy and the development of a single Group brand and progress in harmonising policies, reward and recognition and improvements in staff wellbeing.
209/26	Overall, the Group Chief Executive reported a strong closedown position, with most actions completed and explained that a small number of items would require ongoing oversight which would transition into business as usual programmes.
210/26	Appreciation was expressed to colleagues across both ULTH and LCHS for their work in delivering a complex programme of work, placing the Group in a strong position to deliver improved outcomes. The Board: • **Received the report** • **Endorsed the transition of all remaining activity into appropriate business as usual programmes**
	Item 9 Strategic Aim 1 Patients
211/26	**Item 9.1 Assurance and Risk Report Quality Committee** The Chair of the Quality Committee, Mr Connolly, presented the Committee reports following the meetings held during January and February 2026 with the reports taken together and as read.
212/26	The C.Difficle position remained challenging and off trajectory, however in line with the national position and the Committee was assured that actions were in place to rectify this. An updated microbial reduction plan had been requested for the next two months, and an ophthalmology report had been received with actions to reduce waiting times. The Committee had been assured of risk-based mitigations in place with waiting times having negative impacts on patient outcomes.
213/26	A presentation had been provided on Paediatric audiology where there had been a reduction in the waiting list backlog, however challenges remained on waiting lists. Harm reviews were in place, and no harm had been identified. A safety concern had previously been highlighted to the Committee.
214/26	High risks had been identified within the Risk Register in respect of paediatric and epilepsy services, where there were significant capacity issues and the good work of the team had been recognised. There was however concern expressed as this was a fragile service within the organisation and the Committee received details of significant plans in place for service improvement and transformation.
215/26	There had been some increases in some unjustified breaches relating to mixed sex accommodation and further discussion on the actions and mitigations would be undertaken.
216/26	A national laparotomy audit had been received, and clear actions were in place to support improvements, however there was recognition of challenges with mitigations being put in place.

217/26	Mr Connolly also offered the following updates on CNST Standards and drew particular attention to a risk on maternity and neonatal voices, which the Board had previously been updated on, which remained a concern. Moving forward mitigations were in place for this year, however there still appeared to be a risk for CNST year eight. Mr Connolly added that the Group Chief Nurse was in discussion with the ICB Chief Nurse to resolve the situation.
218/26	For CNST Standard 1 – PMRT; Q3 PMRT report including details of the deaths reviewed from 1 December 2024, any themes identified and the consequent action plans. One eligible perinatal death had not been notified to MBRRACE within 7 working days, resulting in non-compliance (requires 100%). As 100% compliance is required, this results in non-compliance with the whole standard.
219/26	CNST Standard 3 - ATAIN: Update relating to continuation of the Quality Improvement Project 'Midwives as second checkers for neonatal IV antibiotics. Governance for transitional care pathways strengthened with actions to be added to the PeriSIP.
220/26	CNST Standard 4 - Clinical Workforce: Neonatal workforce: - There had been progress against the previously agreed QIS action plan and trajectories which was on the services risk register.
221/26	CNST Standard 5 - Midwifery Workforce: Update on the agreed plan, including timescales, for achievement of the appropriate uplift in funded establishment along with mitigations to cover this shortfall, specifically Ongoing cost pressures managed by the Group, a full review was planned for April and recruitment to 12.1 WTE posts continued.
222/26	CNST Standard 6 - Saving Babies Lives Care Bundle: Progress had been made towards full implementation of Saving Babies Lives Care Bundle, in line with the locally agreed improvement trajectories. Progress had been confirmed by the ICB as demonstrated in the SBLCB implementation tool.
223/26	CNST Standard 7- MNVP: Formal escalation of risk, via the PQSM relating to the MNVP provision. There had been escalation via the PQSM model at Group and LMNS level, reported via MNOG/QC upward reporting process was 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. Progress was noted with the co-produced action plan including the ongoing work to ensure that the free-text responses from the most recent CQC Maternity Survey are reviewed and incorporated into the plan following review with an MNVP lead.
224/26	CNST Standard 9 - Floor to Board: Progress with the Staff Experience Group (maternity and neonatal culture plan), specifically the staff level launch of the Staff Experience Group.
225/26	CNST Standard 10 - MNSI: Receipt of Group legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution and 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. Must have sight of evidence of compliance with the statutory duty of candour.
226/26	CQC visits had taken place during February 2026 to medical wards and discharge lounges where there was potential for areas of improvement, alongside positive feedback.
227/26	In respect of Looked After Children, despite multiple attempts to recruit, this had proved impossible and the service remained reliant on temporary cover. The Group Chief Nurse would raise this with the ICB to look at other possible solutions to bring the service back on track.
228/26	The Deputy Group Chief Nurse added that the CQC visits had commissioned extensive multi-disciplinary responses in respect of areas of improvement, recurrent themes in both the acute and community settings, with learning to consider.
229/26	The Deputy Group Chief Nurse also explained that there had been a reduction in pressure ulcers within the community setting following extensive work undertaken in the wider system. He added that he now had the role of Senior Responsible Officer (SRO) for the work and would continue to work with all agencies within the county to drive this work further forward.
230/26	In respect of Looked After Children, the Deputy Group Chief Nurse added that some of the national operating models were being reviewed and colleagues were linking with other agencies and organisations to ascertain if there were alternative ways of providing this service in the future, rather than continuing to carry a risk.
231/26	The Deputy Group Chief Medical Officer commented that the paediatric audiology news was positive and had started from a much different position. There was currently no backlog, and a process was in place for completing training for paediatric audiologists by the end of the financial year to provide additional capacity. The national laparotomy story was also good and a new Standard Operating Procedure (SOP) for laparotomy in emergency departments included multiple points, however challenges remained regarding geriatric input for inpatients and discussions were continuing to take place.
232/26	The Group Chair acknowledged the improvement in paediatric audiology and added that this was a good example of how the organisation had responded well to challenges and improved outcomes for patients. The Board: • **Received the assurance reports** • **Noted the updates on the CNST Standards as presented** • **Noted the concerns raised in respect of Looked After Children**
233/26	**Item 9.2 Finance Briefing**

	The Group Chief Finance Officer offered a summary of performance at month ten, reporting continued progress in delivery of the 2025/26 financial plan, with a breakeven position maintained across the Group.
234/26	There had been an improving run rate, with a surplus delivered in each month since month seven. Further improvement in the run rate was however required over the remainder of the financial year and into the early part of 2026/27 to support full recovery.
235/26	The Group Chief Finance Officer highlighted three key areas of focus; delivery of income, supported by national “sprint” funding”; the delivery of the efficiency programme which was currently £4.2m behind plan with continued focus on maximising delivery in the remaining months of the year and workforce controls, with good performance reported. The Group Chief Finance Officer explained that bank and agency use remained high however was being monitored weekly through the offices of the Chief Medical Officer and Chief Nurse. He added that a positive impact had been seen from measures implemented earlier in the year.
236/26	The Group Chief Officer offered that the vacancy control process remained in place, including deferrals, to support the financial position whilst managing workforce impacts.
237/26	A year end risk of £9.3m adverse to plan was reported, however a clear route to breakeven had been identified through a combination of internal and external mitigations and the Group Chief Executive expressed confidence in the delivery of the 2025/26 financial plan.
238/26	In relation to capital, the overall programme had increased to £129.1m at Month 10 following additional funding. Expenditure was currently £28.7m behind plan, with a significant level of spend scheduled in the remaining months of the year. Mitigation plans were in place, and the Group Chief Finance Officer was confident in delivering the planned position by year-end.
239/26	Support had been received for a cash application relating to capital spend, linked to 2024/25 bonus funding associated with four-hour performance and operational improvement. The resulting cash benefit was welcomed by the Board.
230/26	The Group Chair welcomed the planned mitigations to achieve the year-end position and noted the encouraging progress. She also reflected on the significant increase in capital investment compared to previous years, recognising the scale of progress achieved.
231/26	The Group Chief Finance Officer took the opportunity to express his thanks to the Estates, Medical Equipment, and IT teams for delivering a significant number of additional initiatives, noting the benefits to patients, staff, and service improvements. The Board: • **Received the report noting the reasonable assurance**
232/26	**Item 9.3 Assurance and Risk Report Finance and Performance Committee**

	Ms Cecchini provided the assurances received by the Finance and Performance Committee, at the meetings held during January and February 2026; the reports were taken as read, noting that there were no escalations.
233/26	The Committee had noted the system pressures which had begun to impact on operational delivery and concerns had been raised in relation to cancer performance. An improvement had been seen during January, which had however declined during February, and the organisation had been placed into oversight.
234/26	The Group Chief Operating Officer explained that the 62-day standard remained challenging, with pressures in breast, colorectal and gynaecology pathways. A recovery plan had been requested for gynaecology, including support from the Chief Medical Officer.
235/26	The Faster Diagnosis Standard (FDS) showed improvement (83.1% in January and 85.5% in February, unvalidated), with confidence expressed in achieving the required target. The 28-day performance position improved in February (unvalidated), although further work was required.
236/26	It was highlighted that national team support was in place, providing additional insight and support, including improvements within booking processes.
237/26	In respect of planned care, good assurance was provided, with delivery in line with 18-week and 52-week trajectories. However, challenges remained in achieving diagnostic targets, particularly MRI capacity, largely due to workforce constraints. A recovery plan was in place, and alternative solutions were being explored.
238/26	Urgent and Emergency Care (UEC) performance remained above trajectory for the four-hour standard. Positive system support from UEC partners was noted as contributing to the overall position. Emergency Department performance remained challenging with January performance reported at 71.88% against a 73% target, February performance 75.59% against a 76% target and month-to-date March performance was 76.05% (unvalidated), with a robust plan in place to deliver 75% for March.
239/26	Attendance growth, particularly in Type 1 activity, continued to impact performance, although Type 3 performance remained consistently above target and the Committee had received assurance regarding mitigations and improvement plans, including oversight reports from Planned Care, UEC, and Out-of-Hospital programmes, which was positive.
240/26	The Committee had been provided with strong assurance in relation to financial reporting and controls, including regular reporting through the savings programme (PITOF) and Performance Review Meetings (PRMs) and continued progress within Estates, with further reporting on Planned Preventative Maintenance (PPM) which would be presented at the next meeting.
241/26	The Committee had also received the Emergency Preparedness, Resilience and Response (EPRR) report, noting that the organisation was substantially compliant for

	2025. Recent Local Resilience Forum (LRF) visits had also returned broadly compliant outcomes.
242/26	The Group Chair commented that the performance challenges were anticipated, with some fluctuation expected and acknowledged that the focus remained on targeted areas to secure improvement and achieve required standards.
243/26	The Group Chief Estates and Facilities Officer advised that the PPM audit would progress through the appropriate governance processes in due course. The Board: • **Received the assurance report**
	Item 10 Strategic Aim 2 People
244/26	**Item 10.1 Assurance and Risk Report People Committee** Mrs Wells provided the assurances received by the People Committee, at the meeting held during January and February 2026 and the reports were taken as read.
245/26	Sickness absence levels for February remain above target, recorded at 5.43% and 6.8% across the organisations. Ongoing work was in place to address this and drive improvements.
246/26	Mrs Well outlined that vacancy rates were in line with expectations due to organisational change, with some vacancies currently being held or deferred.
247/26	Core learning compliance remained in a positive position, exceeding target levels across the group.
248/26	A significant volume of HR activity was in progress, with several achievements noted, although much of the work remained ongoing. A proposed prioritisation initiative for the HR team had been agreed to support effective management of priorities and ensure delivery of key objectives.
249/26	Work has been undertaken to review group benefits alignment to ensure equity across both organisations.
250/26	Significant progress has been made in relation to Annex 20 of the NHS Terms and Conditions Handbook. This would impact Band 5 and 6 nursing staff, aligning pay, banding, and progression with comparable professional groups. It was acknowledged that this presented budget implications, alongside anticipated improvements in nurse capability and retention across the group.
251/26	Safer staffing levels had been maintained despite increased sickness absence.
252/26	The workforce plan remained off track, with current focus directed towards the medical workforce and productivity improvements.
253/26	Mrs Wells outlined that the Patient Services Hub consultation had closed on 20 January 2026.

254/26	The Equality, Diversity and Inclusion (EDI) report provided significant assurance. It was noted that the Group Board had reviewed anti-discrimination approaches, including the relaunch of the “United Against All Forms of Discrimination” campaign.
255/26	There had been an increase in access to menopause services, and this was seen as a positive development.
256/26	The team were also commended for an excellent year in winter vaccination delivery, achieving 55–56%.
257/26	The Group Chief People Officer explained that vacancy rates remained within acceptable levels in the context of organisational change at 6.5% for ULTH and 9.85% for LCHS. She provided assurance that work was ongoing to address priority vacancies with several positions already recruited to and others progressing through the pipeline.
258/26	Sickness absence levels were reported at 5.4% for ULTH and 6.8% for LCHS. The Group Chief People Officer offered that dedicated support had been implemented in high sickness areas, with targeted engagement alongside managers in identified hotspot areas to ensure staff received the appropriate support.
259/26	The Group Chief People Officer informed Board members that the delivery of the workforce plan remained off track. At the time of submission, several mitigating factors were not fully anticipated, particularly relating to TUPE and turnover. Turnover had been slower than expected, alongside continued reliance on temporary staffing. Despite this, the Group Chief People Officer advised that the forecast delivery position remained cautiously optimistic, with additional actions implemented. Positive impacts were beginning to be seen from deferred start dates for newly recruited staff.
260/26	The People consultation and Patient Services Hub processes had now closed, and work was underway to determine next steps, including updates to Staffside representatives and affected staff. Further updates would be presented to the People Committee as appropriate.
261/26	Mr Connolly advised of an escalation from the January Committee meeting regarding national Band 5 nursing developments and the Group Chief People Officer responded confirming that work was progressing in conjunction with the Group Chief Nurse and Nursing Officers. A task and finish group had been established in anticipation of further information expected in early April. Early indications suggested this would be a nationally funded initiative, pending formal confirmation. The Board: • **Received the assurance reports**
262/26	**Item 10.2 Gender and Disability Pay Gap Reports** The Group Chief People Officer presented the Gender and Pay Gap reports which had previously been reviewed by the People Committee, and an overview of the key

	findings was provided. Two separate gender pay gap positions were presented for LCHS and ULTH.
263/26	For LCHS, it was reported that the pay position remained broadly stable and positive. Improvements had been identified and delivered, with performance comparing favourably against the national median gender pay gap. Overall, LCHS was noted to be performing well from a national perspective.
264/26	For ULTH, the Group Chief People Officer described more complex issues noting that the gender pay gap stood at 12.6%, representing an improvement on the previous year. However, it was noted that women remained underrepresented in the highest pay quartile. Other indicators were reported as largely stable, with steady progress being made, including improvements in representation at consultant and senior clinical levels.
265/26	The Group Chief People Officer explained that a Group-wide action plan was being developed to address gender and ethnicity pay gaps. The plan would include targeted actions aimed at addressing key areas of inequality and would provide a structured framework for continued improvement across the Group.
266/26	The Group Chair acknowledged the importance of ongoing focus and commitment to delivering the actions outlined within the plan. The Board: • **Approved the Gender and Disability Pay Gap Reports for publication for ULTH and LCHS** • **Noted and supported the Group-wide action plan to address gender and ethnicity pay gaps**
	Item 11 Strategic Aim 3 Population
267/26	**Item 11.1 Assurance and Risk Report from the Integration Committee** Mr Connolly and Mrs Brown provided the assurances received by the Committee at the meetings held in January and February 2026 noting there were no upward escalations to the Board.
268/26	At the January meeting it had been highlighted that progress was being made to establish Lincolnshire Live Services within the Clinical Assessment Service. A strong presentation was delivered, demonstrating how community left shift transformation was beginning to strengthen and this was expected to reduce reliance on East Midlands Ambulance Service NHS Trust(EMAS) for managing acute falls and support delivery of care in the right place at the right time.
269/26	District Nursing (DN) transformation work was ongoing, with a focus on realigning services into Integrated Neighbourhood Teams. This emphasised a cohesive, person-centred, multidisciplinary team (MDT) approach. Mr Connolly explained that there were links in relation to pressure ulcer reduction and other quality areas previously discussed within the Quality Committee.

270/26	The “Enhancing Better (EB) Lives” programme was referenced as a positive example of how changes in response models can be effectively implemented.
271/26	Mrs Brown provided the highlights from the February meeting where the Committee had received comprehensive assurance overall.
272/26	A concern had been highlighted to the Committee regarding financial improvement progress within the Living Scheme; however, actions were in place to address this, and this would continue to be monitored closely. All other schemes were noted to either be on track or had recovery plans in place.
273/26	A further review of the Annual Plan submission had taken place, and oversight would continue moving forward.
274/26	The Committee had received an update in respect of the new ICB cluster and the Lead Provider Model for End-of-Life (EOL) care. Next steps were being progressed collaboratively with ICB colleagues, with clinical leadership from the Deputy Group Chief Nurse.
275/26	The lymphoedema service transformation programme had delivered significant improvements, particularly in reducing waiting times and associated risks.
276/26	A digital deep dive had been undertaken regarding the transfer of IT services from AGEM, and further work was underway to determine how best to support future developments. This represented a significant area of change and ambition.
277/26	Mrs Brown offered that the Electronic Document Management System (EDMS) scanners were now on site, with a planned go-live at the end of March. This would support the future implementation of the Electronic Patient Record (EPR) system.
278/26	The Group Chief Integration Officer explained that elements of the EPR programme had been reprofiled to avoid delivery of UEC components during peak winter pressures and it was anticipated that the Group Leadership Team (GLT) would sponsor the programme this week. This would create capacity to prioritise the Patient Services Hub programme, ensuring changes were implemented in a coordinated manner.
279/26	The Group Chief Integration Officer offered that the EPR programme was currently in a critical phase, requiring strong engagement and focus from operational teams and end users with further workstreams being designed. Gaps within the organisational development model had been identified and were being urgently addressed and the Group Chief Integration Officer added that Committee oversight of the programme would increase from April 2026.
280/26	The Group Chief Integration Officer reported that seven left shift services were planned and were aligned with the delivery profile following a slower start.
281/26	Four long-term condition (LTC) services had transitioned to the Alliance Care Group, with further work planned to enhance delivery at Grantham, including rehabilitation pathways and community paediatrics, particularly to support pathway decongestion.

282/26	The EOL programme represented a significant achievement, although delivery had been delayed by six months due to ICB clustering changes.
283/26	Community performance was reviewed under the Finance and Performance Committee (FPC) and the Group Chief Integration Officer offered that the elimination of 52-week waits had been achieved, particularly within the lymphoedema service.
284/26	It was noted that progress was advancing at pace, with a significant volume of reporting and a high level of assurance being achieved.
285/26	The Group Chair offered that herself and the Group Chief Executive had recently attended a Midlands meeting, which included presentations on digitalisation, the Federated Data Platform, and EPR and expressed a view that this may be a good Board Development opportunity for the future.
286/26	The Group Chair also acknowledged the importance of positioning the EPR programme within the broader NHS transformation context. The Board: • **Received the assurance reports noting there were no escalations**
287/26	**Item 11.2 Strategy Delivery Q3 Assurance Report** The Group Chief Integration Officer presented the report which was taken as read and provided updates against key milestones. He explained that this aligned with narrative and assurance reports from the past quarter and pace was starting to gather in some areas that were slower during the first quarters of the year.
288/26	The Group Chief Integration Officer offered that a year-end report would be provided at the May Board meeting. The Board: • **Received the report**
289/26	**Item 12 Integrated Performance Reports** The Integrated Performance Report was 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. The report presented was the amalgamation of all Committee reports.
290/26	The Group Chief People Officer commented that further work was required in respect of the headline blocks for the People Committee, to get this into a more digestible position. He added that the Finance and Performance figures were due to be presented at the March Integration Committee.
291/26	One data error on 104+ day waiters was highlighted with the Group Chief Integration Officer offering that this would resolve in due course, as the target was different to the value and metrics.

292/26	The UTC performance had been addressed within the Finance and Performance Committee report and the Group Chief Integration Officer commented on the large scale pressure which had been seen at the UTCs during the winter months.
293/26	Forecasting would also be detailed within the reports early in the new financial year. The Board: • **Received the Integrated Performance Reports noting the moderate assurance**
	Item 13 Risk and Assurance
294/26	**Item 13.1 Group Risk Management Report** The Deputy Group Chief Clinical Governance Officer presented the report and highlighted that the Finance and Performance Committee had reported a reduction in three very high risks.
295/26	Current monitoring indicated that there were 105 risks outside of appetite across several strategic objectives, all reviewed by relevant Committees. Sub-Groups were now reviewing risks outside of appetite to strengthen reporting and focus on the coming months. This would position the organisation to present risk effectively at Board level, with a planned risk Board Development Session to be held in March 2026.
296/26	Next steps would be interpretation of what the report was saying and to determine any adjustments required.
297/26	The Group Chief Integration Officer highlighted the management of programme risks, including maintenance of programme logs and the importance of ensuring programme oversight was maintained. He advised that he was working with the Group Chief Clinical Governance Officer on these areas to ensure comprehensive risk oversight. The Board: • **Accepted the risks as presented noting the significant assurance**
298/26	**Item 13.2 Board Assurance Framework** The Group Director of Corporate Affairs presented the 2025/26 Board Assurance Framework as considered by all the Committees during January and February 2026.
299/26	Two committee workshops had been held to review and strengthen the content of the BAF, the detail of which was now captured within the document and the People Committee had planned a workshop in March to also look at this in more depth.
300/26	There were some actions within the document where the dates had now passed and narrative detailed and recognised the need to pull this out into the Committees in March. There were no proposed changes for the assurance ratings this month.

301/26	The Group Chair commented that it would be useful to tighten up on the timescales within the document, and acknowledged the work undertaken to develop this further which provided a good perspective of the position against the strategic objectives and to identify and close any gaps. The Group Chair was also pleased to hear that the Committees had undertaken deep dives in relation to the BAF. The Board: • **Accepted the 2025/26 Board Assurance Framework which provided substantial assurance**
302/26	**Item 13.3 Assurance and Risk Report from the Audit Committee** Ms Cecchini provided the assurances received by the Audit Committee at the meeting held in January 2026 and the report was taken as read.
303/26	The Committee had received and reviewed a suite of Internal Audit reports, and five had been completed all providing reasonable assurance. Confirmation was also provided that the Internal Audit Plan was on track to be completed by year end. The development of a statement of internal control was also underway.
304/26	Preparations were underway for year-end including initial preparatory meetings with External Auditors and a review of annual accounting policies and reporting timetables paper had been received.
305/26	The Committee received a Counter Fraud update which provided progress updates relating to new legislation on Failure to Prevent Fraud and had been confirmation that updated assurances would be presented at the April 2026 meeting.
306/26	Good progress was being made on outstanding external audit recommendations and improvements were noted in relation to outstanding policies, however it was agreed that this issue should continue to be escalated to the Board for oversight.
307/26	A report on delegated limits for Contract Awards was reviewed and was recommended to the Board for approval.
308/26	The Group Director of Corporate Affairs provided an update on the tender process for Internal Auditors which had now concluded and new arrangements would commence from 1st April 2026. Work was underway to mobilise the new auditors who would introduce themselves into the organisation and Board members were advised that they may be contacted as part of this process. The Board: • **Received the assurance report** • **Acknowledged the position in relation to outstanding policies**
309/26	**Item 13.4 Amendment to Standing Financial Instructions (SFIs)** The Group Director of Corporate Governance presented a proposal to amend the current threshold for Contract Award Reports (CARs) requiring Board approval. She explained that under the existing Standing Financial Instructions (SFIs), CARs

	exceeding £1m must be submitted for approval to the Board, however considering the scale of the Group, the involvement of the two organisations, and rising costs, it was proposed that the threshold be increased to £5m.
310/26	Benchmarking had been undertaken against organisations of a similar size and the proposed threshold aligned. The Board: • **Approved the recommendation to amend the SFIs to increase the threshold for Board approval of CARs from £1m to £5m**
311/26	**Item 13.5 Board Forward Planner** The Forward Planner was presented and received for information. The Board: • **Received the Board Forward Planner**
312/26	**Item 14 Any Other Notified Items of Urgent Business** Mrs Brown commented that colleagues had heard through the meeting of the achievements the Group Chair had successfully navigated over the last ten years and added that one of the hardest objectives to achieve was a positive leadership culture where it was patient focussed, based on improving outcomes, being inclusive, ambitious and open and honest. She added that the Group Chair had lived, breathed and lead development in this year and she expressed a view that past and current Board members had been lucky to serve alongside the Group Chair.
313/26	Mrs Brown commented that the Group Chair's drive and ambition would be greatly missed however the Group would continue to deliver her legacy and keep a passionate culture alive.
314/26	The Group Chair thanked those present for their comments and added that today's meeting had been a delight to be her last, offering that many papers had come to life during the meeting where there had been some examples of good performance with a strong focus on safety and quality of care routinely being provided for the residents of Lincolnshire.
315/26	The Group Chair offered that her position had provided an opportunity to do the right things to improve services for patients, staff and partner colleagues and she was immensely proud of what had been and would continue to be achieved by the organisation. The Group Chair commented that the vision and ambition for transformation had only been possible due to the calibre of leadership around the Board table.
316/26	The Group Chair offered that she had very much been part of a high performing team and was grateful for all the support she had received collectively from Executives and Non-Executives and expressed a view that the direction had been set to commit to the transformation journey the organisation was on and was pleased to hear of new ways of working which would improve standards, performance and compliance.

317/26	The Group Chair wished colleagues every success for the future and added that it had been a privilege to be the Group Chair over the last two years.
318/26	The next scheduled meeting will be held on Tuesday 5th May 2026 via MS Teams live stream.

Voting Members	**6 May 2025**	**1 July 2025**	**2 Sept 2025**	**3 Nov 2025**	**6 Jan 2026**	**3 Mar 2026**						
ULHT/LCHS												
Elaine Baylis	X	X	X	X	X	X						
Rebecca Brown	X	X	A	X	X	X						
Neil Herbert	X	X	X	A	X	A						
Dani Cecchini	X	X	X	X	A	X						
Jim Connolly	A	X	X	X	X	X						
Karen Dunderdale	X	X	X	X	X	X						
Daren Fradgley	X	X	X	X	X	X						
Nerea Odongo	X	X	A	X	X	A						
Colin Farquharson	X	X	X	X	X	A						
Paul Antunes Goncalves	X	X	X	X	X	X						
LCHS												
Gail Shadlock	X											

NHS
Lincolnshire Community and Hospitals NHS Group

Group Chief Executive's Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*5th May 2026*
Agenda item number	*7*
Report title	*Group Chief Executives Board Report*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Information*
Accountable Director	*Karen Dunderdale, Group Chief Executive*
Author(s)	*Karen Dunderdale, Group Chief Executive* *Gemma Coupland, Executive Business Manager*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	
Prior approval process, if applicable	*N/A*
Financial implications, if applicable	*N/A*
Action / decision required	*The Board is asked to note the update on the key points from March and April 2026*

Assurance Rating Key:

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

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

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

System Overview

a) Resident Doctors participated in a further round of national industrial action coordinated by the British Medical Association (BMA) from 7–13 April 2026. During this period the Group maintained above 95% of elective activity. I would like to formally recognise and thank colleagues across clinical, managerial and corporate teams whose professionalism, flexibility and commitment ensured the continued delivery of safe and effective care for our patients.

b) During March, NHS England published the Neighbourhood Health Framework and the new population-based delivery models, setting out expectations for how systems should develop more integrated, preventative and personalised care closer to people's homes, in line with the NHS 10 Year Health Plan. The framework sets out the foundation steps to be taken in 2026/27 to develop local neighbourhood health plans for 2027/28, delivered through joint working. Working with our Integrated Care Board and Local Authority partners, the Group is actively contributing to this agenda as part of system plans to develop local neighbourhood health arrangements during 2026/27

c) The formal launch of the Lincolnshire Institute for Dental and Oral Health (LIDOH) took place in March, which I attended. The event marked the opening of a new specialist dental education and training facility within Lincoln Medical School at the University of Lincoln, made possible through the investment and support of the Greater Lincolnshire Combined County Authority and local investors. This development represents a significant step towards strengthening local and regional dental training capacity and supports the university's longer-term ambition to contribute to national priorities for improving oral health outcomes, particularly across coastal and rural communities.

d) As part of NHS England's ongoing programme of engagement with Chief Executives and Chairs, I attended NHS Leadership Meetings in April. These sessions focused on the emerging 2025/26 planning and priorities, alongside detailed discussions on the development and implementation of the new NHS operating model. The meetings provided valuable insight into national expectations and policy direction, and enabled constructive dialogue on the implications for providers, supporting the Group's preparation for the year ahead.

e) In April, Sir Jim Mackey wrote to all Chief Executives to set out next steps for 2026/27 planning, recognising the progress made by the NHS in restoring operational performance and improving patient experience over the past year.. The Group is working with system partners to maintain delivery momentum while using the multi-year planning framework to support sustainable transformation aligned to the NHS 10 Year Health Plan.

Group overview

a) Services across the Lincolnshire health and care system experienced sustained high demand during March and April, with significant operational

pressures across a number of services, requiring continued system-wide focus on capacity, flow and workforce resilience

b) The Group delivered both its planned revenue and capital positions for 2025/26. Due to delivering the planned break-even position the Group has received an additional allocation of £6.6m. The Group delivered the capital programme with a capital expenditure of £131.4m.

c) The Group closed 2025/26 outside the Workforce plan, with the variance driven predominantly by ULTH, largely due to higher than planned bank usage and substantive workforce changes not originally reflected in the workforce plan. LCHS was slightly adverse to plan, primarily due to increased bank usage. Despite this position, there has been demonstrable improvement in grip and control during 2025/26 through a vacancy control process and Quality impact Assessment to support each vacancy request, this additional grip has led to a reduced bank usage across ULTH, sustained ahead-of-plan agency performance, and delivery of substantive workforce reductions within LCHS through robust workforce controls. Externally funded activity for strikes and RTT backlog recovery has also influenced the year-end position and once fully validated, may reduce the adverse position.

d) Delivery against the 2025/26 Operating Plan has been achieved.. Performance against the Urgent and Emergency Care 4 hour standard strengthened towards the end of the year, with March 2026 delivery reaching 81.3%, reflecting the impact of focussed recovery actions, this has been sustained into April 2026. This has also positively impacted the 12 hour performance standard. Against the RTT standard, the plan of 60% was also exceeded, with delivery of 60.24%, providing assurance of stabilisation and incremental improvement against a challenging baseline.

e) The NHS National Oversight Framework (NOF) Quarter 3 ratings were published in March 2026. The NOF provides the primary mechanism through which NHS trusts are assessed and segmented against national quality, operational and financial metrics. Both Lincolnshire Community Healthcare NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) showed significant improvements reflecting the huge amount of effort that has been put into improvement the quality of care provided to the residents of Lincolnshire. For this quarter LCHS has been placed in segment 2 (with the Trust 24th place out of 61 peer Trusts) and ULTH remains in segment 4 (with the Trust in 109th place out of 134 peer Trusts).

f) The Group executives has continued to meet on a monthly basis with NHSE regional team for the Provider Oversight meetings. The recent meeting was positive, recognising the improved NOF position for both parts of the Group and the continued improved position across performance, workforce and finance.

g) Following submission of the new Capability self-assessments for both ULTH and LCHS, which measure organisations against a range of expectations

including strategy, leadership and planning, quality of care, and financial performance and oversight, NHS England assigned a single overall capability rating to each organisation. The results, published in April 2026, confirm that both ULTH and LCHS have been rated Amber-Green, indicating generally effective board leadership with some areas identified for further improvement.

h) Following receipt of full planning approval, a groundbreaking ceremony took place on 13 March 2026 to mark the commencement of the development of the new Boston Community Diagnostic Centre (CDC). This milestone signifies the start of a 20-week demolition phase, after which construction of the £24.9m centre will commence. The new CDC will provide expanded diagnostic capability, including MRI and CT scanners, X-ray facilities, ultrasound rooms, outpatient consultation rooms and dedicated audiology space. Once operational, the centre will significantly increase local diagnostic capacity, supporting improved access and reduced waiting times for patients across this part of Lincolnshire. The facility is scheduled to open to patients in spring 2027.

i) In parallel, renovation works at the Grantham CDC have been completed, creating three additional clinical rooms. This enhancement is already enabling additional clinics to be delivered from the centre, further increasing diagnostic capacity and patient throughput.

j) Following the successful launch of Martha's Law (Call for Concern) at Lincoln County Hospital and Pilgrim Hospital, Boston, four community hospital wards will be among the first wave of community-based NHS services nationally to introduce the rapid review service. The Call for Concern initiative enables patients, families and carers who are worried about a patient's deteriorating condition whilst on an inpatient ward to contact an independent clinical team directly for urgent advice and review. The service will be available to patients on inpatient wards at John Coupland Hospital, Gainsborough, County Hospital, Louth, Skegness District Hospital and Johnson Community Hospital, Spalding. This development strengthens existing patient safety safeguards by ensuring a timely clinical escalation and rapid review whenever a patient or relative feels it is needed.

k) Nominations for the Group Staff Awards 2026 are now open, celebrating and recognising the dedication and achievements of community and hospital staff across the Group. A range of award categories acknowledge excellence in patient care, compassion and respect, teamwork and innovation. Nominations are welcomed from staff, patients and members of the public.

l) The National Staff Survey (NSS) Results were published during March 2026, alongside those for other acute and community trusts across the country. There was an improvement in overall in response rates across both parts of the Group with 49% for Acute and 68% for Community staff. Both parts of the Group have made significant progress over recent years, however we have heard how challenging it is for colleagues across the Group at the moment which reflects the significant changes both nationally and regionally within the NHS.

m) I am delighted to formally welcome Rebecca Brown as Group Chair. Over the past three years, she has made an invaluable contribution as a Non-Executive Director, providing thoughtful challenge, strong governance oversight and consistent support to both the board and the executive team. Her insight, experience and commitment to our values have been greatly appreciated, and I would like to record my sincere thanks for the dedication and support shown during this period. I look forward to working even more closely with Rebecca in her new role as Chair as we continue to deliver our strategic priorities for the Group.

n) Finally, I would like to formally record my sincere thanks to Professor Colin Farquharson for the leadership, professionalism and commitment he provided during his tenure as Group Chief Medical Officer. Professor Farquharson made a significant contribution to the Group's clinical leadership, patient safety and quality agenda, and his support to the Board and Executive Team was greatly valued. He left the organisation on 31 March 2026 with our very best wishes for the future. I am pleased to welcome Professor Ciro Rinaldi to the role of Group Chief Medical Officer. Professor Rinaldi commences this role at an important time, and I look forward to working closely with him as he builds on this strong foundation and continues to progress our ambitions for high-quality, compassionate care.

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	*05 May 2026*
Agenda item number	*9.1*

Quality Committee Upward Report of the meeting held on 17 March 2026

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

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	
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:	05 May 2026
Report from:	Quality Committee
Report from meeting held on:	17 March 2026
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 17 March 2026 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 (PSG) Upward Report
b) Infection Prevention Group (IPG) Upward
c) Antimicrobial Call To Action
d) High Profile Cases Report

The Committee reviewed the PSG report which highlighted the following:

i. backlog of overdue Datix incidents continued to be a concern. This issue continued to be an area focus within the care group PRMs
ii. a table showing the number of internal incidents reported in December 2025 where the clinical delay causing patient harm field has been completed. The report noted that of the 85 incidents listed, 78 of them caused low harm, 6 of them caused moderate harm and one resulted in death. A Patient Safety Incident Investigation (PSII) had been undertaken taken to review the incident which resulted in death. A review of the incidents which caused moderate harm has been undertaken, with no commonality in themes being identified.
iii. an update on the progress achieved to mitigate and reduce the risk to patient safety in Ophthalmology.

The Committee reviewed the PSII Learning and Recommendation Summaries and noted the improvement actions including the steps being undertaken to plug the reported gaps in microbiology staffing.

The Committee noted that the one Never Event highlighted in the PSG report and expressed the gratitude of the Committee to the clinical teams for all the steps taken to ensure that patients were safe.

The Committee was **assured** by the PSG report.

The Committee reviewed the IPG report and noted these highlights:

i. C. difficile cases remained above trajectory with 108 cases to date in 2025/26. A thematic analysis supported by Microbiology had been completed and the report would be submitted for review by the Quality Committee.
ii. High Consequence Infectious Disease (HCID) update – After a suspected in-patient case of viral haemorrhagic fever (VHF) in August 2025, gaps had been identified in the Group's response mechanism to cases of HCID. A working group had been constituted to work on closing those gaps.
iii. FFP3 mask fit testing organisational compliance – With due regard to the post-COVID fatigue for the wearing of masks, the Infection Prevention and Control team was sending the message widely across the Group that staff should wear masks if they contracted COVID.
iv. The Water Safety quarterly report – the report noted that since the introduction of silver copper ionisation in 2025, there had been a significant reduction in positive detects for both legionella and pseudomonas.

The Committee was **assured** by the IPG report.

The Committee received the report on the Antimicrobial Call To Action which was a follow-up to a deep dive report provided at the Committee's request in May 2025. The Committee had asked for this follow-up report which would focus on Antimicrobial Stewardship (AMS), but in that period the Group also received a national 'call to action' on AMS. This was a combined report to fulfil both the Committee's request and the requirements of the national 'call to action'

The report provided evidence of the strong progress achieved since the deep dive report was submitted to the Committee in May 2025 but was being given an assurance RAG rating of 'amber'. The Committee was informed that though there was clear view of the Group's target and how to achieve that, there was also the awareness that the assurance provided would be deemed insufficient if the actions were not sustained as expected.

The Committee noted the success of the improvement actions and also noted that the change of the position from the last presentation was very significant. The Committee also thanked the Antimicrobial Pharmacist and the Associate Chief Pharmacist for the hard work.

The Committee was **substantially assured** by the report on the Antimicrobial Call To Action.

Assurances in respect of Objective 1a(ii):

a) Patient Experience and Involvement Group (PEIG) Upward Report
b) Safeguarding and Vulnerabilities Oversight Group (SVOG) Upward Report
c) Children and Young People Oversight Group (CYPOG) Upward Report

The Committee reviewed and was **substantially assured** by the portion of the PEIG report which highlighted key improvements around patient pathway development, multidisciplinary collaboration and staff capability-building around complaints handling and communication.

The report also highlighted developments around how the contract for the provider of the Interpretation and Translation Services was being managed and a training provision for staff members on how to access interpretation services. Another highlight of this portion of the report was around the positive impact of the Patient Wellness questionnaires launched after the rollout of the Martha's Rule patient safety initiative.

The Committee was **assured** by the mitigating actions implemented by the Group because of the change in funding by the East Midlands Cancer Alliance – Centre for Psychosocial Health (EMCA-CPH) for level 4 psychological support for cancer patients.

The Committee was **reasonably assured** by the update on the steps being implemented to prevent mixed sex accommodation breaches from occurring. The Committee was informed that there had been an increase in the numbers of reported breaches because the default was no longer to accept that most breaches were 'justified'. A task and finish group had been tasked to develop measures which would prevent these breaches as well develop a tool to assess the impact on affected patients.

The Committee reviewed the SVOG report which was focused on the good MCA/DOLS training compliance, and the operational care groups' strong safeguarding governance processes. The SVOG also focused on the low uptake of Safeguarding Children level 3 training and Children & Young People (CYP) Safeguarding training by clinical staff. The Committee was **assured** by the actions being implemented to get the uptake of safeguarding training by clinical staff to improve.

The Committee was provided with **limited assurance** by the portion of the SVOG report which stated that there had been a slight reduction in initial health assessments for Looked After Children. The Committee reviewed the improvement plan and agreed to a review of how the various children's pathways in the community could be sustainably restructured. The Committee agreed for a referral to be made from the Quality Committee to the Integration Committee for an assessment to be undertaken on which of the children's pathways could be restructured in line with the Group's 'Left Shift' Agenda.

The Committee reviewed the CYOG Upward report and noted the following highlights:

i. That between January 2023 and January 2026, there had been an improved RTT performance from 68% to 83%, which could be attributed to an improvement in diligent outcome tracking by clinic coordinators and secretaries.
ii. In terms of nursing governance, the report noted that there was a delay in the progression of on-going actions and of overdue actions. Steps being taken to improve include work to create an integrated neonatal and acute paediatrics governance forum to enhance governance and the focus on the progression of relevant actions.
iii. Cardiology was noted the have performed extremely well, with the backlog completely cleared. The follow up trajectory was also on target for April 2026.
iv. Learning and education had been taking place on Fridays, as part of regional teaching opportunities for trainee and resident doctors. There was good collaboration between the Group and tertiary hospitals, as well as with the cardiology network
v. The business case for the recruitment of a substantive paediatric cardiology consultant had been approved by the Capital, Revenue and Investment Group (CRIG). After final approval by the Group Leadership Team, the recruitment would proceed with a target to complete by May 2026.

The Committee was **assured** by the CYOG report.

Assurances in respect of Objective 1a(iii):

a) Clinical Effectiveness Group (CEG) Upward Report
b) Medicines Quality and Safety Group Upward Report including final Terms of Reference

The Committee received the CEG report and noted the following highlights:

i. National Neonatal Audit Programme (NNAP) - Workforce and care processes were positive, with strong nursing staffing levels, high parental consultation rates, and good performance in retinopathy of prematurity screening and early respiratory management.
ii. NICE compliance - ULTH was 97% compliant with completed baseline assessment
iii. National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report – There were 4 outstanding actions, out of 35 actions. The outstanding actions were being progressed
iv. Fracture Liaison Outlier - A pathway had been designed, with CDC input, and guidance which was awaiting governance approval. The pathway would ensure automatic referral of all low-trauma fractures from Radiology to the DEXA Team.
v. Sentinel Stroke National Audit Programme (SSNAP) - This had progressed in terms of processes but continued to struggle in terms of workforce, with night-time staffing being reviewed. It was noted that more than half of admissions occurred overnight so there was the need for adequate staffing and registered nurses at night as well.

vi. Planned Care - strong progress had been made in terms clinical audit completion, the reduction of overdue actions and improved compliance across services. Quality improvement activity had also been embedded but there was an ongoing challenge regarding capacity and demand pressures.

The Committee was concerned by the SSNAP data, due to there being little improvement despite continued focus. The Committee noted the actions being undertaken to enhance the Stroke service's staffing capacity, as well as restructure and transform the stroke pathways.

The Committee was **assured** by other the other updates on the CEG report but had **limited assurance** in relation the SSNAP update.

Assurances in respect of other areas:

a) Patient Story
b) Board Assurance Framework 2025/26
c) Committee Annual Report
c) Risk Report
d) Policy Position Update
e) Committee Performance Dashboard (LCHS and ULHT)

The Committee Performance Dashboard advised that from an acute perspective, there had been a decline in the number of falls by 20 to 156 in February 2026 compared to January 2026. There had however, been an increase in moderate to harm falls from the previous month. Significant work surrounding bed rails assessment had been undertaken to assess the causes of the increase and to take improvement actions.

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) One Never Event: Due to there being only one Never Event in 2025/26, the Committee expressed its gratitude to the clinical teams for all the steps taken to ensure that patients were safe.
b) Antimicrobial Stewardship (AMS): The significant success of the improvement actions and the resulting significant improvement of AMS in the Group. The Committee also thanked the Antimicrobial Pharmacist and the Associate Chief Pharmacist for their hard work.

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

Rebecca Brown, Chair, Group Board

17 March 2026

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	*05 May 2026*
Agenda item number	*9.1*

Quality Committee Upward Report of the meeting held on 21 April 2026

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

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	
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:	05 May 2026
Report from:	Quality Committee
Report from meeting held on:	21 April 2026
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Quality Committee at its meeting held on 21 April 2026 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 (PSG) Upward Report
b) High Profile Cases Report
c) Maternity and Neonatal Oversight Group (MNOG) Upward Report
d) Proposed Seated and Corridor Care Areas (SCCA) Quality and Safety Framework

The Committee reviewed the PSG report which highlighted the following:

i. Compliance with the Central Alerting System (CAS) and Field Safety Notice (FSN) processes was good at the Group. The was only one CAS alert which overdue it's deadline, and steps were being taken to conclude the investigation. The Committee noted that the overdue CAS alert was related to bed rails.
ii. Compliance with the Duty of Candour was 100% in the Group.
iii. The number of open incidents had decreased from 835 in February 2026 to 467 in April 2026. The Committee was updated on the actions being implemented to speed up the review and learning from these incidents. The Committee was also assured of the 467 open incidents, 418 were of low or no harm incidents and that the improvement steps being taken to review and learn from them would continue.
iv. The Committee received a report on the actions being implemented around patient safety and health inequalities. The Committee was informed that the PSG had agreed to integrate these actions the wider Transformation agenda being implemented in the Group.

v. After a Health Service Journal (HSJ) article in November 2025 the Group had undertaken a review of its current clinical harm review processes across all tumour sites so they could be strengthened as appropriate.
vi. The Committee was updated that the Group was over trajectory by 23 of C. Diff cases for 2025/26, with 113 cases against a target of 90. The Committee was presented with the comprehensive improvement action log being implemented.
vii. The Committee was also assured that a standard operating procedure had been developed to ensure that there was the appropriate medical cover and escalation process for the Group discharge lounge.
viii. The Committee reviewed and approved the Patient Safety Incident Response Framework Policy v 3.

The Committee was **assured** by the PSG report.

The Committee reviewed the MNOG report and noted these highlights:

i. Regarding the local implementation and operation of the Maternity Outcomes Signal System (MOSS):
   - A recent Level 1 (Amber) MOSS signal was identified at the Boston site. In line with NHS England requirements, a Critical Safety Check was completed within the required timeframe.
   - The review, including both maternity and neonatal care, identified no safety concerns, and management was assessed as appropriate. The case would now progress through standard PMRT processes for routine review.
   - Local implementation of MOSS was progressing. Subject to final comments, documentation would be finalised and fully embedded within the Perinatal Quality Oversight Model (PQM).
   - MOSS reporting would continue as a standing item within the MNOG assurance report, with escalation to Group Board as appropriate.
   - This update was provided for assurance, noting that MOSS was operating as intended, enabling the early detection and structured review of potential safety signals, and providing additional oversight alongside existing mandatory review processes.

ii. Regarding Clinical Negligence Scheme (CNST) Maternity Incentive Scheme (MIS) Year 7 compliance:
   - Following confirmation through the external verification process and discussion with the NHS Resolution Collaborative Advisory Group, ULTH have met all 10 safety actions for Year 7 of MIS.
   - The organisation will now be eligible for the return of the contribution into the incentive fund, with a share of unallocated funds to follow.

The Committee was **substantially assured** by the MNOG report.

The Committee received the Proposed Seated and Corridor Care Areas (SCCA) Quality and Safety Framework and noted that:

i. In December 2025 NHS England published guidance ‘Principles for Providing Patient Care in Corridors’. The guidance defined that the term

'corridor care' was inclusive of any non-designated clinical space and provided six core principles for corridor care.

ii. In January 2026 the Health Services Safety Investigations Body (HSSIB) published an investigation which explored the management of patient safety risks associated with using temporary care environments, often referred to as 'corridor care' and 'temporary escalation spaces'. These were spaces not originally designed, staffed, or equipped for patient care (such as corridors, waiting rooms and chairs on wards).

iii. Additional actions to virtually eliminate corridor care was published March 2026. To ensure consistency in reporting of activity in relation to corridor care, a definition has been developed to allow acute hospitals to accurately record and count corridor care. In summary, a patient has experienced corridor care if they had spent at least 45 minutes in a clinically inappropriate area of an emergency department or general and acute ward.

iv. Based on a recommendation for a multidisciplinary collaborative approach to enable a prompt and sustained delivery of the related requirements the quality framework had been developed in the Group specifically to support oversight and improvement of care being provided in SCCA. The framework would support a streamlined approach and support triangulation of information and early identification of any actual/emerging risks and issues to allow timely intervention and escalation where needed.

The Committee was **assured** by the progress made in developing the quality and safety framework

Assurances in respect of Objective 1a(ii):

a) Patient Experience and Involvement Group (PEIG) Upward Report
b) Children and Young People Oversight Group (CYPOG) Upward Report

The Committee reviewed and was **assured** by the portion of the PEIG report which focused on areas such as planned care services, patient panels, PLACE assessments, and the governance processes for Mixed Sex Accommodation (MSA). These areas demonstrated effective oversight, improving data quality, high patient satisfaction, and increasing organisational learning.

In terms of the Place Assessment, these domains improved from red/amber into green – a) high cleanliness standards were demonstrated, with all sites scoring at or above the national averages; b) Privacy, dignity and wellbeing improved across several sites particularly Louth and John Coopland Hospital; c) Condition, appearance and maintenance remained strong at most ULTH and LCHS locations although some UTCs require minor work (Damage, Storage, Décor). Organisational food, however, dropped due to compliance issues, and ward food variation noted across wards. The Committee was **assured** that the food for patients remained safe and edible.

The Committee was **reasonably assured** by the portion of the PEIG report which focused on the delay in the launch of the new Friends and Family Test (FFT) data set. The delay remained ongoing due to several issues related to completion of the contracting and Information governance processes. The previous provider ended their service on the 31 December 2025 and the first data that would be available from the new provider for ULTH/LCHS would not be before June 2026.

The Committee reviewed the CYOG Upward report and noted the following highlights:

i. That there had been improvements in the Paediatric Cardiology Service with the number of patients on the partial booking waiting list (PBWL) had declined from 94 in March 2026 to 83 in April 2026. To further increase capacity, more clinics delivered over 2 full days once a month had been organised at Pilgrim which would help reduce numbers. Steps were also being taken to ensure the frequent 'was not brought' (WNB) or 'do not attend' (DNA) patients were either referred to safeguarding or discharged back to their GPs. The Committee was also informed that a psychological support service was also in place to support the patients on the PBWL.
ii. That of the 73 new referrals awaiting appointment at Boston and 126 at Lincoln, the majority were under 18 weeks and at level 3. The Committee was informed that any further delays to the approval for a business case to recruit paediatric consultants for both sites would result in another backlog of patients developing.
iii. That the review of Audiology Services was being refocused towards improving clinical capacity and managing activity appropriately. The understanding was that reviewing the service with only an eye on checking progress against achieving the Improving Quality in Physiological Services (IQIPS) would not result in sustained improvements. The Committee was assured that the ultimate aim of the refocused review was to achieve and maintain the desired accreditation.

The Committee was **assured** by the CYOG report.

<u>Assurances in respect of Objective 1a(iii):</u>

a) Clinical Effectiveness Group (CEG) Upward Report

The Committee received the CEG report and noted the following highlights:

i. National Early Inflammatory Arthritis Audit (NEIAA) – In March 2026 ULTH received a potential outlier alert for the current NEIAA audit cycle. The alert was for the metric, 'proportion of adults with early inflammatory arthritis starting conventional disease-modifying anti-rheumatic drug (cDMARD) within 6 weeks'. It was noted that early indicators suggest that only 6% started on treatment within the time frame against a national average of 42%, and an improvement action plan had been requested to improve output.
ii. NICE Derogation CG128 – Autism Spectrum Disorders in Children and Young People: A local autism multi-agency strategy group should be set up, with managerial, commissioner and clinical representation from child health and mental health services, education, social care, parent and carer service

users, and the voluntary sector. The derogation was approved as it was demonstrated that ULTH was not appropriately placed to develop or coordinate a multiagency strategy group as outlined in the NICE guidance. Lincolnshire was better placed to coordinated as it had an Autism Strategy Board (Lincolnshire Autism Partnership Board) with representatives from ULTH, LCHS, Lincolnshire Partnership Foundation Trust (LPFT_, education, social care, DWP, PREVENT, crime and justice, experts by experience, parents/carers, and University of Lincoln.

iii. NICE Derogation NG87 – Attention deficit hyperactivity disorder: Diagnosis and Management: Mental health services for children, young people and adults, and child health services, should form multidisciplinary specialist ADHD teams and/or clinics for children and young people and separate teams and/or clinics for adults. The derogation was approved as within Lincolnshire, mental health services for children, young people and adults are commissioned from LPFT. In view of this, ULTH was unable to provide mental health resource to participate in paediatric clinics as the organisation did not have the required level of expertise to manage the mental health aspects related to the diagnosis and management of ADHD.

iv. Epilepsy 12 Audit – The Committee was informed that despite the fragility of the Paediatric Epilepsy service, the Group benchmarked very well against 8 out of 10 of the national KPI's. That the Group was above the national average was positive and demonstrated the ongoing focus of the service. It was also noted that an action plan was in place and was being progressed as required.

v. Specialised Services Quality Dashboard (SSQD) – The Committee was updated that for Quarter 2, four of the Group's six services on the dashboard have red-rated indicators, signalling areas requiring improvement and strengthened oversight. The red alerts were for the following areas: Cardiac MRI (1 red alert), Neonatal Care (2 red alerts), Radiotherapy (5 red alerts), and Vascular Services (1 red alert). These areas would continue to be monitored through CEG, with actions and assurance sought from the relevant service leads.

The Committee was **assured** by the CEG report.

Assurances in respect of other areas:

a) Patient Story
b) Board Assurance Framework 2025/26
c) Risk Report
d) CQC Assurance Report
e) Topical, Legal and Regulatory Update
f) Quality Impact Assessment Assurance Report
g) Committee Performance Dashboard (LCHS and ULHT)

The Committee Performance Dashboard advised that from an acute perspective, there had been a decline in the number of falls by 20 to 156 in February 2026 compared to January 2026. There had however, been an increase in moderate to harm falls from the previous month. Significant work

surrounding bed rails assessment had been undertaken to assess the causes of the increase and to take improvement actions.

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

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

a) None

4.0 Matters for reporting / escalation to the Group Board

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

a) None

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

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

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the Quality Committee

Jim Connolly, Non-Executive Director (Chair)

21 April 2026

United Lincolnshire Hospitals NHS Trust

Annual Report to the Group Board from the Quality Governance Committee 2025/26

ROLE OF THE COMMITTEE

In 2025/26, in line with all other Committees of the Board, the Terms of Reference were reviewed, amended. Under the agreed terms of reference, the Quality Committee was tasked as follows:

The Quality Committee will:

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

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

MEETINGS

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

The Committee continued to deliver a full agenda through the submission of questions, by Committee members, ahead of the meeting which were responded to during the meeting.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Group Board from amongst the Non-Executive Directors of the Group. During 2025/26 the Committee was chaired by Mr Jim Connolly.

Details of the Committee's membership and attendance during 2025/26 is set out below:

The members of the Committee are:

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

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

Voting Members	15 Apr 2025	20 May 2025	17 Jun 2025	15 Jul 2025	19 Aug 2025	16 Sept 2025	21 Oct 2025	25 Nov 2025	16 Dec 2025	20 Jan 2026	17 Feb 2026	17 Mar 2026
Non-Executive Director (Mr Connolly, Chair)	X	X	X	X	X	X	X	X	X	X	X	A

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Non-Executive Director (Mrs Brown)	X	X	A	X	X	X	X	X	A	A	X	X
Non-Executive Director (Mrs Wells)	X	X	X	X	X	X	X	X	X	A	X	X
Group Chief Nurse	X	X	X	D	X	X	X	X	X	X	X	X
Group Chief Medical Officer	D	A	X	D	D	D	D	A	X	D	D	D
Group Chief Operating Officer	X	A	A	X	X	X	X	X	A	X	X	D
Group Chief Integration Officer	X	A	A	X	D	X	X	X	X	D	X	X
Group Chief Clinical Governance Officer	D	X	X	D	X	X	X	X	X	X	X	X

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

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

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

REVIEW OF BUSINESS

The Quality Committee followed a programme of work for the 2025/26 year.

The Quality Committee has been responsible for the oversight of the Group's Strategic Objective 1(a) in 2025/26:

- Improve patient safety, patient experience and deliver clinically effective care

During 2025/26 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF. Strategic Objective 1(a) at the beginning of the year was rated as follows:

Objective 1a – **AMBER**

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For oversight purposes, Strategic Objective 1(a) was split into three during the year, with a focus on the 3 individual components of the objective:

- 1a (i): **Improve patient safety**, patient experience and deliver clinically effective care
- 1a (ii): Improve patient safety, **patient experience** and deliver clinically effective care
- 1a (iii): Improve patient safety, patient experience and **deliver clinically effective care**

Through the year the Committee continued to receive reports offering assurance against the Strategic Objectives resulting in the individual components continuing to be rated as follows at the end of the year:

Objective 1a (i) – **AMBER**
Objective 1a (ii) – **AMBER**
Objective 1a (iii) – **AMBER**

OVERVIEW

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

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

The reporting groups are:

- Patient Safety Group
- Patient Experience and Involvement Group
- Clinical Effectiveness Group
- Maternity and Neonatal Oversight Group
- Safeguarding and Vulnerability Oversight Group
- Children and Young People Oversight Group

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

The Committee has been well attended by members during the year with members coopted to the Committee as required to provide further insight into areas for consideration. On a bi-monthly basis the Director of Midwifery attended the Committee

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to present updates in respect of Maternity and Neonatal services to support the Clinical Negligence Scheme for Trusts (CNST) submissions and achievement.

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

Key areas of focus of the Committee have included:

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

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

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

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

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

Significant progress on internal audit recommendations was seen with the closure of all outstanding audit recommendations achieved in year and the Committee had

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received regular reporting in respect of the Group Policy documents due to the need to address the position of overdue policy documents in place.

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

The Committee received regular Maternity and Neonatal Oversight Group Upward Reports and associated appendices required in respect of the Clinical Negligence Scheme for Trusts (CNST) Maternity. The upward reports reflected the Group compliance with CNST's requirements.

Risks

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

Performance Review

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

The Committee have actively ensured that the KPIs requiring monitoring by the Committee were reported. At each of the meetings during 2025/26 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified.

The Committee noted the positive position during the year in respect of Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) performance.

The Committee noted in April 2025 that the Patient Safety Group (PSG) had received the first iteration of the Patient Safety Incident Investigation (PSII) report which details how lessons have been learnt and improvements made.

The Committee received and recommended to the Group Board for approval the Group's Patient Safety Incident Response Plan. The Plan outlined the Group's approach to the patient safety profile.

Under the auspices of the Patient Safety Incident Response Framework (PSIRF), the Committee received condensed summaries of the Patient Safety Incident Investigations (PSII's) during the year. The Committee reviewed, for assurance purposes, the condensed summaries which have been completed and approved by the Monthly Executive Oversight Committee.

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In June 2025, the Committee received with assurance the PSG report which provided updates on the recognition of the harm caused by clinical delays, the ongoing actions being taken in respect the MRSA cases within maternity services and an improvement in the use of vascular device management.

In July 2025, the Committee received the Patient Safety Incident Investigation summary report which noted the 1 open overdue Central Alert System (CAS) alert, for which a deep dive would be undertaken so that steps could be taken the address it as appropriate.

The Committee noted in the August 2025 PSG upward report that, following an audit, there was concern in respect of community equipment due to a change in provider. Reassurance was offered that mitigations were in place to address this.

In the September 2025 PSG upward report, the Committee noted positive progress with CAS and Field Safety Notices with the remaining alert relating to bed rails which was being considered to determine how compliance could be gained.

The September 2025 PSG report also noted that Martha's Rule had been launched and had been rolled out across the Group. The Committee would receive a further update at the next meeting.

In December 2025, the PSG upward report updated the Committee on the declining trajectory of the Healthcare Acquired Infections, particularly C-Difficile and E-Coli infections, due to a focus on work in the community. Flu maintained a steady position in December 2025 with the Group introducing mask wearing to support the well-being of patients and staff.

The December 2025 PSG report noted 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.

In January 2026 the Committee reviewed a PSG report which highlighted the actions underway that relate to the currently overdue National Patient Safety Alert (NatPSA) in respect of medical beds, trolleys, bed rails, bed grab handles and lateral turning devices. The Committee noted the significant progress achieved so far and also raised concerns regarding the dissemination of leaning.

In January 2026, the PSG upward report updated the Committee on the trajectory of Healthcare Acquired Infections in the Group, particularly the E-Coli infections continuing to decline in November 2025. The trajectory of C.Diff infections remained off-track in November 2025.

In February 2026, the Committee was informed that the December 2025 data on C.Diff infections remained off-track with 3 occurrences. The Infection Control team had

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undertaken deep dives into themes and sub-themes to determine how these infections can be prevented. The Infection Control team were utilising the information gained from the deep dives to take important preventive steps. The Committee noted that the trajectory for E-coli infections continued to improve in December 2025

In March 2026, C. difficile cases remained above trajectory. A thematic analysis supported by microbiology had been completed and the report would be submitted for review at the April 2026 Committee meeting.

In October 2025, the Committee noted that the national Never Event consultation had been concluded and the outcome of this was that the definition of never events should be revised. Work was now due to commence with a more detailed paper due to be offered to the PSG.

The October 2025 PSG upward report also provided an update in respect of Martha's Rule, that governance issues were being addressed and recognition of the clear actions in place to support delivery of the initiative in the EDs. A rollout plan was also being developed for the roll out of the Manchester Patient Safety Framework which was being used to develop the safety culture of the Group.

In November 2025, the PSG upward report informed the Committee of ongoing work in respect of pressure ulcers both in the community and acute, while C-difficile infections were reported to be above trajectory. Work also remained ongoing in respect of aseptic issues with improvements being seen due to the work of the microbiologists, though contamination rates continued to rise. The report stated that further communications, linked to education, were being undertaken to resolve the contamination rates.

The Committee, in February 2026, reviewed a PSG Upward Report which highlighted the conclusion of the work of a paediatric cardiology incidents review 'task and finish' group. The 'task and finish' group had been asked to review some specific incidents so that the appropriate level of scrutiny and monitoring could be applied.

The Committee was updated on the 'task and finish' group's recommendations which included the implementation of the processes for managing and monitoring incidents and the expedition of the recruitment to two paediatric cardiologists to maintain service resilience. Changes made to the paediatric cardiology service, based on the recommendations of the 'task and finish' group, had resulted in a very significant reduction in the waiting list.

In April 2025, the Committee was informed that a Friends and Family Test (FFT) survey tool was being procured jointly across the Group to support gathering of patient feedback. There was also recognition of the benefit in automating quality metrics within patient experience to support monitoring of progress and support triangulation.

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In May 2025, the Children and Young People Oversight Group (CYPOG) submitted a report to the Committee. The report provided significant updates on areas of risk including the paediatric cardiology, audiology, ENT and diabetes services with the Committee recognising the fragility of some of these services with mitigations in place. The report noted that whilst there were ongoing performance issues in a number of areas this was not resulting in serious harm to patients. The Committee noted the need to ensure reporting extended to community services to provide full oversight.

In June 2025, the CYPOG reported to the Committee that the paediatric epilepsy risk was noted as remaining very high with the service continuing to be fragile with the assurance that there were plans in place. Work was noted to remain ongoing in respect of paediatric cardiology with a recognition that some harm was being caused as a result of delays.

The June 2025 CYPOG report also noted the progress for looked after children in respect of initial health assessments with 85-87% being completed within 20 days which was a significant improvement from the end of the previous year. The Committee would continue to monitor the position.

In July 2025, the CYPOG upward report highlighted the areas of concern known to the Committee (please see May 2025 above), with recognition of the ongoing work to address actions and consider service redesign. Transformation work associated with the services would be considered through the Integration Committee.

The August 2025 CYPOG report updated the Committee on the development of a business case for paediatric cardiology to support progress. The Committee requested that a further update be offered by the service at an appropriate time.

The CYPOG upward report in September 2025 noted the improvements achieved in respect of paediatric cardiology which the Committee had been monitoring for some time. There was recognition of the change in oversight, moving from NHS England to the ICB.

The September 2025 CYPOG report also informed the Committee of the achievement of permanent funding in respect of looked after children which would enable the recruitment of staff into the service. The Committee recognised, however, that the funding would not allow for the service to be delivered to the level required.

In October 2025, the Committee noted that the development of the children and young people dashboard was continuing to provide the Committee great oversight of areas related to medical staff training and education.

The October 2025 CYPOG report informed the Committee of the work being undertaken to develop the pathway for paediatrics within UEC and ED to ensure that support was provided to both staff and patients. The autism and epilepsy business

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cases continued to be a work in progress, and it was noted that the epilepsy deep dive would be expanded across all patient groups, not just paediatrics.

The March 2026 CYPOG upward report informed the Committee that the business case for the recruitment of a substantive paediatric cardiology consultant had been approved by the Capital, Revenue and Investment Group (CRIG). After final approval by the Group Leadership Team, the recruitment would proceed with a target to complete by May 2026.

In May 2025, the Committee also received an update in respect on Pressure Ulcers which identified the ongoing actions being taken to improve the position within LCHS with a focus on education and training for staff with the initiation of an assurance programme supporting the improvements. Progress was also noted in respect of ULTH in pressure ulcer performance with a further update requested by the Committee in 6-months.

In May 2025, the upward report from the Patient Experience and Involvement Group (PEIG) to the Committee identified the significant number of hours offered by volunteers across the Group with 328 volunteers providing support. The Committee recognised the need for the People Committee to be sighted on this area of the workforce due to the significant contribution being made.

The PEIG upward report in August 2025 informed the Committee that there was a gap in assurance in respect of mixed sex accommodation. Executive action would be taken in respect of the management of the mixed sex accommodation approval process and further updates would be offered to the Committee through the upward report.

The August 2025 PEIG report also highlighted the receipt of the Patient-Led Assessment of the Care Environment (PLACE) report which demonstrated areas for improvement. The PLACE report also noted that, through the support of Charitable Funds, progress had been made in supporting dementia patients.

In December 2025, the PEIG report provided limited assurance in respect of equality and diversity due to gaps in compliance. The plan was to improve assurance through the appointment of an EDI lead.

The PEIG report in February 2026 informed the Committee that there had been an increase in the number of unjustified mixed sex accommodation breaches in January 2026. The report noted that January 2026 was a particularly busy period for the Group with significantly heightened patient flow pressures and added that the root causes of the breaches remained predominately linked to a lack of beds.

The Committee was updated on the actions being taken to eliminate unjustified mixed sex breaches including the review of the relevant standard operating procedure to enhance the ward allocation approval process. Other actions were being implemented

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with the areas with the most unjustified mixed sex breaches to determine how they can improve and prevent these unjustified breaches.

Under the March 2026 PEIG report the Committee was informed that though the mixed sex accommodation breaches had increased, the caveat was that there had also been an increase in the reporting of mixed sex accommodation breaches. It was noted that, historically, a number of breaches had been justified, which meant that they were not reported on. Upon reviewing what qualified as justified and unjustified, it was clear this was not appropriate. Part of the ongoing work by a task and finish group, included reviewing the SOP for mixed sex accommodation breaches, with a plan was to elevate the approval of breaches to the corporate level. The Group Chief Nurse advised that elevating the approval process to the corporate level would ensure that there was consistency and better oversight of the approval process.

The Safeguarding and Vulnerability Oversight Group (SVOG) upward report in May 2025, noted the improvement in looked after children and however recognised the ongoing fragility of the service and the impact. The Committee also noted the ongoing work to address and resolve the position.

The SVOG report to the July 2025 Committee meeting highlighted concern in respect of the funding associated with looked after children. The continuing challenges in respect of funding associated with the service would be escalated to the ICB System Quality Group.

The November 2025 SVOG report stated that, though progress was being made, section 42 reports continued to be received. The Committee noted concern in respect of training attendance and uptake with appropriate escalations being made.

The SVOG report in November 2025 informed the Committee that work continued to appoint to the looked after children (CLA) vacancy.

In January 2026, the SVOG escalated concern over the potential of a failure to make a paediatric appointment to the children looked after team, with interviews of candidates scheduled for 28 January 2026. The SVOG was, however, concerned that failure to appoint would have a direct impact on the ability of CLA team to undertake Initial Health Assessments (IHAs) in a timely manner.

In March 2026, the SVOG report informed the Committee that good assurance had been received around the Section 42 processes, the MCA/DOLS training compliance, and the operational care groups' safeguarding governance processes. Limited assurance had been received around Safeguarding Children Level 3 training, training DNAs with 217 staff failing to attend booked safeguarding training in January 2026, and sedation audits with a lack of consistent auditing across clinical areas.

In May 2025, the Clinical Effectiveness Group (CEG) upward report highlighted concern around the governance arrangements in respect of Get It Right First Time

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(GIRFT) however ongoing discussions were taking place to ensure this was strengthened.

In June 2025, the Clinical Effectiveness Group (CEG) upward report provided moderate assurance to the Committee for the clinical audits it received with relevant actions being monitored through the group. Completion of the mortuary refurbishment was noted with ongoing work to finalise the recommendations in the Fuller report.

In July 2025, the Committee recognised the need for further action to be undertaken by the CEG to progress the GIRFT process.

The July 2025 CEG report also noted that the National Early Inflammatory Arthritis Audit (NEIAA) had identified ULTH as an outlier. The report also highlighted the mitigations in place and the backlog of open local audits in the Surgery Care Group. The Committee requested, through CEG, an update on the emergency laparotomy audit, noting the case note review position to date.

In August 2025, the CEG upward report stated the that the ongoing work to refurbish the mortuaries was nearing completion which would address a number of actions from the Human Tissue Authority (HTA) inspection undertaken in 2022. Phase 2 of the outcome of the Fuller report was expected in relation to actions required with work already underway.

The CEG upward report in September 2025 noted the ongoing oversight of clinical audit with a focus on the Intensive Care National Audit & Research Centre (ICNARC) where there had been higher than expected unit acquired infections. It was recognised that the Committee would be holding a focus IPC discussion at the October meeting.

The October 2025 CEG upward report informed the Committee of the national clinical audits that had been undertaken noting that performance in these was positive overall. There was, however, a recognition of the need to strengthen quality assurance of data prior to submission.

In October 2025, the Committee was informed that the HTA actions continued to be progressed with the Committee noting that a single action plan would be developed to ensure clear oversight.

The CEG upward report informed the Committee in December 2025 of an outlier alert for the laparotomy audit with an improvement plan in place which would be monitored on a weekly basis.

In August 2025, the Maternity Service review letter was received by the Committee, and it was noted that the Group would be supporting with the review, where requested, for Nottingham University Hospitals NHS Trust.

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The Committee received the outcome of the safer staffing establishment reviews report in August 2025. The staffing position was noted with recognition that further data collections would be undertaken and analysis of the data completed prior to recommendations being made for the Community establishment.

In May 2025, the antibiotic usage update offered the Committee oversight as to the current position with a recognition of the need to address the culture and ownership of this across the Group. The Committee supported the actions being put in place to address ULTH being an outlier nationally. In order to gain assurance that the actions were addressing the areas of concern the Committee would receive an update in 6-months.

In January 2026, the Committee received an update on the progress achieved against the actions from the reports on CQC inspection visits to ULTH and LCHS from 2021 to 2025. The report also included information on the work by the Group to establish a revised, more proactive approach to CQC preparedness and demonstrate that services were consistently well-led with CQC readiness embedded into day-to-day practice rather than driven by inspection cycles alone.

In January 2026, the Committee received an update on the actions being implemented to reduce the backlog of waiting patients for the Ophthalmology services. There was also an update on the active steps being implemented to profile the waiting patients to assess them, so the necessary harm mitigation measures could be undertaken.

The Committee was updated on the progress of the Surgical Site Infection (SSI) Quality Improvement Project in January 2026 with the implementation of increased orthopaedic consultant oversight and alignment with the orthopaedic surgical pathway. To strengthen SSI surveillance the reporting of orthopaedic activity data onto the SSI database has been strengthened. The Committee noted however, that post-discharge surveillance was not yet operational due to the lack of the appropriate staffing resource.

The Committee received a presentation on a Patient Story in February 2026 from a nurse about a patient who attended ULTH and was diagnosed with terminal cancer with a prognosis of a lifespan of about a month. The presentation highlighted the work undertaken by different functions of the Group to support the patient and their family through to their transfer to palliative care in a hospice. The presentation also informed the Committee of the support provided to the family by a function in the Group after the patient had passed away.

The Committee received a presentation on antimicrobial stewardship (AMS) in the Group, which reflected the significant progress made since a previous presentation on the subject in May 2025.The Committee was significantly assured that the AMS team was track to ensuring that the consumption of antimicrobials by patients was at the appropriate level in the Group.

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In August 2025, the Committee requested for a focused discussion be held in the coming months covering all aspects of Infection Prevention and Control (IPC), including antimicrobial prescribing and the reduction plan. This was due to the trajectories being exceeded for a number of infections.

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

- End of Life Care
- High Risks on the Risk Register
- Clinical Harm
- Safer Discharge
- Infection Prevention and Control
- Pharmacy Medicines Management
- Epilepsy Service
- Neurology Service

During 2025/26 referrals between the Board Committees were made in order to ensure that where necessary additional assurances were sought from the relevant responsible Committee in areas where responsibility for assurance extended beyond the remit of a single committee. A number of referrals to the Committee and from the Committee were made during the year offering opportunities for the Quality Committee to seek further assurances.

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

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Quality Committee
Terms of Reference

1. Authority

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

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

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

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

2. Purpose of the Committee

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

The relevant strategic aim & objectives assigned to the Quality Committee for 2026 / 27 are:

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

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

3. Membership

The members of the committee are:

- Non-Executive Director – Chair
- Non-Executive Director – Deputy Chair

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

The committee will routinely be attended by:

- Director of Corporate Affairs or their representative

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

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

4. Attendance and Quorum

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

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

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

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

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

Observers will be permitted as agreed by the chair.

5. Frequency

The committee will meet monthly.

6. Specific Duties

The Quality Committee will:

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

7. Administrative support

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

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

Agendas and supporting papers will be circulated no later than 5 working days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working

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

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

8. Accountability and Reporting Arrangements

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

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

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

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

9. Monitoring effectiveness and Compliance with Terms of Reference

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

10. Review of Terms of Reference

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

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

Approved: May 2026

Approved by: Group Board

Next Review Date: April 2027

NHS
Lincolnshire Community and Hospitals NHS Group

Proposed Seated and Corridor Care Areas (SCCA) Quality and Safety Framework

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*5 May 2026*
Agenda item number	*9.2*
Report title	*Proposed Seated and Corridor Care Areas (SCCA) Quality and Safety Framework*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Discussion and Approval*
Accountable Director	*Nerea Odongo, Group Chief Nurse*
Author(s)	*Sarah Addlesee, Assistant Director of Nursing*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Reasonable assurance*
Prior approval process, if applicable	*Considered through Quality Committee*
Financial implications, if applicable	*None*
Action / decision required	*The Board is asked to:* • *Receive the report and note the initial data set and gap analysis position* • *Support the proposed Seated and Corridor Care Areas (SCCA) Quality and Safety Framework and associated recommendations*

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	
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

1. Purpose

To provide Board assurance on the Group's current position in relation to care delivered in seated and corridor care areas, outline the actions in place to mitigate risk, and seek support for the implementation of an enhanced quality and safety framework to strengthen oversight, assurance, and improvement.

2. Executive Summary

National expectations have reinforced that care delivered in non-designated clinical spaces is not an acceptable routine model of care and should only ever be used for the shortest possible duration when all other options have been exhausted. In response, the Group has reviewed its current position, existing controls, and areas requiring further strengthening.
Significant work is already in place across operational, nursing, quality, IPC, estates, fire, and governance teams to mitigate risk where seated and corridor care areas are used. This includes local standard operating procedures, risk assessments, daily operational oversight, safety huddles, staffing review processes, electronic patient tracking, incident reporting mechanisms, and executive visibility.

The Group has a number of important controls already in place. However, the review has identified areas where assurance now needs to be strengthened to ensure greater consistency, standardisation, and triangulation of quality, safety, patient experience, and operational intelligence. These include policy control, patient-specific risk assessment, patient communication, medication storage arrangements, more consistent data capture, and a clearer quality oversight structure.

To address this, it is proposed that the Group implements a Seated and Corridor Care Areas (SCCA) Quality and Safety Framework to provide a more robust and standardised mechanism for oversight, escalation, improvement, and Board assurance.

3. Background

During 2025/26, national guidance clarified expectations for the management of patients cared for in non-designated clinical spaces, including corridor care. The key themes are that corridor care should not become normalised, providers must have robust risk assessment and mitigation processes in place, Boards must have visibility of the extent of use and associated harms, and there must be clear actions to reduce and eliminate use over time.

This paper therefore focuses primarily on the Group's organisational response, current assurance, and next actions.

4. Organisational Position

4.1 Current position

The Group has undertaken substantial work to review the use of seated and corridor care areas and align practice more closely with revised national expectations. This has included review of existing spaces, associated risks, clinical processes, and governance arrangements.

A number of areas previously used have already been reviewed by the Group Chief Nurse and supporting teams, with some spaces decommissioned where they did not provide sufficient assurance.

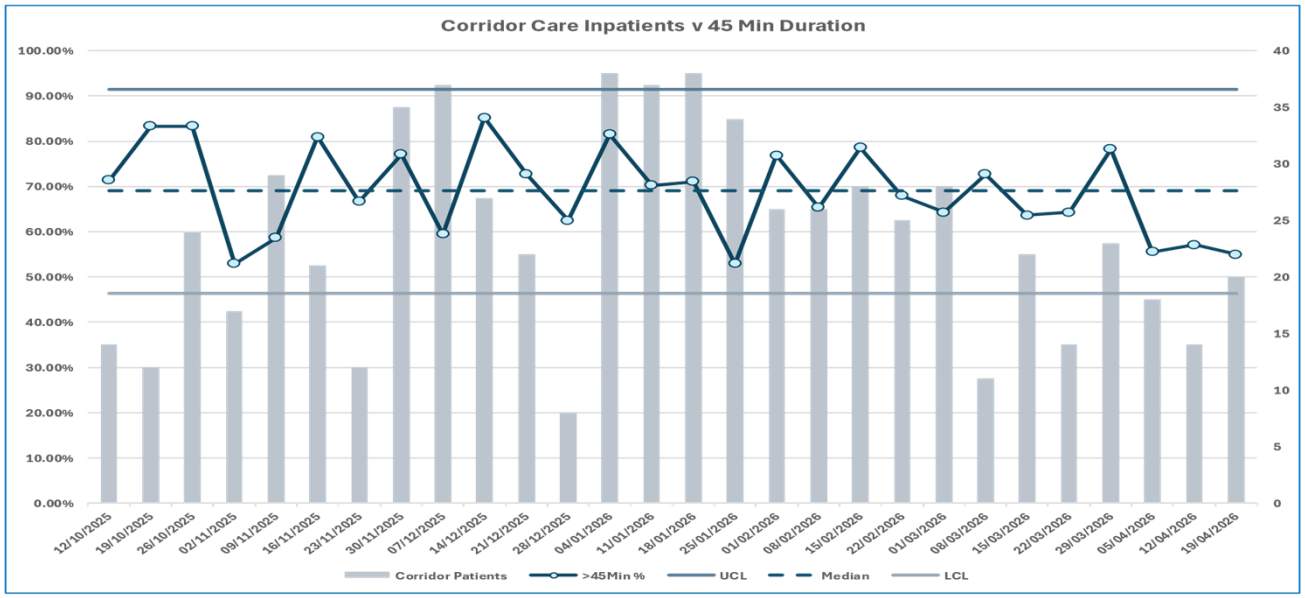
Current use of seated and corridor care areas continues to be supported through existing operational escalation processes and within clinical environments where staff are familiar with the patient group and care setting. Patients are visible on electronic systems including Careflow and WebV, supporting patient tracking, care oversight, and duration in area.

4.2 Snapshot view of Current Corridor Care Data

The below charts demonstrate the dataset currently available to provide visibility regarding utilisation and impact of Corridor Care on a daily and weekly basis, derived from historical Webv coding for inpatient wards that have cared for patients in corridor areas. Going forward it is proposed that the triangulation of data will be provided through the processes within the Seated and Corridor Care Areas (SCCA) Quality & Safety Framework.

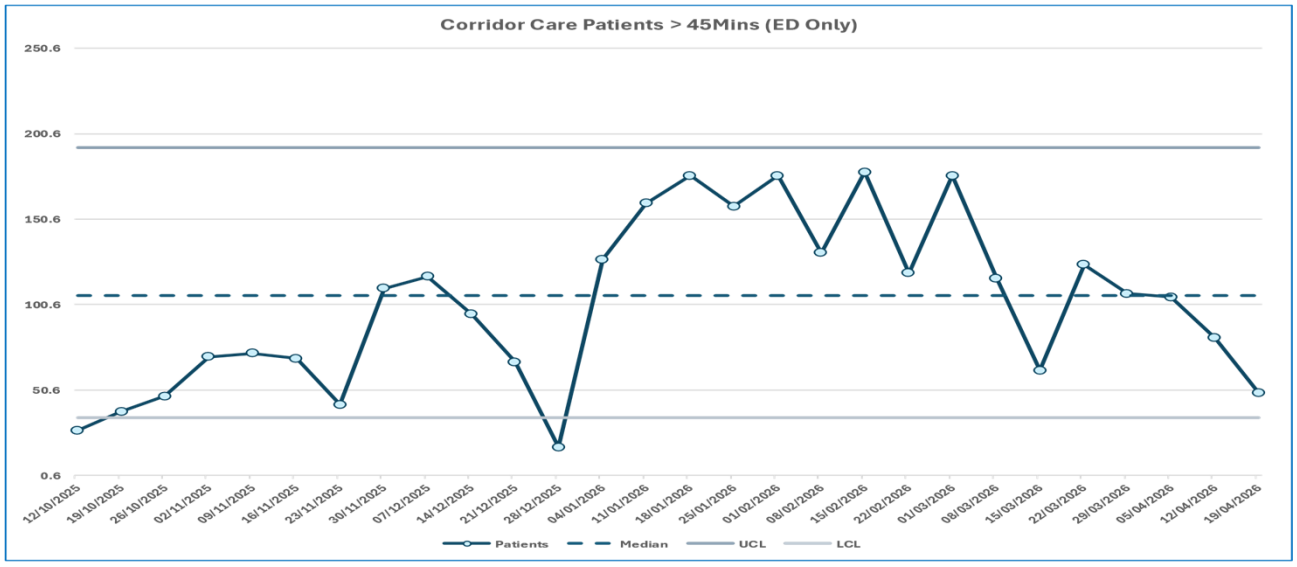
The wards included in the dataset are as follows;

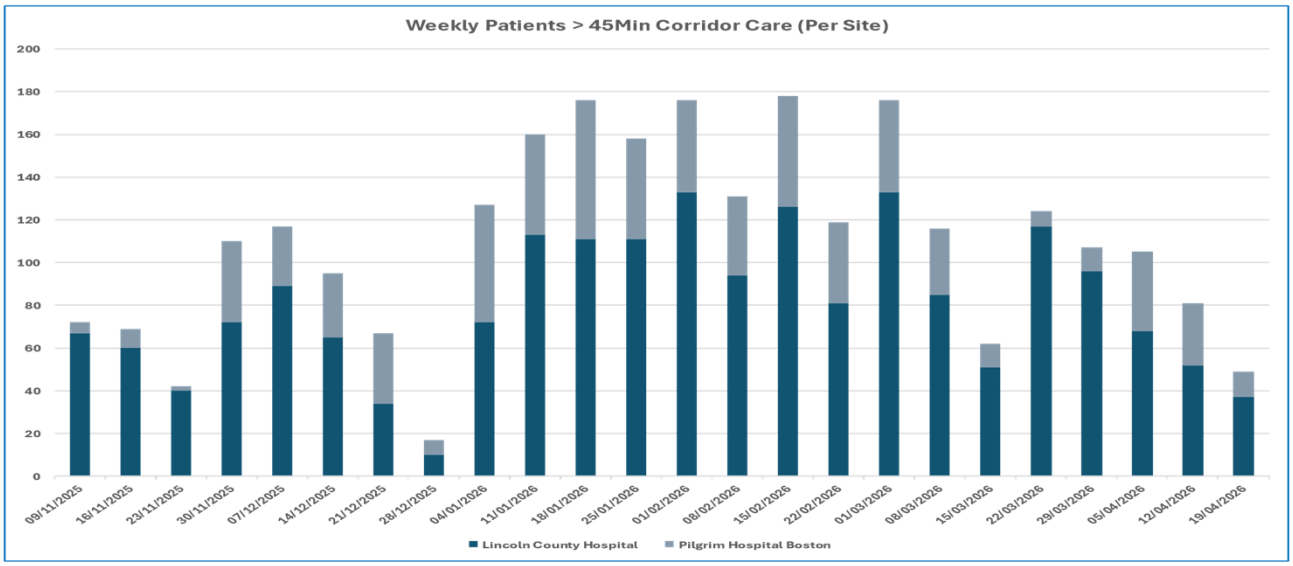
Lincoln: Stroke Unit, Shuttleworth Ward, Burton Ward
Pilgrim: Ward 3B, Ward 6A & Ward 6B
Grantham: EAU (Mon - Fri - due to Sat/Sun space used for SDEC), Harrowby Ward.



Emergency Department Corridor Care

At present, the report includes data only for Lincoln ED.





4.3 Working with Operational Teams to Reduce and Eliminate Corridor Care

Recognising that corridor care is primarily driven by demand, capacity, and patient flow pressures, the Group has strengthened its partnership working between clinical, nursing, and operational leadership to actively reduce and eliminate its use.

This is being led through close collaboration with the Chief Operating Officer and operational teams, with a shared focus on improving patient flow, reducing delays, and ensuring that risk is managed across the whole system rather than within individual departments.

Key elements of this approach include:

- **Daily operational grip and escalation:**
  Corridor care is actively reviewed through daily operational calls, site management processes, and safety huddles, with clear visibility of patients in SCCA and actions to prioritise timely movement to appropriate clinical spaces.
- **Whole-system risk management:**
  Decisions regarding the use of SCCA are made within the context of system-

wide pressures, balancing risk across Emergency Department, wards, and community pathways to ensure the “least worst” position for patient safety.

- **Strengthened flow and discharge focus:**
  Work is aligned to the urgent and emergency care (UEC) improvement programme, with a focus on reducing length of stay, improving discharge processes, and maximising use of community capacity to reduce avoidable occupancy.
- **Clinical and operational joint decision-making:**
  Placement decisions for SCCA are made collaboratively between operational teams, senior nurses, and clinical leaders, ensuring that patient safety, acuity, staffing, and environment are considered in real time.
- **Targeted reduction of SCCA utilisation:**
  There is a clear expectation that the use of corridor care is temporary and actively reduced. Areas are being reviewed, with some already decommissioned where they do not meet safety or quality expectations.
- **Enhanced visibility and accountability:**
  Corridor care is increasingly being treated as a key quality and operational metric, with growing visibility at Care Group and Executive, to support ownership and improvement.

This strengthened partnership ensures that corridor care is not managed in isolation as a nursing or quality issue, but as a whole-organisation priority requiring coordinated operational and clinical action.

4.4 Existing controls and assurance

Current assurance arrangements include:

- Local escalation policies and standard operating procedures.
- Daily operational review and handover processes.
- Staffing review through established safe staffing processes and SafeCare considerations.
- Safety huddles and senior nursing oversight.
- Risk assessments involving IPC, Health and Safety, and Fire teams.
- Incident reporting through DATIX and review through existing patient safety governance routes.
- Ward, matron, and care group quality assurance processes.
- Patient tracking through electronic systems.
- Support for staff to raise concerns through local management routes, Freedom to Speak Up, and Just Culture arrangements.

These controls provide a reasonable level of assurance that risks are being actively mitigated. However, assurance is currently spread across a number of different processes and would benefit from being brought together into one clearer quality and safety framework.

4.5 Key gaps identified

The review has highlighted the following areas for strengthening:

- Some policies and SOPs require review, formal publication, or tighter document control.

- Patient-specific risk assessment needs to be standardised and consistently implemented.
- Not all local processes explicitly reflect revised exclusion criteria and national definitions.
- A more standardised approach is needed for medication storage and readiness checks before opening or changing use of areas.
- Patient information and proactive communication require strengthening.
- Current data is available but remains fragmented and requires better triangulation across quality, safety, experience, and operational measures.
- There is an opportunity to strengthen the visibility of harms, patient feedback, staff experience, and learning associated with these areas.

5. Board Assurance

5.1 What assurance can be given now

The Board can be assured that:

- The Group has responded proactively to revised national expectations.
- A local review of seated and corridor care areas has been undertaken.
- Existing spaces are subject to operational and professional scrutiny.
- Some spaces have already been removed from use where assurance was insufficient.
- Risk mitigation is in place through staffing review, safety huddles, operational escalation, electronic patient tracking, incident reporting, and specialist input from IPC, fire, and health and safety teams.
- The organisation has identified the key areas where assurance requires strengthening and has moved into a planned improvement phase.

5.2 What requires further strengthening

Further assurance is required in relation to:

- Consistent quality oversight across all seated and corridor care areas.
- Stronger standardisation of local risk assessment and readiness arrangements.
- Clearer capture and triangulation of harms, near misses, complaints, and patient/staff experience.
- Improved policy control and publication.
- A more visible improvement plan with named ownership, milestones, and reporting.

6. Risks

The principal risks associated with seated and corridor care areas remain:

- Compromise to privacy, dignity, and patient experience.
- Reduced ability to observe and respond quickly to deterioration.
- IPC, fire safety, and environmental risks.
- Medication and equipment storage risks.
- Increased risk of falls, pressure damage, delirium, and delayed response to need.
- Variation in staff experience and moral distress.
- Risk of corridor care becoming normalised without strong oversight and de-escalation processes.

- Regulatory and reputational risk if the organisation is unable to demonstrate robust control and a clear improvement trajectory.

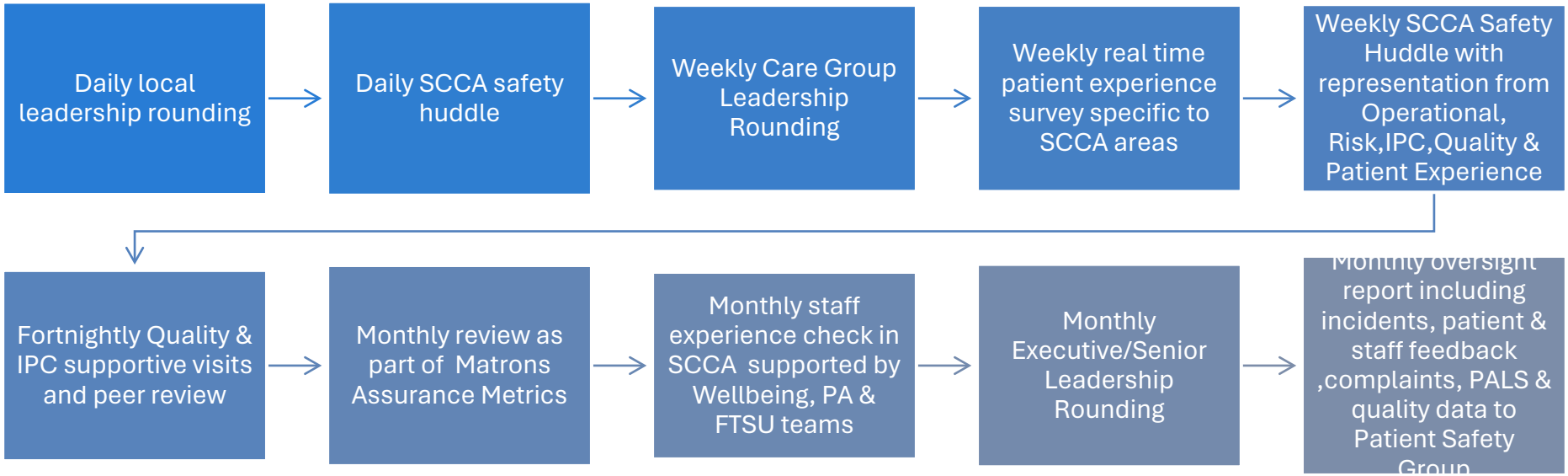
Proposed Seated and Corridor Care Areas (SCCA) Quality & Safety Framework

In acknowledgement of the multifactorial issues impacting patient safety, patient and staff experience that are associated with providing corridor care

It is recommended that the Group introduces a Seated and Corridor Care Areas (SCCA) Quality and Safety Framework to bring together operational, nursing, governance, patient safety, IPC, patient experience, and estates assurance into one structured process.
The framework will:

- Standardise oversight of all seated and corridor care areas.
- Support early identification of emerging risks and issues.
- Triangulate operational, quality, safety, and experience intelligence.
- Provide clearer escalation and de-escalation arrangements.
- Strengthen assurance reporting to Quality Committee and Board.
- Support consistent learning, review, and improvement across sites

Proposed Seated and Corridor Care Areas (SCCA) Quality & Safety Framework



8. Next Actions

The immediate next steps are:

1. Develop and implement a SMART action plan arising from the completed gap analysis, with clear ownership, milestones, and reporting timescales

2. Implement the SCCA Quality and Safety Framework to provide a single oversight structure for quality, safety, patient experience, and operational assurance.
3. Review and update all relevant policies, SOPs, and guidance, ensuring documents are current, aligned to national expectations, and formally accessible through document control systems.
4. Introduce a standardised patient-specific risk assessment and strengthen inclusion/exclusion processes for patients considered for seated and corridor care areas.
5. Introduce patient communication tools, including a patient information leaflet and mechanisms for real-time patient feedback.
6. Strengthen data and triangulation, including routine reporting of:
    a. Current corridor care position,
    b. Length of time in area,
    c. Incidents and harms,
    d. Complaints and patient feedback,
    e. Staffing and operational context,
    f. Improvement actions and themes.
7. Strengthen staff support and learning arrangements, including routes for raising concerns, debrief, and review of staff experience in these environments.

9. Recommendation

The Board is asked to:

- Note the current organisational position and assurance in relation to seated and corridor care areas.
- Note the current snapshot of patients being cared for in corridor care areas, with supporting ward and Emergency Department trend graphs.
- Support the implementation of the SCCA Quality and Safety Framework.
- Endorse the development of a SMART improvement plan and strengthened reporting arrangements through Quality Committee.

NHS
Lincolnshire Community and Hospitals NHS Group

Finance Briefing M12

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*5 May 2026*
Agenda item number	*9.3*
Report title	*Finance Briefing M12*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• Information
Accountable Director	*Paul Antunes Goncalves* *Group Chief Financial Officer*
Author(s)	*Finance Team*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Reasonable assurance*
Prior approval process, if applicable	*Content discussed at Finance and Performance Committee*
Financial implications, if applicable	*None*
Action / decision required	*The Board is asked to:* • *Note the contents of the Finance report in respect of Revenue, Capital, Cash and CIP positions.* • *Note the latest available information on productivity.* • *Note the key areas of focus for 2026/27.*

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 (prepared based on draft accounts)

The Group achieved its' planned breakeven position for 2025/26, which is a significant achievement. To recognise the achievement, both ULTH and LCHS have been granted deficit support funding by the national team to support us in meeting our ongoing financial and performance targets.

- 2025/26 Capital position

The Group **achieved** its' capital programme for 2025/26 with capital expenditure of £131.4m.

- 2025/26 CIP position

The Group delivered savings of £72.2m (£7.1m lower than planned).

- Cash position

The Group ended the financial year with a cash balance of £77.6m (£23.4m higher than planned).

Lincolnshire Community and Hospitals NHS Group
Trust Board – 5 May 2026
Finance Briefing M12

Executive Summary

For 2025/26, the Group achieved financial breakeven across both Trust's, which is a significant achievement. To recognise the achieve both ULTH and LCHS have been granted deficit support funding by the national team to support us in meeting our ongoing financial and performance targets.

Included within the position is a shortfall in our CIP delivery within the acute side of the Group, mainly driven by our medical temporary pay reductions and a delay in our booking centre scheme. This has been mitigated by non-recurrent actions. Although we were short on our target, we have delivered £72.2m of savings which is a significant step up on prior year performance.

Across the Group we have been able to reduce our WTE since the start of the financial year. Our Agency spend for the year totals £15.5m, £1.2m above target, this is a 35% reduction on prior year and will continue to be an area of focus (particularly medical pay) in 2026/27.

Cash has ended the year in a positive position, with £77.6m in the bank. This reflects the improvement in our revenue position and the draw down of our capital cash ahead of supplier payments. Although cash has ended in a positive position, we will continue to monitor cash on a weekly basis and report to FPC and Board.

The Group have delivered the largest capital plan in the organisation's history, utilising £131.4m of capital funding. This includes improvements across our estate, digital infrastructure, medical equipment, service redesign and improvement and community access.

The Group have seen external triangulation on our performance, with the M9 productivity position showing both organisations out performing the national average. For ULTH we have seen steady improvement through the year with M9 reporting 7.8% year on year improvement, this compares to an acute national average of 2.5%. For LCHS performance has been more variable, December's position is 1.0% year on year improvement which compared to national community average of a negative 2%.

The Group have signed up to a breakeven plan for 2026/27, this position is supported by non-recurrent funding so work on our medium-term financial plan is required to ensure financial sustainability. This breakeven plan will be challenging and will continue to require a focus on three key areas:

1. Delivery of our financial efficiency programme
2. Delivery of our activity plan
3. Appropriate controls on our workforce (particularly our bank and agency).

Summary Position

Month 12 Position	Group performance			LCHS performance			ULTH performance		
	In-Month			In-Month			In-Month		
	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m
Surplus / (Deficit) ex DCF	2.8	4.3	1.6	0.6	0.6	(0.0)	2.1	3.7	1.6
Surplus / (Deficit) incl DCF	2.8	10.9	8.1	0.6	2.3	1.6	2.1	8.6	6.5
CIP Delivery	9.5	6.7	(2.8)	1.4	1.2	(0.3)	8.0	5.5	(2.5)
Capital Spend	43.9	71.2	27.3	1.1	0.9	(0.2)	42.8	70.3	27.5
Agency Spend	(1.1)	(1.6)	(0.5)	(0.1)	(0.0)	0.1	(0.9)	(1.5)	(0.6)
Cash Balance	11.4	(4.9)	(16.3)	0.2	12.6	12.3	11.2	(17.4)	(28.6)
Month 12 Position	Outturn			Outturn			Outturn		
	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m
Surplus / (Deficit) ex DCF	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit) incl DCF	0.0	6.6	6.6	0.0	1.6	1.6	0.0	4.9	4.9
CIP Delivery	79.3	72.2	(7.1)	9.5	9.5	0.0	69.8	62.7	(7.1)
Capital Spend	131.4	131.4	(0.0)	3.8	3.8	0.0	127.6	127.6	(0.0)
Agency Spend	(14.2)	(15.5)	(1.2)	(1.6)	(0.6)	1.0	(12.6)	(14.9)	(2.3)
Cash Balance	54.1	77.6	23.4	27.0	27.8	0.8	27.1	49.8	22.7

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	*~~18 March 2026~~5 May 2026*
Agenda item number	*9.4 ~~8.3~~*

Finance and Performance Committee Upward Report of the meeting held on 18 March 2026

Accountable Director	*Paul Anutunes-Goncalves, Group Chief Finance Officer*
Presented by	*Daniela Cecchini, Non-Executive Director*
Author(s)	*Kwame Mensa-Bonsu, Deputy Director of Corporate Affairs*
Recommendations / decision required	*The Board is asked to:* • *note the discussions and assurance received by the Finance and Performance Committee;*

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

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	05 May 2026
Report from:	Finance and Performance Committee
Report from meeting held on:	18 March 2026
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 March 2026 including assurances received and those matters which the Committee wishes 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) Committee Performance Dashboard
b) Operational Performance
c) PRM Upward Report
d) Cyber Posture Update

In relation to the Performance Dashboard, the Committee noted that the areas of concern from the previous month were starting to recover because the pressures associated with winter had begun to recede and improvement measures that were implemented. The amount of Clinical Assessment Service (CAS) cases and increased capacity had resulted in reduced pressure in the ED and Urgent Treatment Centres (UTCs). Additionally, within Planned Care, the Discharge to Assess (D2A) average case load continued to increase due to increased D2A capacity. Performance had begun to return to expected levels or growing because of the interventions to increase capacity and reduce pressure.

The Committee also noted for the dashboard that there had been a significant deterioration in fractured neck of femur figures and agreed for a cross-referral to the Quality Committee to be made to conduct a deep dive and check whether the impact on patients was being managed.

The Committee also agreed for the Integration Committee to undertake a deep dive into the whole fractured neck of femur pathway, with a focus on

the impact of the significant bed pressures in the community and the capacity issues in the Orthopaedics team. It was noted that evidence suggested that when fractured neck of femur patients, who were usually elderly, were treated early they had good outcomes and recover quickly. However, the delay in treatment, due to bed pressures and capacity issues in the Orthopaedics team, ensured that the length of stay for that cohort of patients was a significant outlier at 21 days.

The Committee was **assured** by the Performance Dashboard.

The Committee reviewed the Operational Performance report and noted that the overall position for cancer performance remained challenged, particularly in relation to performance against the 62-day standard which deteriorated from January 2026 to March 2026. The predominant reasons for the deterioration were understood, and a recovery structure was being worked through the internal governance process.

The operational performance reports also noted that the 52-week backlog had been cleared, which had positively impacted on the NOF's scores. RTT performance in relation to the 18-weeks standard was at 95.87%. Urgent & Emergency Care stated that targets were not met in February 2026, with 74.53% being achieved for the 4-hour overall performance, versus the 76% target. However, an improved trajectory was expected for March 2026, with confidence to achieve the target.

The reports noted that the SDEC performance had continued to improve, the 12-hour total wait time in ED standard remained a challenge. There were 2,338 SDEC attendances in February 2026 compared to 1,393 attendances in February 2025. Prior to the implementation of SDEC, these patients would have attended ED and added to the volumes to be seen.

In March 2026, the Committee was updated on steps to resolve the challenges with Diagnostics including steps to procure an additional provider to support the non-obstetric ultrasound service (NOUS), and other steps to enhance MRI capacity. In relation to the MRI capacity issue, the expectation was that the Patient Services Hub would significantly enhance booking capacity while a plan to procure a mobile MRI unit in Pilgrim Hospital would almost double MRI capacity in the area.

The Committee was **assured** by the Operational Performance report.

The Committee received the Cyber Security Posture update for January 2026 and noted that the Group's cyber maturity and resilience had been maintained during November/December 2025. The update informed the Committee that the appropriate remediation/mitigation controls were being implemented in good time by the Group. The Committee noted that the Group's cyber security arrangements remained protected, were capable of threat detection, were resilient, and could recover appropriately and in good time should the organisation become a victim of a malicious targeted cyber event.

The update report noted that for the majority of information security controls and capability, the cyber posture remained robust and mature in most areas of the related National Cyber Security Centre (NCSC) good practice guidance.

The Committee was **reasonably assured** by the Cyber Security Posture update.

Assurances in respect of Objective 1c:

a) Finance Report including CIP, Capital, CRIG and Productivity, Improvement and Transformation Oversight Forum (PITOF) upward report (February 2026) and Annual Plan (Operational & Financial)
b) Post Investment Evaluation
c) Costing & Benchmarking Report (Q3)
d) Procurement Report
e) Contract Award Reports

From the Month 11 Finance Report and associated reports, the Committee was informed that:

i. the Group achieved a £4.1 million surplus whilst working on the path to break even. This had resulted in a £4.3 million deficit year-to-date, and this was £1.6 million behind plan year-to-date.
ii. £65.5 million of CIP schemes had been delivered, which was behind the target of £69.9 million but was a significant achievement for the Group.
iii. The Capital spend had increased to £16.3 million in month, however continued to be behind plan by £27.1 million.
iv. The Plan for 2026/27 was compliant, with both organisations at break-even, and the challenging c £89m 2026/27 CIP target, included £60 million of new- and full-year effect schemes and non-recurrent bonus schemes. A step-up in activity was to be delivered in terms of both the Elective Recovery Fund (ERF) and Community Diagnostic Centre (CDC) activity.
v. In relation to the Board Assurance Framework (BAF) risk entry for the 'Improve productivity and deliver financial sustainability' strategic objective, the Committee agreed to a recommendation for the risk score to be reduced from 12 to 8 and for the assurance rating to be changed from 'amber' to 'green'. The Committee agreed that the revenue and capital positions of the Group was likely to reach their targets, and that the PITOF and PRM reports had shown good trajectories and provided good assurance.

The Committee was **assured** by the Finance Report and associated reports.

The Committee reviewed the Post Project Evaluation report for the challenging Lincoln Mortuary Refurbishment Project and noted that there had been significant delays in the project timeframe, partly because of issues with the supplier. This had resulted in the project increasing from £1.2 million to £1.8 million. Despite the challenges, both the financial and operational

benefits had been delivered, and key learning had been gained, ensuring that the scope of the case was correct.

The Committee was **assured** by the Post Project Evaluation process for the Lincoln Mortuary Refurbishment Project.

The Committee reviewed the Q3 Costing and Benchmarking Report and noted that there had been a year-on-year improvement with activity delivering in line with plan. The report outlined the pressures on the emergency pathway and the requirement for transformation work; noting that the Emergency Department (ED) was a significant outlier compared to peers.

Regarding staffing, the report highlighted the improvements made on nursing in addition to the remaining challenges on the medical workforce. The Committee also noted the assurance levels within the report, and the transformation work being undertaken in the Group.

The Committee was **assured** by the Q3 Costing and Benchmarking Report.

The Procurement Report provided the Committee with **substantial assurance** and noted that the Group had achieved £4m of CIP savings in 2025/26, against a stretched target of £4m. The Procurement team added an overall value of £7.8m in savings in 2025/26.

The report highlighted the positive working relationships across the East Midlands Acute Providers (EMAP) network to share learning and seek scale on benefits. The Procurement teams continue their training and development with all teams actively engaged in different courses. Multiple members of staff were enrolled on the new Training Academy courses developed by NHSE for commercial NHS staff. The Group's Deputy Director of Procurement also attended a "train the trainer" course in March 2026 to help train up other procurement teams nationally as part of the commercial academy.

The Committee reviewed the following Contract Award Reports:

a. Co-Op Pharmacy Extension (LCHS): The Group Chief Finance Officer explained that there was a request to implement a 12- month extension to the current arrangements with the Co-Op, whilst making a transition to an in-house provision. The Committee **approved**:
    - a 12-month extension (1 April 2026 – 31 March 2027) to the Clinical Pharmacy Services contract delivered by Lincolnshire Co-operative.
    - the commencement of a full and compliant re-procurement for a replacement contract.
    - the issuing a formal Contract Variation and publication of any required transparency or modification notices
b. National Grid: This was a part of a requirement to upgrade the Distribution Network Operators (DNO) incoming High Voltage (HV) supply to Grantham District Hospital (GDH). Similar upgrades had been undertaken at Boston Pilgrim Hospital and Lincoln County Hospital by the same supplier. The Committee reviewed and **approved** the

recommendation that the contract award be made to National Grid Electricity Distribution. The contract term will be for about 6 months.

c. Linen and Laundry Service 2026-2027: This was a recommendation report to award a new contract for a fully managed linen and laundry service to the incumbent supplier, Elis, via the NHSSBS National Framework to avoid a break in service. The Committee was informed that the short-term award would give the stakeholder team further time to work on updating the tender pack and preparing for a market test to secure a long-term contract. The Committee **approved** the contract award to Elis for the 2026/27 financial year.

Assurances in respect of Objective 1d:

a) Estates and Facilities Update
b) Planned and Preventative Maintenance (PPM) Report
c) Health & Safety Committee Upward Report

The Committee received the Estates and Facilities update which noted Planned and Preventative Maintenance (PPM) compliance at Lincoln was below target due to staffing levels within the team. The report noted however, that Pilgrim and Grantham were performing well against PPM compliance. The Committee also noted there were several areas below target on the cleanliness audit, due to high footfall in the areas or operational issues impacting on housekeeping staffing levels.

The Committee was also informed that there was a Health and Safety Executive (HSE) notice of contravention at Pilgrim Hospital relating to automatic doors and a failure to undertake a risk assessment. The plan was to undertake the risk assessment, and this would be compliant within the required timescale.

The Committee was **reasonably assured** by the Estates and Facilities update.

The Committee received and reviewed the Planned Preventative Maintenance (PPM) External Review – Briefing Report and Action Plan. The report and action plan contained the findings from the external audit of the PPM management system and a high-level 30/60/90-day action plan.

The Committee noted that the report detailed the resources necessary to deliver the identified improvements and also noted that the current management capacity did not have the bandwidth to deliver the recommendations from the PPM audit at pace.

The Committee agreed with the report's request for permission to proceed with the action plan and associated resources.

The Committee had **limited assurance** that there was the available bandwidth to progress the action plan at the required pace due to the level of work required.

Assurances in respect of other areas:

a) Board Assurance Framework 2025/26
b) Risk Register
c) Policy Position
d) Internal Audit Reports
e) External Audit Reports
f) Topical, Legal & Regulatory Update
g) Information Governance Group (IGG) Upward Report

The Committee received and noted the position in respect of the Board Assurance Framework, Risk Register, Policies, internal audit recommendations, Topical issues and the IGG upward report.

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

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

a) None

4.0 Matters for reporting / escalation to the Group Board

4.1 The Committee agreed on 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):

a) None

6.0 Group Board Action Required

6.1 The Group Board is asked to:

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

Dani Cecchini, Non-Executive Director (Chair)
18 March 2026

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	*24 April 2026*
Agenda item number	*9.4*

Finance and Performance Committee Upward Report of the meeting held on 24 April 2026

Accountable Director	*Paul Anutunes-Goncalves, Group Chief Finance Officer*
Presented by	*Dani Cecchini, Non-Executive Director*
Author(s)	*Kwame Mensa-Bonsu, Deputy Director of Corporate Affairs*
Recommendations / decision required	*The Board is asked to:* • *note the discussions and assurance received by the Finance and Performance Committee;*

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

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	05 May 2026
Report from:	Finance and Performance Committee
Report from meeting held on:	24 April 2026
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the truncated Finance and Performance Committee at its meeting held on 24 April 2026 including assurances received and those matters which the Committee wishes to escalate to the Group Board. The meeting was truncated to accommodate a workshop that had been arranged for a comprehensive annual BAF review to be undertaken.

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) Breast Service Cancer Performance Recovery Plan
b) Committee Performance Dashboard
c) Operational Performance
d) PRM Upward Report

The Committee received and reviewed the Breast Service Cancer Performance Recovery Plan. The Recovery Plan was the developed after the ICB organised a Breast Service Risk Summit in reaction to concerns about the service's performance were raised by the ICB early in April 2026. Prior to those concerns Breast cancer performance at ULTH had resulted in sustained breaches against the 28-day Faster Diagnosis Standard (FDS) and the 62-Day standard, increased patient waiting times, and heightened scrutiny from system partners.

The Committee noted that the current position of challenged performance reflected several factors including exceptional and sustained demand, fragile in-week capacity, workforce constraints across radiology, surgery and administration, front-end diagnostic delays, and the interface risks between Breast Services and Oncology.

The Committee reviewed the Breast Service Cancer Performance Recovery Plan, which was a phased and structured recovery programme to resolve the causes of the poor performance. The Committee noted that the Recovery Plan demonstrated clear ownership, measurable deliverables, realistic timelines and robust governance aligned to existing Trust and system cancer oversight arrangements.

The Committee was **assured** by the Breast Service Cancer Performance Recovery Plan.

The Committee reviewed the performance dashboard and noted the following highlights:

- Acute front-door pressure was ongoing, with continued 12-hour trolley waits and ambulance handover delays, although some stabilisation is evident compared to earlier in the year
- Diagnostics performance has deteriorated further, representing the most significant and sustained gap against national standards.
- Elective recovery indicators show marginal improvement, however long-wait backlogs remain substantially above trajectory.
- Community front-door performance is broadly stable, though compliance with triage and data quality standards remains slightly below target.
- 104+ day cancer waiters: 131 vs target 10 (unchanged and significantly off trajectory).
- >12-hour trolley waits (acute): 1,132 in March (no tolerance; remains materially above standard).
- 18-week incomplete pathways: 56.3% vs 84.1% target (significantly below requirement of 60% delivery).
- 52-week waiters: 464 vs zero tolerance (gradual improvement but backlog persists)
- In unplanned care, 4-hour overall performance in March 2026 was 26: 80.97% against plan of 78.0%. The overall performance in February 2026 was at 74.53%.
- The Type 1 4-hour performance in March 2026 was at 69.19% against plan of 64.5%, The Type 1 4-hour performance in February 2026 was at 53.39%.
- The UTC 4-hour Emergency access standard (Type 3) achieved 97.26% against a Group stretch target of 98%. The national target is 95%
- The year-end financial position delivered plan overall, however this masked under-delivery against the Cost Improvement Programme.
- YTD position: Break-even delivered against plan.
- YTD CIP delivery: £72.2m vs £79.3m plan (≈ £7.1m shortfall).
- Capital programme: Delivered broadly in line with year-end.
- Cash position: £54.1m at year-end, materially stronger than plan.

The Committee was **reasonably assured** by the data included on the performance dashboard.

The Operational Performance reports reviewed by the Committee highlighted the following:

i. That at the end of February 2026, all three cancer standards were below plan and had deteriorated from the stronger position seen in November 2025. The current positions of the 3 standards were –
   - 28-Day Faster Diagnosis Standard: Performance in February 2026 was at 73.2%, from 76.7% in November 2025 and below plan. The decline was primarily driven by challenges within the Breast service.
   - 31-Day Standard: Performance in February 2026 was at 88.9%, from 91.4% in November 2025 and below plan. The main drivers were pressures within surgical specialties, particularly access to theatre capacity, compounded by competing priorities to address long-waiting (65-weeks) activity.
   - 62-Day Standard: Performance in February 2026 was 58.9%, from 69.2% in November 2025 and significantly below plan. Several specialties were contributing to this position due to increasing backlogs, with particularly significant pressures in the Colorectal, Urology, Head & Neck, Lung and Breast services.

ii. Total Waiting List remained better than plan in February 2026 at 69,054 against the planned 69, 447.

iii. In terms of the 52-weeks standard there had been a significant improvement with a delivery of an above plan 464 patients being on the waiting list in February 2026 from 510 patients in January 2026.

iv. In February 2026 the 18-week RTT standard achieved 56.3% against a plan of 59.5%.

v. Diagnostics Waiting Times and Activity (DM01) was being impacted by booking restrictions due to the Patient Services Hub Consultation and associated holding of vacancies. Mitigating actions were being implemented.

vi. For the non-elective pathway at LCH and the March sprint the in-month changes from February 2026 had a positive impact on the KPI measures, despite increase in ambulance conveyances. For the 4-hour overall standard, performance was at 80.97% in March 2026 against a plan of 78.0%. Year-to-date the 4-hour standard was at 75.47% against a plan of 75.0%.

vii. For the out of hospital data, the Committee noted the strong and sustained improved performance against the community metrics including 2-hour urgent care, virtual wards, discharge to assess pathway 1 offer and community waiting lists whilst managing the increase in demand over March 2026.

viii. The progress against improving flow across community capacity following the deep dive into the Discharge to Access (D2A) service in March 2026.

The Committee also noted the continued oversight and drive to improve and transform services where any metric was reported as below the agreed performance standard. The Committee noted the mixed performance data included in the Operational Performance report and was **reasonably assured** by the improvement actions being implemented.

Assurances in respect of Objective 1c:

a) Finance Report including CIP, Capital, CRIG and Productivity, Improvement and Transformation Oversight Forum (PITOF) upward report (March 2026)
b) Contract Award Reports

From the Month 12 Finance Report and associated reports, the Committee noted that the Group:

i. Delivered its' break-even duty for 2025/26 and was allocated £6.6m in Deficit Support Funding.
ii. Delivered its' 2025/26 capital programme in full which equated to capital expenditure of £131.4m. This was significantly higher than the £93.3m capital expenditure achieved in 2024/25.
iii. Ended 2025/26 with a cash balance £23.4m higher than its' planned cash position, which equated to a cash balance of £77.6m.
iv. Did not deliver its' CIP target in full in 2025/26. The Group delivered savings of £72.2m, which was £7.1m lower than planned but equated to delivery of £24.3m more savings than was achieved in 2024/25.
v. Did not achieve its' agency target for 2025/26 with expenditure of £15.5m which was £1.2m higher than planned but was £8.5m lower than expenditure of £24.0m in 2024/25.

The Committee also noted that delivery of both Electronic Patient Record (EPR) and Electronic Document Management System (EDMS) had faced challenges. Across the whole project there was potential to overspend the resource available /projected through the original business case. A review of delivery objectives / timescales and the resources required was currently being undertaken.

The Committee was asked to note that the Group Board in January 2026 approved for the period to 31 March 2026: *The Delegation of authority to the Group Chief Finance Officer, Group Chief Integration Officer, Group Chief Operating Officer and Group Chief Estates & Facilities Officer with 2 out 4 required, to approve the progression of Capital Project Mitigation Options.*

In line with this delegation the Group Chief Finance Officer and Group Chief Estates & Facilities Officer have approved a total of £22.0m of projects up to 31 March 2026.

The Committee **supported** a request for the Group Board to **ratify** the approval by the Group Chief Finance Officer and Group Chief Estates & Facilities Officer of capital projects totalling £22.0m up to 31 March 2026.

The Committee also **supported** the request for the Group Board to be reminded that the delegated authority was in place for the period to 31 March 2026 and has therefore now lapsed.

The Committee was **assured** by the Finance Report and associated reports.

The Committee reviewed the following Contract Award Reports:

i. LCHS has been awarded a contract by NHS Leicester, Leicestershire and Rutland ICB – Delegated Specialised Commissioning (QK1) for the delivery of the Environmental Controls (Electronic Assistive Technology – EATs) Service, supporting adults and children with complex physical disabilities. The service provides assessment, provision, installation and maintenance of environmental control equipment enabling individuals with severe disability to independently operate essential home, communication, and safety functions.

   The total contract value over the initial five-year term (27 October 2025 – 26 October 2030) is £2.66m, with fixed annual values and predictable income flows, with future nationally mandated uplifts to be managed through formal contract variation.

   The Committee:

   a. **Noted** that the contract was signed on 13 April 2026 by the Chief Executive under delegated authority and was being presented to the Committee for governance oversight and assurance.
   b. **Approved** and noted the award of the EATs Service contract to LCHS for the period 27 October 2025 to 26 October 2030.
   c. **Provided** assurance that the contract has been reviewed and executed in line with the Trust's Standing Financial Instructions and Scheme of Reservation and Delegation.

ii. The Committee received Contract Variation CV13, which updated the 2025/26 Community Services NHS Standard Contract between NHS Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Board (ICB) and LCHS. The variation incorporated £3.638m of agreed non-recurrent income into the 2025/26 financial quantum and made associated amendments to the Palliative and End of Life (PEOL) service specification and reporting requirements. The contract would for an initial 10-year term from 01 April 2024 to 31 March 2034 for a total contract value is £127,746,128 as amended by CV13.

   The Committee noted that a number of in-year system funding decisions were agreed to support providers in managing financial pressures, including those arising from industrial action and wider system deficit positions. The Contract Variation CV13 had been issued to formally reflect these agreements within the NHS Standard Contract. The variation supersedes the financial position previously recorded under CV12 and represents the final agreed quantum position for the 2025/26 contract year.

   The Committee:

   a. **Approved** and noted Contract Variation CV13 to the 2025/26 Community Services contract, incorporating £3.638m of agreed non-recurrent income (£2.000m industrial action funding and £1.638m deficit support funding).
   b. **Provided** assurance that Contract Variation CV13 has been reviewed and progressed in line with the NHS England Standard Contract, the Trust's Standing Financial Instructions.

c. **Noted** the associated amendments to the PEOL service specification and reporting requirements, effective from 31 March 2026, as set out within the variation documentation.

iii. The Committee received a report setting out a requirement to replace ageing endoscopy equipment within Theatres and the Endoscopy Units at Lincoln County Hospital, Pilgrim Hospital, Boston, and County Hospital, Louth. The current inventory of endoscopy equipment included within this replacement programme ranged from 12 to 20 years old, significantly exceeding their operational lifespan. Replacing the ageing endoscope inventory with modern equipment was essential to delivering the Group's objectives.

The procurement process had been completed, and the recommendation was to award a contract to Olympus KeyMed (Medical & Industrial Equipment) Group Ltd. The total contract value was £1,110,556.99 (Ex VAT) with an estimated capital cost avoidance of £137,044.51 (Ex VAT), and revenue cost avoidance of £254,384.32 (Ex VAT), and for a term of contract will be a maximum of 3 years based on the term of the equipment's warranty.

The Committee **approved** the proposed contract award to Olympus KeyMed to replace ageing endoscopy equipment.

iv. The Committee received a report setting out the receipt by ULTH of £21m of non-recurrent support funding in 2025/26. This was allocated for the following reasons:

a. Year-end support funding - £6m
b. Winter Surge Funding - £15m
c. RTT Sprint funding - £2.1

In addition, the national team has distributed unearned Deficit Support Funding (DSF) to qualifying health systems, including £4.9m to ULTH.

The Committee:

a. **Retrospectively approved** the income contract variations with the Lincolnshire ICB, valued at approx. £27m; and
b. **Noted** the actions being implemented to strengthen financial governance and ensure future contract variations are approved in accordance with Standing Financial Instructions and delegated authority limits.

<u>Assurances in respect of Objective 1d</u>:

Deferred to accommodate BAF workshop

<u>Assurances in respect of other areas</u>:

a) Board Assurance Framework 2025/26
b) National Cost Collection
c) Internal Audit Reports

The Committee received and noted the position in respect of the Board Assurance Framework, National Cost Collection and internal audit recommendations.

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

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

a) The Committee agreed for a report to be submitted to the May 2026 meeting, identifying the tumour sites with performance issues, and then to have deep dives from June to focus on those individual tumour sites (one deep dive each month).
The Committee also agreed for a more ambitious but realistic Diagnostics recovery plan to be submitted to the May Committee meeting for review.

4.0 Matters for reporting / escalation to the Group Board

4.1 The Committee agreed on 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):

a) None

6.0 Group Board Action Required

6.1 The Group Board is asked to:

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

Dani Cecchini, Non-Executive Director (Chair)
24 April 2026

Finance and Performance Committee
Terms of Reference

1. Authority

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

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

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

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

2. Purpose of the Committee

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

The relevant group strategic aim & objectives aligned to the Finance and Performance Committee for 2026 / 27 are:

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

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

3. Membership

The members of the committee are:

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

The following roles will be routine attendees at the committee:

- Group Director of Corporate Affairs or their representative
- Deputy Director of Finance

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

- Group Deputy Chief Clinical Governance Officer (as required)

4. Attendance and Quorum

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

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

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

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

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

Observers will be permitted as agreed by the chair.

5. Frequency

The committee will meet monthly.

6. Specific Duties

The Finance Committee will:

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

7. Administrative support

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

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

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

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

8. Accountability and Reporting Arrangements

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

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

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

9. Monitoring effectiveness and Compliance with Terms of Reference

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

10. Review of Terms of Reference

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

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

Approved: May 2026

Approved by: Group Board

Next Review Date: April 2027

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

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

Notes

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

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

Lincolnshire Community and Hospitals NHS Group

Annual Report to the Trust Board from the Finance and Performance Committee 2025/26

ROLE OF THE COMMITTEE

In 2025/26, in line with all other Committees of the Board, the Terms of Reference were reviewed and amended. Under the agreed terms of reference, the Finance and Performance Committee was tasked as follows:

The Finance and Performance Committee will:

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

MEETINGS

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

The Committee continued to deliver a full agenda through the submission of questions, by Committee members, ahead of the meeting which were responded to during the meeting.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2025/26 the Committee was chaired by Ms Dani Cecchini.

Details of the Committee's membership and attendance during 2025/26 is set out below:

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

Voting Members	22 Apr 2025	22 May 2025	20 Jun 2025	18 Jul 2025	21 Aug 2025	18 Sept 2025	23 Oct 2025	20 Nov 2025	18 Dec 2025	23 Jan 2026	19 Feb 2026	18 Mar 2026
Non-Executive Director (Ms Cecchini, Chair)	X	X	X	X	X	X	X	X	X	X	X	X
Associate Non-Executive Director (Mrs Buik)	X	X	X	X	X	X	X	A	X	X	X	X
Associate Non-Executive Director (Mr Orrell)	A	X	X	X	X	X	X	X	X	X	X	X
Group Chief Finance Officer	X	X	X	X	D	X	X	X	X	X	D	X
Group Chief Operating Officer	D	X	D	X	X	D	D	X	A	X	X	D

Group Chief Integration Officer	X	X	X	X	D	D	X	X	X	X	X	X
Group Chief Estates and Facilities Officer	D	X	X	X	X	D	X	X	X	D	X	X
Group Chief People Officer	X	A	A	X	A	X	X	X	X	D	X	X

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

REVIEW OF BUSINESS

The Finance and Performance Committee followed a programme of work for the 2025/26 year.

The Finance and Performance Committee has been responsible for the oversight of the following Strategic Objectives of the Trust in 2025/26:

- 1b (i): Reduce waiting times for our patients (Unplanned Care)
- 1b (ii): Reduce waiting times for our patients (Planned Care)
- 1c: Improve productivity and deliver financial sustainability
- 1d: Provide modern, clean and fit for purpose care settings

During 2025/26 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF.

During 2025/26 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF. The Strategic Objectives at the beginning of the year were rated as follows:

Objective 1b – **AMBER**
Objective 1c – **AMBER**
Objective 1d – **RED**

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

The Committee maintained oversight of the relevant Strategic Objectives relevant to its remit through the year under review. For oversight purposes, Strategic Objective 1(b) was split into two during the year, with a focus on the 2 individual components of the objective:

- 1b (i): Reduce waiting times for our patients (**Unplanned Care**)
- 1b (ii): Reduce waiting times for our patients (**Planned Care**)

Through the year the Committee continued to receive reports offering assurance against the Strategic Objectives resulting in the individual components continuing to be rated as follows at the end of the year:

Objective 1b (i) – **AMBER**
Objective 1b (ii) – **AMBER**
Objective 1c – **GREEN**
Objective 1d – **AMBER**

OVERVIEW

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

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

Other key areas of focus of the Committee have included:

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

The Committee receives monthly assurance/exception reports from the reporting groups offering assurance on areas relevant to the remit of the Committee. The Committee maintained clear focus in 2025/26 on reporting from the Information Governance Group due to the concerns noted in meeting statutory requirements in respect of subject access requests (SARs) and Freedom of Information Requests (FOI). Focused work was noted in respect of the Data Security Protection Toolkit (DSPT) with a requirement for full review of the evidence, prior to submission to ensure an accurate submission was made, due to the changes made to the toolkit nationally.

The Committee continued to monitor the requirements to achieve zero 78-week, 65-week and 52 week waits in year and was pleased to note the achievements made at the end of the financial year. Focus was also provided to discharge processes in order to improve flow through ULTH.

The Committee continued to monitor the delivery of the Annual Plan, as well as that of the supporting Cost Improvement Programmes (CIP).

The Committee received reports associated with strategic projects including the national grid contract to upgrade the high voltage supply at Lincoln County Hospital (LCH), the endoscopy uplift, the procurement process for the provision of a Radiotherapy Linear Accelerator Equipment System and the commencement of the Carbon Energy Project in the Group.

Other strategic projects reviewed by the Committee included the capital investment to refurbish the Stroke Unit and Navenby Ward in support of the centralisation of the Stroke Service to LCH, the approval of the full business case for the Boston Community Diagnostic Centre (CDC) and the proposal to invest and expand service capacity for Same Day Emergency Care (SDEC) at LCH in phases.

The Committee was updated on the progress of the action plans to address ventilation issues at Louth Hospital, the fire safety issues at the Community sites, and the external review of Planned Preventative Maintenance (PPM) compliance in the Group. The Committee also noted that internal monitoring had been strengthened with weekly performance reviews of PPM compliance.

Deep dives continued to be received by the Committee into a number of areas where further assurance was required, and the Committee received reports on Community Performance Metrics,

The Committee supported a proposal to accelerate the implementation of the Electronic Document Management System (EDMS) which was procured in 2024/25. The EDMS is an enabler to the Electronic Patient Record (EPR) for ULTH, supporting the move from paper based to electronic records.

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

Risks

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

Performance Review

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

The Committee have actively engaged in the development of the performance dashboard, ensuring that the KPIs requiring monitoring by the Committee were reported. At each of the meetings held during 2025/26 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified.

A. Operational and Performance Reports

In April 2025, the Committee received the operational performance reports which noted that from a ULTH perspective that there had been an increase in demand within the emergency departments. Despite the increased demand, there was significant improvements in the patients waiting 12-hours in the A&E standard and in the ambulance handovers standard. ULTH significantly improved against the 65-weeks standard with those remaining due to patient choice.

In ULTH performance declined against the cancer services for faster diagnosis standard and 62-day cancer performance, driven by the backlog from the Christmas period however early indications were that this would recover in March 2025. Diagnostic performance also continued to be challenging particularly for DEXA, audiology and non-obstetric ultrasound in ULTH.

For LCHS's operational performance, length of stay in community beds was inconsistent due to mixed occupancy, which resulted in an average length of stay of 21 days with a trajectory to reduce to 14 days. The Committee was also informed that a number of pathways in the community required review to ensure they were appropriate as there were a number of disconnected pathways.

The Committee requested a review of a number of LCHS performance areas where gold standard targets had been set, to better understand performance against an appropriate trajectory. The Committee also noted the development of the integrated performance report for the Group which would present the top risks and offer an interactive dashboard as well as a pictorial view of the areas of focus.

In May 2025, the operational performance reports to the Committee indicated the demand for Urgent Community Response (UCR) service had increased but performance declined as a result. Performance in respect of Urgent Treatment Centres (UTCs) had improved but concern was noted in respect of the location some of the services within the estate, and this was being addressed.

Performance in respect of discharge to assess (D2A) was noted with volumes increasing as planned. The reports also highlighted the intention to increase the capacity of the D2A team. Virtual ward improvements were being seen however this needed to be supported by the operations centre to address their capacity constraints.

For ULTH in May 2025, the reports highlighted ongoing challenges in Urgent and Emergency Care (UEC) performance with a deterioration seen in performance against ambulance handover times, patient exceeding 12 hours in the A&E and the overall 4-hour A&E wait standard. This was due to an increase seen during April 2025 of ambulance conveyances and the impact of increased patient acuity on the service. Performance of the 4hr target was noted as 77.32% compared to the target of 78% which had been achieved in March 2025

Diagnostics Waiting Times and Activity (DM01) performance continued to underperform at 67.47% compared to the target of 99%. Concern was noted specifically within audiology and associated wait times however this was recognised as a national issue with work underway to find alternative solutions. Cancer performance was noted as remaining static however there was recognition of positive movement within the urology specialty.

The Committee noted the development of the new performance dashboard which would allow greater oversight of performance due to the ability to drill down into the data.

The operational performance reports to the Committee in June 2025 noted that, in spite of increasing pressures, performance in the areas of ambulance handover times and compliance with the 45-minute UEC standard had stabilised.

The reports in July 2025 also informed the Committee that 4-hour A&E wait performance had further declined to 75.86% with work being undertaken on the flow programme to support this including the expansion of the Same Day Emergency Care (SDEC) capacity. The Group's UTCs were performing to the 98% target with the exception of Grantham and Skegness, with Skegness impacted due to the seasonal increase in residents visiting the coast.

Discharges continued to be an area of concern with a need to ensure that earlier discharges were achieved in the day to resolve the front door pressures with the Committee noting that the go live of the Optica system due in July 2025. The Committee commended the roll out of the system which had been achieved in 3.5 months, quicker than any other Trust.

Planned care was noted to be delivering as expected however concern was noted with delivery against the 52-week target where some fluctuation had been seen however this was expected to improve in the coming months. Diagnostics had seen a

signification improvement in May 2025, however, DEXA, ultrasound and audiology continued to be the main areas of pressure, despite the improvements seen.

In July 2025, the operational performance reports to the Committee noted the challenges with UEC targets which were reported at 72.3% with a target of 77%. Improvements were being seen in respect of the 12-hour A&E wait standard and improvements had been seen across diagnostics in month.

The August 2025 operational performance reports informed the Committee that A&E 4-hour waits had achieved 73.78% against a target of 77% in July 2025. Improvements were expected for August 2025 and there was a recognition of seasonal impact on the position as well as the impact of Industrial Action, which had been well managed. The 12-hour A&E waits standard were noted as an area for improvement with 12% of patients exceeding 12-hours in the emergency departments. Actions were in place to identify a sustainable solution.

The August 2025 reports stated that there were no concerns with DM01 performance. The Committee was also informed of movement in the total waiting list from 70,366 at the end of June 2025 to 69000 in July 2025. Work was in place to address the 52-week waits for children's and young people services. Cancer services were also noted as performing well despite some challenges impacting on the 28-day faster diagnosis standard and pressures associated with the Colorectal Cancer service.

In August 2025, the Committee recognised the scale of the transformation programmes of work being undertaken across the Group and expressed concern about the capacity, capability and culture to support the level of change required. The Committee made a referral to the Integration Committee to consider a wider risk for inclusion on the risk register against transformational change.

In November 2025, the Committee received the operational performance reports, including the new performance dashboard which had been designed to align with the National Oversight Framework (NOF).

The November 2025 operational performance reports also stated that performance for LCHS was as expected. The Committee noted that 52-week wait breaches at LCHS were only present within the Lymphoedema service, which were anticipated to be resolved by the end of November 2025. The reports also stated that UTC performance remained high, despite a slight reduction in-month and UCR was noted to have doubled activity with no additional cost or degradation in performance.

The Committee noted in November 2025 that the D2A service had increased capacity but 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 also noted that this was not a sustainable solution and key actions following the Newton diagnostic work required implementation.

The November 2025 operational performance reports informed the Committee that though the ULTH performance deteriorated with respect to the cancer 28-day faster diagnostic standard (FDS), the additional funding being received was expected to result in improvements from October 2025. The reports also highlighted challenges in the diagnostic services, particularly MRI, audiology and ENT, with a recognition of the national shortage of Audiologists. In terms of the positions on the 52-week and 65-week standards, there was the expectation that the Group would achieve compliance by the end of December 2025 with additional activity taking place to ensure delivery.

The Committee noted in November 2025 that the UEC performance delivered above plan in October 2025, with further improvements noted for November 2025. The Committee noted however, that 12-hour waits in the EDs remained persistent with a review due to be undertaken to determine performance improvements.

The December 2025 operational performance reports updated the Committee that following the release of the Q2 NHS Oversight Framework (NOF), both ULTH and LCHS had moved to 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 December 2025 operational performance reports noted that there had been no significant change in respect of cancer performance however improvement was expected in the November 2025 position. Significant improvement was expected for 52-week waits in November 2025 and December 2025 with recovery plans in place. A decline in diagnostic performance was noted because 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.

The Committee at the December 2025 meeting noted that virtual bed occupancy was above the national 80% target. The Committee was delighted to also note the clearance of all community 52-week waits.

The January 2026 operational performance reports to the Committee stated that though Cancer performance's trajectory remained below plan, the Group slightly improved its month-on-month performance against the national 28-day, 31-day and 62-day standards. The Group expected to continue making improvements in the final months of 2025/26. The Group continued to progress on the plan to reduce the number of patients who had waited over 52 weeks. The Group was on track to deliver the plan for Planned Care in terms of the 18-week RTT and 52-week standards at the end of March 2026.

The Committee was informed in January 2026 that performance against the DM01 standard was impacted in November 2025 due to challenges around capacity arising

from the Patent Services Hub Consultation and other vacancies in the booking team. The Group was implementing mitigation actions to improve performance against the DM01 standard. In relation to UEC, the Group's trajectory against the 4-hour standard remained above trajectory in December 2025, while there was a marginal improvement against the 12-hour breach standard in month.

In February 2026 the Committee received operational performance reports which stated that for cancer performance, the 28-day, 31-day and 62-day standards, were below plan and had deteriorated from a strong November 2025 position. The performance report noted that the Group's cancer performance was not an outlier but reflected the national picture in December 2025. The Group continued to progress on the plan to reduce the number of patients who had waited over 52 weeks. The Group remained on track to deliver the plan in terms of the 18-week RTT and 52-week standards at the end of March 2026.

In February 2026, the Committee was informed that performance against the DM01 standard declined further in December 2025 due to capacity shortfalls in the Audiology, Non-Obstetric Ultrasound (NOUS) and Magnetic resonance imaging (MRI) services. Work was underway to improve the capacities of these services. In relation to UEC, the Group's year-to-date trajectory against the 4-hour standard remained above trajectory in January 2026, while the year-to-date trajectory against 12-hour standard remained below plan in January 2026.

The Committee also noted in February 2026 that for the 45-minute Ambulance Handover standard, the year-to-date Group performance was below plan in January 2026. The UTC 4-hour Emergency access standard (Type 3) was at 96.29% in January 2026 against a Group stretch target of 98%. The report noted that the national target is 95%.

In March 2026, the Committee noted that the overall position for cancer performance remained challenged, particularly in relation to performance against the 62-day standard which deteriorated from January 2026 to March 2026. The predominant reasons for the deterioration were understood, and a recovery structure was being worked through the internal governance process.

The operational performance reports also noted that the 52-week backlog had been cleared, which had positively impacted on the NOF's scores. RTT performance in relation to the 18-weeks standard was at 95.87%. Urgent & Emergency Care stated that targets were not met in February 2026, with 74.53% being achieved for the 4-hour overall performance, versus the 76% target. However, an improved trajectory was expected for March 2026, with confidence to achieve the target.

The reports noted that the SDEC performance had continued to improve, the 12-hour total wait time in ED standard remained a challenge. There were 2,338 SDEC attendances in February 2026 compared to 1,393 attendances in February 2025. Prior

to the implementation of SDEC, these patients would have attended ED and added to the congestion.

In March 2026, the Committee was updated on steps to resolve the challenges with Diagnostics including steps to procure an additional provider to support the non-obstetric ultrasound service (NOUS), and other steps to enhance MRI capacity. In relation to the MRI capacity issue, the expectation was that the Patient Services Hub would significantly enhance booking capacity while a plan to procure a mobile MRI unit in Pilgrim Hospital would almost double MRI capacity in the area.

B. Financial and Capital Reports

In April 2025, the Committee received financial and capital reports which stated that the year year-end position was a £18.2m deficit across the Group with a £18.3m deficit in ULTH and a £0.1m surplus in LCHS. The Committee noted that the position was £11.3m adverse to plan but within the revised control total agreed with NHS England.

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

In May 2025, the financial and capital reports to the Committee noted the Month 1 position of a £4.2m deficit, which was in line with the plan to achieve a breakeven position for 2025/26.

CIP delivery was noted as being on plan with capital delivery slightly behind plan due to timing however this would be corrected in Month 2. The reports also informed the Committee that budget setting would conclude in Month 2 with the Care Groups well engaged in the process.

The June 2025 financial and capital reports received by the Committee noted that the Month 2 position was in line with plan, and while capital was noted as being behind plan, recovery was anticipated in subsequent months. Cash was reported as a positive position with this being higher than expected in Month 2.

CIP delivery was also noted to be on plan in June 2025.

The July 2025 financial and capital reports received by the Committee noted that Quarter 1 had been delivered in line with plan at a £11.1m deficit across the Group. The cash position was noted as being ahead of plan however there was recognition of the in-year challenges that would be present with a need to provide focus to maximise the cash position.

In July 2025 the Committee noted the significant reduction in bank spend and the steps being undertaken to reduce dependence on temporary staff.

The August 2025 financial and capital reports received by the Committee stated that the year-to-date deficit for the Group was at £12.4m in line with plan. There was recognition that there had been 5 days industrial action in month however the Group had applied learning from prior periods of action, minimising activity loss and additional costs whilst maintaining safe services. The reports noted that the ULTH baseline position was £2.4m adverse to plan, being driven by underperformance of activity, industrial actions and slippage against CIP.

The August 2025 reports highlighted the work being undertaken to continue to develop the CIP work to support the step change required to support delivery of the CIP programme.

The cash position was £1.9m ahead of plan, in August 2025, however the position remained challenging due to the application of the (non-cash) technical efficiencies with actions being development in order to mitigate the cash position. The reports informed the Committee that whilst capital was reported behind plan the position could be recovered with forecasting of full delivery in place.

In September 2025, the Committee received the financial and capital reports which noted that the year-to-date position was at £13.3m for the Group, which was broadly in line with plan. Work continued to address the financial position with challenges noted in respect of the recent industrial action, delivery of the Cost Improvement Programme (CIP) trajectory and activity.

The Committee also received a CIP proposal paper in September 2025, which included 21 areas of opportunity with a named Senior Responsible Officer (SRO) identified for each of them. The opportunities would be considered for development of delivery into 2025/26 or 2026/27.

In October 2025, the financial and capital reports to the Committee noted that the year-to-date deficit was at £14.3m which was £0.1m better than planned. The reports also note the variance from the plan relating to delivery of variable income, the costs of industrial action and risks in our Cost Improvement Programme (CIP) delivery. The Committee was informed that the CIP profile was noted to be a blend of both recurrent (75%) and non-recurrent (25%) with some technical efficiencies brought forward to support the year-to-date position.

The Committee also reviewed the post investment case for Skegness CDC which was approved on the basis of being a loss-making business case, supported by national funding. The Committee recognised that the Skegness CDC project was delivered on time and to budget. Learning from the Skegness CDC post investment case would be taken into consideration when developing the Boston CDC proposal.

At the November 2025 meeting, the financial and capital reports to 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 the CIP. CIP recovery plans continued to be developed and delivered, with a focus on the non-recurrent CIP items to mitigate the CIP position, with support established via the Group Leadership Team (GLT) to support with the delivery of the CIP forecast.

The November 2025 financial and capital reports also projected that the Group's Month 8 position would continue to be challenging, impacted in part by the industrial action and the cancellation of activity.

In December 2025, the financial and capital reports noted that the Group delivered a £12.3m deficit, which was £2.4m worse than planned. The impact of the industrial action in November 2025 was also highlighted as it had resulted increase costs and a slight reduction in activity. The Committee also noted that in terms of the CIP, the Group delivered savings of £41.9m, which was £0.7m worse than planned.

In December 2025 the Group was reported to have delivered capital expenditure of £28.4m. The Committee noted that as this was £21.1m lower than planned, there was a revised trajectory for recovery with a £7.7m internal delivery risk, linked to the impact of schemes being delayed and the consequential position into 2026/27.

The Committee received and supported the contents of the Finance Strategy in December 2025. The intent of the Strategy was to bring together the finance teams across the Group, and to focus and align them to the Group Strategy and Values.

The January 2026 financial and capital reports stated that the Group had delivered a £3.4 million surplus in Month 9, which was £1.7 million better than plan. The year to date (YTD) position was a £8.9 million deficit which was £2.2 million adverse to plan. CIP reported a YTD efficiency savings delivery of £49.1m, which was £2.2m worse than planned. LCHS was forecasting to deliver the CIP target in full for 2025-26, but ULTH was currently £8.5m short on target due to deficiencies in the performance of some care groups' CIP schemes.

In February 2026, the Committee was informed that the Group delivered an actual year-to-date £8.4m deficit which was £2.6m adverse to plan. The in-month position was a £0.5m surplus which was £1.9m adverse to plan. CIP reported a YTD efficiency savings delivery of £56.4m, which was £4.2m worse than planned. LCHS was forecasting to deliver the CIP target in full for 2025-26, but ULTH was currently £3.0m short on target due to deficiencies in the performance of some care group's CIP schemes.

In March 2026, the financial and capital reports to the Committee stated that in Month 11 position the Group achieved a £4.1 million surplus, which amounted to a £4.3

million year-to-date deficit. In relation to the Group's 2025/26 breakeven target, the reports noted that the Group was £1.6 million behind plan. CIP performance was at £65.5 million, which though was below the £69.8 million target, represented a significant achievement for the Group.

In March 2026, the Group was reported to have achieved a year-to-date capital expenditure of £60.4m which was £27.1m lower than planned. The reports noted that the forecast expenditure for 2025/26 had been £127.8m.

C. Estates and Facilities Reports

The Committee received an Estates and Facilities Assurance report in April 2025 which noted that NHS Property Services had a robust action plan in place in respect of ventilation issues at County Hospital Louth. The Committee also noted, with concern, the internal audit report on Planned and Preventative Estates Management due to the limited assurance provided and requested further information to a future meeting to provide wider context to this.

The May 2025 Estates and Facilities Assurance report to the Committee noted the impact of current vacancies within the directorate, and the steps being taken to address those vacancies. The report also highlighted the carbon energy fund bid and the need for Group Board approval before funding could be secure to support the progress of the Group's net zero agenda.

The Committee also noted and supported the work being undertaken to identify appropriate space for services where estates concerns had been raised. The report highlighted the commissioning of an external Planned Preventative Maintenance (PPM) Audit to support the provision of external assurance and review of risk for the Group's estate.

The Patient-Led Assessment of the Care Environment (PLACE) report was received in May 2025 for both ULTH and LCHS with improvements noted across both organisations. Concerns were noted however in respect of food for patients in both reports with a request for a referral to the Quality Committee. Action plans had been developed in all areas and would be monitored through the PLACE working groups and would be reported to the Committee via the estates report.

In June 2025, the Committee received the Estates and Facilities Assurance report and noted the fire safety mandatory training compliance in the Group with concern. The Committee made a referral to the People Committee to ensure oversight and progress. The Committee also noted the progress made on the space utilisation agenda with recent recruitment having been undertaken to support it.

The July 2025 Estates and Facilities Assurance report noted that the Group was in the process of commissioning a Group wider strategy that was hoped to be in place by the

end of 2025/26. The Committee was also assured that the recent power failure had been resolved through an increase of capacity, which should ensure future issues would not be experienced. The Committee noted positive trends in respect of water safety and the work underway to further improve compliance with medical gases through designated nurses and medical officer training.

The Committee also noted in the July 2025 Estates report that the fire safety works was continuing, with some actions having been completed. The Committee was informed in July 2025 that the remit of the external PPM review that was being commissioned had been widened to include the Community Diagnostic Centres (CDCs).

The August 2025 Estates and Facilities Assurance report updated the Committee on the progress was being made in respect of the Group Estate Strategy which would incorporate the clinical strategies. The report also informed the Committee that the PPM external audit had been commissioned and would commence in September 2025.

The Committee recognised in August 2025 that the risk associated with fire safety should be re-considered as the most high-risk areas had been addressed. A proposal would be made, to downgrade the risk, following review of the position.

In September 2025, the Estates and Facilities updates offered assurance to the Committee in a number of areas including estates projects, statutory compliance and fire safety. As a result of the increased and continued assurance the Committee considered and confirmed the proposal to move the assurance ratings from red to amber as for the Estate and Facilities-related objectives on the Board Assurance Framework.

The Committee in September 2025 also specifically noted the standardisation of fire safety training across the Group and that the Group Fire Safety Policy had been approved and would be submitted for publication.

The October 2025 Estates and Facilities updates informed the Committee that the external PPM audit review had commenced which had started to identify some areas of focus.

In November 2025, the Committee received the Estates and Facilities Assurance report which provided reasonable assurance as 8 high risk actions remained in respect of fire safety compliance, following an Authorised Engineer (AE) audit. It was noted that AEs were employed by the Group in 2025.

The Estates report in November 2025 also highlighted significant improvements for PPM compliance, however a number of reactive jobs were noted to be impacting and adding pressure to the team

The Estates and Facilities December 2025 report to the Committee noted that the external PPM audit review was on track for completion in January 2026. The Committee also supported a proposal for the risk score for Objective 1d: *Provide modern, clean and fit for purpose care settings* to be reduced from 20 to 16. The recommendation had been based on improved oversight and assurance from the Estates and Facilities' reports, and the progress of the Authorised Engineers which had been replicated across the ULTH and LCHS in terms of the management of risk and governance.

The January 2026 Estates report assured the Committee that the external PPM audit review remained on target for completion in January 2026.

In February 2026, the update on Estates and Facilities to the Committee stated that recently conducted Fire and Rescue Service audits had returned broadly compliant outcomes. The Committee was also informed that the car parking development work was progressing to a new staff car park permit system. A staff survey was launched on 04 February 2026 to build analysis from staff feedback to inform the Group's future travel and transport initiatives.

The draft report from the external PPM audit review, completed in January 2026, had been received and was undergoing a detailed review and factual accuracy before the final document was drafted.

Delivery against the external PPM Audit review action plan would continue to be monitored within this Committee

D. Health and Safety Reports

The April 2025 Health and Safety Committee Assurance Upward Report informed the Committee of the ongoing fire safety issues in respect of Johnson Hospital, Spalding and County Hospital Louth. The Committee noted that assurance was being gained from NHS Property Services' robust action plan. The concern was that LCHS was a tenant at the sites and not the owner.

In November 2025, the Health and Safety Annual Report was received by the Committee and was recommended to the Group Board for approval.

E. Information Governance Group Reports

In April 2025, the Information Governance Group (IGG) Assurance report to the Committee highlighted the ongoing concerns associated with compliance with subject access requests (SARs) and freedom of information (FOI) requests.

In May 2025, the IGG Upward report stated that there had been progress in respect of the SARs backlog with the expectation that there will be no backlog by August 2025. The need for appropriate resource to support FOI requests was also noted.

In July 2025 the IGG Upward report noted that the Data Security Protection Toolkit (DSPT) submissions had been made for both ULTH and LCHS with 'Standards Not Met' and 'Standards Met' reported respectively. It was noted that as a result of the ULTH submission the Trust was required to produce an improvement plan which had been submitted as part of the final submission to NHSE. Once the improvement plan has been approved it was anticipated that the ULTH's status would be amended to show 'Approaching Standards – Improvement Plan'.

In September 2025, the Committee reviewed the IGG Upward report and was pleased to note the improved ULTH SARs position with a significant reduction in the number of overdue requests.

The November 2025 IGG Upward report informed the Committee that the ULTH 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'. The report also stated that, though still not the required level, the improvements in SARs performance continued to be achieved.

The November 2025 IGG report alerted the Committee to the increasing demand on the IG service, which had increased the potential risk of legal non-compliance and potential data breaches.

F. National Cost Collection

In April 2025, the Committee received the 2024/25 National Cost Collection Pre-submissions report and noted the timeline for the submission with a request to the Board to approve delegated authority to the Committee for approval of the final submission for both LCHS and ULTH.

In July 2025, the Committee was informed that, in relation to the National Costing Collection Annual Return, a compliant return had been submitted. The outcome of the reference cost indicator was awaited following the submission.

G. Emergency Preparedness, Resilience and Response

In May 2025, the Committee received the Emergency Preparedness, Resilience and Response (EPRR) Annual Reports for LCHS and ULTH and recommended them to the Group Board of Directors for approval. Significant improvements were noted in the EPRR core standards for LCHS.

The Committee also approved the EPRR policies for LCHS and ULTH as recommended by the Emergency Planning Gorup.

In October 2025, the Emergency Planning Group (EPG) upward report offered assurance on the core standards submission with 58 of the 62 standards fully compliant for ULTH and 57 of 58 compliant for LCHS, those standards which were not compliant were noted to be partially compliant. Business Continuity Plans were also noted to be in a positive position with a significant improvement noted for clinical areas. Focus was now shifting to corporate areas to drive further improvement.

In January 2026, the EPG reported that for the 2025 Annual Assessment of Core Standards for EPRR, both ULTH and LCHS had been assessed as 'substantially compliant' by NHSE and the ICB.

H. Cyber Compliance/Digital Services

In May 2025, the Committee received a cyber assurance update which reported on the position in respect of patching and threat assessments with the recognition of the continuous work within Digital services to ensure the security profile of the Group.

The June 2025 Cyber Compliance report informed the Committee of ongoing efforts of the Digital services teams to deliver the Windows 11 roll out across ULTH.

The August 2025 Cyber Compliance report noted some risks in respect of unsupported and legacy systems in the Group with recognition that the Electronic Patient Record (EPR) and Electronic Document Management System (EDMS) would significantly reduce the number of systems.

The Electronic Patient Record (EPR) approval letter and detail of conditions were received with the Committee noting this offered formal approval. The conditions were being actioned with a number already addressed.

In July 2025, the Committee received an update which stated that though the EDMS programme had been appropriately signed off, it was being represented due to the intent to deliver an accelerated programme. The Committee supported the rephasing of the programme of work and noted the need for additional capital to purchase more scanning equipment. The update noted that there would need to be an increase of onsite scanners to support the enhanced delivery timeframe and whilst this attracted capital additional costs, savings of £2.9m could be realised.

I. Theatre Utilisation/Productivity

In June 2025, the Committee received the Theatre Utilisation update and sought to understand when productivity would result in the reduction of cancelled operations and improvement in performance, supporting elective care and cancer care metrics. Based on the current position the Committee recognised the need for further work in order to increase activity and productivity.

In March 2026, due the internal audit report providing a limited assurance for theatre productivity, the Committee requested a deep dive into theatre delivery by the Integration Committee, with a focus on the issues raised

J. Productivity, Improvement and Transformation Oversight Reports

In July 2025, the Committee received the first Productivity, Improvement and Transformation Oversight Forum (PITOF) Upward report which highlighted the work of the oversight forum in monitoring the CIP schemes and progressing work on additional schemes to address the current forecast gap. Active management of those schemes rated high, or medium was underway to de-risk and improve confidence in delivery.

The July 2025 PITOF report also informed the Committee of the progress in temporary staffing, particularly noting that there was no agency spend in nursing, resulting in a stable workforce with no vacancies.

The Committee received PITOF upward reports during 2025/26. The reports provided an overview of the progress achieved around the portfolio of programmes and projects related to the Group's improvement programme.

K. Others – Submission; Focused Discussions; Referrals

The Committee was advised in December 2025 that the draft 2026/27 Planning Submission had been made on 17 December 2025.

In January 2026, the Committee was assured that the 2026/27 Annual Planning cycle was progressing with key challenges being resolved. The target was to submit the final draft Annual Plan to the Group Board for review and approval on 11 February 2026, and then to submit the approved version to NHSE on 12 February 2026.

In July 2025, the Committee undertook a focused discussion on Community Performance Metrics, with a focus on the redesign of home visiting and urgent community response. The report which supported the discussion noted that there were seasonal pressures being experienced across the urgent treatment centres due to the

expected migration with plans being developed to improve the environment at Skegness.

The July 2025 focused discussion also noted that transitional care activity was beginning to decline as planned due to the reduction of transitional care beds and the increase in the D2A capacity. The Committee also noted the ongoing work in respect of the UCR with developments being made in order to expend the service and provide support to the population through a single point of contact.

In March 2026, the Committee noted a significant deterioration in fractured neck of femur figures and agreed for a cross-referral to the Quality Committee to be made to conduct a deep dive and check whether the impact on patients was being managed.

The Committee also agreed for the Integration Committee to undertake a deep dive into the whole fractured neck of femur pathway, with a focus on the impact of the significant bed pressures in the community and the capacity issues in the Orthopaedics team. It was noted that evidence suggested that when fractured neck of femur patients, who were usually elderly, were treated early they had good outcomes and recover quickly. However, the delay in treatment, due to bed pressures and capacity issues in the Orthopaedics team, ensured that the length of stay for that cohort of patients was a significant outlier at 21 days.

L. Conclusion

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

NHS
Lincolnshire Community and Hospitals NHS Group

2025/26 National Cost Collection – Pre-Submission Update

Caring and building a healthier future for all

Meeting	*Lincolnshrie Community and Hospitals Group Board*
Date of meeting	*5 May 2026*
Agenda item number	*6.5*
Report title	*2025/26 National Cost Collection – Pre-Submission Update*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• Approval
Accountable Director	*Paul Antunes Goncalves* *Group Chief Financial Officer*
Author(s)	*Costing Team*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Reasonable assurance*
Prior approval process, if applicable	*Content discussed at Finance and Performance Committee*
Financial implications, if applicable	*None*
Action / decision required	*The Board is asked to:* • *Note the national requirements and submission timetable for the 2025/26 National Cost Collection.* • *Note the data quality issues identified are not material and are being appropriately managed.* • *Approve the delegation of authority to the Finance & Performance Committee to review and approve the post-submission report on behalf of the Board, in line with NHS England guidance.*

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

Key messages for the Board:

- **Separate submissions** will be made by ULTH and LCHS, reflecting their current legal status; there is no “group” submission for NCC purposes.
- The **submission timetable is earlier than in previous years**, creating a narrow window for completion, validation, and assurance.
- Both Trusts are **mandatorily required** to submit **patient-level cost data** as part of their provider licence conditions.
- Overall, **data quality issues identified are not considered material**, and plans are in place to address known limitations.
- The Board is asked to **delegate authority** to the Finance & Performance Committee to approve the post-submission report, due to the timing of Board meetings.

The Board is asked to note the following:

- The national requirements and submission timetable for the 2025/26 National Cost Collection.
- The data quality issues identified are not material and are being appropriately managed.
- Approve the delegation of authority to the Finance & Performance Committee to review and approve the post-submission report on behalf of the Board, in line with NHS England guidance.

Lincolnshire Community and Hospitals NHS Group
Trust Board – 5 May 2026
2025/26 National Cost Collection – Pre-Submission Update

Executive Summary

This paper provides the Board with assurance on preparations for the 2025/26 National Cost Collection (NCC) submissions for ULTH and LCHS, in line with guidance issued by NHS England on 4 March 2026. It outlines governance arrangements, submission timelines, key risks, data quality issues, and the approvals required to ensure compliance with national requirements.

Key messages for Trust Board:

- **Separate submissions** will be made by ULTH and LCHS, reflecting their current legal status; there is no "group" submission for NCC purposes.
- The **submission timetable is earlier than in previous years**, creating a narrow window for completion, validation, and assurance.
- Both Trusts are **mandatorily required** to submit **patient-level cost data** as part of their provider licence conditions.
- Overall, **data quality issues identified are not considered material**, and plans are in place to address known limitations.
- The Board is asked to **delegate authority** to the Finance & Performance Committee to approve the post-submission report, due to the timing of Board meetings.

Submission Timetable and Governance

- **Submission window opens:** 8 June 2026
- **Initial submission deadline:** 3 July 2026
- **Validation and resubmission window closes:** 17 July 2026
- **Planned final submission date:** 26 June 2026

National guidance requires Board-level scrutiny and sign-off. Given the timetable, the Trust Board will consider:

- **a pre-submission report** (this paper), and
- **a post-submission report,** to be reviewed by Finance & Performance Committee in July and then reported to the Board in September 2026.

Formal sign-off on the day of submission will be provided by the Chief Financial Officer.

Summary of Submission Requirements

United Lincolnshire Teaching Hospitals NHS Trust (ULTH)

- Submission of patient-level costing data across 60 monthly files, covering inpatient, outpatient, emergency, critical care, high-cost drugs and devices, and specified diagnostic services.
- Patient-level data will represent around 80% of total operating expenditure.

- Some community children's nursing activity cannot yet be fully captured at patient level due to historical recording arrangements; this activity will be submitted in line with national guidance at aggregated level, avoiding the need for a formal exclusion.
- Certain national system dependencies (e.g. SDEC reporting) mean limited areas of non-compliance, which will be transparently disclosed.

Lincolnshire Community Health Services NHS Trust (LCHS)

- Submission of 48 monthly files of patient-level data, including community care contacts, admitted and non-admitted patient care, emergency care, and high-cost drugs.
- Non-NHS services (e.g. child health information services, home delivery of drugs) are excluded in accordance with national rules.
- Sexual Health Services will be submitted at aggregated level, as permitted by guidance.
- Patient-level costing is also expected to cover approximately 80% of operating expenditure.

Data Quality, Mapping and Assurance

Previous differences between costing-system activity and national datasets have been reviewed. Activity mapping and coding, particularly for Community Services Care Contacts, has been updated to ensure a more accurate and complete representation of services provided. NHS England's national costing assurance programme highlighted several outlier indicators; the majority have now been resolved. Remaining areas are under active review and will be fully documented in the post-submission report. Importantly, national outliers do not necessarily indicate incorrect data, but differences from national averages that require explanation.

Risks and Mitigations

Risk	Mitigation
Early national submission deadline	Detailed project plan and early internal deadlines
System or data issues late in the process	Senior oversight, documented assurance log, regular escalation
Partial patient-level coverage in limited areas	Use of permitted aggregated submissions and transparent disclosure

Overall delivery risk is assessed as **low** but acknowledged, given the compressed timetable.

Recommendation

Trust Board is asked to note the following:

- The national requirements and submission timetable for the 2025/26 National Cost Collection.
- The data quality issues identified are not material and are being appropriately managed.
- Approve the delegation of authority to the Finance & Performance Committee to review and approve the post-submission report on behalf of the Board, in line with NHS England guidance.

People Committee Upward Report

Caring and building a
healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*05 May 2026*
Agenda item number	*10.1*

People Committee Upward Report of the meeting held on 10 March 2026

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Vicki Wells, Non-Executive Director*
Author(s)	*Kwame Mensa-Bonsu, Deputy Director of Corporate Affairs*
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the People Committee;*

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

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	03 March 2026
Report from:	People Committee
Report from meeting held on:	10 March 2026
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 10 March 2026 including assurances received and those matters which the Committee wish to escalate to the Group Board.

1.2 The meeting was truncated to accommodate a workshop that had been arranged for a comprehensive annual BAF workshop review to be undertaken.

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) Committee Performance Dashboard
b) Education Oversight Group Upward Report
c) Safer Staffing Medical

The Committee reviewed the Education Oversight Group upward report and noted the positive data highlighted in the report. The Group at the end of January 2026 reported core learning compliance to be above the 90% KPI target. LCHS achieved 95.75% compliance, while ULTH achieved 93.30% compliance in January 2026 both of which were above target.

Work continued with subject matter experts (SMEs) to align to national packages for ULTH in line with the national review work, as reported in previous months. Only Safeguarding training remained a local module, although this was more closely aligned to the revised national content anticipated to be published in April 2026.

In January 2026, compliance with the Infection Prevention and Control training module at ULTH was at 89.53%, which was marginally below the 90% compliance threshold. The report noted that compliance with the IPC training module was at 85% in December 2025.

The Committee noted that compliance for new starters continued to be low and was at 68.14% in January 2026. The Committee noted that new starters had a 3-month window to complete their statutory and mandatory training requirements. Though it was known that non-compliance decreased patient safety, and impacted on regulatory and reputational risks, steps were being taken to assess the full impact of the issue in collaboration with subject matter experts. Update on progress on this work would be included through the Education subcommittee report to People Committee.

The report noted that CPD spending trends remained consistent, with allocations across nursing, Allied Health Professional, and multidisciplinary courses. LCHS reported 91% spend utilisation, worth £367k out of a CPD allocation of £401,508.84 in 2025/26. ULTH reported a 77% spend utilisation, worth £845k out of a CPD allocation of £1,100,409 in 2025/26.

In terms of Apprenticeship Levy Utilisation, the report stated that a total of 38 completion payments were recorded in the month of January 2026 across the Group. These payments included 26 x Registered Nurse Degree Apprentices and 8 x Senior Leaders, resulting in a total of 658 live learners currently on programme across the Group. In total there have been 893 apprenticeship completers since the commencement of the apprenticeship levy.

The Education Oversight report noted that the 'Progress on the Safe Learning Environment Charter' was positive, with most objectives achieved and the remaining actions scheduled to be progressed. The report added that regarding the Band 2–3 uplift training, LCHS had completed the training programme and ULTH was on track to complete the programme in June 2026 as scheduled.

The Committee was **substantially assured** by the Education Oversight Group Upward Report

Assurances in respect of Objectives 2b:

a) Workforce Strategy Group Upward Report
b) Workforce Hub Upward Report
c) Patient Services Hub
d) National Staff Survey Feedback

The Workshop Strategy Group report stated that in January 2026, the sickness rate at LCHS improved from 8.1% in December 2025 to 6.7% for January 2026%. Sickness rates at ULTH declined to 5.9% in January 2026 from 6.8% in December 2025.

There were focussed actions and support to managers in place to mitigate and keep improving. This support included the new Absence Manager and two new Absence Coordinators who would work across both LCHS and ULTH to target interventions. The Absence Manager and their team would support with the future roll out of the new Group Absence Management Policy.

To assess the impact of the sickness absence rates on patient safety and the quality of care in the Group, the Committee agreed that a referral be made to the Quality Committee for a review of incidents and the triangulation of reporting.

The report noted that appraisals within ULTH had seen a decline in month at 81.75% and was not within target.

The Committee was **reasonably assured** by the Workforce Strategy Group report.

The Workforce Hub report informed the Committee that seven colleagues remained at risk of redundancy due to organisational or limited suitable alternative employment options. Appropriate mitigations were being implemented including occupational health input and the ongoing exploration of potential roles across the Group. The Committee was informed that despite the mitigations, the potential of redundancy, subject to Remuneration Committee approval, was growing.

The Committee was **assured** by the Workforce Hub report.

The Committee received a verbal update on the progress of the Patient Services Hub (PSH). The update informed the Committee that the PSH consultation document had been reviewed and approved by the Group's Joint Negotiating Forum.

The verbal update provided noted that feedback had been positive, in particular in respect of the additional PSH base at Pilgrim. The Committee were positive that there may not be any redundancies because of the consultation due to the number of vacancies which had been ringfenced during the process.

The Committee was **assured** by the verbal update on the progress of the PSH.

Assurances in respect of Objectives 2c:

a) Culture and Leadership Group Upward Report

The Culture and Leadership Group Upward Report to the Committee focused on the progress of the flu vaccination campaign which was approaching its conclusion. The Committee was informed that ULTH and LCHS had performed exceptionally well and was currently ranked within the top five on the regional flu vaccine leadership board. ULTH was placed 2nd while LCHS was placed 4th. These positions demonstrated significant engagement and operational coordination. The Committee noted that the aim was to secure the top spot by the close of the vaccination campaign.

The Committee was **assured** by the Culture and Leadership Group report.

Assurances in respect of other areas:

a) Chaplaincy Report
b) Policy Position Update
c) Internal Audit Recommendations

The Committee received a report which included feedback on a recent Chaplaincy Engagement Survey. The report informed the Committee that more responses than expected had been received from a wide demographic of Lincolnshire. The feedback indicated that there was a misconception among the staff and patients of what other very beneficial services the Chaplaincy could offer, outside of 'faith'.

The Committee was **assured** by the proposed actions which would be implemented to increase awareness of Chaplaincy Team's offer, improve the team's facilities and provide the team's members with the appropriate healthcare training.

The Committee received and noted the position in respect of the Policies and the internal audit recommendations.

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 on the following matter for escalation to the Group Board:

a) None

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

5.1 The Committee comprehensively reviewed the BAF working through each of the objectives, controls and assurances for which the Committee has oversight. A full refresh was completed and the details of this would be captured within the BAF when it was presented at the April Committee.

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, Non-Execuitve Director (Chair)

10 March 2026

People Committee Upward Report

Caring and building a
healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*05 May 2026*
Agenda item number	*10.1*

People Committee Upward Report of the meeting held on 21 April 2026

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Vicki Wells, Non-Executive Director*
Author(s)	*Kwame Mensa-Bonsu, Deputy Director of Corporate Affairs*
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the People Committee;*

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

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	03 March 2026
Report from:	People Committee
Report from meeting held on:	21 April 2026
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 21 April 2026 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) Committee Performance Dashboard
b) Safer Staffing Medical
c) Safer Staffing Nursing
d) Education Oversight Group Upward Report

The Committee received the Committee Performance Dashboard and noted that in March 2026, the highlights were that:

- the vacancy rate at ULTH was at 6.74% against a Q4 target of 10.60%; the vacancy rate at LCHS was 11.41% against a Q4 target 10.00%.
- the turnover rate at ULTH was at 8.34% against a target of 9.00%; the turnover rate at LCHS was at 9.00% against a target of 9.00%.
- the sickness rate at ULTH was at 5.45% against a Q4 target of 4.50% - It was noted that health and wellbeing would continue to be a focus in 2025/26 and supporting staff to remain well and at work would be a priority; the sickness rate at LCHS was 6.48% which is outside of the Q4 target of 4.50% - there was work ongoing to maximise the recently appointed absence management team to support managers and understand the data insights to support action planning.
- the in-month ULTH appraisal rate was 81.24% against a Q4 target of 90.00%; the in-month LCHS appraisal rate was at 92.28% against a Q4 target of 90.00%. Work continued to educate leaders on the process required to update ESR, including the use of 'how to' guides/sessions and utilising reporting to identify and support areas of low completion.

The Committee was **assured** by Committee Performance Dashboard.

The Committee received the Safer Staffing Medical report and noted the following for February 2026:

- in ULTH medical and dental vacancy rate was at 9.34%; in LCHS the medical and dental vacancy rate was at 14.6%.
- in ULTH the turnover rate was at 6.30% and the area with the highest turnover continued to be Medicine Care Group with speciality medicine having a turnover of 12.30%; in LCHS the turnover rate was at 2.98%.
- in ULTH the sickness rate was at 2.93% which had increased slightly to the highest rate seen over the last 12 months. Surgery was the Care Group that had seen the most significant increases.
- In ULTH the appraisal rate was at 95 in March 2026; in LCHS the appraisal rate was at 100%.

The Committee noted the work that had continued with the Care Groups and the Medical Workforce team to understand the issues related to the significant medical and agency spend variance.

The Safer Staffing Medical report provided the Committee with **reasonable assurance** on the current staffing figures for the Group, and **limited assurance** related to the position of Care Group-driven spend on medical temporary staffing.

The Committee received the Safer Staffing Nursing report and noted that staffing levels remained safe overall, with appropriate mitigations in place where pressure was identified. The areas highlighted by the report as requiring continued oversight, were ULTH unregistered staffing, Community Nursing workforce fragility, AHP shortages and diagnostic risk in Sonography. The Committee noted the ongoing actions and workforce initiatives to strengthen resilience across all services.

The Committee was **assured** by the Safer Staffing Nursing report.

The Committee reviewed the Education Oversight Group upward report and noted the positive data highlighted in the report. The Group at the end of February 2026 reported core learning compliance to be above the 90% KPI target. LCHS achieved 95.83 compliance, while ULTH achieved 93.28% compliance in February 2026 both of which were above target.

The Committee noted that compliance for new starters continued to be low and was at 64.17%% in February 2026 new starters have a 3 month window to complete to statutory and mandatory training. Though it was known that non-compliance increased patient safety. regulatory or reputational risks steps were being taken to assess the full impact of the issue in collaboration with subject matter experts. Update on progress on this work will be included through the Education sub committee report to People Committee.

The report noted that CPD spending trends remained consistent, with allocations across nursing, Allied Health Professional, and multidisciplinary

courses. LCHS reported 99% spend utilisation, worth £397k out of a CPD allocation of £401,508.84 in 2025/26. ULTH reported a 87% spend utilisation, worth £960k out of a CPD allocation of £1,100,409 in 2025/26.

In terms of Apprenticeship Levy Utilisation, the report stated that a total of 26 completion payments were recorded in the month of February 2026 across the Group. These payments included 13 x Senior Leaders and 6 x Team Leaders, resulting in a total of 603 live learners on programme across the Group. In total there have been 970 apprenticeship completers since the commencement of the apprenticeship levy.

The Committee was **substantially assured** by the Education Oversight Group Upward Report

Assurances in respect of Objectives 2b:

a) Workforce Strategy Group Upward Report
b) Workforce Hub Upward Report
c) National Staff Survey Update
d) Freedom to Speak Up Quarterly Update and Annual Report

The Committee received the Workforce Strategy Group and noted that overall workforce performance remained stable, with the majority of key metrics within target and effective controls in place. Vacancy rates across LCHG were broadly within tolerance, with expected movement in Quarter four, turnover remains within acceptable levels, and sickness absence had shown improvement at LCHS.

Core mandatory training compliance remained above target, and job planning compliance had improved to 85% for 2025/26, with remaining gaps managed through mediation processes.

The Committee was **assured** by the Workforce Strategy Group report.

The Workforce Hub report reiterated to the Committee that seven colleagues remained at risk of redundancy due to organisational or limited suitable alternative employment options. Appropriate mitigations were being implemented including occupational health input and the ongoing exploration of potential roles across the Group. The Committee was informed that despite the mitigations, the potential of redundancy, subject to Remuneration Committee approval, was growing.

The Committee was **assured** by the Workforce Hub report.

The Committee received the 2025/26 National Staff Survey Update and noted that 6,528 members of staff responded to the survey questionnaire, representing 49% of ULTH staff and 68% of LCHS staff. The Committee was informed that the high-level results had been shared across the Group after the national embargo on publication was lifted in March 2026.

The update noted that the plan was to organise individual care group/directorate focused interactive workshops between 20 April – 01 May 2026. At these workshops, care group/directorate leadership would be able to listen and interact with their staff to understand their experiences, and work with them to shape meaningful improvements.

By the end of each workshop, the expected output would be a clear culture plan for each care group or directorate, including three to five agreed actions. All care group/directorate culture plans would be collectively signed off by the Group Leadership Team membership and monitored through PRMs. Assurance reports on culture plans progress will be reported quarterly.

The Committee was **assured** by the 2025/26 National Staff Survey Update.

The Committee received the Freedom to Speak Up (FTSU) Quarterly Update and 2025/26 Annual Report. The Committee was informed that following the announcement that the National Guardians Office (NGO) function would be transferred to NHSE there had been further communications. The communications was related to the advice that the NGO would be extended until the end of June 2026 to ensure the transition was finalised adequately. In the interim the NGO would continue to collect the data required from Guardians.

The Committee was also informed that on staff survey dataset, there had been a national decline for this area.. The Guardians had decided to meet with the Guardians at Cambridgeshire Community NHS Trust to learn from as they were always top five in the staff survey output and bring any learning..

The Committee agreed on the need to raise of the profile of the Group's Freedom To Speak Up Guardian function so that staff would have the awareness to utilise their services and noted the ongoing challenge in closing cases organisationally. This data would be presented in PRM meetings going forward

The Committee considered the FTSU Annual Report and agreed that comments would be fed back outside the meeting with the final report presented in May.

The Committee was provided with **assurance** by the FTSU quarterly updateand limited assurance in relation to follow up actions..

<u>Assurances in respect of Objectives 2c</u>:

a) Equality, Diversity and Inclusion Group Upward Report
b) Culture and Leadership Group Upward Report
c) Employee Relations Activity
d) Employee Exclusions

The Equality, Diversity and Inclusion (EDI) Group Upward Report to the Committee focused on the following:

a. Workforce Disability Equality Scheme (WDES) Update – In relation to the first-year progress update on the WDES 3-year Action Plan: 19 actions had been completed and rated green, 6 actions were rated amber and 3 actions rated blue.
b. Workforce Race Equality Scheme (WRES) Update – In relation to the first-year progress update on the WRES 3-year Action Plan: 19 actions had been completed and rated green, 3 actions were in place and 1 action was yet to commence.
c. Reverse Mentoring Pilot Update - 30 applications had been received from the staff networks, and a significant number of Board members had also signed up to support the programme.

The EDI Group report also provided comprehensive updates on the progress of the Group's Staff Networks.

The Committee was **assured** by the EDI Group upward report.

The Culture and Leadership Group Upward Report to the Committee focused on the progress of the Group OD/HR Harmonisation Progress with work to create single policies and align culture, values and the appraisal processes in ULTH And LCHS.

The report also updated on the health and wellbeing provision in the Group and noted that there had been an increased uptake of the Employee Assistance Programme (EAP) across both ULTH and LCHS. This increase was positive, as it indicated that colleagues were being effectively signposted to the appropriate support provision and were confident in accessing it when needed. The top three themes from those accessing the provision were 'anxiety', 'low mood', and 'bereavement' but a new emerging theme across the Group was related to 'change in role'.

The Committee was **assured** by the Culture and Leadership Group report.

The Employee Relations (ER) Activity report stated that ER performance continued to strengthen ULTH. Since the introduction of the case review process in May 2025, there had been sustained progress, increased consistency, and a more proactive approach to resolving complex workforce matters.

The report stated that 211 cases had been closed between May 2025 and February 2026, reflecting a significant uplift in throughput and a more disciplined approach to case management. Medicine and Surgery Care Groups accounted for the highest volume of closures, with concentrated ER support in Medicine delivering clear, measurable improvement.

Overall, the use of informal, just culture approaches was increasing, and tribunal exposure remained relatively stable. Some delays remained, but actions and new People Directorate resources were strengthening future sustainability.

The Committee was **assured** by the update on the ER performance.

The Committee received the Group Employee Exclusions update which highlighted the progress achieved in reducing exclusion duration, strengthened governance arrangements and continued the improvements in case management practice.
The Committee noted that overall, exclusion numbers across the Group remained low and stable, with seven live exclusions within ULTH and one within LCHS at the end of March 2026.

The Committee was **substantially assured** by the report which noted that effective controls were in place, progress continued to be made in reducing both the duration and impact of exclusions, and governance arrangements were operating as intended to support timely, consistent and proportionate case management across the Group.

Assurances in respect of Objectives 2d:

a) Flu Vaccination Programme - Recognition of Achievements
b) Triple AAA Training Programme
c) Staff Achievements
d) Communications and Engagement Dashboard

The Committee received the report titled 'Flu Vaccination Programme - Recognition of Achievements'. The report was focused on the winter vaccination campaign which concluded on 31 March 2026 after a 26-week campaign.

The report stated that 58% of ULTH staff were vaccinated, while 57.03% of LCHS were vaccinated. These results represented a total of 7199 vaccinations across Group in 2025/26 as opposed to the 5186 vaccinated across Group in the 2024-25 campaign. The Committee noted that this surpassed the stretch targets of 50% for ULTH and 55% and LCHS.

The report noted that the success of the campaign could be attributed to several key factors, including the:

- engagement with internal dashboards and collaboration with our occupational health and bank staff.
- strong support from the health and well-being substantive team – this was instrumental, along with the backing from the Senior Leadership Team.
- dedication, commitment and hard work of all teams involved, demonstrating a collaborative approach to maximising vaccination rates.

The Committee extended its appreciation to Leanne Belton and the Health and Wellbeing Team, and all the other teams who had worked hard to successfully conclude the 2025/26 Winter Flu Vaccination Campaign by beating all targets.

Assurances in respect of other areas:

a) Staff Story
b) Board Assurance Framework
c) Risk Report including Risk Register
d) Internal Audit Recommendations

The Committee received a Staff Story which was focused on the actions which were implemented during the recently concluded 2025/26 Flu Vaccine campaign. The campaign concluded with ULTH securing 1st position regionally for uptake and LCHS securing 3rd position regionally for uptake. 7199 vaccinations were delivered to staff across the Group wide, amounting to 57.69% of staff members.

The Committee was updated on the actions to focus resources on problem areas of the Group and overcome vaccine myths or hesitancy to successfully conclude the campaign. The Committee was informed that for the 2026/27 Flu Vaccination campaign:

- vaccines had already been ordered for 2026-2027, with providers expected to deliver more vaccinations than in 2025–26.
- there would be a strong focus on reducing health inequalities, improving uptake in underserved groups, and addressing unwarranted variation.
- the aim was to ensure that the majority of vaccinations should be completed by the end of November 2026, while continuing to offer vaccination up to 31 March 2027 where needed.

The Committee was **substantially assured** by the Staff Story on the 2025/26 Flu Vaccine campaign and the preparations for the 2026/27 campaign.

The Committee received and noted the position in respect of the Board Assurance Framework, Risk Report and the internal audit recommendations.

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 on the following matter for escalation to the Group Board:

a) The Committee extended its appreciation to Leanne Belton and the Health and Wellbeing Team, and all the other teams who had worked hard to successfully conclude the 2025/26 Winter Flu Vaccination Campaign by beating all targets.

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, Non-Execuitve Director (Chair)

21 April 2026

People Committee
Terms of Reference

1. Authority

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

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

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

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

2. Purpose of the Committee

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

The relevant group strategic aim and objectives assigned to the People Committee for 2026 / 27 are:

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

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

3. Membership

The members of the committee are:

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

The following roles will be routine attendees at the Committee:

- Group Deputy Chief People Officer
- Group Deputy Director of People (HR)
- Group Deputy Director of People (OD) Director of Corporate Affairs or their representative

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

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

4. Attendance and Quorum

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

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

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

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

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

Observers will be permitted as agreed by the Chair.

5. Frequency

The committee will meet monthly.

6. Specific Duties

The People Committee will:

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

7. Administrative support

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

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

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

8. Accountability and Reporting Arrangements

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

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

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

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

9. Monitoring effectiveness and Compliance with Terms of Reference

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

10. Review of Terms of Reference

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

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

Approved: May 2026

Approved by: Group Board

Next Review Date: April 2027

NHS
Lincolnshire Community and Hospitals NHS Group

Annual Report to the Board from the People Committee 2025/26

ROLE OF THE COMMITTEE

In 2025/26, in line with all other Committees of the Board, the Terms of Reference were reviewed and amended. Under the agreed terms of reference, the People Committee was tasked as follows:

The People Committee will:

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

MEETINGS

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

The Committee continued to deliver a full agenda through the submission of questions, by Committee members, ahead of the meeting which were responded to during the meeting.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2025/6 the Committee was chaired by Ms Vicki Wells.

Details of the Committee's membership and attendance during 2025/26 is set out below:

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

Members	11 Apr 2025	21 May 2025	24 June 2025	14 July 2025	12 Aug 2025	09 Sept 2025	14 Oct 2025	11 Nov 2025	09 Dec 2025	13 Jan 2026	09 Feb 2026	10 Mar 2026
Non-Exec Director (Vicki Wells - Chair)	X	X	X	X	X	A	X	X	X	A	X	X
Non-Executive Director, LCHS (Gail Shadlock)	X	X										
Non-Executive Director (Duncan French)	A	A	A									
Non-Executive Director (Jim Connolly)			X	X	A	X	X	X	X	X	X	A
Associate Non-Executive Director (Paul Marsden)									X	X	A	X
Group Chief People Officer	D	X	X	X	X	X	D	X	X	X	X	X
Group Chief Medical Officer	X	X	X	D	X	X	X	X	X	D	D	A
Group Chief Nurse	X	X	X	X	X	X	X	X	X	X	D	X

A denotes Apologies given
D denotes Deputy in attendance

REVIEW OF BUSINESS

The People Committee followed a programme of work for the 2025/26 year.

The People Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2025/26:

- 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

During 2025/26 the Committee has utilised the Board Assurance Framework (BAF) to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF. The strategic objectives at the beginning of the year (April 2025) were rated as follows:

Objective 2a – **AMBER**
Objective 2b – **AMBER**
Objective 2c – **AMBER**
Objective 2d – **AMBER**

Through the year the Committee continued to receive reports offering assurance against the strategic objectives. The Committee undertook significant reviews of the BAF and associated assurances resulting in the objectives being rated as follows at the end of the year (March 2026):

Objective 2a – **GREEN**
Objective 2b – **AMBER**
Objective 2c – **AMBER**
Objective 2d – **AMBER**

In March 2026, the Committee undertook a comprehensive review of the Board Assurance Framework.

OVERVIEW

The People Committee has offered a level of assurance to the Board on people and organisational development. The Committee has reported its progress to the Board through upward assurance reports, reporting progress against the delivery of the work plan as defined by the terms of reference, through this annual report.

The work programme for the Committee has focused on the workforce across the Group as well as developing the Group to be an employer of choice and research and innovation.

The Committee has been well attended by members throughout the year, and the Chair has been actively involved in the agenda setting alongside the Group Chief People Officer.

Other key areas of focus of the Committee have included:

- Freedom to Speak Up
- Guardians of Safe Working
- Safer Staffing
- Culture and Leadership Programme
- Education
- Staff Survey

During 2025/26 the reporting groups continued to provide streamlined reporting and further assurances to the Committee.

The reporting groups are:

- Workforce Strategy Group
- Education Oversight Group
- Equality, Diversity and Inclusion Group
- Culture and Leadership Group

The Committee has received the Committee Performance Dashboard which continues to develop as a Group document to provide consistent reporting across the organisations and provided clear oversight of the reporting metrics.

Reporting continued to be received from both the Freedom to Speak Up Guardian and Guardian of Safe Working to the Committee which demonstrates the Groups' commitment to supporting staff to be able to raise concerns to be addressed.

Regular reports are received by the Committee with attendance at the Committee meetings by both Guardians to ensure that appropriate assurances are received and where necessary escalations made. Where escalations have been made by the Guardians, to the Committee, clear actions have been assigned and taken to support the Guardians in their work.

The annual Gender Pay Gap reports were presented to the Committee showing improvement across both organisations and 3-year action plans in place to support parity moving forwards.

Updates were received in respect of recruitment and vacancy rates with the Committee receiving updates in respect of vacancy control processes to support management of the financial position of the Group.

Risks

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

Performance Review

The Committee reviews performance against the agreed Key Performance Indicators (KPIs) and the actions being taken to recover where necessary. The KPIs monitored by the Committee cover vacancies, staffing levels, staff training and development, staff health and wellbeing, sickness absences and equality diversity and inclusion. The metrics presented within the report have been reviewed to ensure that the information presented offers a clear position on the performance of the Group.

At each of the meetings held during 2025/26 the Committee considered all aspects of the performance report and were able to identify and seek further assurance on KPIs where concerns were identified. Significant scrutiny of the KPIs was undertaken through the Workforce Strategy Group enabling the Committee to be directly sighted on areas of concern and to be assured on actions being taken to address those.

In relation to the Guardian of Safe Working (GSW) report, the Committee received the progress updates in relation to the requested actions from the GSW's escalations. The actions which had been completed included those around study leave and exception reporting, while actions in relation to the development of rest spaces for resident doctors continued to be progressed through the Estates team's Space Group.

In August 2025, the Committee requested an executive action be taken to discuss and better understand the impact the lack of rest spaces for resident doctors was having in order to support resolution of the issue.

In September 2025, the Committee supported the actions being taken in relation to NHSE's10-point plan for improving resident doctors working lives. In December 2025, the Committee received a report which demonstrated the progress made against elements of the 10-point plan and noted the ongoing work to address the areas identified by the plan. The Group was required to submit the progress update to NHSE in December 2025.

The Committee received regular updates on the work supported by the Group Leadership Team to promote the Group's 'Values and Behaviour Framework'. The

Framework underpinned the actions to ensure that there was equality across the Group and was launched on 01 October 2025.

In April 2025, the Committee received and approved the Group's equality objectives for 2025/26 and received regular updates on the progress made against those objectives.

In July 2025, the Committee received, with assurance, the Workforce Race Equality Standards (WRES) Annual Report and Action Plan, Workforce Disability Equality Standards Annual (WDES) Report and Action Plan and Equality, Diversity and Inclusion (EDI) Annual Report and Action Plan. The Committee reviewed and supported the improvement actions included within the action plans and also noted that the Group's staff networks would be supporting the implementation of the action plans.

In November 2025, the Committee received with substantial assurance, an update on actions being taken in respect of tackling racism, with work underway as part of the EDI programme and objectives.

In February 2026, the EDI Upward report provided the Committee with significant assurance about the progress of the EDI agenda in the Group. The report informed the Committee that EDI objectives have been fully embedded into Group Board appraisals, which completes a long-standing requirement within both High Impact Action (HIA) and Equality Delivery System (EDS) Domain 3.

Within HIA 6 (anti-bullying and harassment), the organisation has completed a comprehensive review of all bullying and harassment data across all protected characteristics, an expansion from previous years that focused only on disability and ethnicity. This now forms part of business-as-usual monitoring for the Group, and follow-up actions will align with the new Group EDI strategy.

In April 2025, the Committee received a report which offered an update in respect of the work being undertaken to support the Estates and Facilities teams. The Committee recognised the high turnover within the Estates Directorate due to the impact of the roles, such as housekeeping and the engineering-based jobs, on an ageing workforce. The Committee noted that apprenticeships were being considered in respect of the engineering-based roles to support the future workforce.

In May 2025, the Committee received an Education Oversight Group (EOG) Upward report, with assurance, which noted that statutory and mandatory training compliance was at about 90% of KPI for 2024/25. Continuing Professional Development (CPD) spend was also noted as fully allocated and reconciled for 2024/25.

Through 2025/26, the Committee received regular EOG Upward reports which assured Committee members that statutory and mandatory learning compliance was above the 90% target.

In August 2025, the Committee noted in the EOG Upward report that CPD funding had been confirmed for both Trusts with spending plans in place. The Committee was also assured in August 2025, that the apprenticeship levy was being fully utilised across the Group with further steps being taken to promote the apprenticeship offerings in the Group.

In September 2025, the Committee noted that a deep dive undertaken by the EOG in respect of statutory and mandatory training compliance had highlighted that the rates for medical and dental colleagues and doctors remained lower than required.

The Medical Education update in September 2025, highlighted the improvements in medical education in Surgery, Obstetrics, Gynaecology and Medicine. These improvements had been recognised by NHS England and Health Education England after visits to relevant sites in the Group. The Committee also noted and supported the work being undertaken locally to resolve the persistent cultural challenges around the medical education provision.

The Committee has continued to receive and discuss regular reports in respect of Safer Staffing for Nursing and Allied Health Professional staff with moderate levels of assurance continuing to be offered to the Committee. The Committee noted the actions being undertaken to recruit a 'sickness manager' to manage high sickness levels, as well as the actions being implemented to reduce nursing bank and agency use in the Group.

In November 2025, the Committee was updated on the introduction of 'sickness absence coordinators' to provide enhanced support for areas of concern. In December 2025 the Committee was informed that a 'Sickness Absence Manager', due to commence January 2026, had been recruited to support full and comprehensive implementation of the Group Managing Attendance Policy. The Policy was due to go live in April 2026.

In May 2025, the Committee received a Safer Staffing for Nursing report with assurance, which noted that safe care compliance had improved to 90% and that a reduction in harms from falls had been seen in the community.

In February 2026, the Committee received a Safer Staffing for Nursing report with a reasonable level of assurance, which highlighted a development in relation to an update to Annex 20 of the NHS Terms & Conditions Handbook in January 2026. The update was to clarify that the Band 5 to Band 6 progression mechanism applies not only to midwifery, but also explicitly to nursing and allied health professions (AHPs).

The effect of this clarification is that Band 5 graduate entry roles are required to be reviewed via Job Evaluation between 12- and 24-months post-qualification and addressed longstanding concerns that nursing progression has been inconsistently applied across the NHS.

The Committee, through the year, received monthly Medical Safer Staffing reports which provided significant levels of assurance to the Committee's members. The monthly reports provided Committee members with an overview of the Medical and Dental staffing capacity, training and appraisal compliance, temporary staff use, vacancies and sickness levels. The Committee also noted the actions being implemented to reduce medical bank and agency use in the Group.

The Committee received regular Culture and Leadership Group Upward reports which noted the work being undertaken by the Group Leadership Team to keep the staff informed of developments in the Group working arrangements. The Committee supported the development of the 2024/25 Staff Survey action plan and monitored the progress against the actions in the action plan.

In August 2025, the Committee reviewed the Culture and Leadership Group Upward report and recognised the decrease in morale for staff in the Community. The Committee supported the work being undertaken in various fora to support and improve the morale of the staff in the Community.

In July 2025, the Committee received a verbal update on the NHS and System People Plan which noted the change in position due to the national direction of travel in respect of Integrated Care Board (ICB) cluster footprints and the NHS 10-year plan. The Committee was supportive of the development of a local People strategy across the Group, aligned to the 10-year plan.

In August 2025, the Committee reviewed the commencement of the Nursing Establishment Review and recognised the volume of work undertaken.

In August 2025, the Committee also received and reviewed the Annual Medical Revalidation reports for both Trusts in the Group. The Committee recommended the reports to the Group Board for approval.

The August 2025 Workforce Hub Upward report to the Committee assured members that staff still awaiting redeployment were not at risk of redundancy and colleagues were being supported to find suitable roles. Supportive actions including wellbeing support and interview preparation had also been put in place to help staff who needed to redeploy or change roles due to the establishment of the Group working arrangements. The Committee supported the steps being taken to ensure that staff were adequately supported through the redeployment activities.

In September 2025, the Committee received a Workforce Hub Upward report which updated on the progress achieved against 2025/26 Workforce Plan and was not assured that the objectives of the Plan would be achieved. The Committee asked to be sighted on the action plans in place to achieve trajectory.

In August 2025, the Committee received an update on Health and Wellbeing Offer in the Group and noted the health and wellbeing provision across the Group. The Committee supported the work taking place to ensure that the provision was consistent across the Group.

In October 2025, the Committee received an update on the National Nursing Job Profiles work which had commenced in the Group in June 2025. The Committee was assured by the work being undertaken with the expectation that this work would be completed in May 2026.

In January 2026, the Committee received a progress update on the National Nursing Job Profiles work. The Committee reviewed the report and expressed concern about the potential risks associated with the scale of the job evaluation process and the capacity of the evaluation team to undertake the project. The Committee noted that steps were being taken to review the capacity and capability of the job evaluators to conduct the project, including assessing whether resources can be shared among neighbouring NHS employers to progress the project. The Committee also recommended that there should be a clear communication effort around the job evaluation process to manage expectations.

The Committee noted the formal launch of the Sexual Safety Charter in September 2025. The Committee was assured of the firm Executive level commitment around the actions which needed to be implemented to embed the Charter's requirements in the Group.

In January 2026, the Committee reviewed the draft report for the 2025 Staff Survey and noted that 49% of ULTH staff responded, against a 36% response rate in 2024. 68% of LCHS staff responded, against a 55% response rate in 2024. The Committee will receive the published full report in March 2026. The Committee noted the slight declines in all but one of the People Promise scores for ULTH and LCHS, and the improvement actions which were going to be developed.

The Committee, in January 2026, received the Freedom To Speak Up (FTSU) Report, which included updates on the new digital anonymised reporting tool which was is in the final stages of development and the actions being implemented to improve staff engagement with the FTSU Guardian (FTSUG).

The Committee received a Staff Story in January 2026, which focused on the Group's commitment to supporting employees who are affected in any way by menopausal symptoms. The Committee was assured by the steps being taken to

educate and support managers so that employees reporting issues due to the onset of perimenopause or menopause are treated fairly and given the appropriate support.

In February 2026, the Culture and Leadership Group Upward report informed the Committee that the Group's Menopause Service for staff continued to grow month on month, with a substantial referral pipeline and positive feedback.

In February 2026, the Committee received a Staff Story from a registered nurse who began her working career in the retail sector before switching to the NHS due to family reasons. The registered nurse joined ULTH as a housekeeper and then became a healthcare assistant, before qualifying as a nursing associate. After 4 years as a nursing associate, she undertook the 'top-up' course to become a registered nurse. The registered nurse is on the same ward as she was employed as a housekeeper and is working with the Group's Talent Academy to support their work developing talents in the organisation.

In February 2026, the Committee was informed that the Patient Services Hub consultation was closed on 20 January 2026 and the final proposals for the initiative was being developed.

In February 2026, the Committee also noted that the People Directorate consultation on its structure closed on 09 January 2026, with a plan to communicate the final structures later in January 2026.

In March 2026, the Committee received report which provided feedback on a recent Chaplaincy Engagement Survey. The report informed the Committee that more responses than expected had been received from a wide demographic of Lincolnshire. The feedback indicated that there was a misconception among the staff and patients of what other very beneficial services the Chaplaincy could offer, outside of 'faith'. The Committee was assured by the proposed actions which would be implemented to increase awareness of Chaplaincy Team's offer, improve the team's facilities and provide the team's members with the appropriate healthcare training.

During 2025/26 referrals between the Board Committees were made in order to ensure that where necessary additional assurances were sought from the relevant responsible Committee, in areas where responsibility for assurance extended beyond the remit of a single committee. A number of referrals were made during the year offering opportunities for the Committee to seek further assurances.

a. In June 2025, the Committee made a referral to the Integration Committee regarding the inconsistent availability of spaces for the development of rest spaces for resident doctors following escalation by the Guardian of Safe Working.

b. In November 2025, the Committee made a referral to the Quality Committee in respect of the incorrectly completed non-clinical Infection Prevention and Control (IPC) module by clinical staff. The Committee was informed that 3600 clinical colleagues had incorrectly completed the level one non-clinical IPC module, rather than level two, which was intended for clinical colleagues. The Committee was concerned due to the potential risk associated with the completion of incorrect training.

In terms of focussed discussions, the Committee had:

a. a focused discussion (in April 2025) on Healthcare Support Worker (HCSW) vacancy and retention rates and noted that Allied Health Professional (AHP) and dental vacancy rates had seen a reduction which was positive.
b. a focussed discussion (in September 2025) in respect of Health and Wellbeing and the support in place for staff. The Health and Wellbeing work was being undertaken under the supervision of the Culture and Leadership Group.

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

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

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

NHS
Lincolnshire Community and Hospitals NHS Group

National Staff Survey 2025 Overview

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*5 May 2026*
Agenda item number	*10.2*
Report title	*National Staff Survey 2025 Results*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Information*
Accountable Director	*Claire Low, Group Chief People Officer*
Author(s)	*Michael Du Rose, Associate Director of Culture & Wellbeing, Kerry Swift, Deputy Director of People*
Prior approval process, if applicable	*Not applicable*
Financial implications, if applicable	*Not applicable*
Action / decision required	*The Board is asked to note the contents of the report.*

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

Executive Summary

This report provides a detailed overview of the 2025 National Staff Survey (NSS) results across the Acute (ULTH) and Community (LCHS) organisations within Lincolnshire Community and Hospitals Group (LCHG). Participation has increased across both organisations, however, declines are evident in the overall Staff Engagement theme (Motivation, Involvement, and Advocacy) and in the Raising Concerns sub-theme. These areas are key contributors to the National Oversight Framework (NOF) and are therefore likely to impact NOF ratings for 2026/27, depending how other organisations have performed.

In total, feedback was received from 6,528 substantive colleagues across the Group, representing an increase of 1,723 responses compared to the previous year. Response rates improved across both organisations, with the Acute trust achieving a 49% response rate (5,018 respondents) and the Community trust achieving a 68% response rate (1,510 respondents). Overall, the substantive staff response rate increased by 13% compared to 2024. Both organisations now sit marginally above Picker's average response rate for comparable organisations.

Despite improved participation, performance against key benchmarks has declined. The Acute organisation is ranked 47th out of 50 in the overall positive score league table (of those providers that use Picker), representing a deterioration from last year's position of 44th. The Community organisation is ranked 7th out of 8, reflecting a one-place improvement from last year's ranking of 8th. With the exception of one measure, all NHS People Promise scores have declined across both organisations. In the Community organisation, the "We are a team" score remained stable at 6.9, while in the Acute organisation the "We are compassionate and inclusive" score was maintained at 7.0. The declines in a number of areas reflects a similar position to both regional and national NSS results across the NHS.

The key metrics informing the National Oversight Framework (NOF) ratings are the Raising Concerns sub-scores and the Staff Engagement Scores (SES). Both metrics have declined in this year's results across the Group, noting that higher scores indicate better performance. These results highlight areas requiring focused leadership attention and targeted improvement activity.

	ULTH		LCHS	
	2025	2024	2025	2024
Raising Concerns	5.9	6.1	6.6	6.9
Staff Engagement	6.4	6.6	6.8	7.0

Research from similar trusts who have already navigated group programmes, recommend one overarching organisational action plan, focusing on 1-4 key whole organisational themes/actions. The development of local actions plans for care groups/directorates should be encouraged and link to the organisational themes.

Following the sharing of the results with ELT and GLT, workshops with social and operational decision makers have taken place to cascade the data, its context and obtain next step commitments so that key operational leaders develop and take ownership of the local actions to champion in their areas to make the most impact, with the development of culture plans. The actions from the culture plans will be monitored through Performance Review Meetings (PRMs) with assurance reports on progress being upwardly reported to People Committee.

Introduction

This report provides an overview position of response rates to the National Staff Survey (NSS) for 2025. It highlights the initial response rates for both organisations, how they compare to 2024 and our 2025 organisational position, together with a summary of the results.

Background

The NSS 2025 was open from 6th October 2025 to 28th November 2025 over a 7-week period. This is a key staff engagement tool that captures how our people are feeling and is now one of the metrics that informs our NOF rating, based on the overall Staff Engagement Score (SES) determined by these survey results.

Key Messages

There was a marked improvement in the overall response rates across both parts of the Group for substantive staff. The final response rates across the Group are:

Overall (Substantive)	Trust	Final Response Rate	Total voices	% changes vs '24
National Staff Survey 2025	Acute	49%	**5018**	**+13%**
National Staff Survey 2025	Community	68%	**1510**	**+13%**
National Average for Acute Trusts		48%		
National Average for Community Trusts		61%		

Overall (Bank)	Trust	Final Response Rate	Total voices	% changes vs '24
National Staff Survey 2025	Acute	13%	**151**	**12%**
National Staff Survey 2025	Community	17%	**36**	**-2%**
National Average for Acute Trusts		15%		
National Average for Community Trusts		21%		

Picker league table

The league table shows how the overall positive score is ranked in comparison to the overall positive score of every other organisation that ran the NHS Staff Survey 2025 with Picker. The overall positive score is the average positive score for all positively scored questions in the survey. Acute is ranked 47 out of 50 in the position for the league table (for those organisations that completed using Picker) for the overall positive score, which is a declined score from last year (#44). The community was ranked 7 out of 8 in the same table which improved one position from last year (#8).

The key metrics used for our NOF ratings are the raising concerns sub scores, along with the SES. We have seen a decrease in both of these scores within this year's results (a higher score is better in both categories).

	ULTH		LCHS	
	2025	2024	2025	2024
Raising Concerns	5.9	6.1	6.6	6.9
Staff Engagement	6.4	6.6	6.8	7.0

For ULTH, this is further broken down by Care Group/directorate for reference below.

	Organisation Overall	Alliance Care Group	Corporate	Director of Estates & Facil	Family Health Care Group	Medicine Care Group	Surgery Care Group
Motivation sub-score	6.9	6.9	6.8	6.8	7.1	7.0	6.9
Involvement sub-score	6.5	6.6	7.0	5.8	6.6	6.5	6.2
Advocacy sub-score	5.8	6.0	5.8	5.7	6.0	5.7	5.7
Overall 'Staff Engagement' Score	6.4	6.5	6.5	6.1	6.6	6.4	6.3

This is again broken down further by Care Group/directorate for LCHS.

	Organisation Overall	Corporate	Planned	Unplanned
Motivation sub-score	7.0	6.6	7.2	6.7
Involvement sub-score	6.7	7.0	6.8	6.3
Advocacy sub-score	6.6	6.3	6.8	6.5
Overall 'Staff Engagement' Score	6.8	6.6	6.9	6.5

Please see appendix 1 for a detailed staff engagement score heat map for both organisations that GLT are using to take action in their respective areas to support further targeted improvement schemes of work.

People Promise Mapping

All but one of the People Promise scores have declined in both organisations. In the community *"We are a team"* has remained the same (6.9) and in the acute, "*We are compassionate and inclusive"* has retained its score (7.0). A full breakdown of People Promise scores can be found in appendix 2.

Staff Engagement Sub-Theme

Staff Engagement Score (SES) overall, is made up of 3 sub-themes, Motivation, Involvement and Advocacy, and each sub-theme has 3 questions which form that sub-theme - totalling 9 questions which provides a statistically significant score. The SES theme and its relevant sub-themes move from percentage based scores and are scored out of 10. The SES is a critical metric in terms of the National Oversight Framework (NOF) and associated rankings.

Staff engagement scores have declined across both Acute and Community settings with decreases being evident across all three sub-themes: Motivation, Involvement, and Advocacy with Advocacy showing the steepest decline, signalling reduced confidence in organisational priorities and reputation.

Table 1 in appendix 3 details the breakdown of Staff Engagement Scores, sub-themes and questions in terms of the percentages that indicate how many respondents answered positively in ether strongly agree or agree answers.

Raising Concerns Sub-theme

Raising concerns is a sub-theme of the "We each have a voice that counts" People Promise element. It is comprised of 4 questions which provides an overall score out of 10 (with a higher score being better).

Both organisations have declined for the raising concerns score and both settings show a decline in speak-up culture, with Acute scoring lower overall, the implication being that both settings need action to rebuild trust in raising concerns, with Acute showing deeper challenges. Table 2 in appendix 3 details the breakdown of Raising Concerns sub-theme questions and scoring in terms of the percentages that indicate how many respondents answered positively in ether strongly agree or agree answers.

Overall Scores: Most Improved and Most Declined

While Community and Acute share improvements in team clarity and appraisal coverage, both face critical declines in organisational trust, safety, and wellbeing. Acute struggles more with staffing and wellbeing action, while Community faces sharper decreases in career development and fairness. Speak-up confidence is declining across both, signalling a priority area for leadership intervention.

It should be noted that at ULTH 3/10 of the most declined are NOF Rating relevant questions, and for LCHS 4/10 most declined are NOF rating relevant questions.

Community and Acute Declines:

The top ten declined scores in community indicate a significant decrease in staff confidence and experience, primarily in safety, wellbeing, and organisational trust. Declines are evident in organisational trust and reputation, with reduced confidence that patient care is the top priority, lower recommendation rates, and weaker belief that concerns are addressed. This is broken down in appendix 4.

The most significant decreases in acute are in organisational wellbeing action, employer reputation/advocacy, staffing/resources, and follow-through on concerns. This is also broken down in appendix 4.

Wellbeing and motivation have also declined, reflected in lower morale, energy, and enthusiasm. Safety and resource concerns persist, including issues with musculoskeletal health and violence reporting in community teams, and staffing levels alongside material and food provision challenges across both acute and community settings.

Improvements

Results highlighted improvements in team and role clarity across both settings, with staff reporting a better understanding of responsibilities. Line manager basics have also strengthened, with community teams experiencing clearer feedback, encouragement, and openness to flexible working, while acute settings show reduced pressure to work when unwell, greater trust, and more openness to suggestions. In the community setting, process coverage has improved through better appraisal completion and increased access to clinical supervision.

National and Local Benchmarking

The NSS continues to provide a critical insight into staff experience across the NHS, highlighting both areas of sustained strength and ongoing challenge at a national level. Recent national results indicate that while staff remain strongly committed to patient care and organisational purpose, pressures relating to workload, engagement, and psychological safety continue to impact overall experience.

At a national level, Staff Engagement Scores have shown limited improvement, with motivation and advocacy remaining under strain. Involvement continues to be a key challenge, reflecting staff perceptions of influence over decision-making and organisational change. These themes remain closely linked to workforce retention, wellbeing, and performance.

Raising Concerns remains a priority focus nationally. While many staff report confidence in knowing how to raise concerns, fewer feel assured that concerns will be addressed effectively or without fear of negative consequences. This continues to be a significant contributor to National Oversight Framework (NOF) assessments and regulatory interest.

The NHS People Promise themes show variable performance nationally. Areas such as teamwork, compassion, and inclusion generally perform more strongly, while themes linked to feeling valued, having a voice, and working in well-resourced environments continue to score lower. Nationally, there is increasing emphasis on leadership visibility, inclusive behaviours, and meaningful staff engagement as enablers of improvement.

Overall, the acute and community results within LCHG are in line with the national NSS picture, which reinforces the importance of sustained, system-wide focus on culture, leadership, and staff experience. Organisations are expected not only to listen to staff feedback, but to demonstrate clear ownership, visible action, and measurable improvement over time, particularly in those areas most closely linked to staff engagement and raising concerns. Appendix 5 showcases the benchmarking comparisons for SES and people promise elements across all Trusts in the NHS. ULTH are at 108 out of 121 positionally with LCHS being 12th out of 13 in their respective benchmarking groups. In comparison, in 2024 ULTH sat in 97th position however the ULTH benchmark group has grown in 2025 from 116 -121. Community have decreased one position from 11th to 12th in the 2025 survey.

In addition, appendix 6 shows the top and bottom 5 acute and community scores, compared with the average of organisations used by Picker.

Current Actions

NSS cascade packs have been created, referencing the data for LCHG and supportive questions to enable reflection of the information. Organisational Development (OD) are supporting a number of live workshops with each Care Group/directorate to aid the development of local culture plans by operational leaders, that will be aligned to the overarching Group culture plan with up to 5 key objectives/themes.

The NSS cascade workshops are a critical mechanism for translating National Staff Survey insights into meaningful leadership action. Their importance lies not simply in sharing results, but in enabling senior leaders to collectively understand, own, and respond to staff experience at scale.

The key to the development of the local cultural action plans is that they are developed and owned by the local operational leaders, tailored to the specific needs of their area, with support from the OD team. This has been proven to be an effective approach as highlighted by those areas who took ownership for their results, for example, Estates and Facilities and Planned and Unplanned Care in previous years.

Conclusions and Recommendations

As Involvement is a key metric and a driver of Advocacy, our next steps being taken must, in terms of our NSS cascade sessions and culture plans, be a meaningful engagement exercise with colleagues across the Group. Assessment of results and NOF priorities suggests four cultural themes for immediate focus as part of an overarching Group culture plan.

Priority 1: Speak-Up and Organisational Trust
Why: Confidence in raising concerns and organisational follow-through has eroded.
Focus: Strengthen psychological safety, visible action on concerns, and transparent feedback loops that are visibly closed off with individuals raising concerns.

Priority 2: Advocacy and Reputation
Why: Largest falls in recommendation and belief that care is the top priority.
Focus: Rebuild trust through patient-first messaging, recognition of staff contributions, and visible leadership commitment.

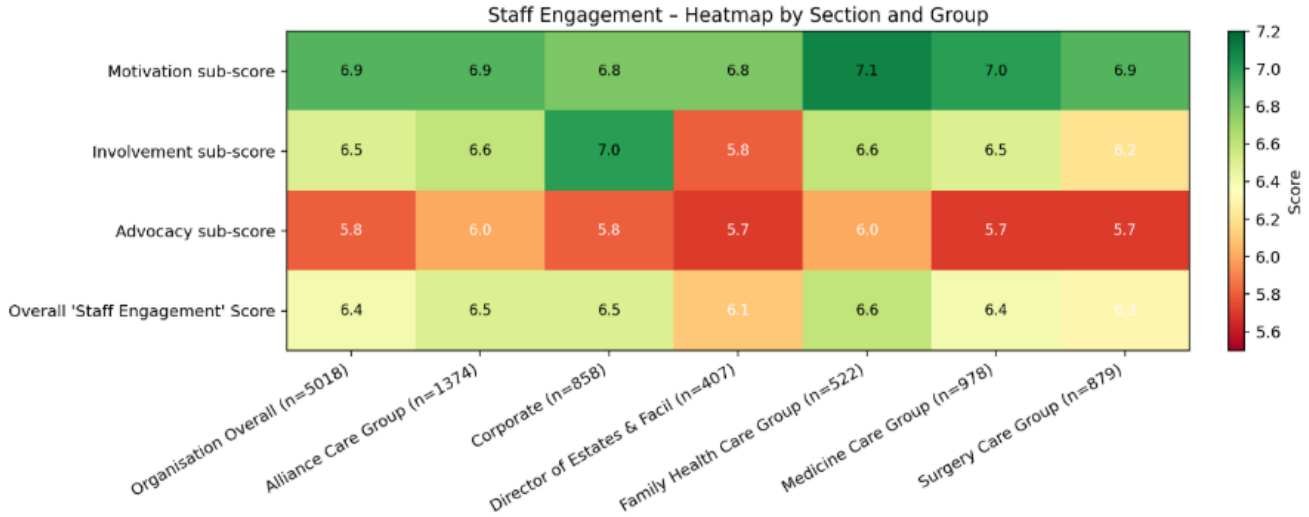
Priority 3: Wellbeing and Motivation
Why: Declines in morale and enthusiasm; Acute reports lower wellbeing action.
Focus: Invest in work-life balance, health and wellbeing programs, flexible working and realistic workload management.

Priority 4: Career Development and Empowerment
Why: Community declines in progression fairness/opportunities; involvement slipping across both.
Focus: Expand career pathways, learning access, and staff involvement in decision-making.

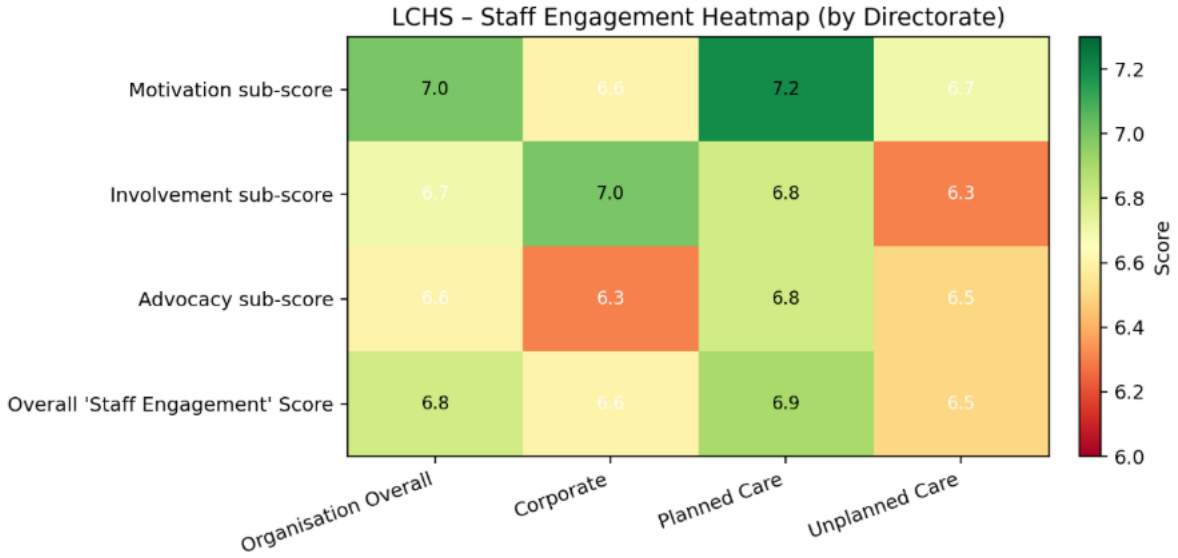
Once the Care Group/directorate culture plans are developed, the actions from these will be monitored via Performance Review Meetings (PRMs), with assurance reports on progress being upwardly reported to People Committee.

Appendix 1

ULTH Heat Map



LCHS Heat Map



Appendix 2

ULTH People Promise Scores

People Promise Element	2025	2024	2023
We are compassionate and Inclusive	**7.0**	7.0	7.0
We are recognised and rewarded	**5.7**	5.9	5.8
We each have a voice that counts	**6.3**	6.4	6.4
We are safe and healthy	**6.0**	6.2	6.0
We are always learning	**5.4**	5.5	5.3
We work flexibly	**6.1**	6.3	6.1
We are a team	**6.5**	6.6	6.5
Staff Engagement	**6.4**	6.6	6.5
Morale	**5.7**	5.9	5.7

LCHS People Promise Scores

People Promise Element	2025	2024	2023
We are compassionate and Inclusive	**7.4**	7.5	7.6
We are recognised and rewarded	**6.1**	6.3	6.4
We each have a voice that counts	**6.7**	6.9	7.0
We are safe and healthy	**6.2**	6.4	6.4
We are always learning	**5.9**	6.0	6.1
We work flexibly	**6.6**	6.8	6.8
We are a team	**6.9**	6.9	7.0
Staff Engagement	**6.8**	7.0	7.2
Morale	**5.8**	6.0	6.1

Appendix 3

Table 1 - Staff Engagement Scores

Sub theme	Question:	ULTH		LCHS	
		2025	2024	2025	2024
Motivation	Often/always look forward to going to work	52%	56%	53%	57%
	Often/always enthusiastic about my job	67%	68%	68%	71%
	Time often/always passes quickly when I am working	71%	71%	75%	75%
	Motivation sub score	**6.9**	**7.0**	**7.0**	**7.1**
Involvement	Opportunities to show initiative frequently in my role	68%	69%	73%	73%
	Able to make suggestions to improve the work of my team/dept	67%	66%	71%	73%
	Able to make improvements happen in my area of work	49%	51%	54%	55%
	Involvement sub score	**6.5**	**6.6**	**6.7**	**6.8**
Advocacy	Care of patients/service users is organisation's top priority	62%	68%	**72%**	79%
	Would recommend organisation as place to work	45%	52%	**56%**	64%
	If friend/relative needed treatment would be happy with standard of care provided by organisation	43%	49%	**67%**	76%
	Advocacy sub score	**5.8**	**6.2**	**6.6**	**7.1**
Staff Engagement Overall		**6.4**	**6.6**	**6.8**	**7.0**

Table 2 - Raising Concerns Scores

Sub Theme	Question:	ULTH		LCHS	
		2025	2024	2025	2024
Raising Concerns	Would feel secure raising concerns about unsafe clinical practice	65%	65%	77%	80%
	Would feel confident that organisation would address concerns about unsafe clinical practice	47%	48%	62%	66%
	Feel safe to speak up about anything that concerns me in this organisation	52%	56%	66%	70%
	Feel organisation would address any concerns I raised	38%	42%	52%	60%
Raising Concerns sub score		**5.9**	**6.1**	**6.6**	**6.9**

Appendix 4

LCHS score declines

Question	Question Text	Question towards NOF ratings
q13d	Last experience of physical violence reported	No
q25f	Organisation would address concerns I raised	**Yes**
q24b	Opportunities to develop career in organisation:	No
q15	Organisation acts fairly: career progression	No
q3h	Adequate materials, supplies, and equipment	No
q25b	Organisation acts on concerns raised by patients/service users	No
q11b	Not experienced MSK problems due to work (12 months):	No
q25d	Happy with standard of care	**Yes**
q25a	Care of patients/service users is organisation's top priority	**Yes**
q25c	Would recommend organisation as a place to work	**Yes**

ULTH score declines

Question	Question Text	Question towards NOF ratings
q11a	Org takes positive action on health & wellbeing	No
q25c	Recommend as a place to work	**Yes**
q3i	Enough staff to do my job properly	No
q25d	Happy with standard of care	**Yes**
q4b	Extent org values my work	No
q25a	Patient care is top priority	**Yes**
q6b	Org committed to work–life balance	No
q22	Nutritious/affordable food at work	No
q14d	Last harassment/bullying/abuse was reported	No
q25b	Org acts on concerns from patients/service users	No

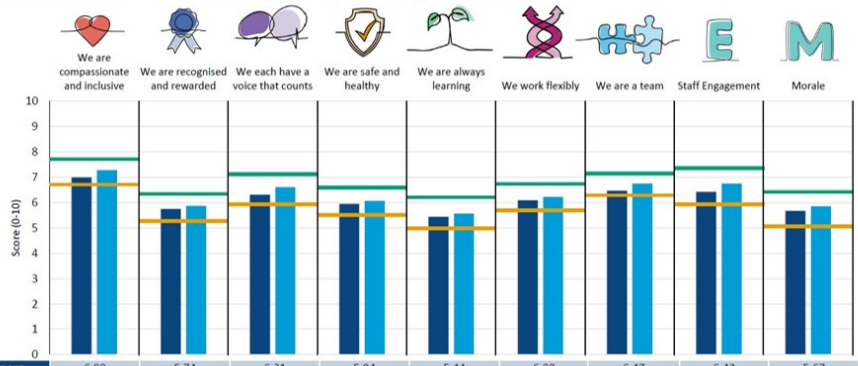
Appendix 5

Acute benchmarking compared with respective peer organisations across the NHS

Acute Benchmark- People Promise Themes

121 in benchmark group

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**



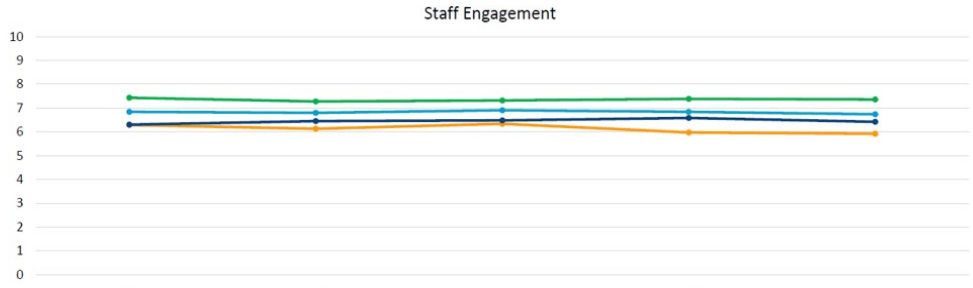
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.99	5.74	6.31	5.94	5.44	6.08	6.47	6.42	5.67
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	5009	5005	4988	4986	4797	4988	5005	5012	5012

Acute Benchmark- Staff Engagement

121 in benchmark group

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**

Theme: Staff Engagement



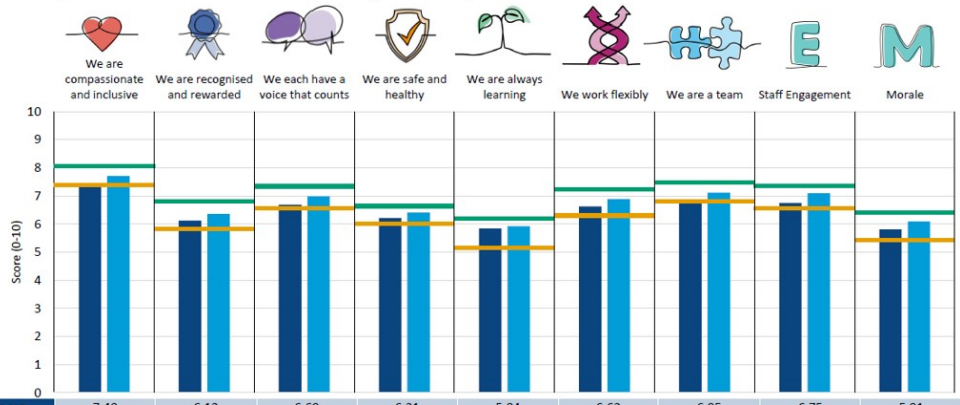
	2021	2022	2023	2024	2025
Your org	6.30	6.45	6.49	6.58	6.42
Best result	7.43	7.28	7.32	7.39	7.36
Average result	6.84	6.80	6.91	6.84	6.74
Worst result	6.29	6.13	6.34	5.98	5.92
Responses	4010	4413	3997	3553	5012

Community Benchmarking compared with respective peer organisations across the NHS

Community Benchmark- People Promise Themes

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**

13 in benchmark group



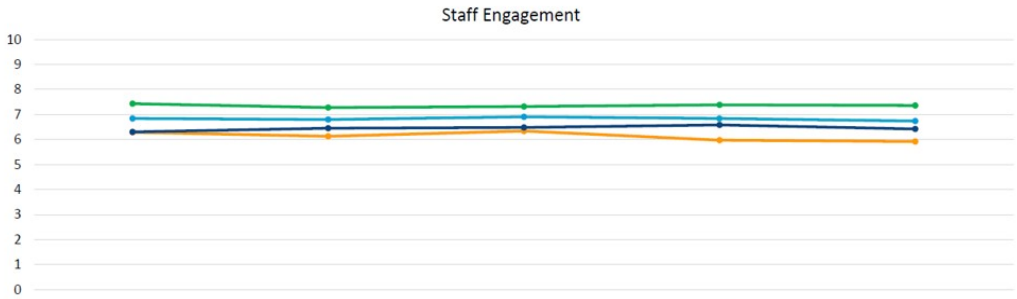
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.40	6.12	6.69	6.21	5.84	6.62	6.85	6.75	5.81
Best result	8.05	6.79	7.34	6.64	6.18	7.23	7.47	7.36	6.41
Average result	7.70	6.36	6.98	6.41	5.92	6.89	7.12	7.09	6.09
Worst result	7.40	5.82	6.56	6.00	5.14	6.30	6.81	6.56	5.44
Responses	1507	1508	1506	1503	1459	1508	1507	1510	1510

Community Benchmark- Staff Engagement

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**

Theme: Staff Engagement

13 in benchmark group



	2021	2022	2023	2024	2025
Your org	6.30	6.45	6.49	6.58	6.42
Best result	7.43	7.28	7.32	7.39	7.36
Average result	6.84	6.80	6.91	6.84	6.74
Worst result	6.29	6.13	6.34	5.98	5.92
Responses	4010	4413	3997	3553	5012

Appendix 6

Acute Top 5 and Bottom 5 Scores compared with Picker organisational average

Top 5 scores vs Organisation Average	Org	Picker Avg
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	63%	60%
q11c. In last 12 months, have not felt unwell due to work related stress	62%	59%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	93%	91%
q11e. Not felt pressure from manager to come to work when not feeling well enough	79%	78%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	76%	75%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	43%	60%
q25c. Would recommend organisation as place to work	45%	56%
q19c. Organisation ensure errors/near misses/incidents do not repeat	57%	66%
q25b. Organisation acts on concerns raised by patients/service users	58%	67%
q19d. Feedback given on changes made following errors/near misses/incidents	51%	60%

Most improved scores	Org 2025	Org 2024
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	68%	63%
q13d. Last experience of physical violence reported	71%	67%
q23a. Received appraisal in the past 12 months	89%	86%
q11e. Not felt pressure from manager to come to work when not feeling well enough	79%	77%
q3a. Always know what work responsibilities are	85%	83%

Most declined scores	Org 2025	Org 2024
q11a. Organisation takes positive action on health and well-being	47%	55%
q25c. Would recommend organisation as place to work	45%	52%
q3i. Enough staff at organisation to do my job properly	27%	34%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	43%	49%
q4b. Satisfied with extent organisation values my work	38%	44%

Community Top 5 and Bottom 5 Scores compared with Picker organisational average

Top 5 scores vs Organisation Average	Org	Picker Avg
q23a. Received appraisal in the past 12 months	97%	94%
q4c. Satisfied with level of pay	37%	34%
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	67%	65%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	44%	43%
q24f. Able to access clinical supervision opportunities	72%	71%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q5c. Relationships at work are unstrained	43%	53%
q13d. Last experience of physical violence reported	68%	78%
q19d. Feedback given on changes made following errors/near misses/incidents	59%	66%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	67%	74%
q25c. Would recommend organisation as place to work	56%	62%

Most improved scores	Org 2025	Org 2024
q7d. Team members understand each other's roles	74%	69%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	79%	76%
q3a. Always know what work responsibilities are	82%	79%
q9b. Immediate manager gives clear feedback on my work	71%	68%
q9d. Immediate manager takes a positive interest in my health & well-being	75%	73%

Most declined scores	Org 2025	Org 2024
q13d. Last experience of physical violence reported	68%	81%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	67%	76%
q25f. Feel organisation would address any concerns I raised	52%	60%
q25c. Would recommend organisation as place to work	56%	64%
q24b. There are opportunities for me to develop my career in this organisation	47%	54%

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	*5 May 2026*
Agenda item number	

Integration Committee Upward Report of the meeting held on 26 March 2026

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

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

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	5 May 2026
Report from:	Integration Committee
Report from meeting held on:	26 March 2026
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 26 March 2026 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) Update on Stroke Rehabilitation and Next Steps
d) Patient Service Hub Update

The Estates and Facilities Upward Report offered updates on the major capital schemes with recognition of the challenges in delivering year end targets.

Progress was noted across a number of the schemes, including the anticipated completion dates for Pilgrim ED and the Endoscopy Unit as May 2026. Work remains ongoing in respect of property rationalisation with recognition of to the activity to better utilise space on the Skegness site to improve the patient journey and release efficiencies.

The Committee was provided with **substantial assurance** by the Estates and Facilities Upward Report.

The Committee noted that the final planning submission had taken place on the 18 March with a breakeven position submitted alongside an £81m CIP programme for ULTH and £9m for LCHS and a headcount reduction of 700 WTE over the next 3 years.

Concern was noted in respect of the external delivery partner Newton due to needing to wait for regional approval processes to conclude. It was recognised that delays in the funding approval could deteriorate the Groups ability to deliver improvement plans.

The Committee was provided with **partial assurance** in respect of Continuous Planning.

A positive update was received in respect of the Stroke Rehabilitation work with the Committee noting the impact of the enhanced community model with over 120 admissions to community stroke beds and home delivery. The service was consistently operating at full capacity with a managed waiting list, and clinically meaningful improvements were being seen for patients.

The Committee received **substantial assurance** in respect of the changes to the service and noted that future development of the pathway would be the delivery of a stroke virtual ward to support early discharge patients.

The Committee was provided with **partial assurance** following the update on the Patient Services Hub, noting the progress that had been made and the conclusion of the consultation period.

Assurances in respect of Objective 3b:

a) Integrated Neighbourhood Teams Update
b) Draft Neighbourhood Health and Wellbeing Plan (**appended**)
c) National Neighbourhood Health Framework
d) Alliance Steering Group Upward Report

An update was provided on the development of the Integrated Neighbourhood Teams with the Committee noting the alignment of the teams with the PCN areas and the implementation of a neighbourhood health clinical business unit.

There was recognition of the need to algin the work of the teams to ensure this was population health focused, to support the national direction of travel with a further update to be provided to the Committee in order to close the current gap present.

Reasonable assurance was provided to the Committee in respect of the Integrated Neighbourhood Teams update.

The Committee received the Draft Neighbourhood Health and Wellbeing Plan noting that the strategic direction of neighbourhood health would be owned by the Health and Wellbeing Board. This would result in them coordinating the system view and groups needed to sit beneath the Board in order to translate the strategic intent.

A dashboard would be developed to support provision of assurance to the Committee and demonstrate the accountable elements for the Group and how these were being progressed.

The Committee received and noted the National Neighbourhood Health Framework update noting that a gap analysis has been published and demonstrated that the Group was in a strong position with **reasonable assurance** being provided.

The Committee received a report, which was taken as read and provided an aggregated view of progress, developments, risks and escalations across the four Alliance Programmes: 1) Unplanned Care Integration; 2) Left Shift; 3) Planned Care & Integrated Neighbourhood Working; and 4) Health Inequalities. It was noted that work continued in respect of the workstreams with the Committee noting the work of the teams to move at pace to realise fundamental changes in service delivery.

Assurances in respect of Objective 3c:

a) Deep Dive – EPR Programme Update
b) Monday.com presentation

The Committee received a report which detailed the Electronic Patient Record (EPR) programme update and offered a deep dive into the 3 phases of the programme. These included

Phase 1- Front door systems, patient safety bundle, bed and flow management and investigations

Phase 2 - Electronic prescribing, investigations read and interact, inpatient paperless and infection prevention control

Phase 3 - PAS, theatres, patient engagement elements, outpatient clinicals and final elements on interfaces with other systems

The Committee recognised the risks associated with the programme, particularly that of EPR go lives requiring the approval of the Chief Executive of NHS England and organisational capacity for change due to the size of the programme. Support was in place for staff in respect of communication and training with digital teams working closely with nursing colleagues.

The Committee noted that there had been a change in the approach originally proposed which had been approved by GLT and would be taken forward.

The Committee received **reasonable assurance** for the EPR update, but recognised the enormity of the program.

A report was received by the Committee in respect of the PMO Digital Solution Monday.com with all CIP plans being uploaded to the system and training being

provided for all project and programme managers. Further use of the software was being considered across the Group where this could add benefit.

The Committee was provided with **substantial assurance** in respect of the Monday.com

Assurances in respect of Objective 3d:

a) Productivity, Improvement and Transformation Oversight Forum (PITOF) Group Upward Report

The March 2026 PITOF meeting took place on the 16 March with the Committee taking the report as read, due to majority of schemes having been considered throughout the duration of the agenda.

Assurances in respect of other areas:

a) Board Assurance Framework 2025/26
b) Committee Performance Dashboard
c) Risk Register
d) Policy Position
e) Committee Annual Report and Self-Assessment

The Committee reviewed the Board Assurance Framework (BAF) noting that changes were not required to the risk or assurance ratings however reflected the need or clarity to be made on gaps and controls.

The Committee reviewed the February 2026 Performance Dashboard noting the positive trends in community unplanned care metrics and strong performance was noted within community services, particularly within Urgent Treatment Centres, despite continued front door pressures.

Diagnostic services remained challenged with discussions ongoing regarding an approach to recovery of the position. The Committee was pleased to note the achievement for LCHS moving to segment 2 of the National Oversight Framework and the significant work taken to drive improvements.

The Committee received the self-assessment and annual report, noting that the self-assessment had not identified any concerns to be addressed. Comments would be offered outside of the meeting in respect of the annual report so that final approval could be received.

The risk register was received with the Committee noting there was no movement in the risks presented from the previous month.

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) Concerns over timeliness of regional approval for Newton to commence work
b) EPR Programme Deep dive discussion and associated risks

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

26 March 2026

DRAFT

Joint Health & Wellbeing Strategy for Lincolnshire

and

Strategic Neighbourhood Health Plan

Draft - V0.3

Date – 06 March 2026

DELETE THIS PAGE BEFORE PUBLISHING

Prepared By	Role
Alison Christie	Head of Service

Authorisation		

Version Control		
Version	Change	Date
V0.1	First draft	23 December 2025
V0.2	Additions from Partners	27 January 2026
V0.3	Editing & further additions from partners	06 March 2026

Content

Foreword by Chairman and Vice Chairman

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2. About Lincolnshire

3. About the Health and Wellbeing Board

4. Wider System Changes

5. System Governance & Oversight

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Healthy Weight Priority
Homes for Independence
Mental Health and Dementia
Physical Activity

Part B Strategic Neighbourhood Health Plan for Lincolnshire

Context
Our Approach to Developing Neighbourhood Health
Vision
Design Principles
Informed by Data and Intelligence
Neighbourhood Structure & Geographies
Priorities
Monitoring & Evaluation

Foreword

It is with great pleasure that we, as Chair and Vice Chair of Lincolnshire's Health and Wellbeing Board (the Board), present our approach to realising the potential of the national ambition to bring health and wellbeing closer to home.

People in Lincolnshire have been clear and consistent about how they want to receive support from the health and care system. We hope that anyone reading this plan will recognise our determination to respond to these needs as a central and recurring theme.

The overall message to the Board during the development of this plan was that, while people value the dedication of staff, they want a system that is easier to access, communicates clearly, works collaboratively and recognises the whole person. A more coordinated, personalised and preventative approach is essential to meeting these expectations.

We will know that this plan—and the work of partners involved in delivering it—is succeeding when real, tangible change can be felt by everyone. We expect to see this in several ways:

- **Better self-management of health and wellbeing**. People will feel more able to take control of their health, supported by improved health literacy and confidence. Communities will have increased capacity and leadership to enable more local and community-led health initiatives.
- **More preventative and proactive activity.** Services will shift resources toward better targeting and improved access to proven preventative interventions. This will enable more people to benefit and will reduce avoidable illness and poor health and wellbeing outcomes.
- **A reduction in health inequalities.** People who face multiple barriers to good health will experience improved acceptability, access and outcomes. There will be proactive engagement with the most challenged groups and households to ensure no one is left behind.
- **Greater sustainability through efficient resource use.** We will implement integrated service delivery at scale across estates, information management and technology, and workforce activity—reducing duplication, unnecessary hand-offs and unwarranted hospital activity in both planned and urgent care.
- **More people reporting seamless integrated care.** People will no longer notice the joins between services commissioned or provided by the many partners involved in neighbourhood health. They will feel that their needs were at the centre of their experience, regardless of where or how they accessed support.

The publication of this plan marks the acceleration of the excellent work already underway. Together, we can realise Lincolnshire's full potential for healthier, stronger communities. We commend this plan to you

Add in photograph & signature of Cllr Clegg & Clare Raybould

1. Introduction

There is a long history of joint working in Lincolnshire between the Local Authority, the NHS, and wider partners. Through the Lincolnshire Health and Wellbeing Board we have worked hard to build the relationships needed to support the people of Lincolnshire to enjoy the highest quality health and wellbeing for themselves, their families, and their communities. We are pleased with the progress we have made and are confident we have developed the right principles and values to guide us. But there is more that must be done to give **everyone the best possible start in life and to be supported to live, age, and die well.** We also recognise that achieving this requires us to think and work differently—both with each other and alongside our communities.

This document outlines how health and care partners in Lincolnshire will collaborate to improve the population's health and wellbeing and reduce health inequalities. It is divided into two sections:

Part A – the **Joint Health and Wellbeing Strategy for Lincolnshire** is a shared plan developed in 2024 by the Health and Wellbeing Board to improve the health and wellbeing and reduce health inequalities in Lincolnshire. It sets out five priority areas for action based on evidence in the Joint Strategic Needs Assessment.

Part B – the **Strategic Neighbourhood Health Plan for Lincolnshire** which focuses on a place-based approach, bringing together health, care, and community partners to meet local needs and deliver integrated care and prevention within neighbourhoods. It is a new requirement for the Health and Wellbeing Board from 2026, supporting the government's ambition to shift care from hospitals into local communities.

Both parts provide a framework for partners to work together on agreed goals that will have the greatest impact on health and wellbeing outcomes in Lincolnshire.

2. About Lincolnshire

Lincolnshire is England's fourth largest county, characterised by its diverse geographical landscape, dispersed population, and significant variation in health and wellbeing. These structural factors shape how services are delivered, influence health outcomes, and create distinct challenges for urban, rural, and coastal communities. Understanding these dynamics is essential to designing a sustainable and equitable health and care system.

Lincolnshire's mix of urban, coastal, and rural communities creates varied but connected health challenges. Urban areas face overcrowded and poor-quality housing; coastal and rural areas experience ageing populations, workforce gaps, lower health literacy, and seasonal pressures. Rural residents face long travel distances, limited transport, and colder, less efficient homes. These combined factors drive inequalities and highlight the need for tailored place-based approaches.

Population Profile

Lincolnshire has a resident population of around 790,000 with approximately 820,000 patients registered with local GP practices. The population life stage age split is approx. 16% Infants, children & teens (0-15) 60% Working age adults (16-65) and 24% older people (65+). (Source: ONS)

The county has a significantly ageing population:

- 24% (180,000 people) are aged 65+, well above the national average.(Source: ONS)
- By 2045, this is projected to rise by 42%, reaching approximately 270,000 people.(Source: ONS; 2022)
- The 80+ population is expected to more than double in the same period, reaching 65,000 persons. (Source: ONS)

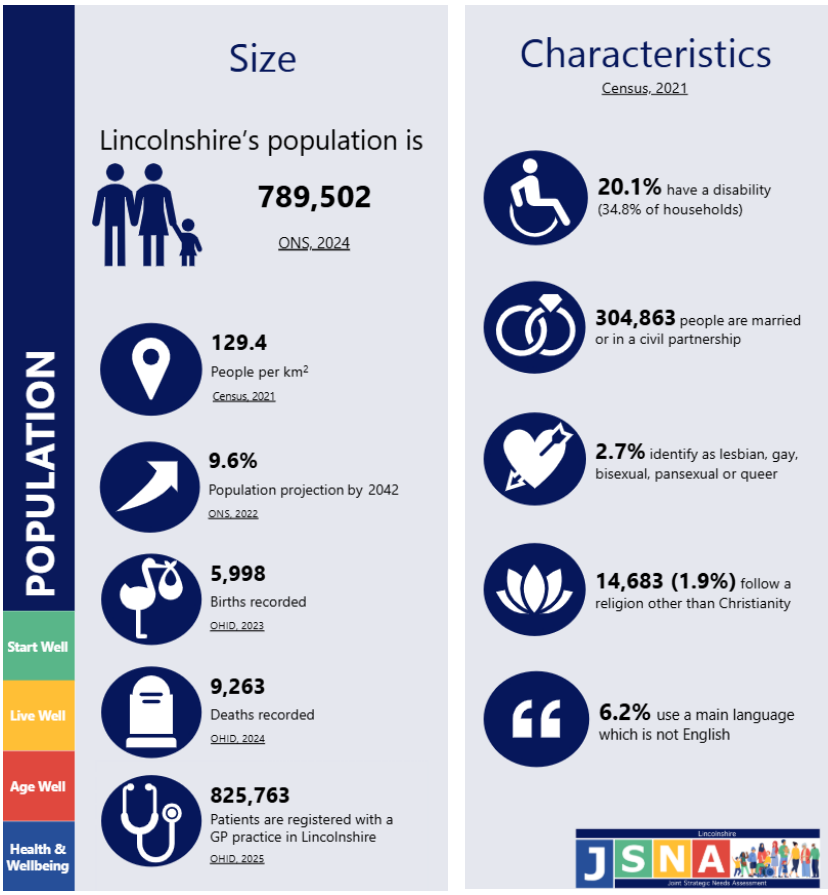

Figure xx JSNA Population Infographic (Source: Lincolnshire JSNA)

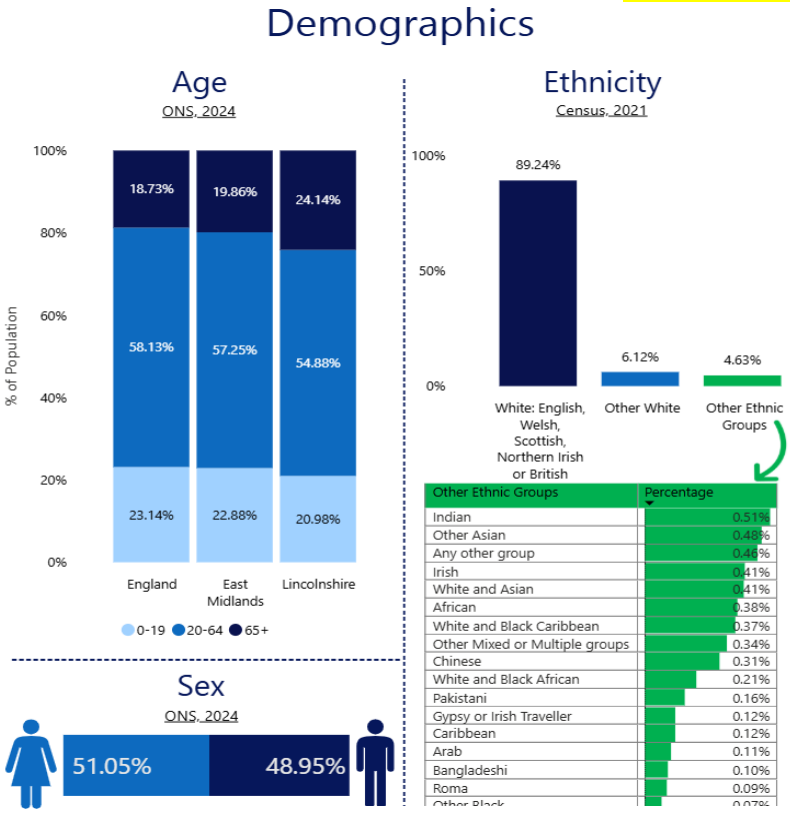

Figure xx JSNA Population Infographic (Demographics) (Source: Lincolnshire JSNA)

Inequalities and Deprivation

Lincolnshire's demographic profile shows several factors that contribute to widening health inequalities across the county. A higher proportion of older residents compared with the East Midlands and England means a greater risk of long-term conditions, multimorbidity and increased demand for health and care services. This is paired with a relatively small working-age population, which can intensify pressures on local economies, carers and frontline services.

The population is also less ethnically diverse than the national picture, but the minority ethnic groups that are present

may experience additional barriers such as language, access to services, and cultural exclusion which can lead to poorer health outcomes if not addressed through targeted, culturally sensitive support.

While county level deprivation aligns with national averages, this conceals significant inequalities. Many areas particularly in the north and east experience high levels of deprivation that directly impact health outcomes.

In parts of the First Coastal Primary Care Network (Mablethorpe and Skegness), around 85% of residents live in the most deprived 20% of neighbourhoods in England. Deprivation drives earlier onset of multimorbidity and reduces healthy life expectancy. Hidden pockets of deprivation also exist within otherwise affluent communities, meaning a place based, person-centred approach is essential to designing equitable services.

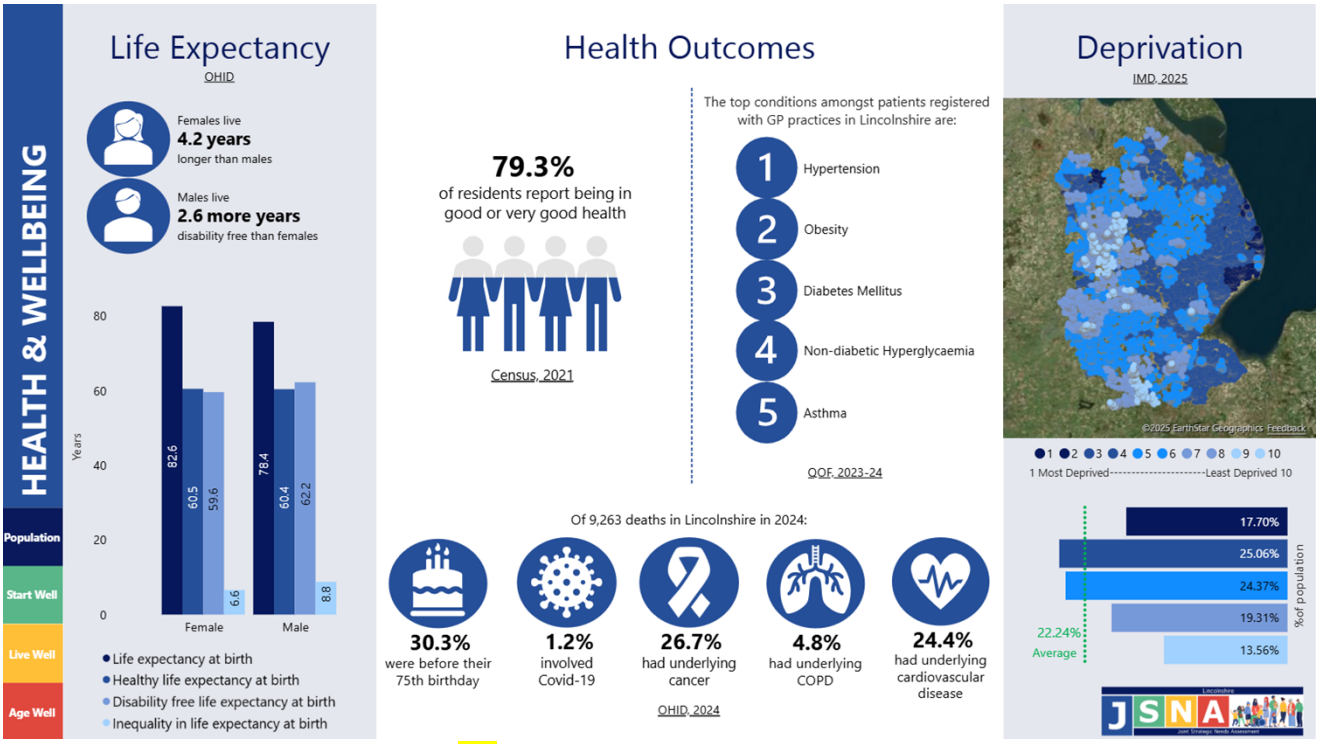

Figure xxx JSNA Health & Wellbeing Infographic (Source: Lincolnshire JSNA)

Figure X highlights a clear interplay between health outcomes, life expectancy, and deprivation across Lincolnshire. While most residents report good health, significant variation persists driven by preventable long-term conditions such as hypertension, obesity, and diabetes, alongside marked inequalities in life expectancy and disability-free years. These challenges are further compounded by pockets of high deprivation, where poorer health outcomes and earlier mortality are more concentrated. Together, this picture reinforces the need for a targeted, place-based strategy that focuses on prevention, early intervention, and reducing inequality across our communities.

3. About the Lincolnshire Health and Wellbeing Board

Under the Health and Social Care Act 2012, the Health and Wellbeing Board (the Board) for Lincolnshire was established to act as a forum in which those who are responsible for improving and protecting the health and wellbeing of local populations and communities, can do so in a joined up effective way.

As a formal committee of the county council, the Health and Wellbeing Board for Lincolnshire includes representatives from Lincolnshire County Council, NHS Lincolnshire Integrated Care Board (ICB), local NHS Providers, Police and Crime Commissioner, District Councils, Healthwatch Lincolnshire, Higher Education, Local Enterprise Partnership, Care Sector and NHS England.

The functions of the Board are:

- to encourage persons who arrange for the provision of any health and social care services in the area to work in an integrated manner
- to provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging joint commissioning
- to prepare and publish a Joint Strategic Needs Assessment (JSNA)
- to prepare and publish a Joint Health and Wellbeing Strategy (see Part A)

Following the release of the government's Ten-Year Health Plan, all Health and Wellbeing Boards (HWBs) are being asked to lead the development of a strategic Neighbourhood Health Plan for their area. This plan should outline the vision and roadmap for improving neighbourhood health, with the goal of enabling healthier lives. Lincolnshire's Strategic Neighbourhood Plan can be found in Part B.

4. Wider System Changes

4.1 Local Government Reorganisation

The *Your Lincolnshire* proposal sets out Lincolnshire County Council's preferred option to establish a single tier of local government within Greater Lincolnshire by retaining the two unitary councils of North Lincolnshire and North East Lincolnshire, and bringing together the seven districts with Lincolnshire County Council to create a new whole Lincolnshire council (as illustrated by Fig x).

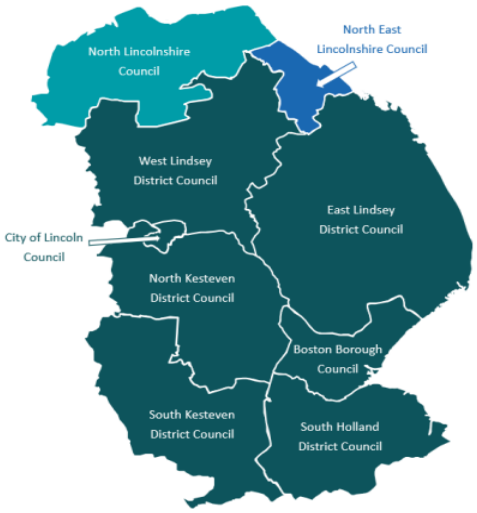

Figure x – Your Lincolnshire proposal

This approach will:

- **Strengthen our foundation for the future** – Delivering high-quality, resilient services that are financially sustainable,

driving economic growth, supporting local businesses, and giving communities a stronger voice.

- **Simplify services for residents** – Clearer structures will ensure residents know who to contact and how to access support quickly. With a stronger focus on local communities, council services will be more accessible, transparent, and responsive to local needs.
- **Save money by delivering better value for residents** – Reducing duplication and bureaucracy will enable more efficient and cost-effective operations. The savings generated will be reinvested into frontline services, ensuring communities benefit directly.

From a health and care system perspective, establishing a single unitary authority aligned with the current county council footprint is the preferred option. This approach would result in minimal disruption to existing service delivery and working arrangements between the upper-tier local authority and local NHS organisations. Staying unified protects safe, high-quality health and social care. Other advantages include:

- **Service continuity –** No need to disaggregate services, as delivery would remain within the same geographical footprint and therefore avoids breaking the link with NHS Lincolnshire ICB**.**
- **Streamlined governance –** Simplified structures reduce the complexity of aligning differing political or strategic priorities.
- **Consistency in care –** Minimises the risk of service variation or inequities in access and outcomes, therefore protecting vulnerable groups as support will remain coordinated and consistent.
- **Aligned strategies and budgets –** Easier to coordinate health and care strategies, transformation plans, and financial planning.
- **Integrated service delivery –** Supports joined-up planning and delivery across health, social care, and public health.
- **Reduced duplication –** Fewer overlapping roles, meetings, and administrative processes.
- **Data sharing –** Simplifies system integration and supports better population health management.
- **Consistent HWB footprint –** The HWB would continue to operate across the same area, maintaining its focus on improving population health.

If local government reorganisation resulted in Lincolnshire being divided into two or more unitary authorities, this would create significant challenges for neighbourhood working. From a health and care system perspective, multiple unitary authorities within the Lincolnshire footprint represents the least preferred option, as this structure would be complex to manage and could lead to inconsistencies in service provision and access. Health and Care outcomes in Lincolnshire depend on integrated systems, shared intelligence, and county-wide partnerships. Such fragmentation risks undermining efforts to deliver equitable and integrated care and would disrupt intelligence-driven health and care delivery. Other challenges include:

- **Significant leadership effort** to reconfigure single statutory services such as Adult Social Care and Children's Services into multiple organisations, which will distract from and delay implementation of neighbourhood working.
- **Voluntary and community organisations** that currently operate across Lincolnshire may also face challenges if local authority boundaries change. There would be reduced ability for voluntary groups to operate consistently across neighbourhood boundaries. Such changes could introduce additional administrative burdens, potentially affecting their ability to deliver services efficiently.
- **Disaggregation of commissioned services –** Health services currently commissioned by Lincolnshire County Council, such as Sexual Health, would need to be split and funding reallocated based on the new unitary boundaries**.**
- **Joint funding arrangements –** Existing pooled budgets, would need to be disaggregated and apportioned accordingly.
- **Reconfiguration of governance and partnership structures –** HWBs and system partnership working mechanisms would need to be reconstituted to reflect the split geography. Local NHS organisations would be required to engage with multiple HWBs, adding complexity to strategic planning and coordination.

4.2 Integrated Care Board Clustering

The Department for Health and Social Care and NHS England have approved a 'clustering arrangement' between NHS Lincolnshire Integrated Care Board (ICB) and two other integrated care boards in the East Midlands. The two other integrated care boards are NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB. Nationally, it has been reported that the 42 integrated care boards will be grouped into 26 clusters, with the emphasis on making smaller integrated care boards sustainable. The NHS has stated that the objective of clustering is to strengthen integrated care boards as strategic health commissioners, which will be central to realising the ambitions set out in the national Ten-Year Health Plan.

These arrangements follow an announcement by the Secretary of State for Health and Social Care in March 2025 to reduce the running costs of integrated care boards by 50%. The NHS has stated that clustering at this scale will also support this required reduction in running costs that all ICBs nationally have been tasked with achieving and ensure sustainability.

It has been reported that the clustering arrangements will allow integrated care boards to develop shared teams and operating models and identify any opportunities to remove any examples of duplication. The arrangements do not at this stage represent a formal merger between any organisations, which will continue as separate entities.

Within the local clustering arrangement, arrangements for the health scrutiny function are unchanged. In addition to this Committee, equivalent health overview and scrutiny committees will continue in Derby, Derbyshire, Nottingham and Nottinghamshire.

5. System Governance & Oversight

The governance and oversight arrangements for neighbourhood health and wellbeing in Lincolnshire are built on a strong, place-based partnership model that connects strategic leadership with local delivery.

The Lincolnshire Health and Wellbeing Board provides the system-wide direction and statutory oversight, supported by scrutiny from the Health Scrutiny Committee for Lincolnshire. The Chief Officers Group, operating as the Place Based Partnership (PBP), acts as the central coordinating body, bringing together Lincolnshire County Council functions—including Children's Services, Adult Care and Public Health—with key strategic system partners such as the ICB, NHS provider organisations, district councils, the Primary Care Network Alliance and the voluntary and care sectors.

The structure illustrated in Figure x ensures alignment between organisational governance forums and shared system priorities. Beneath the PBP, delivery is driven through Joint Health and Wellbeing Strategy Delivery Groups, the Neighbourhood Health Working Group and the Neighbourhood Health Board, enabling coordinated action across thematic priorities and supporting the development of neighbourhood-level delivery mechanisms. This integrated governance model ensures clear accountability, consistent collaboration and a strong line of sight from strategic decision-making through to local implementation.

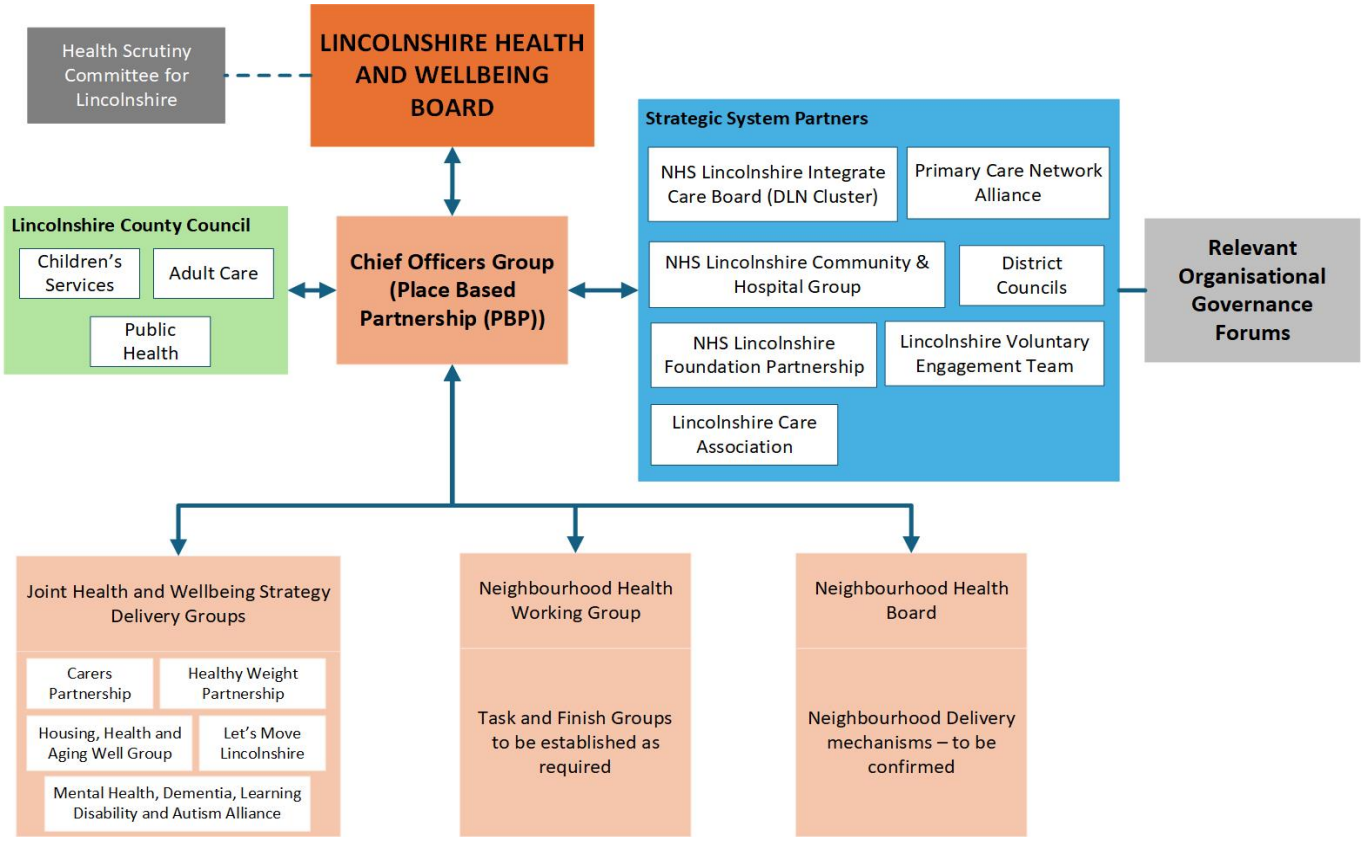

Figure XX – High level governance and partnership arrangements in Lincolnshire

PART A
JOINT HEALTH AND WELLBEING STRATEGY FOR LINCOLNSHIRE

(First Published March 2024)

Introduction

The Joint Health and Wellbeing Strategy (JHWS) (published March 2024) enables the Health and Wellbeing Board to champion the shared ambition and aims and sets out a direction of travel for health and wellbeing in Lincolnshire. The purpose of the JHWS is to:

- Provide a context, vision and overall focus for improving the health and wellbeing of local people and reducing health inequalities at every stage of people's lives.
- Identify shared priorities and clear outcomes for improving health and wellbeing and reducing inequalities.
- Support effective partnership working that delivers health improvements.
- Provide a framework to support and drive the innovation required to enable change.
- Support board members to embed these priorities within their own organisations and reflect these in their commissioning and delivery plans.

To turn the Board's ambition into action to give **everyone the best possible start in life and to be supported to live, age, and die well,** four key aims have been agreed to guide how partners will work together:

- Have a focus on prevention and early intervention.
- Tackle inequalities and equity of service provision to meet population needs.
- Deliver transformational change in order to improve health and wellbeing.
- Take collective action on health and wellbeing across a range of organisations

Our JHWS takes a life-course approach, spanning from pre-birth through to older age, and is structured around three themes: ***Start Well***, ***Live Well***, **and** ***Age Well.*** For each **local** priority, objectives and outcomes have been identified using the Joint Strategic Needs Assessment (JSNA). The JHWS sets out how the Health and Wellbeing Board will work to improve health and wellbeing across different age groups. The strategy emphasises the importance of age-appropriate health promotion and prevention throughout the life course, while recognising that some issues—such as housing—impact all ages.

How have we identified the priorities

In March 2024, Lincolnshire's Joint Strategic Needs Assessment (JSNA) was republished. Using the evidence from the new JSNA the Board undertook a prioritisation. Using a prioritisation matrix, the 36 health and wellbeing areas identified in the JSNA were mapped according to their potential impact on Lincolnshire's population and the recent direction of travel (improving or worsening). Full details on the prioritisations process can be found in the Joint Engagement Approach 2023 Report presented to the Health and Wellbeing Board in June 2023.

How we will report our progress

Each priority has specified several outcome measures related to their "we will" statements.

These proposed outcomes will be reviewed at regular intervals and progress for each priority reported to the Health and Wellbeing Board. In addition, an Annual Assurance Report will be presented to the Board every June.

Internal peer review will be conducted, and any issues identified will be escalated through the Health and Wellbeing Board.

CARERS

Why is this a priority?

An unpaid carer is anyone who provides unpaid help to a friend or family member needing support, perhaps due to illness, old age, disability, a mental health condition or an addiction. We have a legal obligation to support unpaid carers and therefore need to understand our local carer population and their needs to provide the right balance of support.

In Lincolnshire there are an estimated 70,391 (Source: Census 2021) unpaid carers and given the county's ageing population, this number is predicted to increase. Many carers do not recognise themselves as a carer, so numbers are likely to be an underestimate. This lack of realisation also makes it more likely that carers are not getting the support they need. Carers make a major contribution to society, with the value of labour provided by Lincolnshire's unpaid carers of all ages estimated to be the equivalent of £1,677m each year – more than seven times the annual budget of Adult Social Care.

Being an unpaid carer places a significant strain on the individual and can impact their own health and wellbeing and quality of life. The NHS Long Term Plan recognises that carers are twice as likely to suffer poor health compared to the general population, primarily due to a lack of information and support, financial concerns, stress, and social isolation. There can also be an adverse effect on education and employment, with many carers giving up work or foregoing education. These factors make it vital to ensure pathways and services are in place to support unpaid carers to be effective and prevent carer breakdown leading to escalation of formal care provision.

Further information – JSNA Carers page

Objectives

We will.....

Start Well	• Work in partnership to Identify carers at the earliest possible opportunity. • Work collaboratively with other professionals to develop working practices, including the 'whole family approach'. • Support all professionals working with Young Carers, including the transition from children to adult services.
Live Well	• Raise awareness and increase the number of carers that receive support by providing good quality information, advice, and guidance. • Engage with carers to identify their needs and improve their outcomes.

	• Support working age unpaid carers to access voluntary and working opportunities.
Age Well	• Improve and develop digital options that support unpaid carers. • Work to improve how we identify unpaid carers and strengthen support for them to manage their own health needs which can increase as they age. • Work with partners to co-produce the Carers Emergency Response Service so it is fit for purpose.

What difference will we see?

- Carers are identified at the earliest opportunity.
- More carers supported to access or remain in employment.
- Carers are able to access information, advice, and guidance online.
- Carers have contingency conversations and plans in place should they be unable to care for an individual.

How we will deliver this

The Carers Steering Group oversees the delivery and ongoing development of the Carer's Strategy to meet the objectives of the Carers Priority. The Steering Group includes representatives from key partners, including Lincolnshire County Council, the Lincolnshire Integrated Care Board, Lincolnshire Community Health Services NHS Trust, United Lincolnshire Hospitals NHS Trust, Lincolnshire Partnership NHS Foundation Trust, Carers First, Serco and the Lincolnshire Voluntary Engagement Team. The terms of reference and membership are reviewed annually to ensure membership supports the strategic aims and the delivery of actions.

Carers Delivery plan – Carers_2025_26.pdf

HEALTHY WEIGHT

Why is this a priority?

Having a healthy weight is one of the most important things we can do to protect and improve our overall health. Being overweight increases the risk of several health conditions and obesity is believed to be the third biggest risk factor contributing to premature death. Being active is also one of the most important ways to boost our health and wellbeing and helps us to stay at a healthy weight, making these priorities intrinsically linked.

In children, obesity has long-term effects on physical, social, educational, and mental health outcomes. Problems related to childhood excess weight are likely to persist into adulthood.

At the population level, overweight and obesity are thought to cost the NHS over £6 billion a year, and to contribute towards inequalities in life expectancy and disability-free life expectancy. The causes of the high levels of obesity in the UK are interlinked, complex & multifaceted. Importantly, these causes aren't equally distributed for all; it is easier for those with more resources to stay healthier which contributes to health inequalities.

At a local level, obesity levels will be affected by a wide range of circumstances such as opportunities for physical activity and active travel, the nature of the employment market, cultural attitudes towards weight and physical activity, and access to affordable healthy food. This highlights the importance of analysing population needs at small scale as well as large, district level, scale.

In Lincolnshire, over two thirds of Lincolnshire's adult population is overweight, above England's average. A quarter of children in Reception are overweight, and this rises to well over a third of children by Year 6.

Preventing the onset of unhealthy weight gain and tackling unhealthy weight is fundamental to helping more people in Lincolnshire to benefit from long term good health and wellbeing.

Further information – JSNA Healthy Weight page

Objectives

We will.....

Start Well	• Ensure that families have access to the right information & support to empower them to make healthy choices from birth. • Provide services and support to help families with children identified as being overweight or obese as part of the National Child Measurement Programme.
Live Well	• Ensure everyone who wants to lose weight can access services that can help. • Reduce inequalities by working to lower barriers to accessing services in areas of higher need. • Ensure equity of access to specialist weight management services. • Develop a 'whole system approach' by working with partners to address the factors that make it easier to gain weight

Age Well	• Ensure support is available to older adults to lose weight and to stay healthy. • Ensure support is proactively offered to those who could benefit, including adults with hypertension, musculoskeletal condition.

What difference will we see?

- Children and adults are supported to be happy, healthy & well.
- Adults, Children and families that want to lose weight are able to access high quality, effective support that gets them the help they need.
- We will help prevent diseases such as Type 2 Diabetes, cancers & heart disease, which will help people live healthier, longer lives.

How we will deliver this

The work programme will be overseen by the Healthy Weight Partnership, a delivery group of Lincolnshire's Health & Wellbeing Board.

All partners involved in Lincolnshire's Integrated Care System & Partnership have a role in building the 'whole system approach' to addressing the causes of overweight & obesity in Lincolnshire.

Healthy Weight Delivery plan – Healthy-Weight_2025_26.pdf

HOMES FOR INDEPENDENCE

Why is this a Priority?

Evidence shows that living in familiar, safe, accessible, warm accommodation that we call 'home' promotes mental and physical wellbeing and reduces hospital admissions, social isolation, and loneliness. Our vision is for people to live independently, stay connected and have greater choice in where and how they live as they age. This priority addresses aspects of housing affecting those who may need extra help to maintain their wellbeing and independence at different stages of their lives, e.g., those with health and care needs, those moving from hospital inpatient or other facilities, and care leavers amongst others.

Ensuring homes are safe, warm, and dry reduces accidents such as falls and prevents illnesses, especially respiratory conditions, including child and adult asthma and Chronic Obstructive Pulmonary Disease (COPD). The home environment is important for children and young people in determining their life chances and future development. Having a good home throughout life is important because it can determine health outcomes, reduce levels of stress, and make people feel more confident. Preventing homelessness and rough sleeping by addressing the underlying causes leading to homelessness is, therefore, a priority. Ageing in a home that supports independence has multiple benefits including familiarity, comfort, cost-effectiveness, and enabling social engagement and personalised care.

Private sector housing is a challenge as homeowners and landlords are responsible for their own repairs and improvements. There are around 29,000 low-income owner-occupied households that may struggle to maintain independence in the home due to falling behind with mortgage repayments, bills, or making repairs. Tenants might also fall behind with rents. 47,114 (13.9% of) households were estimated to be living in fuel poverty in 2021. 18% of private sector houses are estimated to contain serious hazards, of which 9% are cold homes. In addition, a reported 6,600 people live in caravans on the Lincolnshire east coast, that were not intended for permanent occupation, for a large part or all year.

Maximising levels of independence for people with care and support needs of all ages (e.g., children with disabilities, adults with mental health issues, dementia, learning disabilities, and autism and frail older people). This includes providing appropriate small aids, equipment, and home adaptations to meet people's needs through streamlined mechanisms and processes.

Further information: JSNA Housing Conditions page; JSNA Insecure Homes and Homelessness page; JSNA Unsuitable Homes page

Objectives

We will.....

Start Well	• Enable pregnant women, babies, and children to live in a safe and warm home environment which is not overcrowded. • Improve our understanding of the impact of poor housing on children's health and effectively target low-income families.

	• Support children and young people to find, manage and maintain a suitable home when leaving care.
Live Well	• Facilitate quality, choice, and diversity of housing for people with care and support needs to achieve a proportional move towards maximising independence for working-age adults. • Address the underlying causes leading to homelessness and provide appropriate support for those who need it. • Ensure services to support people to remain living in their current home complement each other as a system-wide approach and are easy to access by all.
Age Well	• Improve services to extend people's housing choices in preparation for later life, including making better use of digital technologies. • Influence delivery of housing to provide greater choice of supported housing, including more extra care housing of different levels to meet demand.

What difference will we see?

- Children and young people will live in suitable housing that supports them to achieve their educational goals and enables them to maintain social connections.
- People of all ages will have fewer home accidents and improved health and wellbeing by being safe, warm and well at home, evident through self-reported satisfaction.
- Improved health outcomes such as lower levels of respiratory conditions associated with cold damp homes and reduced seasonal excess deaths.
- There will be a reduction in homelessness and rough sleeping and better access to support and healthcare services for those who need them.
- Older people will be supported to live independently in extra care housing, supported housing, or their own home as an alternative to care homes.

How we will deliver this

The Housing Health and Ageing Well Delivery Group (HHAWDG) continues to oversee the Lincolnshire Homes for Independence blueprint – a call to action for partners to work collaboratively towards a common aim. The HHAWDG maintains a Delivery Plan of actions to meet the above objectives for the Homes for Independence priority. Membership and terms of reference are routinely reviewed and updated, to ensure appropriate representation from all partners, effective communication, and focus.

The Lincolnshire Housing and Health Network (LHHN) is an officer group of senior housing leads that coordinates action to achieve the Delivery Plan for the HHAWDG with actions allocated to subgroups including:

- Greater Lincolnshire Energy Efficiency Network
- Lincolnshire Healthy and Accessible Homes Network
- Lincolnshire Homelessness Strategy Group
- Lincolnshire Housing Standards Group.

These groups share some people (strategic leads) and financial resources that have accelerated implementation of the HHAWDG Delivery Plan. It is recognised that additional resources may be needed to complete an ambitious programme of work.

Homes for Independence Delivery plan –Homes-for-Independence_2025_26.pdf

MENTAL HEALTH AND DEMENTIA

Why is this priority important?

Good mental health and wellbeing are fundamental for a happy and healthy life. Mental health problems can significantly affect any individual, their family, community, and wider society. In the UK, half of life-long mental health problems start before the age of 14, and three quarters before the age of 25. Children today have poorer mental health outcomes than previous generations. The Covid-19 pandemic has exacerbated this situation. Demand modelling suggests 1.5 million children may need initial or additional mental health support because of the pandemic.

For adults, one in four will experience a mental health problem in any year. Together with substance misuse, mental illness accounts for 21.3% of the total morbidity burden in England. People living with diagnosable mental ill health, for example depression, bipolar disorder, or schizophrenia, can be living in good mental wellbeing despite their mental ill health diagnosis. The burden of physical ill health is higher in people with severe mental illness (SMI).

Suicide is a significant cause of death amongst people with mental illness. It devastates families and communities. Suicide, and injury or poisoning of undetermined intent, is the second biggest killer of males aged 35 to 49 years (after accidental poisoning). It is also the leading cause of death for males and females aged 20 to 34 years in the UK (ONS, 2020).

Dementia was the leading cause of death in England and Wales in 2022. Dementia has a profound impact on an individual's life, their family, friends, and the communities in which they live. Although age is the strongest known risk factor for dementia, it does not exclusively affect older people. Young onset dementia (defined as the onset of symptoms before the age of 65 years) accounts for up to 9% of cases. Even though there is no cure for dementia the most recent review of evidence on dementia prevention found that around 40% of dementia cases worldwide might be attributable to 12 potentially modifiable risk factors (Lancet, 2020). This means that almost a half of predicted dementia could be prevented by tackling risk factors such as smoking, diet, physical activity, and social isolation. Early detection, diagnosis and intervention can delay the onset of complex needs that make it more difficult to support and care for an individual with dementia in their home environment.

Further information:

JSNA Mental Health and Emotional Wellbeing page

JSNA Dementia page

Objectives

We will.....

Start Well	• Provide support for perinatal mental health and developing good parent-infant relationships during early years.

	• Support children and young people to have good mental health and wellbeing through a focus on mental health promotion. • Increase access to timely and effective advice and in schools and communities. • Ensure all children and young people suffering from mental illness can access a high quality, timely mental health assessment, with support and treatment in their community.
Live Well	• Embed seamless pathways between children and young people and adult mental health services to ensure smooth transitions between them. • Improve the range of community-based provision for adult mental health and wellbeing services and ensure care is provided as close to home as possible. • Improve the uptake of Health Checks for people with Severe Mental Illness, ensuring timely follow up and intervention. • Reduce the stigma surrounding suicide and ensure a range of support is available to prevent suicide and support people who are feeling suicidal. • Support people to understand how to lower their risk of dementia in later life.
Age Well	• Embed seamless pathways between adult and older adult mental health services, ensuring timely identification, referral, diagnosis, post-diagnosis support through to end-of-life care. • Ensure appropriate peri-diagnostic support and care planning is available for all those with dementia. • Promote care planning whilst people can communicate their needs and wishes.

What difference will we see?

- Children and young people, and their families, can access the support they need to stay healthy.
- Mental health needs are identified early so that children and young people who need help can access timely support.
- People will know how to access help and support that matters to them, and their needs, assets, wishes and goals will be respected.
- People will be supported to transition between services, with 'no wrong door'.
- There will be fewer unnecessary specialist and crisis hospital admissions, particularly for people with a learning disability and autistic people.
- Professionals and patients (with their families and carers people are unable to make their own decisions) will work together to make decisions about care and treatment.
- There will be fewer deaths from suicide in Lincolnshire, and people will feel able to speak openly about suicide and receive the support they need.
- Fewer people with Serious Mental Illness or a Learning Disability will die prematurely.
- More people will be aware of how to reduce their risk of dementia and fewer people will develop dementia.
- People with dementia will be supported to live well and get the right care when they need it.

How we will deliver this

Lincolnshire has established a Mental Health, Dementia, Learning Disabilities and Autism (MHDLDA) Alliance that works together as an integrated system to address our key priorities. To support with this work, the Alliance has drawn on the "No Wrong Door: a vision for mental health, autism and learning disability services in 2032".

The MHDLDA Alliance Executive Group is a partnership comprised of senior representatives in the health and care system in Lincolnshire. As a partnership we work closely together to understand challenges and opportunities in the system, to drive positive change, to continuously improve/transform what we do and to improve outcomes for the people we serve. All our work is underpinned by a strategic focus on all age prevention and early intervention (including wellbeing). We work closely with groups of people with lived experience, and over the coming years we will afford these groups greater opportunity to contribute and ensure that their voices are placed much closer to the centre of our work. Our strategic priorities were coproduced by people with lived experience and are:

- Prevention and early intervention
- Maximising independence
- Improving quality and experience
- Reducing inequalities in access, experience, and outcomes
- Improving on outcomes that matter to people

Mental Health and Dementia Delivery plan – MH_D_2025_26.pdf

PHYSICAL ACTIVITY

Why is this a priority?

Physical activity has been described as 'the miracle cure', physical inactivity is highly correlated with health inequality. There is overwhelming evidence for the positive impact and life changing benefits being active has physically, socially, and mentally, to individuals and society.

Physical activity has health benefits across the life course; it is cumulative and helps prevent disease and early death. It helps prevent and manage over 20 chronic health conditions, from cancer to cardiovascular disease, obesity to osteoporosis, dementia to diabetes, and reduces the risk of depression by 30%. There is a proven link between physical inactivity and increased rates of multiple long term health conditions especially in adults over 50. In 2018 physical inactivity placed a £257m burden on Lincolnshire's health and care system. Tackling the challenge of inactivity requires a systems-based approach.

Physical activity is more than just structured and facility-led activity, it is all movement found in all the places and spaces we live and influenced by the systems, environments and structures that exist. Many sectors have a part to play in system change to tackle the challenge of inactivity. Having a relevant, accessible, and affordable physical activity, sport, and leisure offer that meets local need both reduces pressures on the health system and supports job creation and economic contribution. Every £1 spent on community sport and activity generates nearly £4 for the economy. There is a proven link between physical activity levels and the economic prosperity of a place, educational attainment, and improved job opportunities.

Inactivity is more prevalent in lower socio-economic groups, people with long term health conditions, those with disabilities, women and girls, minority ethnic communities, LGBTQ++ people, and adults over the age of 55. More resource and focus must be targeted at those who face greater challenges to participation. The greatest health benefits come from inactive people being moderately active.

Further information – JSNA Physical Activity Page

Objectives

We will.....

Start Well	• Develop positive experiences for children and young people to be active, working with the sport and physical activity sector, community organisations, families, and education. • Support excellence in welfare, safeguarding, safety, and an inclusive offer for participants. • Work together with system partners to reduce barriers and the inequalities that exist in the provision of activities for children.
Live Well	• Embed physical activity options into health and care pathways and touch points, in workplace environments and in environmental policies and planning.

	• Develop the sport and physical activity workforce to respond to and reflect the characteristics and needs of the people it serves. • Advocate for a whole system approach by working with partners to address the barriers to enabling people to be more active in their daily lives.
Age Well	• Focus on those experiencing the greatest inequalities, protected characteristics, and deprivation. • Advocate for social change that seeks to reduce ageism and recognises a personalised and strengths-based approach. • Support the sport and physical activity workforce with skills and innovation to meet the needs of older adults.

What difference will we see?

- Increased opportunities for everyone in Lincolnshire to be physically active every day.
- More people are being active, taking part in activities tailored to their needs.
- More people are aware of the benefits of being active every day.
- More accessible, relevant activities.

How we will deliver this

The work programme will be overseen by the Let's Move Lincolnshire Taskforce that has strategic oversight of the Let's Move Lincolnshire physical activity strategy. Active Lincolnshire are the umbrella organisation supporting and enabling the sport, physical activity and community voluntary sector. Public Health including commissioned services and the ICB have key roles as system partners to embed physical activity in their systems. District Authorities have a lead role in community and public leisure provision working together through the District Health and Wellbeing strategy.

Physical Activity Delivery plan – Physical-Activity_2025_26.pdf

PART B
STRATEGIC NEIGHBOURHOOD HEALTH PLAN FOR LINCOLNSHIRE

1. Context

This strategic plan builds on the government's *Fit for the Future: A 10-Year Health Plan for England*, published in July 2025. The national plan sets out a new model of care rooted in the founding principles of the NHS—universal access, free at the point of use, based on need and funded through general taxation—whilst recognising that the current system is unsustainable.

The government's vision for the next decade is driven by three transformational shifts:

- **From hospital to community** – delivering care closer to where people live.
- **From analogue to digital** – embracing technology to improve access and efficiency.
- **From sickness to prevention** – prioritising health and wellbeing.

Too many resources remain concentrated in hospitals, creating a system disconnected from communities and reliant on patients travelling for care. Health and care services are fragmented across multiple sectors—community, primary care, mental health, hospitals, social care, local government, and the voluntary sector—resulting in poor coordination and a lack of truly integrated, patient-centred care.

To address these challenges, local health and care systems are being asked to design and develop a **Neighbourhood Health Service**, to:

- Deliver services locally and closer to home.
- Bring professionals together in patient-centred teams.
- End fragmented service delivery.
- Replace the 'one size fits all' approach with tailored, responsive care.
- Reintegrate healthcare into the social fabric of communities.

This strategic plan sets out how health and care partners in Lincolnshire will align with the national vision, ensuring our local system is fit for the future and capable of delivering high-quality, integrated care that meets the needs of our population.

2. Our Approach to developing Neighbourhood Health

Lincolnshire's approach strengthens the link between strategic intent and operational delivery, as shown in Figure X. At the strategic level — 'the what' — the Health & Wellbeing Board sets the overarching vision, outcomes, priorities, and governance requirements. This Strategic Neighbourhood Plan brings these elements together, ensuring all partners work within a coherent, shared framework.

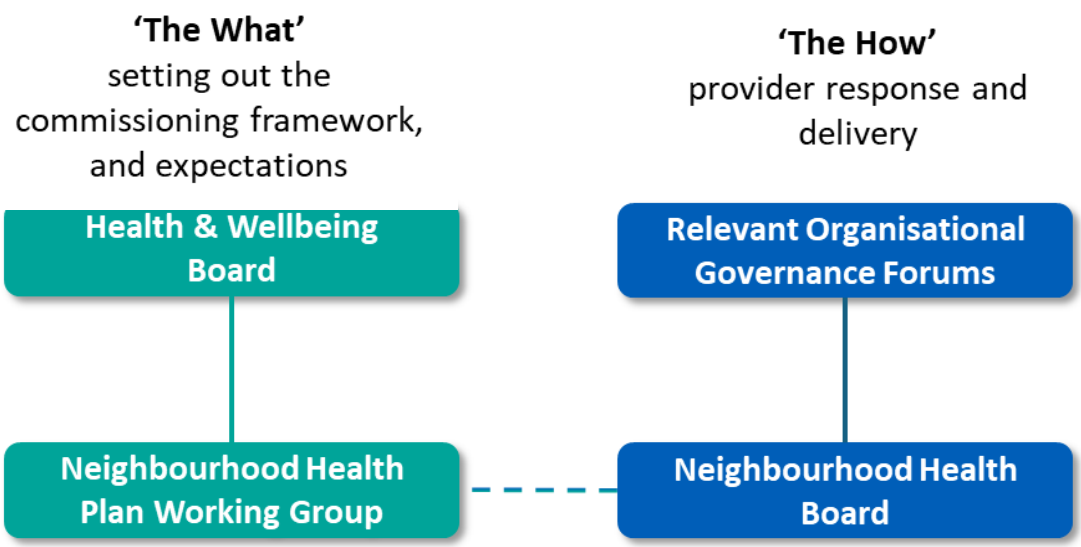

Figure x: Lincolnshire's Approach

Operational planning — '*the how*'— then turns this intent into action at neighbourhood level. Through the Neighbourhood Operational Governance Forums and the Neighbourhood Health Board, partners develop and deliver plans shaped by local needs, resources, and insight. This includes coordinating contributions, monitoring progress, and adapting activity as priorities evolve. Maintaining this structured link between strategy and delivery supports clearer decision making, better use of resources, and improved outcomes, while giving neighbourhood teams the autonomy and clarity needed to act effectively.

Going forward the Health and Wellbeing Board will delegate strategic 'place' leadership for its strategies, priorities and plans – including the onward development and delivery of neighbourhood health to a chief officer level group called xxxxxxxxxxxxxxx. This group will shape the evolution of leadership at all levels of place in Lincolnshire including:

- Evolving the 'what' and 'how' groups, which have developed this plan, into ongoing collaborative leadership groups, supporting the xxxxx group and Health and Wellbeing Board to deliver on our ambitions.
- Supporting the strengthening of the leadership of single neighbourhoods, adding skills and capabilities from existing agencies to those already deployed to support integrated neighbourhood team working.
- Commissioning the development of models of leadership and delivery at the multi-neighbourhood and place level which will bring the ambitions of the wider 10-year plan to fruition.
- Continuously involve people, communities, staff and stakeholders will inform, strengthen and evaluate the ongoing development of neighbourhood health.

3. Vision

3.1 What People Across Lincolnshire Are Telling Us

People across Lincolnshire consistently describe a health and care system that contains compassion, professionalism and pockets of excellent support — yet feels fragmented, difficult to navigate and unable to meet needs consistently. The strongest messages relate to access, communication and coordination, particularly for people who are rural, vulnerable, or part of seldom-heard communities. There is a clear appetite for a more compassionate, joined-up and personalised system that sees and responds to the whole person.

Access to Health and Social Care Services

Access to GP appointments, diagnostics, hospital care, mental health support, social care, dentistry and pharmacy services remains difficult. Long waits, digital barriers and poor transport including unreliable patient transport particularly affect rural and lower income communities.

Communication Breakdowns Across the System

People report unclear or late information about treatments, results and waiting times. Discharge processes are a key weak point, with poor information sharing and limited support for carers. Lack of digital interoperability forces people to repeat their story and undergo unnecessary reassessments reinforcing a sense of fragmentation.

Lack of Continuity, Coordination and Personalised Care

Care often feels reactive, disjointed and impersonal. People struggle to see the same practitioner, lack of follow ups and limited holistic assessment of wider social factors such as housing isolation. Both the public and workforce value personalised, relationship-based care, but capacity use of time and siloed services limit this.

Staff Attitudes, Behaviours and Culture

Staff are praised for compassion and skill, but some people report concerns about dismissive or discriminatory behaviour. Neurodivergent people and those with disabilities often feel misunderstood. Pressures and risk averse processes can make personalised care harder to deliver even when they want to.

Inequalities and Barriers for Seldom-Heard Communities

Seldom heard communities face persistent barriers, including stigma, cultural misunderstandings, limited interpreters, accessibility issues and difficulties registering with services. People emphasise the need for culturally competent and flexible approaches.

Wider determinants and the need for a holistic, preventative approach

People's experiences show health is shaped by housing, finances, loneliness, caring pressures and major life events. When services work proactively and address these factors together, outcomes improve and reliance on crisis care decreases.

The **overall message** is people appreciate the dedication of staff but want a system that is easier to access, communicates clearly, works together and recognises the whole person. A more coordinated, personalised and preventative approach is essential.

3.2 Our Vision

As we build on these foundations, it becomes essential to articulate a shared vision that brings together our ambition for the future of local health and wellbeing. This vision sets the direction for how neighbourhood-based services will evolve, ensuring that our approach remains centred on people, prevention, and partnership working.

Our shared vision is simple....

Everyone in Lincolnshire will benefit from community-based services that help us stay healthier for longer and, when we need it, enable us to receive personalised and coordinated care closer to home.

3.2 What good Neighbourhood Health will look and feel like to people?

Good Neighbourhood Health will feel personal, local and intuitive, a way of delivering care that genuinely reflects the realities, strengths and needs of Lincolnshire's communities. For residents, this means being surrounded by a system and community that understands them, works with them, and supports them to live well for longer.

A system that starts with me and my community
People will feel that services are designed with them, not for them. They will be actively involved in shaping local solutions, asked what matters to them, and listened to in ways that influence real decisions. Their experiences, insights and community strengths will help set priorities and design neighbourhood-based support.

Proactive, preventative support that keeps me well
People will experience a system that doesn't wait for problems to escalate. Good Neighbourhood Health means early identification of risks, timely support, and services that stay curious about changes in people's lives. Instead of repeatedly reaching crisis points, people will feel supported to stay healthy, independent and confident in managing their own wellbeing.

Whole-person care that reflects the realities of my life
Good Neighbourhood Health will recognise the full picture, social connections, housing, emotional wellbeing, work, finances, and caring responsibilities. Support will feel joined-up and personal, with professionals who understand "life beyond the diagnosis" and who take time to build trust.

Care that is coordinated and easy to navigate
People will feel the difference as services communicate better, share information and work together. Instead of repeating their story or feeling passed from one service to another, people will experience smooth transitions, clearer plans and a sense that professionals are working as one team around them.

Support that strengthens independence, capability and resilience
People will feel seen as partners in their own health. Neighbourhood teams will help build confidence, skills and knowledge so residents can make informed choices, manage their conditions, and feel more in control. Local communities will also feel more connected, supported and resilient, with more opportunities to stay active, healthy and engaged.

A more resilient, active and supported community
People will be able to access more activities and support that help them stay well in social groups, wellbeing initiatives, local networks and spaces that bring communities together. They will see statutory and community organisations working side by side, making the neighbourhood itself a source of health and wellbeing.

Local access to the right support, at the right time
Neighbourhood Health will make services feel closer and more responsive. People will see:

- **Easier access** to advice and support from integrated local teams with a wide range of skills.
- **More care available locally**, reducing the need to travel long distances.
- **Clear, simple routes for urgent help**, with timely responses delivered as close to home as possible.

Residents will feel that their area "works better" not because of more services, but because services are more connected, proactive and aligned with what their community needs.

4. Design Principles

To deliver the ambition set out in the national direction and Lincolnshire's strategic intent, the neighbourhood model is shaped by a set of design principles that guide how services evolve, integrate, and operate across the system. These are:

- **Pragmatism and Simplicity -** built on a commitment to keeping processes, definitions, and governance as simple as possible. By reducing unnecessary complexity, this will allow neighbourhoods to adapt within agreed parameters to meet local needs, resource pressures, and operational realities.

- **Prioritising Relationships and Collaborative Culture -** successful neighbourhood working is fundamentally relational. Strong leadership, partnerships, mutual trust, and collaborative behaviours are essential to supporting integrated models of care. Aligning with Our Shared Agreement and the five foundations, this way of working will be prioritised above rigid governance or bureaucratic processes, ensuring that neighbourhood teams can focus on shared purpose and collective impact.

- **Neighbourhoods as Meaningful Units of Delivery for People -** neighbourhoods must function as practical units for integrated service delivery while also aligning with the identities and lived experience of local communities. In a large place such as Lincolnshire, different people within our communities identify with many, and different 'communities'. Where we work, shop, play and seek public services will be different depending on a whole range of factors.

- **General practices, as an all-age direct access service, are the most common neighbourhood health experience for most people.** For this reason, the Lincolnshire model for establishing 'meaningful neighbourhoods' which mean something to most people is based on general practice registered populations. General practices have grouped together and developed service delivery footprints already and these will be the strong basis from which neighbourhood health implementation will evolve.

- **Evolving from Combined General Practice Population Neighbourhoods (PCNs) -**These populations form a strong basis for the development of our neighbourhood health ambitions, but they must flex to meet the needs of neighbourhoods. A neighbourhood may need to encompass multiple PCN populations, or a PCN population may evolve into more than one neighbourhood. Each neighbourhood will receive primary medical services from one general practice grouping (PCN), and its member practices. This ensures coherence and avoids fragmentation and places the neighbourhood at the centre of service organisation. Other organisations are expected to align their planning and delivery to neighbourhoods - or clusters of neighbourhoods reinforcing the shift toward integrated, place-based working.

- **Population Footprints for Integrated Delivery -** integration will be organised across three complementary population footprints:

    - **Combined General Practice Level (PCN) Population level** for proactive, personalised, and preventive care, divided into more than one neighbourhood where

variance in need necessitates. Each neighbourhood forming from these building blocks will service 30-70,000 people.

- **Services organised to serve Multiple Neighbourhoods.** Will be organised around a median population of 250,000 people starting with defined multi-neighbourhood services aligned to neighbourhoods. Volume and design of services to single neighbourhoods from this level will be based on need, with resource shifts over time where there are constraints to overcome.

- **Countywide Provision Aligned to Neighbourhoods -** to support the development of integrated neighbourhood teams. This ensures a consistent foundation for delivery across Lincolnshire while retaining the flexibility to respond to local priorities and population needs. County level for strategic planning, standardisation, and system wide oversight. These footprints will be regularly reviewed to ensure they continue to reflect evolving population needs and enable the development of hyperlocal solutions.

5. Informed by Data and Intelligence

In Lincolnshire, we use data and local insight to understand what our communities need and to design more preventative, personalised health and care. By bringing together information from GP practices, hospitals, mental health services, community teams, social care and public health, we can see what affects people's health, where inequalities exist, and which groups need the most support.

Each neighbourhood receives a clear set of information packs showing who lives locally, common health issues, how services are used, and where there are differences between areas. Local teams combine this intelligence with people's real-life experiences—resident feedback, patient stories, staff insight and community voices to agree priorities and shape services that better fit their communities. This neighbourhood work remains aligned with our Joint Strategic Needs Assessment (JSNA) to ensure a consistent, countywide understanding of need.

Population Health Management (PHM) underpins this approach. PHM helps us anticipate needs, reduce health inequalities, redesign services, and manage future demand and financial risk. Our Integrated Care System is committed to using PHM at the heart of transformation bringing together PHM, reducing health inequalities and personalisation into one shared approach. We aim to build a coalition of colleagues across all organisations who actively champion PHM.

Our intelligence infrastructure is a key enabler. Through strong collaboration on Information Governance, we have created the Lincolnshire Joined Intelligence Dataset (LJID), linking data from primary care, acute and mental health care, community services and adult social care for the whole Lincolnshire population. This dataset one of the most comprehensive nationally supports analysts across the system.

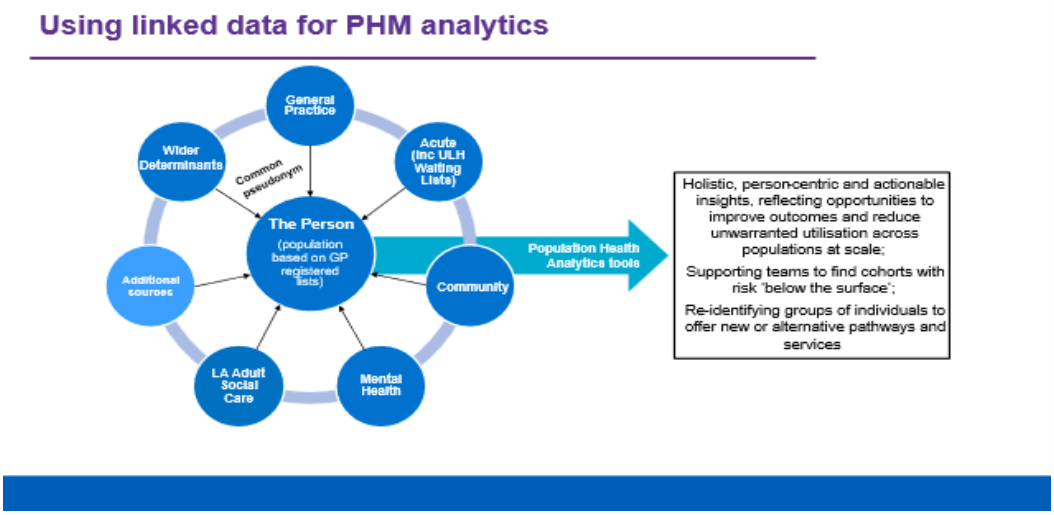

Figure x:

Using the PHM Resource Suite, analysts can interrogate this data through segmentation, risk stratification and financial modelling. Our Strategic Segmentation Model gives us a shared way of understanding the population, defining outcomes for each segment, and measuring our impact.

Together, this gives Lincolnshire a strong and consistent platform for understanding need, improving services, and achieving better outcomes for local people. By embedding PHM and a robust intelligence function at the heart of neighbourhood planning, will ensure that decisions are transparent, equitable and grounded in the best available evidence. This supports a consistent, system-wide approach while enabling each neighbourhood to respond flexibly to local need ultimately improving outcomes and reducing health inequalities across Lincolnshire.

6. Neighbourhood Structure & Geographies

6.1 The Structure of the Lincolnshire Neighbourhood Model

Lincolnshire's neighbourhood model as outlined in figure X below is built as a series of connected tiers, moving from Place (countywide strategy and specialist services) to Multi-Neighbourhoods (broader hubs for diagnostics, reablement and resilience), and finally to Neighbourhoods the local 30–70k footprints where people live, work and access most day-to-day support. This stepped structure shows how strategic oversight scales down into personalised, community led delivery, with Neighbourhood Teams coordinating care around local needs. The approach aligns existing geographies wherever possible, ensuring coherence without reorganisation.

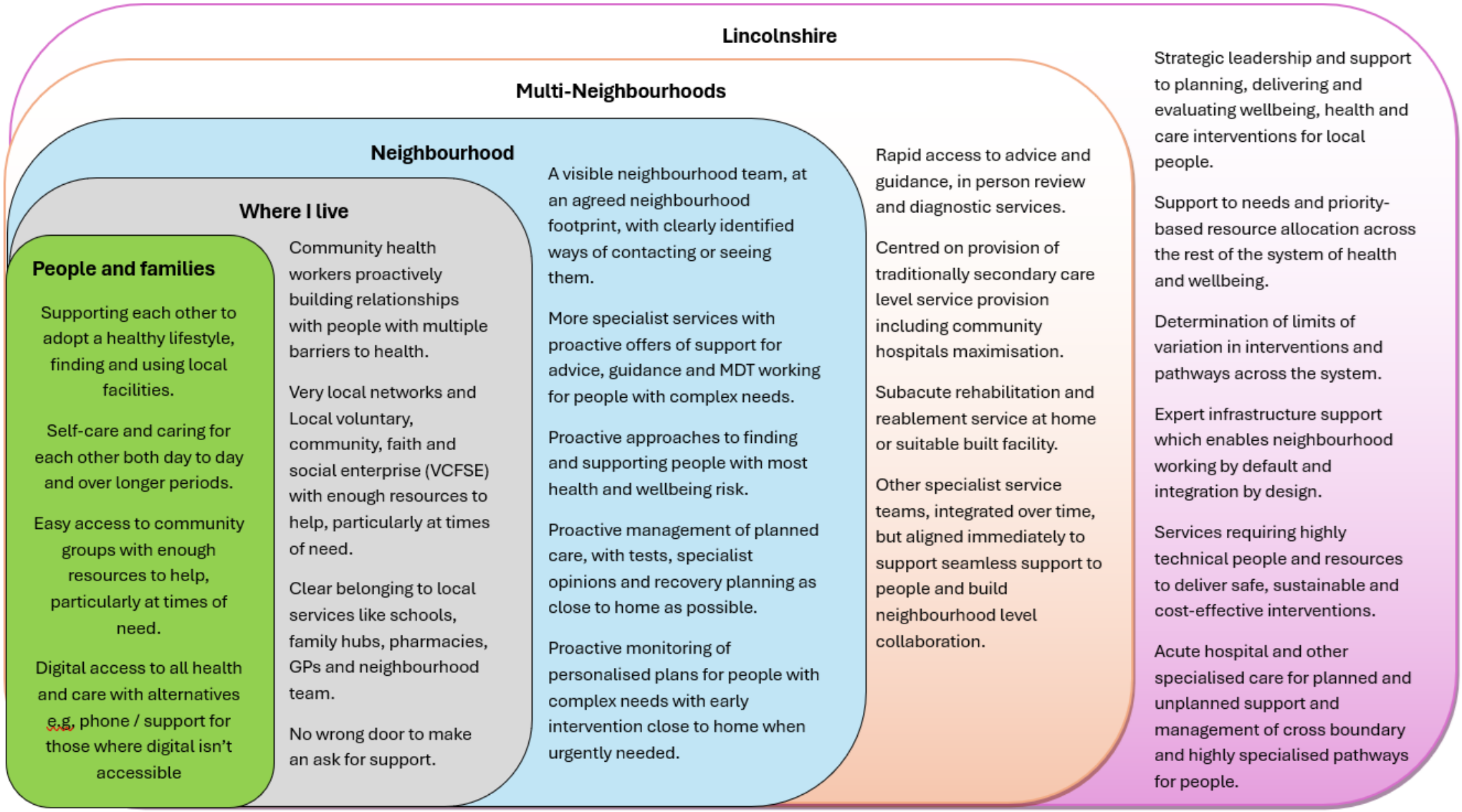

Figure x: Lincolnshire's Neighbourhood Model

Utilising the principles and approaches above, the starting point for the development of a Lincolnshire system of neighbourhoods, at the single neighbourhood level is outlined in the map (Figure x) below.

Add in how cross border working is going to work within the Neighbourhood Health model

6.2 Partnership approach (*All partners*)

6.2.1 Lincolnshire County Council - Public Health

Public Health will drive the shared vision for Neighbourhood Health by offering strategic leadership, high-quality intelligence, and a strong prevention focus that shapes local priorities. Using JSNA and PHM insight, Public Health will help neighbourhoods understand needs, address inequalities, and design evidence-based, person-centred interventions aligned with countywide ambitions.

Working across all tiers, Public Health specialists will promote a "one system, one team" culture, embedding prevention into everyday practice and supporting integrated, community-focused ways of working. Their expertise in population health, inequalities, data literacy, and evidence-based practice will strengthen workforce and leadership development across the system.

Public Health currently shares population-level intelligence through JSNA, PHM insights, and small-area profiles. To improve shared decision-making, greater interoperability, wider access to linked datasets, and consistent data-sharing protocols will be essential.

The team will continue to lead system-wide population health approaches through segmentation, risk stratification, and robust intelligence to guide planning and monitoring, ensuring alignment with JSNA, JHWS, and national priorities.

6.2.2 Lincolnshire County Council - Adult Social Care

Shared vision & roles:

Lincolnshire County Council's Adult Social Care wants to help everyone in the neighbourhood stay healthy and live safely in their own homes. Our job is to work closely with local health services, charities, and community groups to make sure people get the support they need. We aim to build strong local teams that help people look after themselves and each other, hopefully reducing the need for extra help from health or social care services.

One team culture:

Adult Social Care teams regularly work together with the NHS, charities, and local groups to make sure everyone is pulling in the same direction. We take part in local meetings and want to set up joint training, regular catch-ups, and shared ways of working. Good communication, respect, and clear leadership are key to making this work smoothly. Because social care services are not free for everyone, it's important to pool budgets so resources are used fairly. All partners need to formally commit to working as one team, with strong leadership and clear rules, so everyone knows what's expected. Respect, honesty, and agreeing on the best way forward are vital to keeping everything joined up.

Workforce & leadership:

Adult Social Care is keen to help staff develop their skills by working together with other organisations on leadership programmes, learning events, and joint recruitment. We want to build strong teams who learn from each other and share good ideas. By sharing training and best practices with health and charity partners, we hope to make sure everyone has the tools they need to do a great job. For Intermediate Care, we suggest bringing together different types of care like social work, occupational therapy, and physiotherapy into one team so people can move smoothly between services and get the best help possible.

Data sharing:

Adult Social Care currently shares key operational information such as assessments and hospital discharge details with NHS colleagues. To enhance shared decision making and support integrated care, improvements in system interoperability, consistent data sharing protocols, and robust consent processes will be required. Strengthening the digital infrastructure will ensure timely, secure, and person centred information flow across partners.-making and support integrated care, improvements in system interoperability, consistent data-sharing protocols, and robust consent processes will be required. Strengthening the digital infrastructure will ensure timely, secure, and person-centred information flow across partners.

Population health:

Adult Social Care will play a key role in neighbourhood level population health approaches by working with Public Health, NHS, and community partners to identify local need, understand vulnerability, and target support effectively. Using shared intelligence, Adult Social Care can help shape prevention focused pathways, address health and care inequalities, and ensure interventions reflect local priorities and lived experience.-level population health approaches by working with Public Health, NHS, and community partners to identify local need, understand vulnerability, and target support effectively. Using shared intelligence, Adult Social Care can help shape prevention-focused pathways, address health and care inequalities, and ensure interventions reflect local priorities and lived experience.

Pooled budgets:

There are significant opportunities to strengthen joint planning and commissioning through mechanisms such as Section 75 agreements and the Better Care Fund (transitioning to the Integrated Care Funding Framework). These arrangements enable shared investment in integrated services, simplify funding flows, and support the delivery of more coordinated person centred care. The Lincolnshire Joint Commissioning Oversight Group will continue to provide systemwide stewardship and assurance for pooled resources.-centred care. The Lincolnshire Joint Commissioning Oversight Group will continue to provide system-wide stewardship and assurance for pooled resources.

Shared estates & resources:

Lincolnshire County Council could make better use of places like day centres and offices by sharing them with other organisations. Working together in these spaces can help us deliver services more smoothly, train staff together, and run community events. By coordinating how we use transport and technology, we can work more efficiently and help more people. If the Intermediate Care Strategy goes ahead, bringing together Active Recovery Beds and Transitional Care Beds will mean people get consistent support and care as they recover, all in one place.

6.2.3 Lincolnshire County Council - Children Services

Children's Services will continue to work with partners to provide support for children, young people and families.

The Children's 0-19 Health Service provides a Health Visiting and Children and Young People's Nursing service for school aged children, aligned to the Healthy Child Programme. Some support is available universally and some support is for individuals based on their needs, more information can be found here.

Children's Services provide a range of support in the community for families, particularly for children in their early years, through Children's Centres and Family Hubs. A range of professionals including Early Years Practitioners, Midwives, Speech and Language Therapists and voluntary community faith and social enterprise organisations offer early education, public health promotion and support these community venues. There are a range of universal activities and some support for individuals based on their needs, more information can be found here.

If there are safeguarding concerns about a child, then Children's Services Social Care Teams provide support from family help to statutory intervention. We believe that children should live with their own families and networks if it is safe. Our practice is underpinned by the value we place on working collaboratively with families and partners with a restorative, holistic whole-family approach to support them in finding their own solutions and building on their strengths.

Children's Services was chosen by the Department for Education as a pathfinder to help design and test the government's new Families First for Children reforms. The pathfinder focuses on improving:

1. Family Help

2. Child Protection Reform

3. Greater Use of Family Networks

4. Stronger Multi-Agency Safeguarding, including Multi-Agency Child Protection Teams (MACPTs)

MACPTs are a new statutory requirement, designed to strengthen child protection practice by bringing together key safeguarding partners into a single integrated team.

Children's Service Special Educational Needs and/or Disabilities (SEND) Service supports children and young people with SEND up to age 25. The service works with families, early years and education settings, health commissioners and providers and a range of voluntary community faith and social enterprise organisations to ensure most children and young people can have their

needs met in a mainstream educational setting. If further support is needed then an assessment of need and support plan may be required that will be jointly consider a child's education, health and care needs.

The Children's Services above already work at a neighbourhood level, providing support in the local community. Access to support will continue to be through existing routes because these are well embedded. Children's Services staff will work alongside families and professionals in the most appropriate way to improve outcomes for children and young people.

6.2.4 Lincolnshire NHS Strategy

This section aggregates and summarises the organisational strategies of the NHS Lincolnshire ICB, Lincolnshire Community and Hospitals NHS Group, Lincolnshire Partnership NHS Foundation Trust and Primary Care Network Alliance.

In line with the vision set out in "Fit For The Future | 10 Year Health Plan for England", the commissioning and provider strategy across the NHS in Lincolnshire is focussed on achieving three radical shifts: from Hospital to Community; from Analogue to Digital; from Treatment to Prevention. The development of neighbourhood health services is the delivery mechanism through which the three shifts are made real at local level.

Current Context	The NHS is currently hospital-centric, detached from communities and organises its care into multiple, fragmented siloes. The NHS remains a distinctly analogue service: staff are still forced to put up with obsolete computer systems and paper records, while patients do not have the digital tools that give them real control over their healthcare. People are living too long in ill health, the gap in healthy life expectancy between rich and poor is growing and nearly 1 in 5 children leave primary school with obesity. The social determinants of ill health cluster in the more deprived parts of the country. On average, people with a serious mental illness, a learning disability and severely autistic people, die earlier than the general population, and this is unacceptable.
Vision	The neighbourhood health service will bring care into local communities, convene professionals into patient-centred teams and end fragmentation. It will embody our new preventative principle that care should happen as locally as it can: digitally by default, in a patient's home if possible, in a neighbourhood health centre when needed, in a hospital if necessary. We will harness the NHS's unique advantages - world-leading data, procurement power and the means to deliver equal access – to take the NHS from the 20th century technological laggard it is today, to the 21st century leader it has the potential to be. It will provide universal access to the best digital tools and health apps, free at the point of need. This will be

	underpinned by a single patient record, that allows for care, whether digital or physical, to be personalised and seamless. Our overall goal is to halve the gap in healthy life expectancy between the richest and poorest regions, whilst increasing it for everyone, reduce the health inequalities that exist for some of our most vulnerable people in our communities, and to raise the healthiest generation of children ever. We will achieve our goals by harnessing a huge cross-societal energy on prevention. We will work with business, employers, investors, local authorities and mayors to create a healthier country together.
Neighbourhood health priority areas include:	• Delivering the NHS elements of more joined-up, preventative, community-based care: standardising the core components of existing practice to achieve greater consistency of approach; bringing together the different components into an integrated service offer to improve coordination and quality of care, with a focus on people with the most complex needs; scaling up to enable more widespread adoption; rigorously evaluating the impact of these actions, both in terms of outcomes for local people and effective use of public money. • Increasing coordination, consistency and scale in delivering health and social care to specific cohorts identified through analysis of our population health needs: children and young people's obesity; children and young people's mental health; people aged 40-64 with multiple long term conditions; adults with moderate or severe frailty; people of all ages with palliative care or end of life care needs people of all ages with high intensity use of emergency departments. • Redesigning outpatient services, so most of this care happens outside of hospitals: extending consultant advice and guidance, so less patients need to travel to appointments; standardising Patient-initiated Follow-Up with rapid re-access; increasing the use of virtual consultations, remote monitoring and patient-reported outcome/ symptom tracking to reduce unnecessary face-to-face follow-ups. • Strengthening general practice: ensuring sufficient capacity, equitable access high-quality proactive management) to enable earlier identification, proactive long-term condition management, continuity for complex patients and timely access to appropriate care. • Making greater use of digital infrastructure and solutions to improve care (e.g. NHS App pathways; interoperable shared care record; remote monitoring; automation/AI for admin; patient messaging - digital call/recall) and as a force for inclusion.

	• Maximising the role of vaccination and screening, two of the most effective population health interventions available for: preventing illness, detecting disease earlier, reducing avoidable hospital activity and narrowing inequalities in healthy life expectancy. • Addressing the wider determinants of health and wellbeing as part of our approach to build resilient communities: working with partners to influence employment/occupation, housing and social connection/isolation – supporting everyone that wants one to have a job, a home and a friend. • Investing more in community care: making the hospital to community shift real by moving money, capacity and accountability into neighbourhood delivery; using mechanisms such as the new single/multi-neighbourhood contracts and outcomes-based specifications; adopting a proportionate universalism approach to our priorities as we look to improve health outcomes for the entire population while ensuring that those with the greatest need receive the most support.

6.3 Resilient Communities

Recognised as 'the custodians of universal support and… of people's wellbeing' in Lincolnshire's Adult Social Care Strategy Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations hold strong and deep relationships with the communities they support.

Communities not only sit at the heart of neighbourhoods. They are a catalyst for self-organising support, with groups growing organically out of local necessity and therefore VCFSE organisations play a key role in adapting to evolving need and supporting people in their 'natural neighbourhoods'. It is in these non-clinical, non-medicalised, but equally impactful community spaces that much prevention work can take place and where support for people living with long term health conditions and low-level mental health challenges can be facilitated and delivered. There are also significant opportunities to provide and connect social care support for people in their immediate neighbourhoods – enabling access to community-based activities and supporting people to continue and start living active lives.

VCFSE organisations will work to identify existing strengths, collect and collate public voice, support co-production and identify opportunities to maximise increase their impact on neighbourhood health.

Involvement of VCFSE organisations ensures the plan is rooted in the communities and the 'natural neighbourhoods' people occupy in their everyday lives and will ensure the contribution of community-based support to health, social care and wellbeing is fully realised in the places where people live and which can support the neighbourhood model.

6.4 Social Care Provision

Social care provision may be commissioned by Continuing Healthcare or Lincolnshire County Council, but residential care for older people is increasingly being purchased by individuals (self-funders). There are also individuals receiving social care in Lincolnshire who are funded by other local authorities.

All of the individuals receiving social care may call upon the neighbourhood health system.

Lincolnshire care providers have been included in the health and care system, delivering as much care as possible in the place that people call home.

Care providers are committed to playing a full part in neighbourhood health. Residential care homes are aligned to an individual GP practice. Home care coverage areas may not match exactly to the neighbourhood footprints, but they are likely to be close enough to enable participation by one or two providers.

Nursing homes in particular, can be key partners in the delivery of care to the frailest older people closer to home. For this to be achieved, nurses should have access to appropriate health pathways and patient records.

7. Priorities

7.1 National Priorities (*TD/FM to draft waiting for guidance*)

7.2 Local Priorities (*TD/FM to add to Create a Year 1 priority matrix (cohort × geography).*)

The DLN ICB Cluster's "Five + Three" framework provides a clear and focused approach to improving population health and reducing inequalities over the coming years. The Five priority population groups, children and young people's obesity, children and young people's mental health, early multimorbidity in adults aged 40–64, frailty in older people, and end-of-life care directly reflect the JHWS life-course ambitions to enable people to Start Well, Live Well and Age Well. The Three cross-cutting system priorities, strengthening general practice, increasing vaccinations and screening uptake, and redesigning outpatient and follow-up pathways, provide the essential enablers that support improvement across all stages of the life course. Together, these priorities align seamlessly with the Neighbourhood Health Plan, using Integrated Neighbourhood Teams to deliver targeted, proactive and coordinated support closer to communities. In doing so, they ensure that neighbourhood-level actions, partnerships and resource shifts contribute directly to the shared JHWS goals of improved health, better experiences of care and reduced inequalities across Lincolnshire.

7.3 Integrated Care Funding Framework Priorities

For 2026/27, the priorities to reform the BCF, into the Integrated Care Funding Framework (ICFF) will focus on a model that prioritises consistent, jointly commissioned services necessitating fully integrated delivery specifically in discharge, intermediate care, reablement, and rehabilitation. These are recognised as critical enablers for integrated health and social care and will then be incorporated into the Neighbourhood Health Plans.

Lincolnshire's ICFF strategic objectives will continue to be centred around prevention, intermediate care, and neighbourhood-based initiatives. These priorities are aligned with the Neighbourhood Health Plan to ensure the provision of co-ordinated, community-centric support. Through ICFF investment, we will continue to drive the strategic alignment and integration of resources, fostering robust collaboration across the system's partners.

Current ICFF programmes are closely aligned with system partners to advance neighbourhood collaboration, workforce integration, and the delivery of the integrated intermediate care strategy. The ICFF funded initiatives are designed to support and enhance discharge processes, intermediate care, rehabilitation, and reablement. Funding is allocated to services that champion community-based care, maximise independence, and strengthen preventative and early intervention measures.

8. High Level Systems Outcomes

The strategic plan sets out a level of transformation to the way wellbeing, health and care will be organised for local people which will be costly and effort intensive to deliver. As such, the Board would wish to be clear on the 'macro' outcomes being pursued for local people in return for this significant investment.

Outcomes will continue to be developed and refined with involvement from people and communities to understand priorities and embed 'real life' outcomes important to people.

- **Better self-management of health and wellbeing**. People will feel more able to take control of their health, supported by improved health literacy and confidence. Communities will have increased capacity and leadership to enable more local and community-led health initiatives.

- **More preventative and proactive activity.** Services will shift resources toward better targeting and improved access to proven preventative interventions. This will enable more people to benefit and will reduce avoidable illness and poor health and wellbeing outcomes.

- **A reduction in health inequalities.** People who face multiple barriers to good health will experience improved acceptability, access and outcomes. There will be proactive engagement with the most challenged groups and households to ensure no one is left behind.

- **Greater sustainability through efficient resource use.** We will implement integrated service delivery at scale across estates, information management and technology, and workforce activity—reducing duplication, unnecessary hand-offs and unwarranted hospital activity in both planned and urgent care.

- **More people reporting seamless integrated care.** People will no longer notice the joins between services commissioned or provided by the many partners involved in neighbourhood health. They will feel that their needs were at the centre of their experience, regardless of where or how they accessed support.

9. Monitoring & Evaluation

Lincolnshire will monitor and evaluate the JHWS and Strategic Neighbourhood Health Plan through a joint approach led by our Place Based Executive Partnership (called Better Lives Lincolnshire Leadership Team?) and supported by the Neighbourhood Health Strategic and Delivery groups, ensuring alignment with countywide priorities for improved outcomes, prevention, integration and reduced inequalities. This shared governance reflects national expectations for coordinated neighbourhood-level planning and will support transparent reporting to the HWB. The Monitoring and Evaluation Framework is set out in Appendix 1.

The Health Scrutiny Committee (HSC) for Lincolnshire will play a pivotal role in ensuring that our neighbourhood health arrangements genuinely reflect and respond to the needs of the communities they serve. In doing so, the Committee will examine whether people's experiences and priorities are being meaningfully incorporated into the planning and delivery of services, while also providing an important mechanism for holding NHS bodies and other health providers to account for their decisions and performance. Ultimately, the HSC is central to ensuring that neighbourhood health plans remain transparent, responsive, grounded in local need, and aligned with wider ambitions for improving population health across Lincolnshire.

Monitoring and Evaluation Framework **Appendix 1**

Monitoring & Evaluation Focus	**Strategic Vision & High-Level Outcomes** *Everyone in Lincolnshire will benefit from community-based services that help us stay healthier for longer and, when we need it, receive personalised and coordinated care closer to home* • *Better self-management of health and wellbeing* • *More preventative and proactive activities* • *A reduction in health inequalities* • *Greater sustainability through efficient resource usage* • *More people reporting seamless integrated care*		**JHWS Priorities** • *Carers* • *Healthy Weight* • *Homes for Independence* • *Mental Health and Dementia* • *Physical Activity*
Method	Annual Report	Quarterly / ad hoc reporting	Themed meetings and development sessions Annual Assurance Report
Owner (From)	Director of Public Health / Senior Leadership Group	*Neighbourhood Health Working Group / Neighbourhood Health Board / JHWS Delivery Groups*	Relevant groups, partnerships and leads responsible for the JWHS priorities
Recipient (To)	Lincolnshire Health and Wellbeing Board	Senior Leadership Group (Place based Partnership)	Senior Leadership Group / Lincolnshire Health and Wellbeing Board
Content	***How is the system delivering Neighbourhood Health?*** • Update on collective actions and progress aligned to the system high level outcomes • National and local priority metrics • ICFF • Progress on co-production • Qualitative intelligence – stories, case studies, lived experience • Update on partnership working	***Ongoing development and delivery of Neighbourhood Health and Wellbeing in Lincolnshire*** • High level progress reporting and oversight of neighbourhood health arrangements • Progress on priorities in the JHWS & Strategic Neighbourhood Health Plan • Oversight of service integration and partnership working • Oversight of ICFF • Feedback and evaluation • Personalisation and co-production	***What progress has been made to deliver the Joint Health and Wellbeing Strategy?*** • To review progress • Update on delivery plan and collective actions to reduce inequalities and improve health and wellbeing • Provide assurance on progress
Feedback Loop	The Health and Wellbeing Board can request further action as required	The Senior Leadership Group can escalate matters to the Health and Wellbeing as required and can submit updates via the Chairman's Announcements if a full report is not required	Any matters of concern escalated to the Senior Leadership Group. As required topic focussed/ad hoc reports can be produced for the Health and Wellbeing Board to drive partnership action

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Integration Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*5 May 2026*
Agenda item number	

Integration Committee Upward Report of the meeting held on 23 April 2026

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

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

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	5 May 2026
Report from:	Integration Committee
Report from meeting held on:	23 April 2026
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 23 April 2026 including assurances received and those matters which the Committee wish to escalate to the Group Board.

2.0 Matters considered by the Committee

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

Assurances in respect of Objective 3a:

a) Estates and Facilities Update
b) Continuous Planning Update (Transformation)
c) Acute Floor Update

The Committee received the Estates and Facilities Update noting the continued large and complex portfolio with continued strong performance on delivery of a number of high-profile schemes. A number of these had delivered or were close to completion including the Pilgrim ED phase 2, LINAC and the Boston CDC demolition. The Committee was pleased to note the early and under budget completion of the Lincoln CDC works with the go live planned for the 5 May 2026.

Allocation of £6.25m of funding with green status was noted, enabling the draw down of monies to support with design fees. Work continued on estates rationalisation and the hand back of surplus leased accommodation.

The Committee noted the number of schemes taking place in the financial year recognising that capacity remained an issue for the team however the quality of the work being delivered was commended, especially with the pace of change.

The Committee was provided with **substantial assurance** by the Estates and Facilities Upward Report.

The Continuous Planning update report was received, and it was noted that a session had been held with the Group Leadership Team to discuss productivity improvement and the transformation programmes. The session had focused on the understanding of the governance, schemes and roles and responsibilities and delivery expectations.

The Committee noted the breakeven plan submitted with a £90m Cost Improvement Programme for the Group, with £81m for ULTH and £9 for LCHS. Ambitious trajectories were noted for a number of schemes alongside the 5 big programmes including the single front door, planned care, out of hospital intermediate care, integrated neighbourhood teams and left shift.

The was recognition that the majority of the programmes would be overseen by the PITOF meeting and supported by the new PMO software Monday.com which included mapping and resource planning.

The Committee held detailed discussions around the risks associated around the delivery of the plan noting that delays in the commencement of work would result in a material issue for the Group. As such it has been agreed and supported by the Committee that a new risk on the risk register around delivery, at a score of 25, would be added. The focus of this risk is the impact of delays in transformational change with patient safety, reputational and financial implications.

The Committee was provided with **partial assurance** in respect of the Continuous Planning update.

The Committee received and noted the presentation in respect of the work associated with the Acute Floor which, on delivery, would achieve significant change both internally and externally across the system.

Assurances in respect of Objective 3b:

a) Alliance Steering Group Upward Report
b) Group Partnership Plan (**appended**)

The Alliance Steering Group report was offered to the Committee detailing the work of the community teams in transforming and improving services, which was now embedded in practice. There was recognition that small scale change was being achieved however this now needed to scale up to large system change in order to drive forward impacts. Support to achieve this was required from a delivery partner.

It was noted that progress continued in respect of the 8 specialty areas with data now being linked to population health data in order to determine how work could be scaled up. Health inequalities heat tools were now available on the intranet and required engagement with the Care Groups to ensure these were utilised to support change.

Reporting to the Committee would be developed in order to offer the overall achievements, rather than showing progress in individual programmes of work and themes currently being seen by the Committee.

The Committee noted the updates made to the BAF during a recent Board Development Sessions that would strengthen the reporting of delivery be system partners against the work of the Group.

Reasonable assurance was provided to the Committee in respect of the Alliance Steering Group Upward Report.

The Committee received the Partnership Plan noting that this had been developed over a number of Board Development sessions and detailed the 6 partnership principles, covering the engagement and leadership approach in addition to the reporting to the Committee.

The report was supported by the Committee to the Board for approval.

Assurances in respect of Objective 3c:

a) Research and Innovation Group Upward Report
b) EPR Programme Update and EMAP Peer Review
c) LPFT Digital Novation

The Committee received the Research and Innovation Group upward report and supported the proposed change in the governance process for separate strategic and operational groups to be established, in line with previous updates offered to the Committee.

The Committee was provided with **reasonable assurance** however further assurance is required in respect of capacity and resource of the function to deliver.

Following the deep dive of the EPR the previous month the Committee received the update on the programme along with the peer review noting the continued progress to date. The Committee was pleased to note that the programme status had moved from red to amber, since the report had been written for the Committee with the go live 3 plans having been signed off earlier in the week.

There was noted the right resource in place to ensure delivery and the peer review and offered some recommendations which had mitigations in place. The go live of the EPR was a significant programme and had been mitigated through delivery in 3 stages with continued oversight required given the cultural change.

The Committee was offered **reasonable assurance** and continued focus would continue to be given by the Committee.

The Committee took the LPFT Digital Novation paper as read noting the detailed work taking place to novate the digital service provision to the Group. The Committee noted the position of the hosted services in the scale of the

expansion of these and recognised the risks presented. **Reasonable assurance** was received and endorsed the focus on stabilisation and strategic opportunities.

Assurances in respect of Objective 3d:

a) Sustainability and Green Plan Update
b) Productivity, Improvement and Transformation Oversight Forum (PITOF) Group Upward Report

The Committee received the Green Plan update noting that progress was not being made as hoped with a need to consider the approach being taken in the coming 12 – 18 months in order to determine the delivery approach and wider work. Key deliverables and measurables still required identification however the Committee noted that further ELT discussions would be needed to support progress.

The Committee noted the updates that had been provided during the course of the meeting in respect of PITOF, recognising the reset of the meeting and how this would be managed for the coming year.

Assurances in respect of other areas:

a) Theatre Productivity (FPC referral)
b) Board Assurance Framework 2025/26
c) Committee Performance Dashboard
d) Risk Register

The Committee received the Theatre Productivity internal audit report which had been referred by the Finance and Performance Committee to ensure that existing plans in place in this area fully addressed the concerns raised. An update would be offered to the Committee, including assurance on the delivery timescales identified, through the PITOF report.

The Committee reviewed the Board Assurance Framework (BAF) noting the movement for objectives 3a, 3b and 3d moving from amber to green ratings. It was recognised that the risk score for objective 3a had reduced from 12 to 6, these would be presented to the Board for approval in May.

The Committee received the March 2026 Performance Dashboard noting the reducing pressure in the UTCs, with performance starting to recover. Urgent Community Response was noted to be progressing however there was recognition of this needed to move at pace to develop further.

The new dashboard was reviewed by the Committee noting that this offered performance across the patient pathway with the development of this having commenced in readiness for the work of Newton. This was demonstrating areas for improvement, aligned to the weighting of the National Oversight Framework, however continued improvement and transformation was required.

The risk register was received with the Committee noting there was no movement in the risks presented. Work is taking place with Executives to ensure that these are appropriately aligned to the Committees.

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) Partnership Plan supported by the Committee and appended to the report for Board approval
b) Transformational change risk rated 25 due to patient safety, reputation and financial implications

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 the following changes were proposed:

a) Objectives 3a, 3b and 3d proposed to move from amber assurance ratings to green
b) Risk score for objective 3a proposed to reduce from 12 to 6

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the Integration Committee;
- approve the changes proposed to the Board Assurance Framework risk and assurance ratings as detailed in the report
- formally support the endorsement of the Partnership Plan by the Committee

Jim Connolly, Non-Executive Director

23 April 2026

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Partnership Plan Update

Caring and building a healthier future for all

Meeting	*Trust Board*
Date of meeting	*23rd April 2026*
Agenda item number	*TBC*
Report title	*LCHG Partnership Plan Update*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Information* • *Approval*
Accountable Director	*Daren Fradgley, Group Deputy CEO, Group CIO*
Author(s)	*Sameedha Rich-Mahadkar, Group Director of Strategy, Improvement and Redesign* *Vicky Holden, Group Deputy Director of Strategic Partnerships* *Angela Sharp, Group Associate Director of Strategic Partnerships*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	*Reasonable*
Prior approval process, if applicable	*Integration Committee approved 23rd April 2026*
Financial implications, if applicable	*Positive – partnerships create opportunities for new income and efficiency and productivity.*
Action / decision required	*The board is asked to:* • *Review and approve the new LCHG Partnership Plan as one of the key enabling plans to support delivery of the LCHG Strategy.*

Assurance Rating Key:

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

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*X*
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings	
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 review and update a new LCHG Partnership Plan which will ensure we can respond effectively to our changing operating environment for our people, patients and population.

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 was proposed to take place in Q3 2025/26 during which time it became 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, Integration Committee received a report outlining a proposal to Close down the 2024-27 Partnership Plan and Delivery Plan and develop a new Partnership Plan and Delivery Plan for 2026-30 bringing it back into alignment with the LCHG 5-year Strategy.

During Q4 of 2025/6 a full review of the Partnership Plan and Delivery Plan has been undertaken, which included engagement with other LCHG enabling functions and a Board development session to review stakeholder alignment.

The new LCHG Partnership Plan now aligns with other existing and new enabling plans in development for 2026/27. The intention will be to undertake a review of the Plan in each of its four years to retain alignment to the outputs of the annual planning rounds and develop the details and respond to what is likely to be continued volatility and uncertainty.

Board are now asked to receive and approve the new LCHG Partnership Plan following recommendation from the Integration Committee.

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Partnership Plan
Our Enabling Strategy 2026 - 2030

Caring and building a healthier future for all

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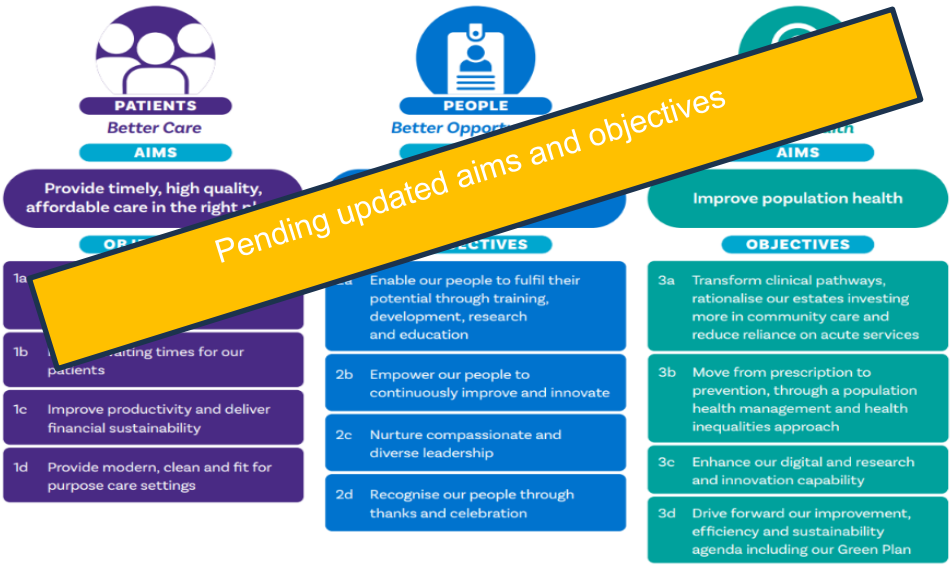
Our Partnership Plan

The health and care needs of Lincolnshire's population are increasingly complex and require coordinated, place-based solutions that bring together NHS, Local Authority, voluntary sector, academic and industry partners. This Partnership Plan sets out *how* LCHG will work with partners to deliver integrated, equitable and sustainable services across neighbourhoods, place and the wider system.

The plan builds on the broader strategic context to focus on the **specific partnership arrangements, delivery objectives, and measures of success** that will enable us to deliver the Group Strategy.

Our Group Strategy

The LCHG Strategy provides strategic direction for both Lincolnshire Community Health Services (LCHS) and United Lincolnshire Teaching Hospitals Trust (ULTH) on how we will provide better care, better opportunities and better health as a way of caring and building a healthier future for all within Lincolnshire.



Partnership Context: Partnership is a **golden thread** that runs through our LCHG 5-Year Strategy, our clinical operating model, and our enabling plans including People, Research & Innovation, Digital and Estates.

All three values are representative of working together as a Group. They encapsulate the voices of both acute and community colleagues. These values represent how we identify, the beliefs that motivate us, and what is important to us. Ultimately, these are the foundations upon which we are building LCHG. They are the basis for us all in coming together to build a better, healthier future for our patients and people.

Partnership Context: Our values also underpin how we partner – **co-design with communities**, **shared accountability with system partners**, and **transparent, ethical collaboration**.

The Partnership Plan articulates a **golden thread** from Strategy → Action → Outcomes:

- Defines the **Partnership Principles** that shape how we work with others.
- Explains **how LCHG will partner** across sectors to deliver our Strategic Objectives of Patients, People and Population.
- Describes how partnership **impact and progress** will be measured.
- Clarifies how we will deliver **Commercial & Economic Value** through ethical, transparent partnerships with industry and the independent sector where net returns are **reinvested** to strengthen NHS services.

Alignment with system strategies

This Plan is consistent with the strategic direction set out in the next section, including national, ICS and local frameworks. It aligns with:

- The LCHG Strategy (Better Care, Better Opportunities, Better Health) 2025-30
- The Lincolnshire Joint Health and Wellbeing Strategy 2024
- Better Lives Lincolnshire Integrated Care Partnership Strategy 2024
- The NHS Lincolnshire Joint Forward Plan 2023-2028
- Neighbourhood Health Framework, March 2026
- Fit for the Future: towards population health delivery models, March 2026
- The Neighbourhood Operating Model agreed by the Lincolnshire Neighbourhood Health and Care Board in November 2025.

Alignment with LCHG enabling plans

The Partnership Plan aligns to other current or emerging enabling plans across LCHG including People, Research & Innovation (R&I), Digital, Estates, and Communications & Engagement.

It also aligns with our LCHG Green Plan and anchor themes including:

- Workforce and System Leadership
- Sustainable Models of Care
- Digital Transformation
- Travel and Transport
- Estates and Facilities
- Food and Nutrition
- Medicines
- Supply Chain and Procurement
- Adaptation.

National Picture

As we move forward, the NHS is navigating a complex landscape shaped by ongoing recovery efforts, financial pressures, and a renewed push for transformation. Nationally, the focus is on improving access, boosting

productivity, and delivering care in ways that are more responsive to local needs.

Elective recovery remains a top priority, with systems working towards treating 65% of patients within 18 weeks. Urgent and emergency care is also under the spotlight, with targets to improve flow and reduce waiting times in A&E departments. Alongside this, there's a strong emphasis on making it easier for people to access care across all points of delivery.

Financially, the NHS continues to face significant challenges. Despite a modest increase in funding (3% average annual increase over three years to reach £226 billion by 2029), rising costs and inflation mean that trusts are being asked to deliver more with less. Productivity improvements and cost reductions are expected across the board, prompting a need for smarter working, better use of data, and more integrated service models.

Looking ahead, the Department of Health and Social Care's 10-Year Health Plan is driving three major shifts: moving care closer to home, accelerating digital transformation, and focusing more on prevention. These changes aim to make services more sustainable and better aligned with what patients need. In addition to this "The Neighbourhood Health Framework and Fit for the Future: Towards population health delivery models", published by NHS England on 17th March 2026, set out the government's plan to establish a neighbourhood health service across England. The guidance is intended to support integrated care boards (ICBs) and local authorities - including health and wellbeing boards (HWBs), providers, voluntary, community and social enterprise (VCSE) partners and wider system partners - to collaboratively deliver more accessible, integrated and preventative care as part of the 10-Year Health Plan. The development of a Lincolnshire Strategic Neighbourhood Health and Care Plan ('the what') and establishment of the Lincolnshire Neighbourhood Health and Care Board ('the how') will provide the local context, priorities and oversight to enable delivery of our ambitions. At the strategic level – 'the what' – the Health

and Wellbeing Board (via the Neighbourhood Plan Working Group) sets the overarching vision, outcomes, priorities and governance requirements. The operational planning – 'the how' is being managed through the Neighbourhood Health Board by turning the strategic intent into action at neighbourhood level.

Importantly, local systems are being given more freedom to shape services around their populations. With fewer nationally mandated priorities and more flexible funding, there is a real opportunity to innovate and lead change from the ground up. This approach will be supported by new delivery architecture across commissioning structures and provider models such as Single Neighbourhood Providers, Multi Neighbourhood Providers and Integrated Health Organisations (IHOs) which will enable a move towards outcome-based commissioning and resource movement form acute to community-based services.

The development of the Lincolnshire Integrated Neighbourhood Teams Operating Model will be a key enabler of our delivery model as seen in Figure 1 below.

Now	Action	Measures	Key points
Unplanned Care Disruption	Attendance Avoidance Admission Avoidance LOS reduction Urgent care in primary Care Mental Health EDs	Bed Days reduction Reduced A&E attendance	*Disrupt people in crisis (turn unplanned back into planned).* *Activity in the community, impact in unplanned care.* *Impact assessments on community resources and unpaid carers* *Health take the lead.*
Planned Care Integrated Neighbourhood Teams Long term conditions Management Left Shift into the community	Long term conditions OPDs with GPs CDCs/diagnostics Risk stratification of primary care Complex case management with integrated neighbourhood teams	Reduced primary care demand Increased community care demand More days in your own beds Less demand in acute by pathway Less demand in specialist mental health services	*Left shift is the plug; neighbourhoods are the socket.* *PCNs and NHS providers wrap into neighbourhoods.* *Some services at multi-neighbourhood level.* *Impact assessments on community resources and unpaid carers* *Health take the lead.* *Increased community demand as a measure, but in the right places. Getting this right = more activity in primary care and the VCFSE sector and less activity in hospitals and specialist community teams.*
Resilient Communities - Self Care Service for residents Prevention 	Social determinants of health Co-ordinate public sector directory of prevention services	Reduced unnecessary demand on primary care	*Community asset base e.g. community connectors, HoICP model (brings together).* *Personalisation – community and personal resilience.* *Key role for communities, VCFSE, housing associations etc.* *Role of prevention.* *Impact on community resources and unpaid carers.* *Digital Accessibility* *LA/VCFSE take the lead.* *Health is a stakeholder - may sometimes support in this space to coordinate, convene, facilitate and sometimes provide where there is no willing provider in place.*

Figure 1 – Lincolnshire Integrated Neighbourhood Teams Operating Model

Partnerships Context:

National policy emphasises *integration, prevention and digital transformation*. LCHG will deliver these through **purposeful partnerships** for our Patients, our People and the Populations we serve spanning NHS providers, primary care, Local Authority, VCSE, academia and industry - anchored in our **6 Partnership Principles**.

Local Context

Our Population

Lincolnshire is the 2nd largest county by area in England. It has a population of c. 775,000 however seasonal variation means this increases significantly at certain times of the year (there are 812,00 patients registered with a GP).
The county is made up of large towns, small dispersed rural areas and coastal communities, with population density around a third of the average for England. While deprivation in Lincolnshire is in line with the national average, and some urban areas e.g., Lincoln are relatively affluent, coastal resort towns such as Skegness and Mablethorpe are among the 10% most deprived districts in England.

A core component within our Lincolnshire Community and Hospital Group (LCHG) 5-year Strategy 2025-30 includes tackling health inequalities, delivering care closer to people's homes, and exploring innovative digital solutions. We will utilise a data driven, proactive Population Health Management (PHM) approach to improve the health and wellbeing of the population while reducing health inequalities. This is supported through the use of the Lincolnshire linked data set which will allow us to effectively identify areas of opportunity and to measure the impact of the changes we make.

Partnerships Context:

Population needs in coastal, rural and deprived communities will be addressed through **neighbourhood-level integrated working** and **Population Health Management** with partners, focusing on improving access, increasing equity of health outcomes, and prevention and early intervention.

Anchor Institution

LCHG recognises our responsibilities as an Anchor Institution which means that, as a large non-profit, public-sector organisation, we acknowledge that our long-term sustainability is tied to the wellbeing of the populations we serve and that we have a significant influence on the health and wellbeing of the citizens in our communities.

We have a role in influencing the wider health and wellbeing of our populations, and along with our system partners we have committed to focusing on building healthier, safer and more resilient communities, promoting local skills and employment, decarbonising and safeguarding our environment, and supporting the growth of responsible local or regional business.

Our ULTH and LCHS Green Plans for 2025-2028 which describe how we will work towards achieving net zero carbon emissions by 2040 are key enablers of some of our priority Anchor responsibilities and ambitions, and we will work with our local communities and partners to deliver even greater local benefits (e.g. through procurement, supply chains, partnership working, community outreach).

Working collaboratively as a Lincolnshire Anchor System will allow us to maximise the impact of our activities and directly support the aims of both LCHG and the Health and Care System

Partnership Context: As an **Anchor**, LCHG works with NHS, primary care, Local Authority, VCFSE, education and industry partners to create social, economic and environmental value – through local skills pipelines, responsible procurement and decarbonisation. In addition, our **Commercial & Economic Value** principle commits us to **income-generating partnerships**, where net returns are **reinvested** to strengthen NHS services.

Who are our Partners?

LCHG has a vast number of stakeholders and partners, and many of these can be seen in Figure 2 below, which illustrates our partners in five main groupings: Direct System Delivery Partners, Place, Communicatees and Democratic Accountabilities, Education, Workforce and Skills, Research, Innovation and Regulation and Commercial and Enabling Ecosystem. However, this is not an exhaustive list.

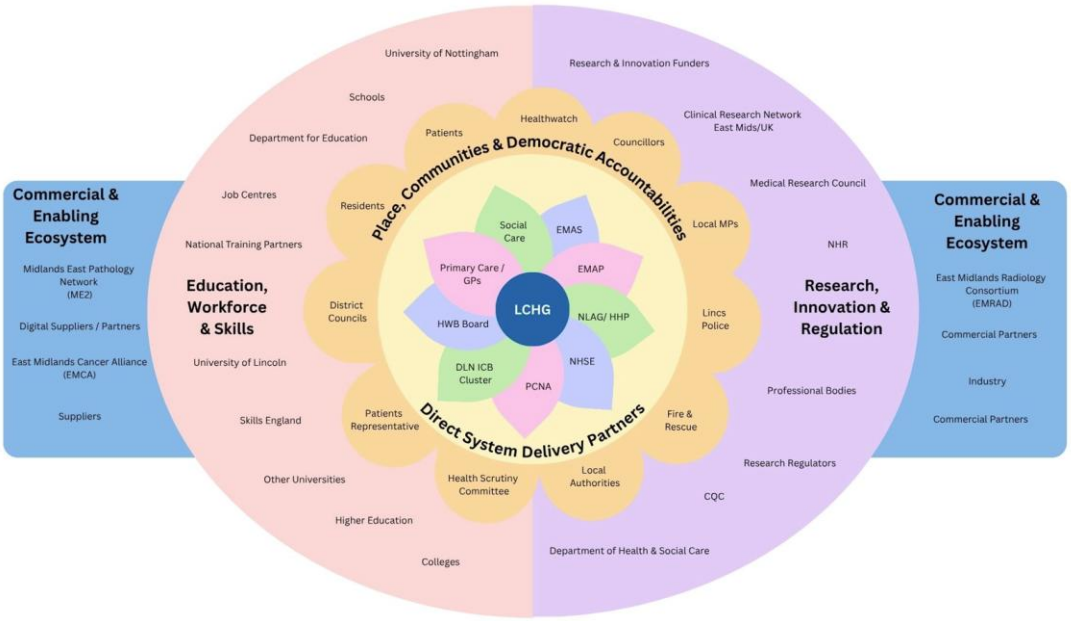


Figure 2 LCHG Stakeholder/Partnership Universe

All partners are stakeholders, but not all stakeholders are partners. Stakeholders influence our work; partners help to deliver it with us.

Partners are organisations or groups with whom the Group has a shared accountability for outcomes, shared objectives, or formal agreements to deliver services or outcomes. Our partners are those who help us deliver our strategic priorities and transformation and who we share risks, resources and objectives with.

There will be varying degrees of strategic engagement and importance required across our stakeholders and partners depending on the focussed area of work involved. In order to ensure that we secure the maximum impact from our strategic partnerships, there will be clear ownership of the relationships between LCHG board members and operational leads for all partnership activities. More detail on this can be found in Appendix 2: Stakeholder/partner executive leads.

To support our understanding of the areas of strategic focus that our partnerships will support, Table 1 below outlines the key partner types, lists some of these partners alongside their role to support delivery of our strategic aims and objectives and the engagement approach we will take.

Partner Type	Key Partners	Role in Delivery	Engagement Approach
Statutory Partners	Lincolnshire Partnership Foundation Trust, Lincolnshire County Council, East Midlands Acute Provider network	Strategic alignment, **maximise use of collective resources,** and **collective development and oversight of system priorities**.	System governance groups e.g., BLLET; LLG; System delivery groups e.g., Planned and UEC Care Boards, Neighbourhood Health and Care Board; strategic networks e.g., EMAP board, joint planning workshops; enablers including shared metrics e.g., INW dashboard.
Primary Care and General Practice	GPs, PCNs, LMC, GP Federations, Community Pharmacy,	Delivery of **neighbourhood health and community-based services.**	Neighbourhood Health and Care Board; MDT forums; shared workforce; digital initiatives; lead

Partner Type	Key Partners	Role in Delivery	Engagement Approach
	Dentistry, and Optometry.		provider models; subcontracting delivery.
Voluntary & Community Sector	LVET, St Barnabas, Age UK Lincolnshire, Marie Curie, Carers UK, HART, Macmillan, local community groups	**Resilient communities** (support community capacity, wellbeing, and social prescribing); service delivery partner.	Community resilience; co-production groups; Community Leadership Network; meaningful delivery partners (lead provider/subcontracting models).
Commissioners	Derbyshire, Lincolnshire and Nottinghamshire (DLN) ICB, Lincolnshire County Council, NHS England	**Commissioning for population need;** innovative / new delivery models e.g., lead provider.	BLLET; LLG; system delivery groups; Health and Wellbeing Board; Health Scrutiny Committee; contract monitoring forums.
Academic & Innovation Partners	University of Lincoln, Health Innovation East Midlands, Lincolnshire Institute for Rural and Coastal Health	**Workforce development**; **research**; evaluation; and **innovation** adoption.	Annual research symposium; shared learning academies; communities of practice; data-sharing agreements.
Commercial & Anchor Partners	Local employers, suppliers, and estate partners,	**Anchor commitments** e.g., skills,	Anchor Partnership Board; Green and Economic Taskforce;

Partner Type	Key Partners	Role in Delivery	Engagement Approach
	University of Lincoln	sustainability, local procurement, and innovation adoption.	local business networks/Chamber of Commerce; Combined Mayoral Authorities.
Patients & Citizens	Patient Panel, Patients with Lived Experience, University of Lincoln, GPs, ICB, Healthwatch Lincolnshire (and alternative bodies post closure), Patient Participation Groups.	Involvement in **co-design**, **feedback**, and governance.	LCHG patient engagement team; Neighbourhood engagement panels; digital feedback platforms.

Table 1 – Partner Types

Evolving Models of Partnership

As the Lincolnshire system matures, organisations are moving from transactional service arrangements to **collaborative and transformational partnerships** that share accountability for outcomes, resources and improvement.

LCHG will work with partners at neighbourhood, place and system level to:

- Integrate care and pathways.
- Share and use intelligence and population health insight.
- Communicate, engage and consult effectively with partners and other stakeholders.

- Redesign workforce models to support left-shift and partnership pathways.
- Accelerate digital and innovation adoption.
- Deliver our Anchor responsibilities.
- Maximise social, clinical, economic and environmental value.

This evolution is represented in the *Spectrum of Integration* (Figure 3) which can be used to support across a number of clinical or non-clinical partnerships approaches.

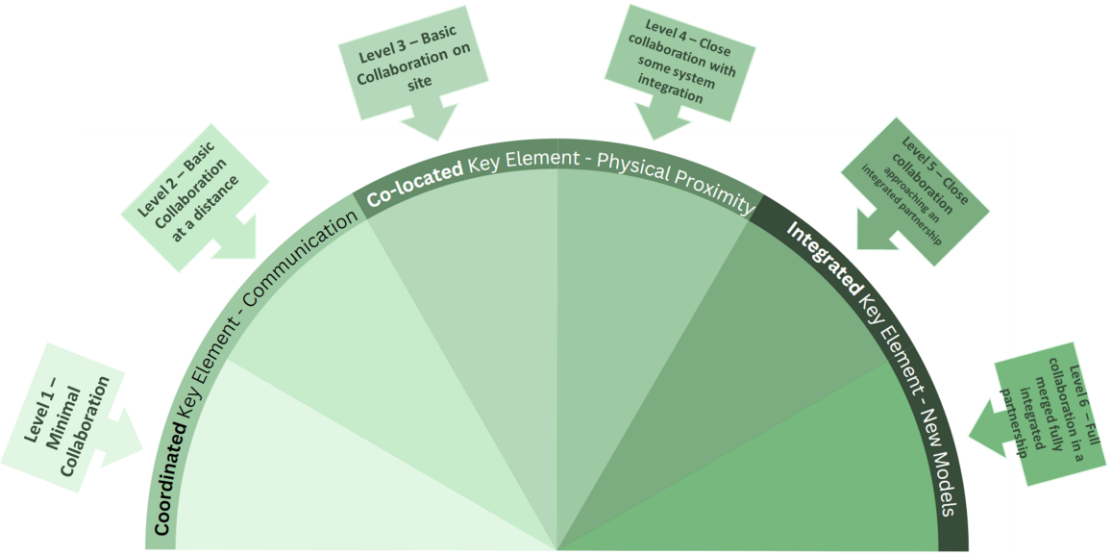


Figure 3 LCHG Spectrum of Integration

In order to illustrate the spectrum of integration above, an example of what this could look like for each level has been provided below in Table 2:

Level	Characterised by	Examples
Level 1 – Minimal Collaboration	Isolated working, ad-hoc communications and no shared planning	Occasional, reactive email exchanges between LCHG Clinicians and GPs about specific patient issues Referring a patient for social services assessment with no shared plan

Level 2 – Basic collaboration	Regular communication but still no shared workforce, systems or physical space	Regular virtual MDTs between LCHG and GPs Routine clinical liaison huddles with LPFT for patients with complex mental & physical health needs Telemedicine consultations with tertiary clinicians
Level 3 – Basic collaboration on site	Teams work in the same building or hub, with separate systems and governance	GPs or PCN teams co-located within LCHG sites to support rapid assessment pathways Social workers embedded in hospital discharge teams Visiting tertiary consultants running outreach clinics on LCHG sites
Level 4 – Close collaboration with some system integration	Shared teams, shared pathways, shared processes but separate organisations	Integrated Discharge Teams Joint chronic disease management pathways e.g. shared heart failure pathways with community diagnostic input Shared regional elective recovery programmes e.g. coordinated waiting lists for mutual aid
Level 5 – Close collaboration in consistent partnerships	Shared governance, joint service leadership, pooled workforce or budgets	Development of INTs/neighbourhood Health and Care Plans

		Formalised specialty networks e.g. stroke or vascular Primary Care Network Alliance (PCNA) formal and informal collaboration including contracted delivery arrangements
Level 6 – Extensive integration across organisational boundaries	New models of care, shared budgets, blended teams and single pathways across a system	The LCHG Model – unified Board System-wide integrated urgent and emergency care models Neighbourhood Hubs Regional networks with a single waiting list and workforce across the east midlands

Table 2 – Spectrum of Integration Examples

Our Six Partnership Principles

To deliver this plan, strategic partnerships will be underpinned by the LCHG Partnerships Principles outlined below, ensuring we focus our attention and energy on those partnerships which will provide the most impact on the delivery of our strategic aims and objectives.

1. **Population Health & Equity**: Partnerships will improve outcomes and reduce inequalities for our population.
2. **Innovation & Research:** Partnerships will accelerate research, digital solutions and new models.
3. **Sustainability & Value:** Partnerships will enable environmental stewardship and efficient use of resources.

4. **Personalisation & Empowerment:** Partnerships enable the co-design of services with communities, through engagement and consultation.
5. **Workforce & Capability:** Partnerships will strengthen the redesign of workforce models and leadership, supporting the development of current and future workforce.
6. **Commercial & Economic Value:** Partnerships will enable ethical income-generating opportunities with industry and the independent sector, where net returns are reinvested to strengthen NHS services.

Figure 4: Our Partnership Principles

The seven areas of strategic focus from a partnership perspective that will contribute most significantly to the delivery of our Strategic Aims and Objectives are set out in the next few pages. These all align to one or more of the partnership principles above, as should be the case for all LCHG strategic partnership activities.

1. Strengthen Neighbourhoods & Community Partnerships to Deliver Hospital to Community Shift

Purpose:

To work with system partners to shift care closer to home by strengthening neighbourhood-level collaboration, redesigning pathways, and developing integrated models that reduce avoidable hospital activity while improving patient experience and outcomes.

What we will do

- Integrated Neighbourhood Delivery – embed INT's with shared risk, governance and performance arrangements, test and scale urgent neighbourhood service models, develop and implement neighbourhood health contract models e.g. lead provider, IHO
- Pathway and Model Redesign – support left-shifted care including virtual wards, joint budgets and shared clinical leadership, strengthen primary-community-secondary care interfaces to improve flow and reduce fragmentation
- Estates and Enablers – explore integrated neighbourhood estate solutions including local hubs and expanded use of CDC's, align procurement and commissioning models to support innovation, flexibility and value
- Communities and Prevention – partner with the VSFCE sector to support resilient communities, prevention and self care, collaborate on public health priorities aligned to neighbourhood health

Key Partners

- Primary Care networks, General Practice and wider primary care,
- Acute providers, wider NHS Partners, ICB, Health and Wellbeing Board and ICS/ICP partners
- Adult social care and Public Health
- Voluntary, Community, Faith and Social Enterprise (VCFSE)organisations

What Success Looks Like (Expected Outcomes)

- Reduced avoidable emergency attendances and admissions, reduced length of stay and improved patient flow
- Improved access to community services, improved neighbourhood maturity and integration indicators, shared KPI's for INT's
- Improved patient and staff experience
- Increased delivery of care away from the acute estate

Leadership and Alignment

- Executive Lead: Group Chief Integration Officer & Group Chief of Estates & Facilities
- Strategic Objectives Supported: 1a, 1b, 1d, 3a, 3b
- Partnership Principles: Population Health & Equity, Sustainability and Value, Personalisation & Empowerment, Commercial & Economic Value

2. Improved Sustainability of Services through Collaboration

Purpose:

To improve the sustainability and resilience of clinical services by working with system partners to identify, mitigate and reduce service fragility, ensuring safe, high-quality and continuous care for patients.

What we will do

- Manage Fragility and Risk – implement the Sustainable Services review (SSR) framework across the Group, refresh fragility assessments and develop targeted action plans
- Collaborative Solutions – develop shared clinical pathways and services models across the EMAP footprint
- Oversight and Visibility – Improve organisational and system wide visibility of fragile services and ensure fragility and sustainability considerations are embedded within continuous planning

Key Partners

- EMAP provider organisations
- ICB
- Primary Care networks and General Practice
- Lincolnshire County Council and system partners

What Success Looks Like (Expected Outcomes)

- Reduced service fragility and clinical risk
- Improved continuity of care and access to services
- Improved staff moral and retention in fragile services
- Clear system understanding of sustainability risks and mitigation plans

Leadership and Alignment

- Executive Lead: Group Chief Integration Officer & Group Chief Operating Officer
- Strategic Objectives Supported: 1a, 1c, 3a
- Partnership Principles: Population Health & Equity, Sustainability and Value

3. Working with partners to develop our workforce through education, research and innovation, and estates partnerships

Purpose:

To develop a resilient, skilled and future-ready workforce by working with system, academic and industry partners across education, research, innovation and estates.

What we will do

- Workforce Supply and Development – develop shared workforce models, joint roles and rotational posts, expand entry level and early career routes
- Health, Wellbeing and retention – work collaboratively to expand support for staff
- Promote healthier, more resilient workforces across partner organisations
- Research & innovation – Build capability and partnerships to support research readiness and growth in R&I activity, strengthen engagement with higher education to develop clinical academics
- Estates – address critical workforce risks within estates and facilities, including recruitment

Key Partners

- Schools, FE and HE providers (including University of Lincoln)
- Health Innovation East Midlands and research networks
- Industry and commercial partners
- Local and national workforce, skills and training bodies
- EMAP and NHS system partners

What Success Looks Like (Expected Outcomes)

- Improved recruitment, retention and vacancy rates
- Increased participation in joint training and education programmes
- Growth in research activity, funding and clinical academic roles
- Improved staff wellbeing and reduced sickness absence
- Improved workforce sustainability in E&F

Leadership and Alignment

- Executive Lead: Group Chief People Officer, Integration Officer, Group Chief Medical Officer, Group Chief of Estates and Facilities
- Strategic Objectives Supported: 2a, 2b, 3c, 3d
- Partnership Principles: Workforce & Capability, Innovation & Research, Sustainability and Value

4. Amplifying our impact through Digital and Emerging Technology Partnerships

Purpose:

To work with partners to harness digital innovation and emerging technologies to improve access, quality, productivity and patient experience, while reducing digital exclusion.

What we will do

- Digital Transformation – expand use of remote monitoring, virtual care and AI enabled solutions, align digital transformation with system wide priorities and the EMAP Digital & data Collaborative
- Innovation & data – scope the development of an Innovation Hub with academia, technology and voluntary sector partners, support safe and ethical use of anonymised data for research and innovation
- Inclusion and Access – ensure digital solutions are accessible and inclusive, with targeted support for those at risk of digital exclusion

Key Partners

- NHS Trusts and system partners
- Universities and research institutions
- Technology and industry partners
- Primary care, VCFSE organisations and communities

What Success Looks Like (Expected Outcomes)

- Improved digital maturity and capability
- Improved access, choice and patient experience
- Reduced digital exclusion
- Attraction of high-quality innovation and commercial partners
- Sustainable digital solutions that support environmental goals

Leadership and Alignment

- Executive Lead: Group Chief Integration Officer
- Strategic Objectives supported: 1c, 2b, 3c
- Partnership principles: Innovation & Research, Population Health & Equity, Sustainability and Value

5. Building Our Commercial Partnerships and Sponsorship Opportunities

Purpose:

To strengthen financial sustainability by developing commercial partnerships, income-generating opportunities and innovative service models that support patient care and system objectives.

What we will do

- Commercial Capability – establish processes, tools and capacity to support bids, tenders and commercial opportunities
- Income Generation – develop new income streams including advertising concessions, private patient services and repatriation of activity
- Collaborative Growth – work with partners to bring care closer to home and reduce reliance on out of area provision

Key Partners

- EMAP partners
- Industry and commercial partners
- Independent sector partners
- ICB and estates partners

What Success Looks Like (Expected Outcomes)

- Increased commercia income and financial resilience
- Successful bids and tenders aligned to Group strategy
- More patients receiving care locally
- Stronger, more sustainable partnerships with Industry

Leadership and Alignment

- Executive Lead: Group Chief Integration Officer
- Strategic Objectives Supported: 1c, 1d, 3a, 3c
- Partnerships Principles: Sustainability & value, Commercial and Economic Value, Innovation & Research

6. Delivering on Our Anchor and Green Responsibilities through Partnership

Purpose:

To maximise LCHG's role as an anchor institution by working with partners to deliver social value, support the local economy, and progress towards net zero.

What we will do

- Social Value and Anchor Impact – embed anchor metrics into performance and procurement processes, support local and regional businesses, including SME's to participate in procurement opportunities
- Green Plan Delivery – deliver green plan commitments through collaborative approaches to sustainability, estates and procurement, strengthen partnerships with academia to support environmental initiatives
- Procurement and Capability – promote sustainable procurement and system wide integration with national frameworks, provide training and support to embed best practice and social value approaches

Key Partners

- NHS and system partners
- Local authorities and public health
- Higher education providers
- Local, regional and national suppliers
- VCFSE organisations

What Success Looks Like (Expected Outcomes)

- Progress towards net zero and reduced carbon footprint
- Increased local employment and supplier spend
- Improved health inequalities outcomes
- Stronger, more sustainable procurement practices

Leadership and Alignment

- Executive Leads: Group Chief Integration Officer, Group Chief of Estates & Facilities, Group Chief Finance Officer
- Strategic Objectives Supported: 1d, 2a, 3d
- Partnership Principles: Sustainability & Value, Workforce & Capability, Commercial & Economic Value

7. Maximising Opportunities through the East Midlands Acute Provider (EMAP) Partnership

Purpose:

To improve equity, quality and sustainability of acute services by collaborating across the EMAP partnership to deliver shared solutions for patients and the system.

What we will do

- Equity and Access – identify opportunities to improve equity of care and outcomes across specialist pathways, reduce unwarranted variation
- Shared Delivery and Resilience – collaborate on sustainable service reviews, workforce and procurrent initiatives, provide mutual aid and coordinate improvement networks
- Commercial and Service Opportunities – scope joint commercial and service opportunities where they support patient outcomes and system value

Key Partners

- EMAP Acute Trusts
- ICB and regional partners
- Independent Sector and higher education partners

What Success Looks Like (Expected Outcomes)

- Improved equity of patient access and outcomes
- Reduced service fragility and waiting times
- Improved continuity of care across pathways
- Financial and operational benefits from shared initiatives

Leadership and Alignment

- Executive Lead: Group Chief Integration Officer
- Strategic Objectives Supported: 1a, 1b, 1c, 3a, 3b
- Partnership Principles: Population Health & Equity, Sustainability & Value, Workforce & Capability

Measuring Success

All partnership initiatives will have associated KPI

existing governance structures and to the relevant committees that oversee the specific enabling plans e.g. partnerships that improve productivity and deliver financial sustainability may report into the Finance Committee, partnerships that help to transform clinical pathways will report into the Integration Committee and partnerships that support the development of our people through training and education will report into the People Committee.

Figure 5 illustrates some examples of the KPIs that effective partnerships can contribute towards achievement of the strategic aims and objectives of the Group:

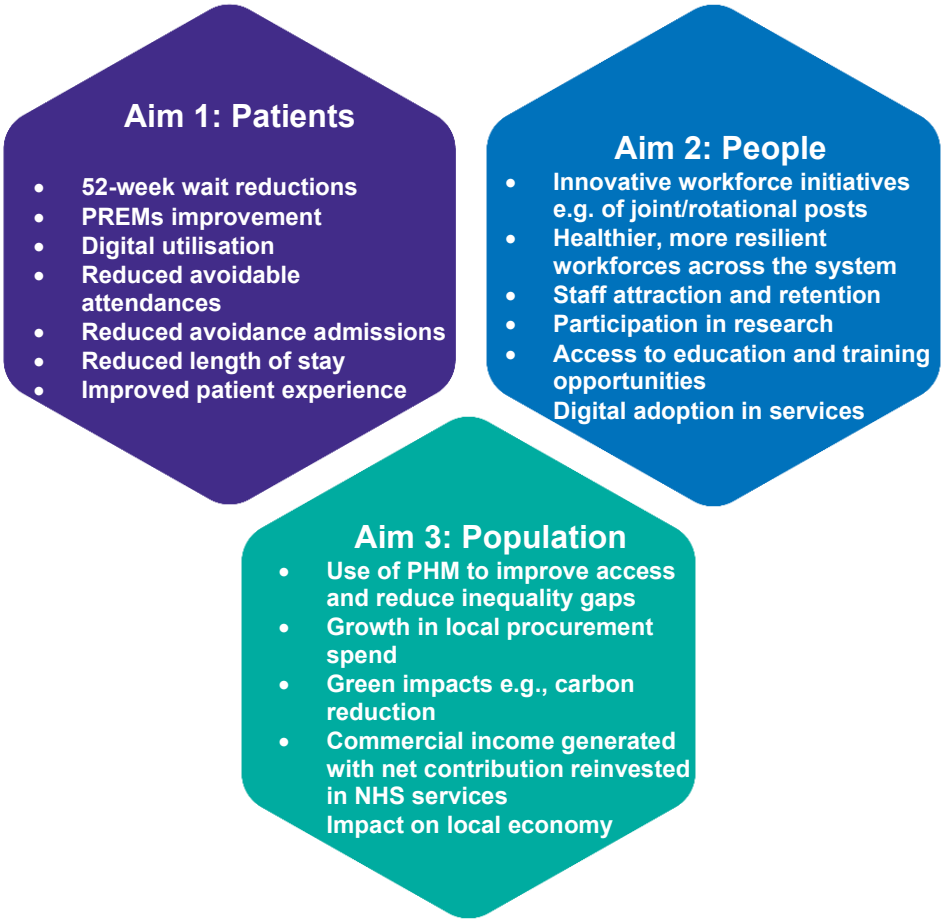


Figure 5 – KPI example

To monitor the delivery of this enabling plan, a quarterly report will be submitted to the Integration Committee on how our partnerships are helping us to deliver against our Strategic Aims and Objectives. The report will highlight successes, challenges, risks, and opportunities in partnership delivery.

How we measure partnership effectiveness

We will also gather data to monitor the effectiveness of our partnerships through the Partner Feedback Tool; a survey aligned to Kings Fund collaboration principles (see Appendix 4: Partnership Assessment Questionnaire).

Get In Touch

This enabling plan reflects our commitment to improving partnerships across the Group, and we would like to thank our dedicated teams of staff, our patients and our system partners for your collaborative efforts which will enable this strategy to become a reality, ultimately improving the health of our Lincolnshire residents.

If you would like any further information regarding this enabling plan, please contact ulth.sirtadminsupport@nhs.net

Appendices

Appendix 1: References

Publication name	Web link
NHS 10-Year Plan 2025	10 Year Health Plan for England: fit for the future
Lincolnshire Integrated Community Partnership Strategy 2024	ICP Strategy 2024
Lincolnshire Joint Health and Wellbeing Strategy 2024	JHWS approved
NHS Lincolnshire Joint Forward Plan 2023-28	NHS Lincolnshire Joint Forward Plan 2023-28
NHS Lincolnshire Joint Forward Plan Delivery Plan 2023-28	NHS Lincolnshire Joint Forward Plan 2023-28 Delivery Plans
Lincolnshire Joint Strategic Needs Assessment	JSNA - Lincolnshire Health Intelligence Hub
Director of Public Health Annual Report 2024	DPH-Annual-Report-2024.pdf
Better care, Better opportunities, Better health, LCHG Group Strategy 2025-30	Lincolnshire-Community-and-Hospitals-NHS-Group-strategy.pdf
Neighbourhood Health Framework	Neighbourhood health framework
Fit for the future: towards population health delivery models	Fit for the future: towards population health delivery models
LCHS Green Plan 2025-28	LCHS Green Plan 2025-28
ULTH Green Plan 2025-28	ULTH Green Plan 2025-28
LCHG One Digital Strategy 2025-28	LCHG One Digital Strategy 2025-28
LCHG People Strategy	In development in 2025/6
LCHG Research and Innovation Strategy	In development in 2025/6
LCHG Estates Strategy	In development in 2025/6

Appendix 2: Stakeholder/Partner Executive Leads

Stakeholder/Partner	Executive Lead	Key areas of Focus	LCHG Strategic Aim/Objective
LCHG Staff	Group Chief People Officer	Culture change programme Transformation projects Single entity Staff surveys	2a, 2b, 2c, 2d
Staffside/Unions	Group Chief People Officer	Staff consultation	2a, 2b, 2c, 2d
University of Lincoln	Group Chief Medical Officer Group Chief Nurse Group Chief People Officer	University Hospital Status R&D activity, culture and capability Workforce development Innovation	2a, 2b, 2c, 3c
CQC	Group Chief Nurse Group Chief Clinical Governance Officer	Patient Safety/Standards of Care Effectiveness Caring Responsive Well-led	1a, 1b, 1c, 1d, 2c
NIHR	Group Chief Medical Officer	Growing research activity, culture and capability	1a, 2a, 3c
Health & Wellbeing Board	Group Chief Executive Officer Group Deputy CEO/Group Chief Integration Officer Group Chief Finance Officer	Delivery of safe and timely services Financial sustainability Key service developments/change	1a, 1b, 1c, 1d, 3a, 3b, 3d

Media	Group Chief Executive Officer	All aspects of service provision	All
Schools/Colleges	Group Chief People Officer	Workforce pipeline	2a, 2b, 2c
EMAP	Group Chief Integration Officer	EMAP 26/27 programme	1a, 1b, 1c, 3a, 3b, 3c
Third Sector (LVET)	Group Chief Integration Officer	Neighbourhoods and Resilient Communities	3a, 3b
NHSE	All Execs	Financial sustainability Key service developments/change Workforce sustainability and development	All
Primary Care/PCNA/GP's	Group Chief Integration Officer Group Chief Medical Officer	Neighbourhoods Interface Left shift	1a, 1b, 1c, 3a, 3b
Patients/Residents	Group Chief Nurse	Single entity Key service developments/change including left shift, neighbourhoods Delivery of safe and timely services Co-design & feedback	1a, 1b, 1c, 1d, 2a, 3a, 3b
Lincolnshire Health Scrutiny Committee	Group Chief Executive Officer	Delivery of safe and timely services Single entity Key service developments/change including left shift and neighbourhood	1a, 1b, 1c, 3a, 3d
Local MPs	Group Chief Executive Officer	Single entity Key service developments/ change including left shift	All

		Quality/regulatory issues	
Healthwatch Lincolnshire	Group Chief Nurse	Delivery of safe and timely services Financial sustainability Key service developments/change	1a, 1b, 1c, 1d, 3a, 3b, 3d
Digital Suppliers	Group Chief Integration Officer	EPR Digital Innovation Patient Services hub	1a, 1c, 3a, 3b, 3c
Estates Suppliers	Group Chief Estates Officer	Estates capital programme	1d, 3a, 3d
Local Authorities (including social care)	Group Chief Executive Officer Group Chief Integration Officer Group Estates Officer Group Chief Operating Officer	Neighbourhoods Key service developments/change including left shift, discharge and flow and Intermediate care Estates transformation	1a, 1b, 1c, 3a, 3b
DLN ICB Cluster	All execs	Delivery of safe and timely services Financial and service sustainability Key service developments/change Workforce sustainability and development	1a, 1b, 1c, 3a, 3b

Appendix 3: Glossary of Terms

Abbreviation/ terminology	In full	Description
Anchor Institution	Anchor Institution	First developed in the US, the term anchor institution refers to large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve by being a large local employer and having purchasing power.
CQC	Care Quality Commission	CQC is the independent regulator of health services and adult social care in England.
Communities	Communities	Groups of people that are interconnected, by where they live, how they identify or shared interests. They can exist at all levels, from neighbourhood to national, and be loosely or tightly defined by their members.
INW	Integrated Neighbourhood Working	Local network and neighbourhood team arrangements and deliver care closer to home by supercharging joint working across statutory and non-statutory services at a locality level.
Core20PLUS5	Core20PLUS5	Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.
EMAP	East Midlands Acute Providers	A collaborative of 8 acute providers within the East Midlands including United Lincolnshire Hospitals NHS Trust, Nottingham University Hospitals NHS Trust, Chesterfield Royal Hospital NHS Foundation Trust, University Hospitals of Leicester NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, United Hospitals of Derby and Burton NHS Foundation Trust, Northampton

		General Hospital NHS Trust and Kettering General Hospital NHS Trust.
HIEM	Health Innovation East Midlands	Established by NHS England in 2013 to spread innovation at pace and scale – improving health and generating economic growth (previously known as East Midlands Academic Health Science Network).
ICP	Integrated Care Partnership	Each ICS is required to have a partnership at system level established by the NHS and local government as equal partners. The ICP is a Joint Committee of the ICB with the local authority, rather than a statutory body. Lincolnshire only has one upper tier local authority, namely Lincolnshire County Council, and as such only has one ICP called the Lincolnshire Integrated Care Partnership.
ICP	Integrated Care Partnership	NHS organisations and upper-tier local authorities in each Integrated Care System convene a joint committee called an ICP. However, the ICP is a broad alliance of partners who all have a role in improving local health, care and wellbeing including social care, VCFSE, education, housing, employment, police and fire services.
ICS	Integrated Care System	Integrated Care Systems (ICSs) are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population. The following partners make up the Lincolnshire ICS: East Midlands Ambulance Service NHS Trust (EMAS), Lincolnshire Community and Hospitals Group (LCHG), Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire County Council

		(LCC). The Lincolnshire ICS is known as 'Better Lives Lincolnshire'.
INW	Integrated Neighbourhood Working	INW describes a collaborative approach where partners across health, social care, local councils, VCFSE, fire, police etc, work together with local people to deliver improved neighbourhood health by coordinating their efforts and addressing needs holistically within a community. INW aims to break down silos and address complex issues that affect health and wellbeing.
LICB	Lincolnshire Integrated Care Board	The NHS Lincolnshire Integrated Care Board (ICB) is a statutory body which came into being on the 1st July 2022 with the general function of arranging for the provision of services for the purposes of the health service in England in accordance with the Health and Care Act 2022.
Neighbourhood Health	Neighbourhood Health	Neighbourhood Health focuses on improving the overall health and wellbeing of people within a specific local area. It could involve initiatives to promote healthy lifestyles, address local health concerns, and improve access to services.
Personalisation	Personalisation	Represents a different relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to have a voice, to be heard and be connected to each other and their communities. Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs.
PCN	Primary Care Network	A group of GP practices that collaborate with other local health and social care services to provide integrated care for their community. PCNs are

		designed to allow practices to offer a wider range of services than they could on their own, improve patient access, and better coordinate care by working with community services, social care, mental health, and voluntary organisations. They typically serve communities of 30,000 to 50,000 people.
PCNA	Primary Care Network Alliance	PCNA is a collaborative organisation dedicated to supporting PCNs and GP practices across Lincolnshire. It works to strengthen primary care, drive innovation, and foster partnerships across health and social care to improve patient outcomes and is in the process of becoming a legal entity.
PH	Population Health	The broad goal of improving physical and mental health outcomes, promote well-being, and reduce health inequalities for a group of people or across an entire population.
PHM	Population Health Management	Improves population health through data-driven planning and the delivery of proactive care to optimise health outcomes e.g., using data analysis, risk stratification, and partnerships to proactively design and implement interventions that address specific health issues, reduce inequalities, and improve overall community well-being.
Resilient Communities	Resilient Communities	Community resilience is the sustained ability of communities to withstand, adapt to, and recover from adversity. Health—meaning physical, behavioural, social, and environmental health and wellbeing—is a big part of overall resilience.
SSR	Sustainable Service Review	Services where because of either and/or both sustained demand or capacity drivers there is difficulty meeting statutory targets, national

		guidance/accreditation or safe levels of staffing (previously referred to as fragile services).
VCFSE	Voluntary, Community, Faith and Social Enterprise Sector	A diverse sector of non-governmental, non-profit organisations providing services, support, and activities within local communities. The sector plays a key role in connecting communities, supporting vulnerable people, and working with public sector bodies like the NHS and local councils to improve health and well-being outcomes.

Appendix 4: Partnership Assessment Questionnaire

How will we know if we are a good partner?

Our principles for effective partnerships are based on those proposed by the Kings Fund (The practice of collaborative leadership: Across health and care services, July 2023). This framework can be used by **anyone involved in developing or managing partnerships** to help them deliver their strategies or strategic priorities.

1. Safe, inclusive and trusting environment

This means:

- Putting the values of the partnership into practice.
- Partners showing commitment to the partnership by ensuring the appropriate level of membership.
- The partnership communicates effectively to people outside the partnership and promotes what they do.

2. Build and maintain relationships

This means:

- Being clear about the functions and roles of the partnership ensuring effective delivery and implementation.
- Being clear about the partnerships lines of responsibility and ensuring these are made clear to the public.

3. Developing a shared purpose

This means:

- Being clear about the purpose of the partnership and its intended outcomes.
- Ensuring partners actively commit to working together.
- Ensuring members are responsible for the work of the partnership.
- Ensuring partnership aims are consistent with other plans and priorities.

4. Managing power dynamics, surface and manage conflict

This means:

- Partners feel they have equal influence and power within the partnership.
- Partner members ensure their organisational plans reflect partnership priorities.
- There are clear processes for engaging and disengaging form the partnership.

5. Shared decision-making processes

This means:

- Being rigorous and clear about how decisions are made.
- Having and using good quality information, advice and support.
- Ensuring that an effective risk management system is in operation.

Completing the Assessment

There are two purposes for the Partnership Assessment Questionnaire:

- To review **existing partnerships** at regular intervals and provide recommendations on how to improve partnership working where it is needed.
- As a checklist during the **establishment of a new partnership** to ensure the best possible partnership working is achieved from the outset.

The assessment uses a traffic light scoring system to identify the areas that are working well and those where improvements could be made:

Red	Principles not embedded; partnership outcomes not yet achieved. Partnership does NOT meet a specific requirement.
Amber	Progress visible but inconsistent across partnerships. Partnership could be IMPROVED around that requirement.
Green	Partnership principles consistently demonstrated; measurable benefits realised. Partnership is working EFFECTIVELY around the requirement.

Annual self-assessment against this framework will provide transparent evidence of partnership maturity and impact, reported via the It is recommended that an Action Plan is developed to help focus on the activities required to improve any red or amber scores.

1. Safe, inclusive and trusting environment

a. Does the partnership put their values into practice, and do members promote these values externally?			
Red	**Amber**	**Green**	**RAG rating**
Partners cling to their own organisational culture at a cost to the partnership and don't share or understand the values of the partnership	The partners values are understood by all members	Partners actively stick to and promote the values of the partnership both internally and externally	

b. Do partners show their commitment to the partnership by sending the appropriate level of staff to the partnership or board?			
Red	**Amber**	**Green**	**RAG rating**
Partners send different representatives to each board meeting who never seem to be briefed or able to make decisions	Partners have commitments to the partnership. Sometimes resource is an issue and it is difficult to send the most appropriate member of staff	Partners have the appropriate commitment to the progress of the partners and invest in this by sending the most appropriate member of staff	

c. Does the partnership communicate effectively to people outside of the partnership and promote what they do and their achievements?			
Red	**Amber**	**Green**	**RAG rating**
The partnership has poor communication internally and externally and does not promote achievements	The partnership has good lines of communication	The partnership communicates and effectively promotes what they do and their achievements	

2. Build and maintain relationships

a. Are the functions and roles of the partnership clearly defined?			
Red	**Amber**	**Green**	**RAG rating**
Partners have been forced to engaged in the partnership and don't feel they understand how the partnership works	The partnership has defined functions and roles which at times are difficult to carry out	The partnership has clearly defined functions and roles for delivery which are carried out	

b. Does the partnership have clear lines of responsibility?			
Red	**Amber**	**Green**	**RAG rating**
Partners members don't know what the partnership is responsible for	The partnership has clear lines of responsibility, but these are not published	The partnership has clear lines of responsibility which are made clear to members and the public	

3. Shared purpose of the Partnership

a. Have all partners taken part in creating the vision for the partnership and is there a collective understanding of the purpose?			
Red	**Amber**	**Green**	**RAG rating**
Finding excuses and putting up blocks to developing a shared vision and purpose for the partnership. Partners don't know or understanding their roles.	Partners believe the vision is important but other commitments may get in the way of supporting the development of the vision fully. Partners feel personally responsible for the work of the partnership, but other organisational priorities get in the way	Partners actively commit time and energy to work together positively to shape the vision and understanding and commitment to the purpose is clear	

b. Does the partnership have a partnership agreement?			
Red	**Amber**	**Green**	**RAG rating**
Excluding communities and other stakeholders in the development of the vision	The partnership has developed a partnership agreement that most partners have signed up to	Partners have developed a partnership agreement which all partners have agreed to and the agreement defines fair and equitable membership	

c. Are the partnership aims consistent with other relevant plans and priorities?			
Red	**Amber**	**Green**	**RAG rating**
The partnership aims do not relate to other plans and priorities	The partnership aims are consistent with most other plans and priorities	The partnership aims are fully consistent with other plans and priorities	

d. Are good relationships in place that enable the building of trust between partners?			
Red	**Amber**	**Green**	**RAG rating**
Partners concentrate on their own organisational priorities to the detriment of other partners	Members recognise the importance of building relationship and trust however its isn't always easy to deliver	The partnership develops relationships that enable the building of rust between partners	
e. Do the vision/aims of the partnership agreements include equality, diversity and inclusion?			
Red	**Amber**	**Green**	**RAG rating**
Not being inclusive or adhering to EDI	The vision/strategic objectives adhere to equality however some members need support to develop their practices in relation to equalities	The vision/strategic objectives and practices adhere to EDI	

4. Managing power dynamics, surface and manage conflict

a. Do all members feel they have equal influence and power within the partnership?			
Red	**Amber**	**Green**	**RAG rating**
Not knowing or ignoring rules of engagement	The partnership respects and values feedback form all members. However, some members can become uncomfortable with constructive feedback or have difficult offering this	Respecting and valuing feedback from partners and feeling comfortable giving and receiving constrictive feedback	

b. Do partner's members ensure their organisational plans reflect partnership priorities?			
Red	**Amber**	**Green**	**RAG rating**
Individual members don't think the priorities of the partnership are important to them or their organisation	Most partner organisational plans reflect partnership priorities	Individual partner organisations' plans reflect and embrace partners priorities	

c. Are there clear processes for engaging and disengaging form the partnership?			
Red	**Amber**	**Green**	**RAG rating**
The partnership does not communicate its processes/rules for engaging and disengaging	The partnership has processes for engagement and disengagement however these are not communicated beyond the partnership	Clear processes are in place and communicated for engaging and disengaging from the partnership	

5 Shared Decision Making

a. Do partner representatives have the authority to take decisions on behalf of their organisations?			
Red	**Amber**	**Green**	**RAG rating**
Not being fully committed to the partnership purpose and not having the authority to make decision on behalf of your organisation	Members of the partnership are committed although they are not entirely able to make decision on behalf of their organisation	Partners have full commitment to the partnership purpose and are able to make decision on behalf of their organisation	

b. Does the partnership have a mechanism for resolving disputes?			
Red	**Amber**	**Green**	**RAG rating**
There is no mechanism for resolving disputes	The partnership has a system for resolving disputes but has never tested its effectives	The partnership has effective mechanisms for resolving disputes and these have been tested	

c. Does the partnership make effective use of resources and is the impact of these measured?			
Red	**Amber**	**Green**	**RAG rating**
The partnership is not open, honest and transparent about resource allocation and not measuring impact. There is no dedicated resources or support mechanisms in place	The partnership has committed to being open, transparent and honest but sometimes members feel uncomfortable with this. Support and dedicated resources not always available	The partnership has dedicated resources and support mechanisms in place. It is open, honest and transparent about resource allocation ensuring impact is measured and efficiencies are made where possible	

d. Does the partnership have a programme for managing risk?			
Red	**Amber**	**Green**	**RAG rating**
Ignoring any risks and failing to put in place programmes for managing these	The partnership is honest about risk and tries to manage risk	Being upfront and honest about risk and being prepared to take managed risks, with appropriate mechanisms in place for risk management and mitigations	

Integration Committee
Terms of Reference

1. Authority

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

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

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

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

2. Purpose of the Committee

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

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

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

The relevant group strategic aim & objectives aligned to the Integration Committee for 2026 / 27 are:

Population: Better Health – Improve Population Health:

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

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

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

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

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

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

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

3. Membership

The members of the committee are:

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

The following roles will be routine attendees at the Committee:

- Group Director of Corporate Affairs or their representative
- PCNA Representative
- Group Deputy Chief Integration Officer
- Group Director of Strategy Improvement and Redesign

4. Attendance and Quorum

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

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

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

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

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

Observers will be permitted as agreed by the committee chair.

5. Frequency

The committee will meet monthly.

6. Specific Duties

The Integration Committee will:

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

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

7. Administrative support

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

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

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

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

8. Accountability and Reporting Arrangements

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

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

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

9. Monitoring effectiveness and Compliance with Terms of Reference

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

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

10. Review of Terms of Reference

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

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

Approved: May 2026

Approved by: Group Board

Next Review Date: April 2027

United Lincolnshire Hospitals NHS Trust

Annual Report to the Group Board from the Integration Committee 2025/26

ROLE OF THE COMMITTEE

In 2025/26, in line with all other Committees of the Board, the Terms of Reference were reviewed, amended. Under the agreed terms of reference, the Integration Committee was tasked as follows:

The Integration Committee will:

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

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- Ensure that key enablers to the delivery of the integration agenda are properly considered as part of the agreement of the group integration plan and programmes of work and that these plans and programmes of work are appropriately aligned to the longer-term strategy, vision and values for the group.
- Review and provide assurance to the Group Board on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance and actions where necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions.

MEETINGS

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

The Committee continued to deliver a full agenda through the submission of questions, by Committee members, ahead of the meeting which were responded to during the meeting.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Group Board from amongst the Non-Executive Directors of the Group. During 2025/26 the Committee was chaired by Mrs Rebecca Brown.

Details of the Committee's membership and attendance during 2025/26 is set out below:

The members of the Committee are:

- Non-Executive Director (Chair)
- Non-Executive Director
- Associate Non-Executive Director
- Group Chief Integration Officer / Deputy Group Chief Executive
- Group Chief Operating Officer
- Group Chief People Officer
- Group Chief Medical Officer or Group Chief Nurse (as required)
- Group Chief Estates and Facilities Officer

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Voting Members	24 Apr 2025	27 May 2025	19 Jun 2025	24 Jul 2025	22 Aug 2025	25 Sept 2025	24 Oct 2025	25 Nov 2025	19 Dec 2025	29 Jan 2026	20 Feb 2026	27 Mar 2026
Non-Executive Director (Mrs Brown, Chair)	X	X	A	X	X	X	X	X	X	A	X	
Non-Executive Director (Mr Connolly)	X	X	X	A	X	X	X	X	X	X	X	
Non-Executive Director (Ms Shadlock)	X	A										
Associate Non-Executive Director (Mrs Buik)	X	X	X	X	X	X	X	X	X	X	X	
Group Chief Nurse	D	X	D	X	A	D	X	D	X	X	A	
Group Chief Medical Officer	D	D	X	D	D	D	A	D	D	D	D	
Group Chief Operating Officer	X	X	D	X	X	D	A	A	A	A	X	
Group Chief Integration Officer	X	X	X	X	X	X	X	X	X	X	X	
Group Chief Clinical Governance Officer	X	X	X	D	X	X	X	X	D	X	X	
Group Chief Estates and Facilities Officer	D	X	X	X	X	X	X	D	D	D	X	

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

Colleagues are co-opted onto the Committee to offer expert opinion and assurance when required, such as the Group Deputy Chief Integration Officer and the Group Director of Strategy Improvement and Redesign.

REVIEW OF BUSINESS

The Integration Committee followed a programme of work for the 2025/26 year.

The Quality Committee has been responsible for the oversight of the Group's Strategic Objectives 3a, 3b, 3c and 3d in 2025/26:

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

During 2025/26 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF. Strategic Objectives 3a, 3b, 3c and 3d were newly developed and were not rated at the beginning of the year.

Through the year the Committee continued to receive reports offering assurance against the Strategic Objectives resulting in the individual components continuing to be rated as follows at the end of the year:

- Objective 3a – **AMBER**
- Objective 3b – **AMBER**
- Objective 3c – **AMBER**
- Objective 3d – **AMBER**

OVERVIEW

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

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

The reporting groups are:
- Alliance Steering Group
- Research & Innovation Group
- Productivity, Improvement & Transformation Oversight Forum
- Estates & Facilities Group
- Digital Oversight Group

The Committee has been well attended by members during the year with the Group Deputy Chief Integration Officer and the Group Director of Strategy Improvement and Redesign members being required attend regularly to provide further insight into areas for consideration.

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

Staff stories were received by the Committee demonstrating the commitment of the Group to deliver the best patient care in both the acute and community settings. The stories highlighted the improvements in the health care provision implemented to patient care and experience and the steps taken by staff to overcome various challenges.

The Committee continued to have a focus on the Newton Consulting's Diagnostic Improvement project to identify the opportunities across the healthcare system in Lincolnshire so It could become more proactive and connected. The goal of the project is to ensure that the people of Lincolnshire are supported to be as independent and healthy as possible and, when necessary, that they are treated in the right setting for them.

The Committee was regularly updated on the progress on the workstreams underpinning the Group's 'Left Shift' Programme, and as required by the NHS's 10-year Plan. The programme is contributing to the Group's ambition of delivering integrated, community-focused care, improving population health, and reducing the reliance on acute services. The workstreams are working in tandem to shape new pathways and redesign services, and to shift those services from the acute setting into the community setting.

The services being shifted into the community setting under the auspices of the Alliance Care Group include:

a. Diabetes
b. Dermatology
c. Rheumatology
d. Women's Health
e. Children and Young People
f. Surgery (High Volume, Low Complexity Activity)

The working streams are also utilising population health management data in all the service re-designs and to champion health equity by identifying and addressing inequalities in the patient population.

The Committee, in line with its remit, monitored the progress being made in the implementation of the action in the Group's Health Inequalities Action Plan. The Committee was assured that the work to implement the actions was on track to delivered from a data perspective, with further data triangulation undertaken and national benchmarking demonstrated. To embed health inequalities data in the planning and activities, steps have been taken to develop a dashboard to support the understanding of available data.

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The Committee monitored the progress of the Electronic Patient Records (EPR) system procurement project being undertaken by the Group. The Digital Oversight Group upward reports also informed the Committee of the progress of all the digital improvement project being undertaken in the Group.

During the year the Committee received monthly Productivity, Improvement and Transformation Oversight Forum (PITOF) upward reports which reviewed the status of the programmes and projects aligned to the Group's 2025/26 transformation goals. The programmes and projects include:

a. **Flow Programme –** aim is to strengthen flow governance, improve discharge pathways, and ensure the system is ready for the implementation of Newton Consulting's delivery model.

   In line with this programme, the Committee reviewed a Safer Discharge Report. The report provided an overview including an assessment of patients which indicated that the readiness for discharge was where it was required. The report also noted that the risk appetite was higher at peak times of activity resulting in patients being discharged sooner than ready. The report assured the Committee that though harm was not being caused to patients through current discharge processes, steps were being taken to improve and rebrand discharge services through the work being undertaken with support partner Newton.

   The Committee several updates on the benefits accrued after the adoption of the Optimised Patient Tracking & Intelligent Choices Application (OPTICA) system by the Transfer of Care Hubs. The benefits included improved patient flow, time savings, and enhanced visibility and accountability in discharge processes. The adoption of OPTICA has also resulted in the discontinuation of inefficient practices, and improved team cohesion and stakeholder engagement.

b. **Patient Services Hub** – the purpose of which will be to restructure and centralise how the Group delivers patient services. The hub will consolidate, standardise, modernise and digitise the outpatient and inpatient administrative services that deliver the coordination of care to patients to reduce duplication, and to improve consistency and patient experience. The consultation of the affected staff on the proposal to develop a Patient Services Hub was completed in January 2026. Follow up actions are being implemented.

c. **Nursing Workforce Programme** – the aim is to reduce the use of temporary staffing and improve the quality of nursing care through better workforce planning and better sickness management.

d. **Medical Workforce Programme** – the aim is to reduce the utilisation of temporary staff and improve consultant job planning.

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The Committee also received regular updates on the Group's Space programme with a focus on how the allocation of clinical and non-clinical spaces in the Group was being managed and how the steps to improve the utilisation of space in the Group was progressing.

The Committee had a focused discussion during the year on the 'Role of Integrated Neighbourhood Teams'. The report which underpinned the discussion stated that the Integrated Neighbourhood Teams (INTs) had been positioned as the new delivery vehicle for neighbourhood health and had become a core component of the NHS's 10-Year Plan. The report added that the INTs moved the 'front door' to the community and enhanced earlier intervention in the neighbourhood and introduced diagnostics in the neighbourhood, along with the transformation of community nursing.

In August 2025, the Committee reviewed the Group's Refreshed Green Plans for 2025 – 2028 and recommended it for Group Board approval. The refreshed Green Plans was developed in alignment with the NHS's refreshed statutory guidance on green plans published in February 2025. The Group is committed to embedding sustainability and low carbon practice in the way vital healthcare services are offered, to help the NHS to become the first health service in the world with net zero greenhouse gas (GHG) emissions.

The Committee received regular reports which highlighted the steps taken by the Group to increase the capacity and ability of staff to engage in research while removing other associated challenges to the progress of the research and innovation agenda. Through the year, the Committee was updated on the progress made in the work to improve engagement across the organisation on the need for research and innovation to be fully embedded in all clinical activities.

The Committee, during the year, received and reviewed a plan to develop a specialist palliative and end of life (PEOL) care model across the new Derbyshire, Lincolnshire and Nottinghamshire (DNL) ICB cluster. The Committee was informed of planned steps by the Group to work with commissioners to develop the role of the lead provider, the governance arrangements, and the approach for novating existing contracts. The Committee asked for the development of a PEOL care model which was ambitious and suitable to the needs of the population served by the cluster.

Fragile Service Reviews – The Committee received updates on the work to redesign and transform services in the Group which were not performing as required, resulting in issues such as long-waiting patients. Over the year the Committee noted the improvements made by the redesigned services, and these included, the:

a. Tuberculosis Service
b. Children's Speech and Language Service
c. Lymphoedema Service
d. Musculoskeletal (MSK) Service
e. Paediatrics (Acute and Community) Service

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Risks

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

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NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Strategy Delivery Q4 Assurance Report (2025/26):

End of Year Strategy Delivery

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*5th May 2026*
Agenda item number	*11.2*
Report title	*LCHG Strategy delivery Q4 assurance report*
Report purpose: • Discussion • Approval • Assurance • Information • 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* *Pauline Bazett, Strategy and Planning Senior Support Officer*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	*Reasonable*
Prior approval process, if applicable	*Daren Fradgley – Group Deputy CEO / Group Chief Integration Officer*
Financial implications, if applicable	*N/A*
Action/decision required	*Board is asked to:* *Receive the Q4 report to demonstrate delivery against the LCHG 5-year strategy and note close down of our year 1 LCHG 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 Q4 report provides reassurance against the delivery of the Trust Strategy. The overall assurance rating for Q4 is Reasonable as 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.

Strategic Pillar 1: Our Patients – Better Care
Q4 Progress:
IPC performance remains strong, with consistently high hand hygiene and sepsis compliance, and SAIS delivery above regional and national averages. Staff vaccination uptake improved to 55.8% (LCHS) and 56.6% (ULTH) from 35% ULTH in 2024/25. Mortality indicators remain within the expected range. UEC performance exceeded the 4-hour standard in March (80.97% vs 78% target), with reduced 12-hour trolley waits (1,132 from 1,296) and non-elective LOS within target (4.34 vs 4.50 days). Elective RTT performance remains strong (95.26% within 18 weeks). The Group delivered breakeven, achieved £72.2m of £79.3m CIP, and ended the year with £54.1m cash. CDC developments in Boston and Lincoln remain on track.
Key actions:
Focus remains on medication safety, medicines reconciliation and VTE compliance below 95%, alongside pressure ulcers and falls with harm. Patient experience remains challenged, particularly complaints timeliness (78% ULTH vs 100% target) and paused FFT. Diagnostics and cancer pathways remain under pressure (DM01 50.55%; FDS 73.2%; 62-day 58.9%; 131 patients >104 days), compounded by ambulance handover delays.

Strategic Pillar 2: Our People – Better Opportunities
Q4 Progress:
Mandatory training exceeds target (92.97% ULTH; 92.35% LCHS) and appraisal rates are at or above target (80.05% ULTH; 92.67% LCHS). Workforce stability continues to improve, with reduced turnover (8.29% ULTH; 7.63% LCHS) and vacancy rates below target (6.5% ULTH; 9.84% LCHS). Leadership and equality programmes (WRES/WDES) are embedded, with strong staff engagement and 88 staff recognised through Long Service Awards.
Key actions:
Protect time for role-specific training, strengthen absence management (5.43% ULTH; 6.80% LCHS), deliver staff survey action plans, and implement the medical workforce programme to halve consultant vacancies by March 2027.

Strategic Pillar 3: Our Populations – Better Health
Q4 Progress:
Estate utilisation has improved following centralised booking at ULTH (Nov 2025), with rollout to LCHS underway. The *Left Shift* programme is progressing, supporting the transition of 7 services into community settings. Frailty at the Front Door is live, with UCR, Virtual Wards and Home Visiting on track for Q4 delivery. Digital programmes continue, with EDMS go-live in March 2026 and EPR go-lives planned for Oct 2026 and Apr 2027. Sustainability engagement continues to grow, including the planned planting of 100 trees by end-2026.
Key actions:
Complete LCHS estate rollout, address declining Progress Living occupancy (71% to 55.5%) through recovery actions and contract renegotiation in 2026/28, maintain grip on digital and community delivery, and ensure sustainability initiatives deliver measurable benefits.

Our Assessment of Year 1 Strategy Delivery against our LCHG Strategy & Moving into 2026/27

Overall direction
The Trust is in a **solid but fragile position**. Performance is largely controlled, but several risks remain persistent. The next phase needs to **move from recovery to sustained delivery**, with tighter grip, clearer ownership and stronger evidence of impact. In summary:

Pillar 1 – Our Patients: Better Care
Across the year, delivery against the Patients pillar **has remained largely controlled, despite sustained system pressure**. Early quarters focused on recovery with improvements in infection prevention, elective pathways and core safety arrangements. As the year progressed, several challenges became persistent rather than episodic, notably medication safety, pressure ulcers and falls, diagnostics capacity, ambulance handover delays and cancer pathway performance.

By Q4, the Trust is clear that the priority is no longer new initiatives but consistency and reliability at ward, service and pathway level. RTT performance and financial balance provide important assurance. Although RTT performance is strong, the growth in long waiters and diagnostic backlogs presents a real risk if left unchecked.
In next year's annal plan we need to:

- Tighten operational and clinical grip on known safety gaps.
- Continue momentum on patient experience improvement.
- Accelerate diagnostic and cancer recovery while protecting urgent and elective flow.
- Strengthen productivity and CIP delivery by embedding improvement into pathway redesign rather than relying on short-term fixes.
- Use estates and CDC investment more deliberately to support access, flow and resilience.

The Trust therefore ends the year with **reasonable assurance**, reflecting effective control overall, but with clear need for sustained grip to convert improvement into sustained performance.

Pillar 2 – Our People: Better Opportunities
Workforce performance has been a **relative strength throughout the year**, with consistently high compliance for mandatory training and appraisals, improving stability and sustained engagement and recognition of staff contribution. Early confidence was built on strong recruitment, leadership development and culture programmes.
However, as delivery pressures increased, capacity and resilience emerged as the critical issues, particularly sickness absence, protected time for training and medical workforce gaps. By Q4, the narrative has matured from one of compliance to one focused on capability, wellbeing and leadership effectiveness as enablers of delivery.

The next phase should focus on **moving from compliance to capability**:

- Creating space for staff to train, develop and improve services, not just meet minimum requirements. Focus on building a culture where staff feel valued.
- Making staff feedback visibly matter by translating NHS staff survey results into meaningful local change.
- Strengthening leadership capability to manage absence, wellbeing and team culture more proactively.
- Delivering the medical workforce plan at pace to reduce consultant vacancies and dependency risks.
- Sustain WRES/WDES delivery, embedding inclusive leadership behaviours into everyday management practice.
- Use cultural intelligence effectively, including the 'Hot Spot' Dashboard, to intervene early where culture indicators deteriorate.

Overall assurance **remains reasonable**: the workforce is stable and engaged, but ongoing focus is required to ensure staffing pressures do not constrain safety, productivity or transformation.

Pillar 3 – Our Populations: Better Health

Progress under the Populations pillar has been **directionally strong**, with substantial mobilisation of transformation programmes across community pathways, estates optimisation, digital infrastructure and sustainability. Early in the year the emphasis was on programme set-up and momentum, including Left Shift initiatives, Community Diagnostic Centres and major digital investments.

By the second half of the year, attention rightly shifted to **delivery risk and benefits realisation**, particularly around estate utilisation and the complexity of EPR delivery. In Q4, the Trust is clear that success now depends on embedding change into business as usual and demonstrating measurable impact on demand, flow and outcomes. During 2025/26, the Trust has made **steady progress in strengthening Research and Innovation**, moving from growth and mobilisation toward clearer governance. Changes to national NIHR funding arrangements were identified as a positive opportunity for the Trust, reducing reliance on historical performance and creating greater incentive for active delivery. The R&I function was restructured into clearer operational and strategic oversight arrangements. By Q4, the focus has shifted to **embedding research into business as usual**, supported by the development of a multidisciplinary R&I strategy and clearer integration with core corporate governance.

Key priorities include:

- Fully embedding the Left Shift so care genuinely moves into community/INT settings with demonstrable impact on admission avoidance, attendance avoidance and LOS reduction.
- Maximising estate utilisation, addressing under-occupancy across all our estates (acute and community) and ensuring estates decisions align with clinical strategy.
- Keeping tight control of complex digital programmes (EPR and EDMS) to deliver benefits without destabilising services.

- Moving population health and prevention from strategy into business-as-usual decision-making.
- Turning sustainability ambitions into tangible, measurable outcomes that support long-term service viability.
- Implement refreshed Research & Innovation governance, embedding research activity into routine service delivery and workforce roles.
- Maintain tight grip on EPR and EDMS delivery, managing risk, phasing complexity and user readiness.
- Develop digital skills across the workforce, enabling effective use of new systems

The year ends with **reasonable assurance**: transformation is well-aligned and progressing, but requires sustained focus to translate ambition into consistent system

Conclusion

The Trust has made solid progress across all three strategic pillars, underpinned by strong performance in patient safety, workforce stability, urgent care delivery and financial control.

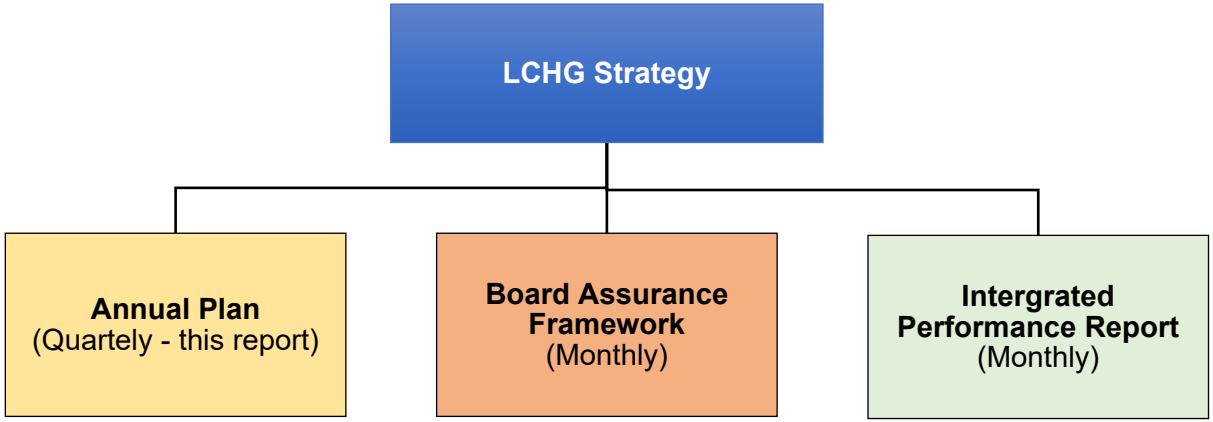
The Trust now needs to **consolidate gains, close recurring gaps and continue driving impact**, particularly in safety, access, workforce resilience, transformation programmes and digital delivery. The emphasis for the next period should be **sustainable delivery.**

This approach will be reflected in the Trust's strategy refresh, aligning with the NHS 10-Year Plan and the emerging neighbourhood working framework, and will be set out clearly within the 2026/27 Annual Plan.

LCHG Strategy Delivery – Q4 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) – Q4 Strategic Assessment against delivery of ambitions set for 2025/26

Strategic Aim	Strategic Objective	What we will achieve in 2025/26?	Board Assurance Framework Strategic Risks
Patients: Timely, high quality and affordable care in the right place	1a: Improve patient safety, patient experience and deliver clinically effective care	Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm, improved IPC practices and reviewing external reports and assessments of our services Identify areas where services do not meet best practice requirements and deliver demonstratable improvement in those areas. Focus on improving the top three patient feedback themes: Communication, appointments and clinical practice	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny
	1b: Reduce waiting times for our patients	Utilise best practice from HVLC/GIRFT, deliver a number of planned care improvement programmes to maximise patient experience and flow to support elimination of 52 week wait and 18-week RTT Deliver a number of improvement programmes and projects focussed on unplanned care pathways, that deliver a reduction in A&E waiting times, and improve category 2 ambulance response times Better utilise our Community Diagnostics Centres and increase % of patients receiving diagnostic test within six weeks to support plans to address elective/ cancer backlogs and diagnostic waiting time	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm
	1c: Improve productivity and deliver financial sustainability	Robust CIP and productivity monitored through our LCHG Productivity, Improvement and Transformation Forum (PITOF) Embed a culture of Quality Improvement	If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients
	1d: Provide modern, clean and fit for purpose care settings	Manage our backlog maintenance liability and deliver our capital programme Optimise property and space utilisation and improve functionality Improve our internal resilience across all services	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives

		Fully integrate group working across acute, community, private and system where possible	or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny

Key Highlights

1. Clinical Safety

Clinical safety remains a key priority for the Trust. Medication safety continues to be a concern, with both medication incidents causing harm and medicines reconciliation performance below target. This is being addressed through the Patient Safety Incident Response Framework (PSIRF), with harm reduction identified as a priority workstream.

NHS England published the updated Maternity Care Bundle; a new national framework aimed at reducing maternity mortality and serious maternal morbidity across England with minimum standards of care expected to be implemented by March 2027.

2. Infection Prevention and Control (IPC)

- LCHS will continue to host and deliver the School Aged Immunisation Service (SAIS) in Lincolnshire for a further 3 years. The service was recognised as one of the leading performers in the region, surpassing both Midlands and national averages.
- Hand hygiene and sepsis management remain strong and consistently compliant.
- Staff Vaccination Programme – 2025/26 rates are 55.8% for LCHS and 56.58% for ULTH; a significant improvement for ULTH compared to rate of 35% for 2024/25.

3. Safeguarding Adults

- Category 2 pressure ulcers remain significantly above target, although stabilising from previous month's peak.
- Falls resulting in moderate harm remain above target, with month-to-month fluctuation but no sustained improvement trend.
- Venous Thromboembolism (VTE) risk assessment compliance remains below target – ongoing challenges relate to consistent completion within the electronic prescribing system. Remains escalated through clinical governance structures to strengthen oversight and drive improvement.

4. Patient Experience

- Complaints response timeliness remains below the 100% target, with no significant recovery in performance.
- **Friends & Family Test**: Switched to a new supplier in January 2026 and following technical glitches reporting was paused. It is due to recommence in May (Q2 2026/27); LCHS 89.62% (Q3 figures).
- **Complaints**: investigated and responded to within agreed timescales (March - ULTH 78% against a target of 100%) (March - LCHS 5.49 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**: Compliance is broadly in line with expectations and remains an important aspect of patient safety and experience.

5. Clinical Effectiveness

- Following marginal improvement this month VTE risk assessment compliance remains below 95% target indicating continued compliance gap despite ongoing actions.
- Issuing of Estimated Date of Discharge within 24 hours remains broadly stable but below target.
- Mortality indicators continue to remain a consistent area of assurance being in the *"as expected"* range with no evidence of emerging concerns.

6. Operational Performance

Urgent and Emergency Care

- Operational pressures across urgent and emergency care pathways remain significant. In March, the Trust recorded an overall A&E 4-hour performance of 80.97%, above the 78.0% target.
- Despite these pressures, there was an improvement in 12-hour trolley breaches, which reduced at M12 to 1132 from 1296.
- Ambulance handover delays remain a concern, with 85.21% handovers delayed under 45 minutes. Late afternoon and evening surges continue to contribute to crowding.
- The non-elective length of stay (LOS) for March was 4.34 against a target of 4.50.

7. Elective and Cancer Pathways

- Referral to Treatment (RTT) performance is above national expectations, with 95.26% of patients treated within 18 weeks in March against a target of 65.00%. However, the Trust reported 131 patients waiting over 104 days in March, an increase from February's 118, against a target of 10 and 2 patients waiting over 65 weeks in February, a decrease of 4 from January's 6. The number of patients waiting over 52 weeks was 464 in February, a decrease of 46 from January's 510.
- The total waiting list stood at 69,054 at the end of February, an increase of 1,688 from January. Specialties with sustained pressure remain the focus of targeted recovery and transformation efforts.

- Diagnostics (DM01) significantly below target (50.55% in March vs 99%) with most breaches in Audiology, Ultrasound and MRI. Ultrasound and MRI increase in demand due to AQP contract ending and lack of admin staff to book patients. Ultrasound using agency where possible and additional shifts as ultrasound staffing is a national issue. Audiology is working on an ambitious recovery trajectory. Patients seen in clinical priority.

8. Cancer pathway performance remains variable:

- Faster Diagnosis Standard (28-day): 73.20% in March, showing an increase from February but is below plan.
- 31-day combined treatment: 88.90% in February (target: 96%).
- 62-day combined treatment: 58.90% in February (target: 85.00%).
- 104+ day waiters: Increased to 131 patients in March from February's 118 (target: 10).

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 12, the Group reported a break-even position against plan. Delivered £72.2m in CIP savings vs £79.3m plan, which is a £7.1m shortfall. The Group's cash position at year-end is £54.1m, materially stronger than plan.

10. Estates and Facilities

The Trust continues to invest in estate safety and sustainability.

- Full planning permission received for new Community Diagnostic Centre (CDC) in Boston with 20-week site demolition phase scheduled to begin on 5 March 2026.
- Lincoln CDC extension remains on track with a go-live planned for April 2026.

Strategic Aim 1 (Patients) Summary

The Trust continues to operate in a highly pressured environment while maintaining assurance in several core areas, including mortality indicators, hand hygiene compliance, sepsis management, and RTT performance. Clinical safety and patient experience remain priority focus areas, with challenges around medication safety, VTE risk assessment compliance, pressure ulcers, falls, and complaints responsiveness. Operationally, urgent and emergency care performance shows signs of resilience despite sustained demand, and elective performance remains strong overall, although long-waiter and diagnostic backlogs persist. Financial performance has achieved break-even with a strong cash position, though delivery against the full CIP target fell short. Continued investment in estates, including Community Diagnostic Centres, supports longer-term system resilience.

Areas for Improvement & Actions:

Clinical Safety
- Medication safety incidents; medicines reconciliation and VTE compliance below target.
- Deliver PSIRF harm reduction priorities; improve e-prescribing compliance, reconciliation processes, and governance oversight.

Infection Prevention & Control
- Staff vaccination uptake still moderate.
- Sustain vaccination campaigns; maintain strong hand hygiene, sepsis, and SAIS performance.

Safeguarding Adults
- Pressure ulcers and falls with harm above target; VTE compliance issues.
- Strengthen prevention programmes, ward-level ownership, and routine compliance monitoring.

Patient Experience
- Complaints response times below target; FFT reporting interruption.
- Implement complaints recovery plans; restore FFT reporting; continue use of patient feedback for learning.

Clinical Effectiveness
- VTE assessments and Estimated Date of Discharge below target.
- Reinforce expectations, use real-time dashboards, and share best practice.

Operational Performance (U&E)
- Ambulance handover delays and peak-time crowding.
- Improve system flow, focus on peak demand, and continue reducing long waits and LOS.

Elective, Diagnostics & Cancer

- Rising long-waiters; diagnostics significantly below target; variable cancer performance.
- Accelerate recovery plans, expand diagnostic capacity, prioritise long-waiter and cancer pathway management.

Financial Performance

- CIP delivery shortfall.
- Strengthen CIP governance and delivery while maintaining financial discipline.

Estates & Facilities

- Maintain delivery to support diagnostic recovery.

Pillar 2 (Our People) – Q4 Strategic Assessment against delivery of ambitions set for 2025/26

Strategic Aim	Strategic Objective	What we will achieve in 2025/26?	Board Assurance Framework Strategic Risks
People: Develop, empower and retain great people	2a: Enable our people to fulfil their potential through training, development and education	Support our Divisions to provide all staff with an appraisal, clear objectives and clear relevant statutory and mandatory training Increase the number of staff involved with research activity across LCHG Harness new roles, integrated roles and rotational roles where there is further opportunity for productivity or integration through a 'grow our own' approach and maximising the apprenticeship levy Ensure all staff have the correct training and support available to them to fulfil their role as a leader	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable, less efficient services and the inability to attract and retain staff
	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 Ensure Medical and Dental staff have a fully agreed job plan agreed with the Division. Improve consultant and middle tier stabilisation and succession planning 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 Work to be an employer of choice by developing our one desired culture of Civility and Respect through: a. Embedding the 'Just Culture' principals and developing an inclusive culture across the Trust. b. Actively listening to our staff experience through the National Staff Survey. c. Working closely with our Staff Networks Creation of a 'Hot Spot' Dashboard which includes cultural elements including turnover, vacancies, complaints, datix, HR cases, FTSU concerns, sickness which will highlight cultural positions	If we do not **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement

	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 for December of 92.97% (ULTH) and for March of 92.35% (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 January were 80.05% (ULTH) and 92.67% (LCHS)** against a target of 80.00%.

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.
- Medical workforce has remained stable over the last three months; a working group has been set up to look at how we halve the consultant vacancy position by end of March 2027.

13. Nurture Compassionate and Diverse Leadership

- Culture and Leadership Programmes are in place across the group.
- Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) – action plans continuing to be delivered.
- Sickness absence for ULTH in January was 5.43% against a Q4 target of 4.50% and in December for LCHS was 6.80% against a Q3 target of 4.96%. Additional resource is being put in place to support the active and robust management of absence over the next 12 months.
- Turnover rate reducing in both Acute and Community Services; January was 8.29% against a target of 9.00% (ULTH) and 7.63% against a target* of 15.00% (LCHS). *The “target” level of 15% represents a ceiling to stay within.
- Vacancy rate for January was 6.50% against a Q4 target of 10.60% (ULTH) and 9.84% against a Q4 target of 10.00% (LCHS). This was as expected due to vacancies being held/deferred as opportunities for staff displaced by organisational change programmes.

14. Thanks, and Celebration

- **Long Service Awards** celebrated 88 LCHG clinical and support staff receiving certificates for 20, 30 or 40 years of NHS service.

Strategic Aim 2 (People) Summary
Workforce performance remains strong overall, with mandatory training and appraisal compliance meeting or exceeding targets across both ULTH and LCHS. Staff engagement is actively reviewed, supported by divisional action plans and leadership development programmes. Workforce stability is improving, evidenced by reduced turnover and vacancy rates, although sickness absence remains above target and requires sustained focus. Medical staffing remains stable, with a clear plan in place to reduce consultant vacancies. Positive staff contributions continue to be recognised through long service awards.

Areas for Improvement & Actions:

Training, Development and Education
- Improve protected time for role-specific mandatory training
- Continue targeted support for staff with ≤50% compliance and monitor performance.

Continuously Improve and Innovate
- Strengthen delivery of divisional action plans from staff feedback.
- Implement medical workforce actions to reduce consultant vacancies by March 2027.

Compassionate and Inclusive Leadership
- Address sickness absence through enhanced absence management.
- Continue WRES/WDES delivery and leadership development programmes.

Workforce Resourcing and Retention
- Manage vacancies in line with organisational change.
- Sustain focus on retention to maintain reduced turnover.

Recognition and Engagement
- Continue celebrating staff contributions, including long service awards.

Pillar 3 (Our Populations) – Q4 Strategic Assessment against delivery of ambitions set for 2025/26

Strategic Aim	Strategic Objective	What we will achieve in 2025/26?	Board Assurance Framework Strategic Risks
Population: Improve our population health	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	Deliver left shift transformation through the Alliance Care Group, focussed on key specialties OPAT/IV Therapies, Stroke, Dermatology, Weight Management, Respiratory, Rheumatology, Therapies Rehab, Paediatrics, cataract surgery, ENT surgery, Neurology Transform acute wards to community wards to improve pathways of care Strengthen integrated working with Primary Care/GPs/PCNAs and provider partners through collaboration in the Alliance Division Develop our estates strategy for rationalisation and develop business cases for maternity and theatres	If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience
	3b: Move from prescription to prevention, through a population health management & health inequalities approach	Embed a BAU population health-based approach to service change and transformation that supports a reduction in health inequalities across our population Deliver the LCHG Health Inequalities Action plan Embed CDC pathways into primary care Deploy neighbourhood health model	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes
	3c: Enhance our digital, research and innovation capability	Become a paperlite digital Group, deliver our Digital Strategy and Implement an Electronic Prescribing system Upgrade our technological infrastructure and provide our people with real-time data to support high quality care delivery Enhance our organisational digital capability and skills through training Develop a new LCHG Research Strategy which will support additional research opportunities and improvements in patient care Attract and increase number of clinical academics and principle investigator opportunities across our workforce to build a strong R&I culture within LCHG and with the University of Lincoln Host system wide provision of Digital and Business Intelligence	If we do not **enhance our digital, research and innovation** capability then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale

	3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	Robust CIP and transformation delivery monitored through our LCHG Productivity, Improvement and Transformation Oversight Forum New Board-approved Green Plan for LCHG which provides a clear roadmap toward the net zero 2024 target, increasing staff understanding and awareness of the green agenda Develop a sustainability dashboard to provide clear baseline carbon footprint measure and track progress Produce Adaptation Risk Assessments for both ULTH and LCHS	If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable

Key Highlights

15. Transform Clinical Pathways and Rationalise our Estates

- **Estates and Facilities:** Improvements continued in space utilisations since new centralised booking process for Open Space utilisation commenced November 2025 in ULTH. Plans commenced for roll out and successful launch to LCHS ensuring reduction of space under-utilisation and financial savings for the Group.
- **Progress Living:** steps being implemented to increase occupancy rates due to continued decline between April – December 2025 (from 71% to 55.5%). Planned to negotiate revised contracts when they fall due in 2026 and 2028.

16. Move from Prescription to Prevention

- **Alliance Steering Group**: Left Shift Programme Board established in January 2026 to support the Group's 'Left Shift' agenda; overseeing transition of 7 services from acute to community setting to improve patient care and reduce reliance on the Group's acute setting.
- **Integration of UCR, Virtual Wards & Home Visiting** remains on track for end-Q4 delivery.
- **Frailty at the Front Door Response Team** now live, supporting earlier intervention.

17. Enhance our Digital and Research and Innovation Capacity

- **Electronic Patient Record (EPR) Project** will be delivered in 3 phases, with revised plans for the first two go-lives in October 2026 and April 2027, pending agreement with Nerve Centre. Phase 3 will be more complex due to patient services hub integration.
- **Electronic Document Management System (EDMS)** work progressed with 9 scanners installed across sites, training underway and go-live scheduled for end of March 2026.
- **Research and Innovation Group** – will be restructured into a weekly Operations Group meeting, and a monthly Strategic Oversight Group with both reporting into Integration Committee.

- **Multidisciplinary Research & Innovation Strategy** development underway with stakeholders including midwives, nurses, doctors and allied health professionals ensuring research is embedded in BAU activities.

18. Drive Forward our Improvement, Efficiency and Sustainability Agenda

- **Green Workshops** – a series of interactive workshops held to provide an overview of the Group's green plans, information on key programmes of work, details of what this means for our services, patients, and staff and opportunities for staff to get involved.
- **LCHG Green Champions** – The network of Green Champions continues to grow to share ideas and support making sustainable changes across the Group.
- 100 trees to be planted towards end of 2026 as part of The New Orchard, the first Biodiversity Net Gain (BNG) Habitat Bank after ULTH partnered with Wilder Doddington. This initiative will provide an accountable and transparent source of BNG Units to offset the environmental impact of the new Endoscopy Unit at Lincoln County Hospital.

Strategic Aim 3 (Populations) Summary
Good progress is being made in transforming clinical pathways, shifting care into community settings, advancing digital programmes, and embedding sustainability. Estates optimisation is delivering improved utilisation, preventative models of care are expanding, key digital programmes remain on track, and staff engagement in green initiatives continues to grow. Some areas require further focus, notably estate occupancy, EPR delivery complexity, and ensuring programmes translate into measurable benefits.

Areas for Improvement & Actions:

Clinical Pathways & Estates
- Estate under-utilisation and low Progress Living occupancy.
- Roll out centralised booking to LCHS; implement occupancy recovery actions and renegotiate contracts in 2026/28.

Prevention & Community Care
- Consistent impact from shifting services out of acute settings.
- Maintain Left Shift Programme Board oversight; complete UCR, virtual wards and home visiting integration; monitor Frailty Front Door outcomes.

Digital, Research & Innovation
- Delivery risk and complexity of phased EPR rollout; embedding research into BAU.
- Maintain grip on EPR and EDMS programmes; implement refreshed R&I governance and deliver multidisciplinary strategy.

Improvement, Efficiency & Sustainability
- Translating sustainability ambition into measurable outcomes.
- Grow Green Champions, continue staff engagement, and deliver biodiversity commitments including tree planting and BNG offsetting.

NHS
Lincolnshire Community and Hospitals NHS Group

26/27 LCHG Annual Plan

Caring and building a healthier future for all

Meeting	Lincolnshire Community and Hospitals Group Board
Date of meeting	5th May 2026
Agenda item number	11.3
Report Title	26/27 LCHG Annual Plan
Report purpose: • Discussion / Approval / Assurance / Information • Other – please insert details	Approval
Accountable Director	Daren Fradgley, Group Chief Integration Financial Officer / Deputy CEO
Author(s)	Dave Plumb, Associate Director Strategy & Planning
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• Reasonable
Prior approval process, if applicable	ELT
Financial implications, if applicable	N/A
Action / decision required	TB are asked to note and approve the 26/27 Annual plan which sets the delivery of year 2 of our LCHG strategy. • The 26/27 update sets out priority delivery actions across the three strategic aims: Better Care, Better Opportunities, and Better Health. • The refresh sharpens focus on operational performance recovery, workforce development, productivity, and accelerating the shift of care into the community.

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	✓
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	✓

LCHG 26/27 Annual plan (delivery of our strategy)

- The Trust has made solid progress across all three strategic pillars last year, underpinned by strong performance in patient safety, workforce stability, urgent care delivery and financial control.

- The Trust now needs to **consolidate gains, close recurring gaps and continue driving impact**, particularly in safety, access, workforce resilience, transformation programmes and digital delivery. The emphasis for the next period should be **sustainable delivery.**

- This approach will be reflected in the Trust's strategy refresh, aligning with the NHS 10-Year Plan and the emerging neighbourhood working framework, and is out clearly within the 2026/27 Annual Plan (this document).

Key highlights

26/27 is more:

- Operationally focused – stronger KPIs, clearer priorities
- Digitally enabled – integrated digital and data across pathways
- Culture-intentional – civility, leadership, and employee experience
- Transformation-driven – broader left-shift ambitions and estates alignment

25/26 was more:

- Foundation building – QI maturity, new roles, early digital steps
- Initial left-shift testing – fewer specialties, earlier stage programmes
- Early-stage culture work – starting Just Culture, leadership basics
- Roadmap creation – Green Plan baseline, estates strategy development

Cross-Cutting Differences

1.Maturity Shift

- 25/26 = Build and stabilise (e.g., CIP structures, initial left shift, early digital steps).
- 26/27 = Optimise and embed (e.g., expanded specialty transformation, improved digital integration, mature workforce culture frameworks).

2. Operational Performance

- 26/27 places a heavier emphasis on performance recovery—waiting times, flow, ventilation across diagnostics and planned care—reflecting increased national scrutiny.

3. Digital Enablement and Innovation building

- Marked shift from "deliver digital strategy" in 25/26 to "use digital to optimise clinical pathways, booking, tracking, workforce productivity, and diagnostics" in 26/27.

4. People & Culture

- 26/27 is going beyond compliance and leadership training. Using cultural intelligence effectively, including the 'Hot Spot' Dashboard, to intervene early where culture indicators deteriorate

Refreshed LCHG 2025-2030 Strategy

Vision: Caring and building a healthier future for all

	PATIENTS	PEOPLE	POPULATION
	Better Care	*Better Opportunities*	*Better Health*
AIMS	Provide timely, high quality, affordable care in the right place	Develop, empower and retain great people	Improve population health
OBJECTIVES	1a Improve patient safety, patient experience and deliver clinically effective care 1b Reduce waiting times for our patients 1c Improve productivity and deliver financial sustainability 1d Provide modern, clean and fit for purpose care settings addressing our requirements for sustainability and our Green agenda	2a Enable our people to fulfil their potential through high-quality training, development and education, underpinned by a positive and inclusive culture 2b Create a culture that empowers our people to deliver change through continuous improvement and innovation 2c Nurture compassionate and diverse leadership 2d Recognise our people through thanks and celebration	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services 3b Move from prescription to prevention, through a population health management and health inequalities approach 3c Enhance our digital capability, EPR delivery and research and innovation in support of population health needs 3d Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities

Strategic Aim 1:
Timely, high quality, affordable care in the right place

Strategic Objective	What are we doing in 26/27 to deliver this objective?
1a Improve patient safety, patient experience and deliver clinically effective care	• Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm , improved IPC practices and reviewing external reports and assessments of our services • Identify areas where services do not meet best practice requirements and deliver demonstratable improvement in those areas. • Focus on improving the top three patient feedback themes; Communication, Appointments and Clinical Practice • Deliver safe, person-centred and clinically effective medicines management that consistently meets legal/regulatory standards and improves patient experience
1b Reduce waiting times for our patients	• Utilise best practice from HVLC/GIRF/NHSE benchmarking delivering a number of planned care improvement & transformation programmes across acute and community, supported by digital pathway optimisation and tracking tools, to maximise patient experience and flow and support elimination of 52 week waits, delivery of 18 week RTT and community waiting lists • Deliver a number of improvement & transformation programmes and projects focused on unplanned care pathways across acute and community, enabled by digital solutions and intelligent dispatch of resources, to reduce A&E waiting times, moving the front door and improve Category 2 ambulance response times. • Better utilise our Community Diagnostics Centres, supported by digital booking, triage and capacity management systems, to increase the % of patients receiving diagnostic tests within six weeks and support plans to address elective and cancer backlogs and diagnostic waiting times. • Ensure timely availability of medicines, including aseptic treatments, to prevent delays and support reduced waiting times for patients
1c Improve productivity and deliver financial sustainability	• Operate within our financial envelope, deliver our CIP and capital investments • Embed financial discipline and benefits realisation • Robust CIP and productivity delivery monitored through our LCHG productivity, improvement and transformation oversight forum (PITOF)
1d Provide modern, clean and fit for purpose care settings addressing our requirements for sustainability and our Green agenda	• Manage our backlog maintenance liability & deliver our capital programme • Optimise property & space utilisation and improve functionality • Improve our internal resilience across all services • Fully integrate Group working across acute, community, private and system where possible • Increasing staff understanding and awareness of the green agenda • Undertake a Clean Air Hospital Assessment • Embed sustainability objectives in Transformation Programmes • Undertake a baseline carbon footprint measure for ULTH and LCHS and track progress/create roadmap to NetZero (2040) • Undertake Climate Adaptation Risk Assessments for both ULTH and LCHS and develop Climate Adaptation Action Plan

Strategic Aim 2:
Develop, empower and retain great people

Strategic Objective	What are we doing in 26/27 to deliver this objective?
2a Enable our people to fulfil their potential through high-quality training, development and education, underpinned by a positive and inclusive culture	• Support our Care Groups to provide all staff with clear objectives and ensure that they can access the relevant training and support to fulfil their role. • Increase the number of staff involved with research activity across LCHG • Harness new roles, integrated roles and rotational roles where there is further opportunity for productivity or integration through a 'grow our own' approach and maximising the apprenticeship levy • Ensure all staff have the correct training and support available to them to fulfil their role as a leader.
2b Create a culture that empowers our people to deliver change through continuous improvement and innovation	• Actively listen to our staff experience through the National Staff Survey and Quarterly Pulse Survey results and free text comments and have clear improvement and delivery plans in place at a Group and Care Group Level • Ensure Medical and Dental staff have a fully agreed job plan agreed with the Care Group • Improve succession planning and deliver the workforce plan • Build a stronger culture of innovation and research, linking improvement activity directly to service outcomes. • Embed a culture of Quality Improvement as core driver of implementing our LCHG strategy
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 and development of management toolkits • Work to be an employer of choice by developing our one desired culture of Civility and Respect through: a. Embedding the 'Just Culture' principals and developing an inclusive culture across the Trust. b. Actively listening to our staff experience through the National Staff Survey. c. Working closely with our Staff Networks • Develop and embed a 'Hot Spot' Dashboard which includes cultural elements including turnover, vacancies, complaints, datix, HR cases, FTSU concerns, sickness which will highlight cultural positions. • Improve the overall employee experience by communicating clearly what staff can expect at 'moments that matter' within their employee journey across the Group. • Embed a culture of 'Join Well > Grow Well > Work Well > Belong Well > Stay Well' within our Group.
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. • Publish information relating to staff achievements including apprenticeship completion and number of long service awards across the Group to recognise and celebrate our staff.

Strategic Aim 3:
Improve population health

Strategic Objective	What are we doing in 26/27 to deliver this objective?
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 Dermatology, Respiratory, Rheumatology, Diabetes, Neurology, Therapies Rehab, Paediatrics, Women's Health, PCNA/PTL opportunities, Integrated neighbourhood Teams readiness, Moving the front Door, Palliative End of Life, and scoping future tranches including MSK, Pain, Urology, Cardiology, Ophthalmology, ENT, Diagnostics and Cancer. • Embed urgent community models in neighbourhoods, including UCR, virtual wards, and home visiting. • Robust CIP and transformation delivery monitored through our LCHG productivity, improvement and transformation forum (PITOF) • Develop our estates strategy for rationalisation and develop business cases for maternity and theatres
3b Move from prescription to prevention, through a population health management and health inequalities approach	• Embed a BAU population health-based approach to service change, redesign and transformation that supports a reduction in health inequalities across our population • Deliver the updated LCHG Health Inequalities and Personalisation action plan in line with the new LCHG Health Inequalities & Personalisation Policy. • Embed the HEAT assessment tool including through individual Care Group plans and a support offer including training and templates. • Embed CDC pathways into primary care • Support the deployment of resilient communities • Use Population Health Management insights to target medicines optimisation interventions that prevent avoidable harm and reduce health inequalities across our secondary-care population
3c Enhance our digital capability, EPR delivery and research and innovation in support of population health needs	• Become a paperlite digital Group, deliver our Digital Strategy and Implement an Electronic Prescribing system • Upgrade our technological infrastructure and provide our people with real-time data to support high quality care delivery • Enhance our organisational digital capability and skills through training and create an innovation team • Embed the new LCHG Research Strategy which will support additional research opportunities and improvements in patient care • Attract and increase number of clinical academics and principal investigator opportunities across our workforce to build a strong R&I culture within LCHG and with the University of Lincoln • Host system wide provision of Digital and Business Intelligence
3d Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	• Strengthen integrated working with Primary Care/GPs/PCNAs and provider partners through delivery of key priorities within the Neighbourhood Health and Care Board • Work with partners to deploy a full INT blueprint including Integrated staffing model , leadership and governance, pathways and cohorts etc • Utilise insights from a performance dashboard through the Neighbourhood Health & Care Board aligned to the five national goals and local metrics • Co-design neighbourhood health priorities with local communities

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	*5 May 2026*
Agenda item number	*12*
Report title	*Integrated Performance Report*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Information*
Accountable Director	*Daren Fradgley, Group Chief Integration Officer/Deputy Group CEO*
Author(s)	*Callum Gray, Lead Analyst*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial Assurance*
Prior approval process, if applicable	*N/A*
Financial implications, if applicable	*N/A*
Action / decision required	*The Board is asked to:* • *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	
1c: Improve productivity and deliver financial sustainability	*x*
1d: Provide modern, clean and fit for purpose care settings	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	

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

Executive Summary

The People Committee section has been removed from the board report due to the dashboard being a work in progress. This will be able to be shared once complete.

Overall performance at Month 12 remains challenged, with continued pressure across Urgent & Emergency Care, Planned Care recovery, and Workforce. While there are areas of stability within Quality indicators and some workforce fundamentals, front door flow, cancer pathway recovery, sickness absence and vacancy levels continue to present material operational and delivery risks. The overall position provides reasonable assurance, with several areas requiring sustained Board oversight and system-wide intervention.

Urgent & Emergency Care (UEC)

Key Concerns

- 12-hour trolley waits remain significantly above target, with 1,132 breaches in March, although this represents an improvement from February.
- UTC Under 4-hour performance continues to underperform against trajectory.
- EMAS handover <45 minutes remains below target, contributing to front door congestion.

Mitigations in Place

- Daily tactical review of potential 12-hour waits, with harm reviews completed and escalations in place.
- Strengthened consultant presence at ED front doors and enhanced rapid assessment arrangements.
- System-wide discharge improvement actions, including 24/7 Discharge Lounge staffing and agreed admission criteria.
- Continued active engagement with system partners and regulators.

Planned Care & Cancer

Key Concerns

- 104+ day waiters remain significantly above target, with 131 patients as of mid-April, concentrated in colorectal, lung, head & neck and urology pathways.
- 31-day first treatment performance remains below standard at 87.4%.
- 62-day cancer standard continues to underperform, impacted by pathway, workforce and capacity constraints.
- Backlogs remain materially above pre-COVID levels across several tumour sites.

Positive Indicators

- Intensive Support Meetings are in place for the most challenged tumour sites.
- Targeted actions underway to optimise theatre utilisation and reduce last-minute cancellations.
- Workforce and process improvements progressing within priority specialties, including dermatology and oncology.

Quality & Safety

Strengths

- Summary Hospital Mortality Indicator (SHMI) remains below the upper threshold.
- Falls performance across Acute and Community services remains within acceptable ranges.
- Continued assurance through strengthened review processes and quality oversight.

Areas for Improvement

- Category 3 pressure ulcers remain above target in both Acute and Community settings, despite a reduction in incidents in March.
- Complaint response timeliness remains below target, particularly in Acute services.
- Ongoing focus required on preventing deterioration in skin integrity and reducing harm escalation.

Workforce

Key Risks

- Sickness absence remains above target across both Acute (5.45%) and Community (5.73%) services.
- Community vacancy rate has increased further to 10.88%, representing the highest level this financial year.
- Workforce pressures are most acute within Unplanned Care, compounded by national recruitment challenges and data quality issues.

Stability Indicators

- Mandatory training compliance remains strong and above threshold.
- Turnover rates are broadly stable.
- Targeted HR, wellbeing and management capability interventions are in place, supported by Workforce Strategy Group oversight.

Overall Assessment

The principal risks continue to relate to:

- Sustained UEC flow pressures and discharge delays
- Cancer pathway recovery, particularly long waits
- Workforce capacity, with a specific focus on sickness absence and vacancies
- While quality indicators remain broadly stable, operational performance gaps persist

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 Report M12

Lincolnshire Community and Hospitals NHS Group

Overall Summary

Finance Committee	Integration Committee Scorecard	Quality Committee Report
2.14	2.25	2.11

Finance & Performance

Community - Unpl…	Community - Fron…	Acute - Front Doo…	Acute - Planned 4	Acute - Unplanne…	Community - Plan…	Group - Finance 7
1.85	2.29	2.50	2.80	2.80	1.77	1.97

Integration

Community - Unplanned 1	Acute - Front Door 2	Acute - In Hospital 3	Community - Planned 4
2.08	2.33	2.69	2.08

Quality

Clinical Effectiveness 7	Patient Safety 8	Patient Experience 9
2.07	2.09	2.22

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 Report M12

Lincolnshire Community and Hospitals NHS Group

Acute - Quali…	Community -…	Acute - Work…	Community -…	Community -…	Acute - Fron…	Acute - Plan…	Acute - Unpl…	Community -…
2.10	2.00	2.30	2.30	2.13	2.36	2.70	1.50	2.00

Metrics Out of Range

Section Name	Org Name	Metric Name	Value	Target	LCHG Score
Acute - Quality	United Lincolnshire Teaching Hospitals	Acute - Pressure Ulcers category 3	6.00	4.30	3.50
Acute - Workforce	United Lincolnshire Teaching Hospitals	Acute - Sickness Absence	5.45%	4.31%	3.50
Community - Workforce	Lincolnshire Community Health Services	Workforce - Sickness Rate	5.73%	4.81%	3.50
Community - Workforce	Lincolnshire Community Health Services	Workforce - Vacancy Rate	10.88%	6.99%	3.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	Acute - >12hr Trolley Waits	1132	0	3.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 104+ Day Waiters	131	10	3.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - Diagnostics achieved	50.55%	99.00%	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
Acute - Quality	United Lincolnshire Teaching Hospitals	Acute - Complaints investigated and responded to within agreed timescales	78.00%	100.00%	2.50
Community - Quality	Lincolnshire Community Health Services	Complaints - Rate per 1000 WTE	5.49	2.62	2.50
Acute - Workforce	United Lincolnshire Teaching Hospitals	Acute - Number of Vacancies	6.74%	10.60%	2.50
Acute - Workforce	United Lincolnshire Teaching Hospitals	Acute - Staff Appraisals	79.44%	90.00%	2.50
Community - Unplanned	Lincolnshire Community Health Services	IUEC - 2 Hour Response	88.28%	80.00%	2.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	Acute - % EMAS Conveyance Delayed <45 mins	85.21%	95.00%	2.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	Acute - % Triage Data Not Recorded	0.25%	0.00%	2.50
Acute - Front Door	Lincolnshire Community Health Services	UTC - 15 Minute Triage Compliance	93.78%	95.00%	2.50
Acute - Front Door	Lincolnshire Community Health Services	UTC - Monthly 4 Hour Waits	97.26%	98.00%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 18 week incompletes	56.33%	84.10%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 28 days faster diagnosis	73.20%	75.00%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 52 Week Waiters	464	0	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 65 Week Waiters	2	0	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - Hospital Average LoS (Elective)	3.41	2.80	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - Waiting List Size	69054	58965	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Cancer - 31-day Treatment (Combined)	88.90%	96.00%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Cancer - 62-day Treatment (Combined)	58.90%	85.00%	2.50
Community - Planned	Lincolnshire Community Health Services	52 Week Waits %	99.78%	100.00%	2.50

Information on Scoring Methodology

Report Performance Dashboard

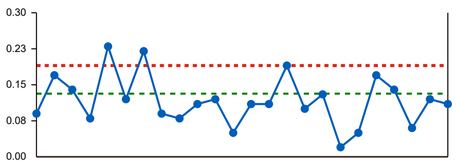
Lincolnshire Community and Hospitals NHS Group

Acute - Quality

Acute - Falls per 1000 bed days resulting in moderate, severe

United Lincolnshire Teaching Hospitals — **Target: 0.19**

Activity Volume

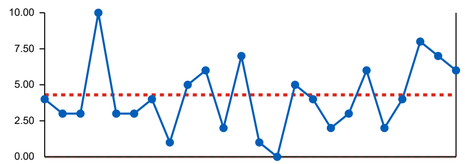


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19

Acute - Pressure Ulcers category 3

United Lincolnshire Teaching Hospitals — **Target: 4.30**

Activity Volume

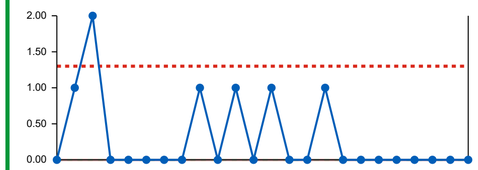


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30

Acute - Pressure Ulcers category 4

United Lincolnshire Teaching Hospitals — **Target: 1.30**

Activity Volume

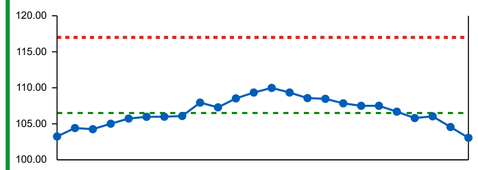


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30

Acute - Summary Hospital Mortality Indicator (SHMI) (rolling y

United Lincolnshire Teaching Hospitals — **Target: 117.00**

Activity Volume

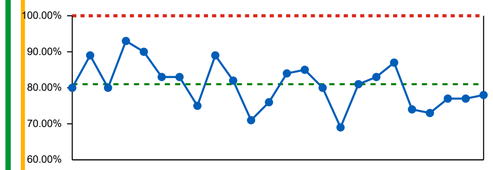


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
117.00	117.00	117.00	117.00	117.00	117.00	117.00	117.00	117.00	117.00	117.00	117.00

Acute - Complaints investigated and responded to within agre

United Lincolnshire Teaching Hospitals — **Target: 100.00%**

Activity Volume



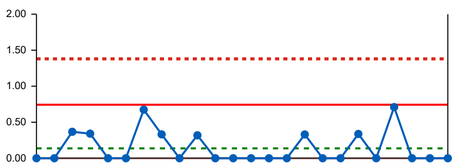
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Community - Quality

Community Hospital Injurious Falls per 1000 OBDs

Lincolnshire Community Health Services — **Target: 1.38**

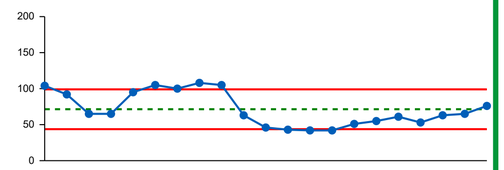
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38

Quality - Pressure Ulcers Category 3

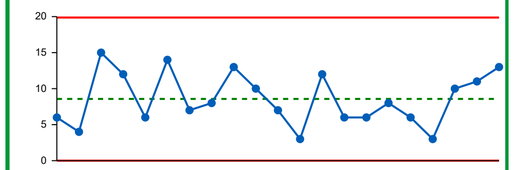
Lincolnshire Community Health Services



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
63	46	43	42	42	51	55	61	53	63	65	76

Quality - Pressure Ulcers Category 4

Lincolnshire Community Health Services

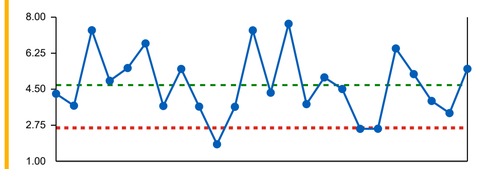


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
10	7	3	12	6	6	8	6	3	10	11	13

Complaints - Rate per 1000 WTE

Lincolnshire Community Health Services — **Target: 2.62**

Activity Volume



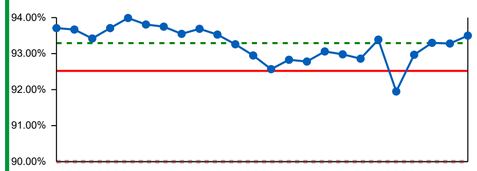
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2.62	2.62	2.62	2.62	2.62	2.62	2.62	2.62	2.62	2.62	2.62	2.62

Acute - Workforce

Acute - Overall percentage of completed mandatory training

United Lincolnshire Teaching Hospitals — **Target: 90.00%**

Activity Volume

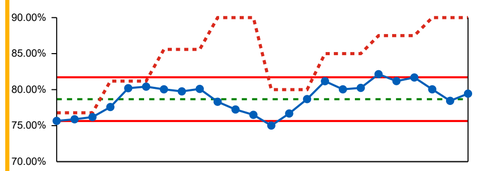


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

Acute - Staff Appraisals

United Lincolnshire Teaching Hospitals — **Target: 90.00%**

Activity Volume

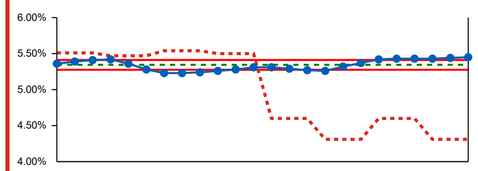


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
80.00%	80.00%	80.00%	85.00%	85.00%	85.00%	87.50%	87.50%	87.50%	90.00%	90.00%	90.00%

Acute - Sickness Absence

United Lincolnshire Teaching Hospitals — **Target: 4.31%**

Activity Volume

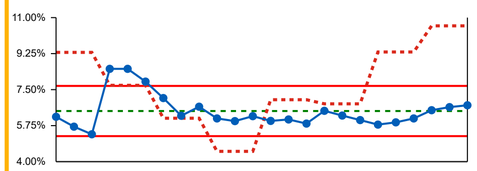


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.60%	4.60%	4.60%	4.31%	4.31%	4.31%	4.60%	4.60%	4.60%	4.31%	4.31%	4.31%

Acute - Number of Vacancies

United Lincolnshire Teaching Hospitals — **Target: 10.60%**

Activity Volume

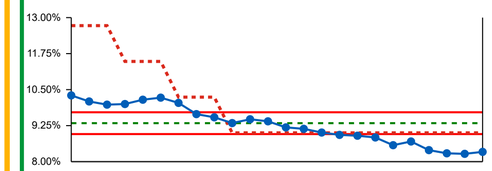


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
7.01%	7.01%	7.01%	6.81%	6.81%	6.81%	9.33%	9.33%	9.33%	10.60%	10.60%	10.60%

Acute - Staff Turnover

United Lincolnshire Teaching Hospitals — **Target: 9.00%**

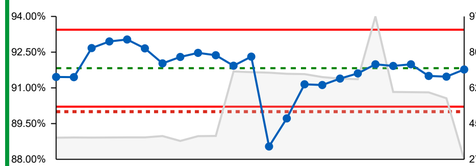
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
9.00%	9.00%	9.00%	9.00%	9.00%	9.00%	9.00%	9.00%	9.00%	9.00%	9.00%	9.00%

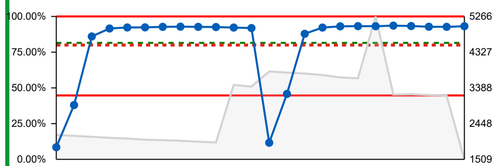
Community - Workforce

Workforce - Overall Compliance
Lincolnshire Community Health Services — **Target: 90.00%**
Activity Volume



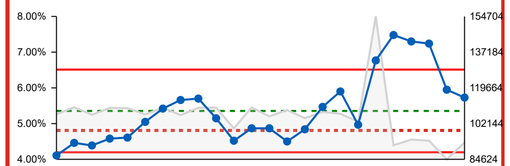
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

Workforce - Appraisals
Lincolnshire Community Health Services — **Target: 80.00%**
Activity Volume



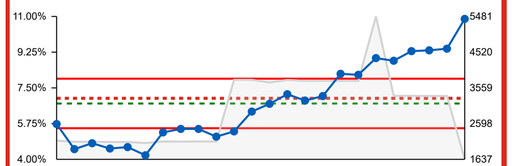
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%

Workforce - Sickness Rate
Lincolnshire Community Health Services — **Target: 4.81%**
Activity Volume



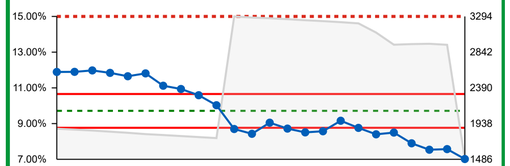
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%

Workforce - Vacancy Rate
Lincolnshire Community Health Services — **Target: 6.99%**
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%

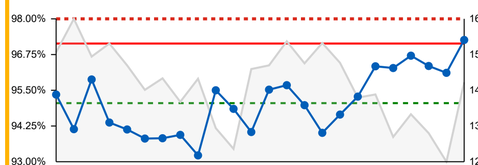
Workforce - Turnover
Lincolnshire Community Health Services — **Target: 15.00%**
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%

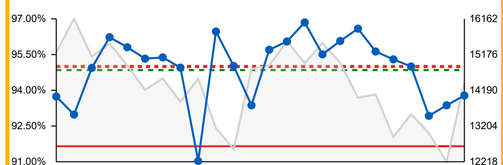
Acute - Front Door

UTC - Monthly 4 Hour Waits
Lincolnshire Community Health Services — **Target: 98.00%**
Activity Volume



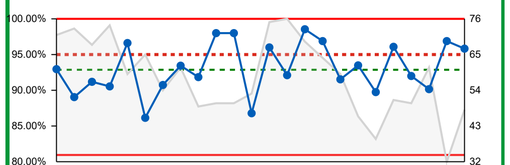
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%

UTC - 15 Minute Triage Compliance
Lincolnshire Community Health Services — **Target: 95.00%**
Activity Volume



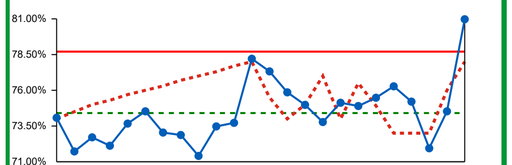
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

UTC - 15 Minute Ambulance Handover
Lincolnshire Community Health Services — **Target: 95.00%**
Activity Volume



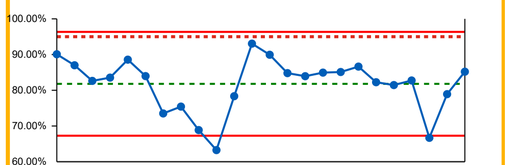
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Acute - Under 4 hour performance
United Lincolnshire Teaching Hospitals — **Target: 78.00%**
Activity Volume



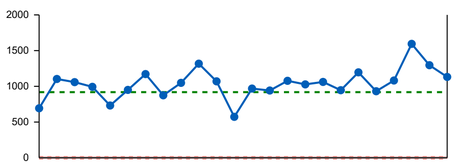
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
75.50%	74.00%	75.00%	77.00%	74.00%	76.50%	74.92%	73.00%	73.00%	73.00%	76.00%	78.00%

Acute - % EMAS Conveyance Delayed <45 mins
United Lincolnshire Teaching Hospitals — **Target: 95.00%**
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Acute - >12hr Trolley Waits
United Lincolnshire Teaching Hospitals — **Target: 0**
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
0	0	0	0	0	0	0	0	0	0	0	0

Acute - % Triage Data Not Recorded
United Lincolnshire Teaching Hospitals — **Target: 0.00%**
Activity Volume

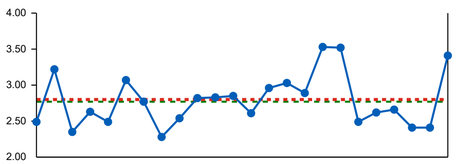
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Acute - Planned

Acute - Hospital Average LoS (Elective)

United Lincolnshire Teaching Hospitals — **Target: 2.80**

Activity Volume

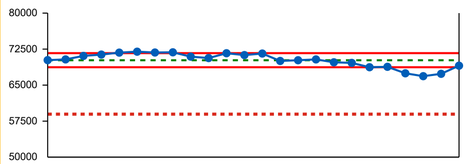


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80

Acute - Waiting List Size

United Lincolnshire Teaching Hospitals — **Target: 58965**

Activity Volume

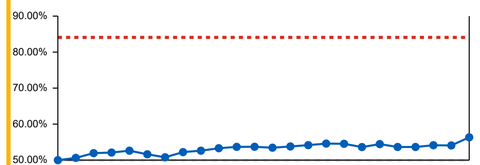


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
58965	58965	58965	58965	58965	58965	58965	58965	58965	58965	58965	

Acute - 18 week incompletes

United Lincolnshire Teaching Hospitals — **Target: 84.10%**

Activity Volume

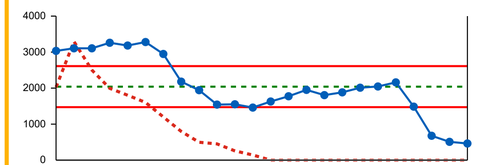


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	

Acute - 52 Week Waiters

United Lincolnshire Teaching Hospitals — **Target: 0**

Activity Volume

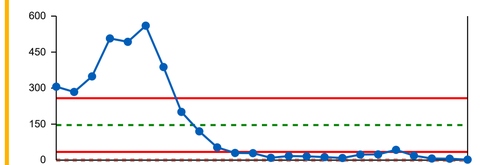


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
0	0	0	0	0	0	0	0	0	0	0	

Acute - 65 Week Waiters

United Lincolnshire Teaching Hospitals — **Target: 0**

Activity Volume

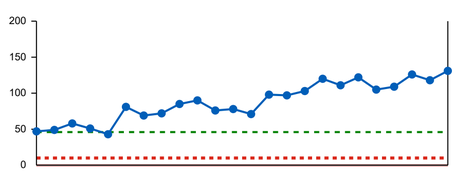


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
0	0	0	0	0	0	0	0	0	0	0	

Acute - 104+ Day Waiters

United Lincolnshire Teaching Hospitals — **Target: 10**

Activity Volume

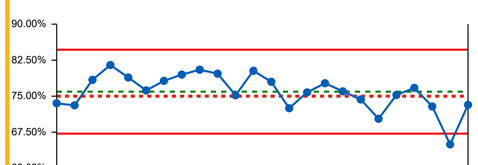


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
10	10	10	10	10	10	10	10	10	10	10	10

Acute - 28 days faster diagnosis

United Lincolnshire Teaching Hospitals — **Target: 75.00%**

Activity Volume

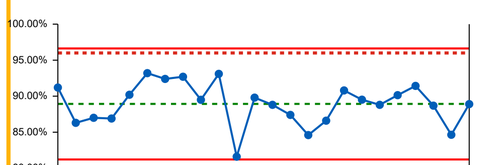


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	

Cancer - 31-day Treatment (Combined)

United Lincolnshire Teaching Hospitals — **Target: 96.00%**

Activity Volume

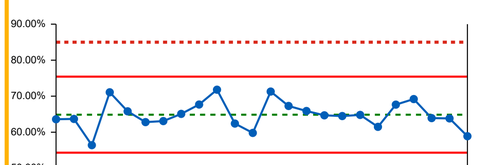


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	

Cancer - 62-day Treatment (Combined)

United Lincolnshire Teaching Hospitals — **Target: 85.00%**

Activity Volume

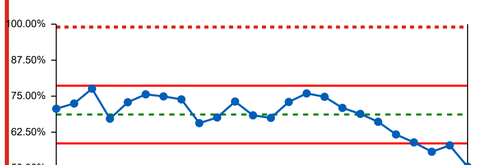


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	

Acute - Diagnostics achieved

United Lincolnshire Teaching Hospitals — **Target: 99.00%**

Activity Volume



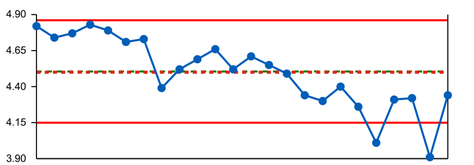
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%

Acute - Unplanned

Acute - Average LoS (Non Elective)

United Lincolnshire Teaching Hospitals — **Target: 4.50**

Activity Volume

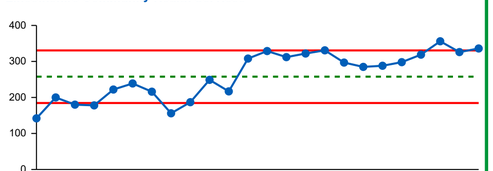


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50

Community - Planned

LCHS - LoS Reduction

Lincolnshire Community Health Services

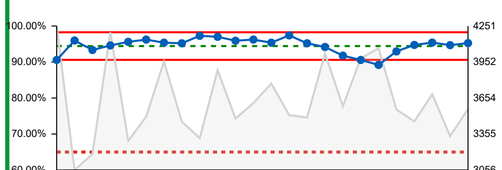


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
329	312	322	331	297	285	288	298	319	356	326	336

18 Week Wait

Lincolnshire Community Health Services — **Target: 65.00%**

Activity Volume

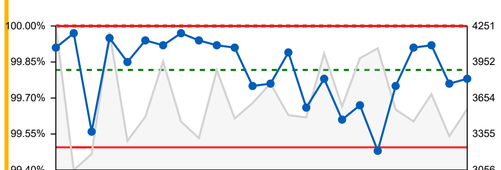


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%

52 Week Waits %

Lincolnshire Community Health Services — **Target: 100.00%**

Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

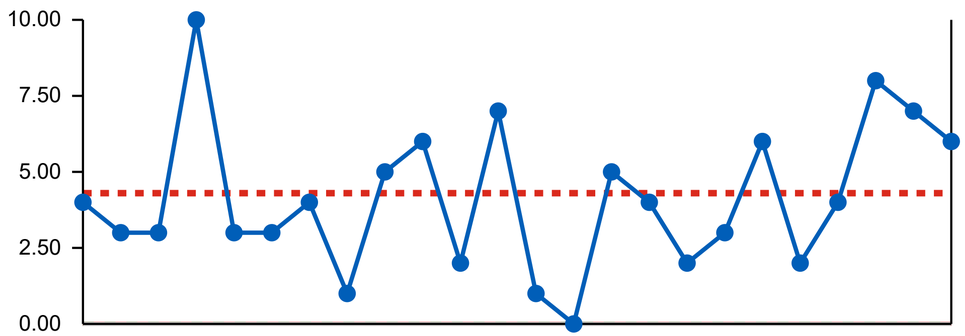
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - Pressure Ulcers category 3

United Lincolnshire Teaching Hospitals **Target: 4.30**

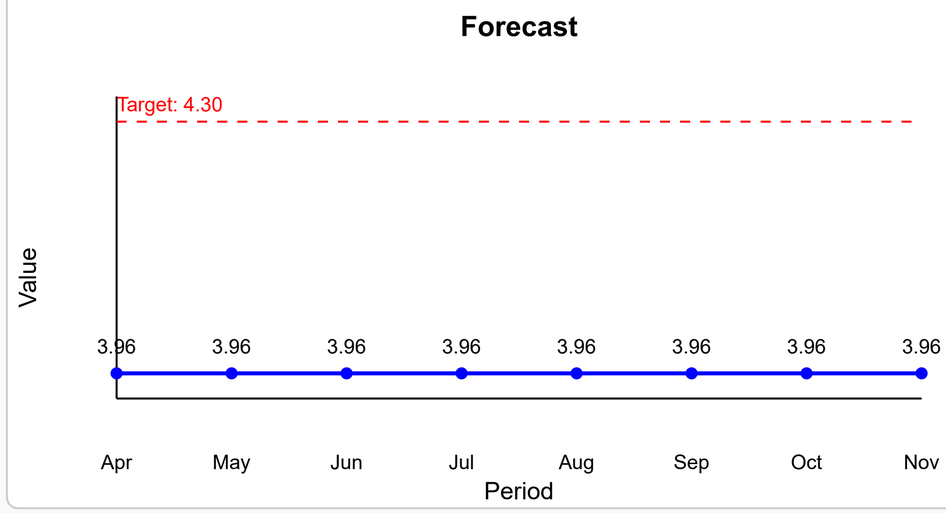
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30

The number of Category 3 incidents in March have decreased by 1 from February 2026. 2 of these incidents were device related, which is an increase of 2 device incidents from February 2026 All Category 3 pressure ulcers reported in March would have previously been categorised as Unstageable. Themes identified as areas of focus for improvement are: Reducing the number of pressure ulcers that deteriorate to Category 3 damage

All Category 3 incidents will be reviewed at the weekly Pressure Ulcer Support and Supervision Panel meeting. The Tissue Viability and Quality Matron Team undertake a detailed review of these incidents to identify any additional learning. Utilise quality assurance checks to provide teams with coaching and learning from incidents. Ambassador network to share and cascade best practice advice relating to reviewing and updating patients skin integrity management care plans.



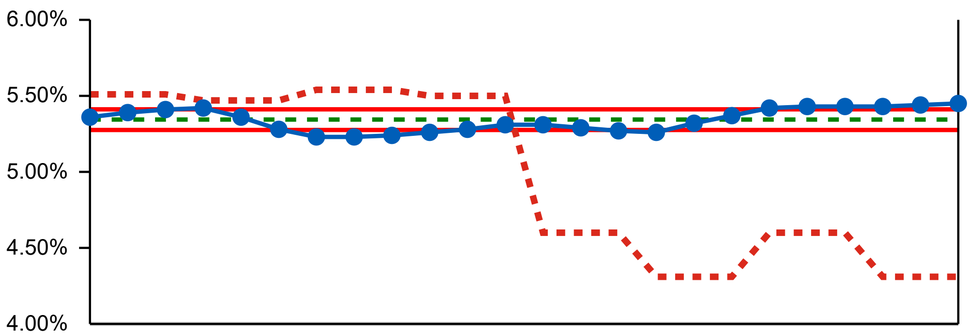
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - Sickness Absence

United Lincolnshire Teaching Hospitals **Target: 4.31%**

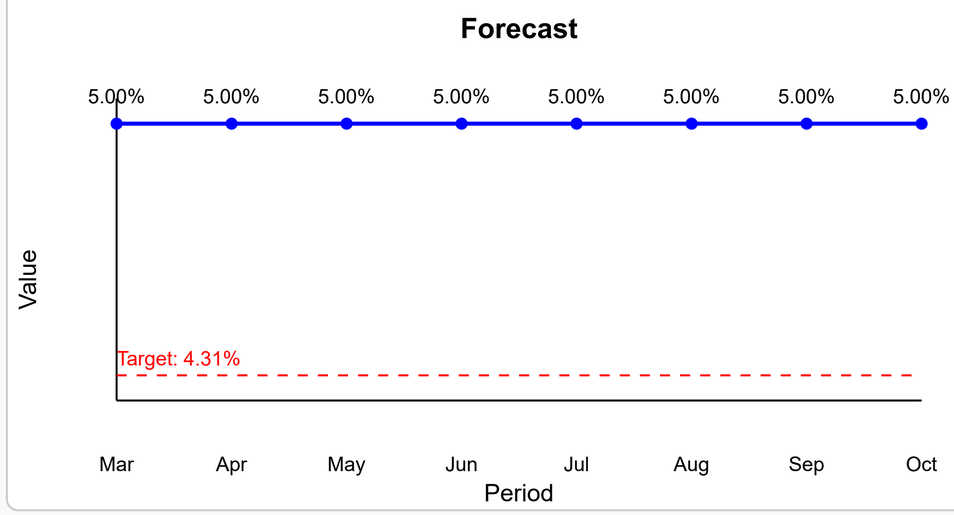
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.60%	4.60%	4.60%	4.31%	4.31%	4.31%	4.60%	4.60%	4.60%	4.31%	4.31%	4.31%

Our March 2026 Sickness Rate is 5.45% against a Q4 Target of 4.50%, and a stretch Target of 4.31%. This is outside of the Q4 Target although we expected to see an increase during the winter months, and levels of absence have remained static for the last 12 months. Reducing long term absence to mitigate impact on services.

There is a continued focus on supporting managers and leaders in absence processes and supporting our people to attend the work environment will be delivered through the mandated 'People Management Essentials' training. Additional resource allocated to absence to support the co-ordination and support to staff. Deep dives into areas of high absence to understand trends and support with actions and interventions as required in line with policy.



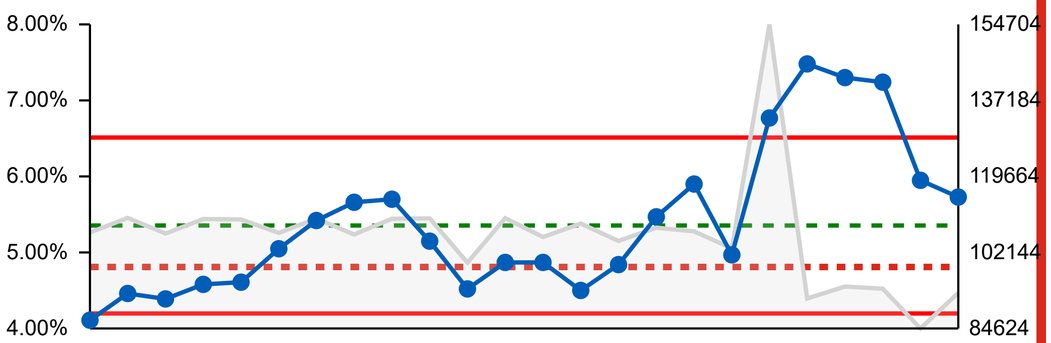
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Workforce - Sickness Rate

Lincolnshire Community Health Services **Target: 4.81%**

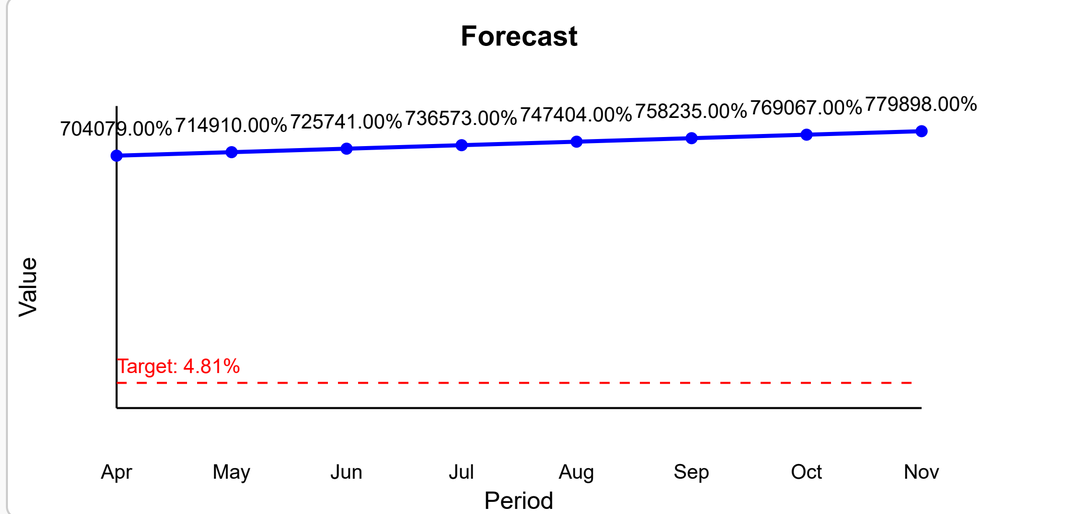
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%

Overall sickness has reduced in March to 5.73%, compared to 5.95% in February, but remains above the 4.81% target. Unplanned Care sickness has increased to 8.86%, up from 8.13% in the previous month. Data quality issues have been identified, including: Duplicate long-term absence (LTA) records for the same period. An employee on LTA incorrectly attributed to Unplanned Care rather than Planned Care within Power BI. These issues may be inflating reported sickness levels. National context highlights ongoing pressure: CIPD and Simplyhealth research shows UK employees averaged 9.4 sick days over the past year – the highest in 15 years. Mental ill health and stress are the leading causes of long-term absence and a significant driver of short-term absence. Stress, anxiety and depression remain the top absence reason, with 531.98 days lost, increasing from the previous month. This is the leading cause across Ops Centre, PAS, D2A, Home Visiting, Lincoln UTC and Skegness UTC. Other key causes include musculoskeletal conditions and cold/flu, indicating both wellbeing and seasonal factors.

An absence summit was held on 7 April to support leaders and strengthen organisational grip on sickness absence. A key action is to deep-dive all LTA cases over six months with Divisional Managing Directors. Targeted HR support continues, including: Ongoing coaching and advice for managers in line with the Your Attendance Matters policy. Monthly absence reporting and KPI reviews with Deputy Divisional Leads and Clinical Team Leads. Proactive HR engagement to support staff on LTA and facilitate timely, sustainable returns to work. Management capability is being strengthened through: Monthly absence workshops for managers, with further sessions planned. Workforce Strategy Group oversight of return-to-work meetings, sickness stages and policy compliance. Unplanned Care deep-dives have identified improvement actions, including: Earlier wellbeing conversations and stress risk assessments. Faster completion of return-to-work discussions. Timely ordering of specialist equipment. Use of short-term redeployment where staff cannot return immediately to substantive roles. Avoiding delays to sickness meetings while awaiting Occupational Health input. Further Unplanned Care absence reviews are scheduled for 20 April and 26 May to maintain focus and momentum.



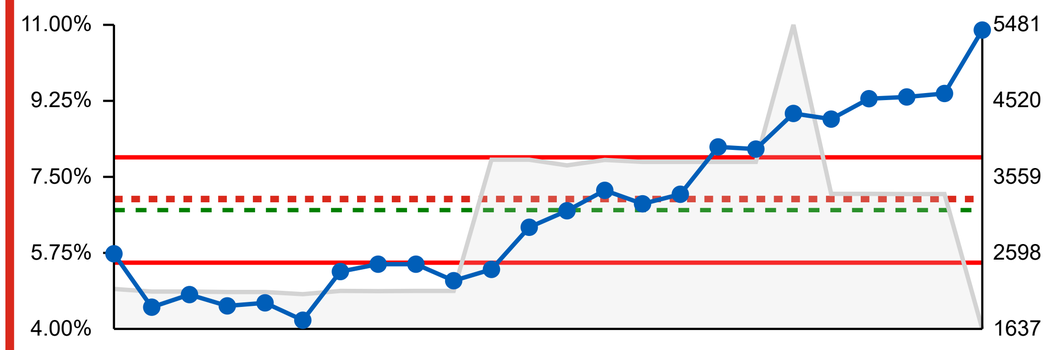
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Workforce - Vacancy Rate

Lincolnshire Community Health Services **Target: 6.99%**

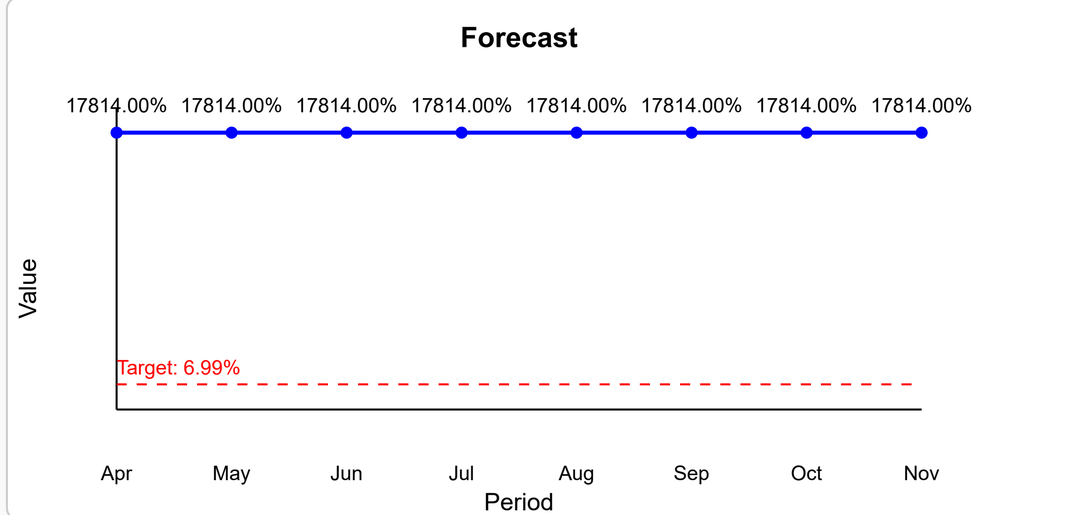
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%

The vacancy rate has increased in March to 10.88%, compared to 9.42% in February, and is at its highest level this financial year. Budget and workforce planning pressures In Central Planned Care, the Head of Service role was not budgeted for in 2025/26, creating short-term pressure, although this has been corrected in the 2026/27 plan. Within Children and Young People (CYP), WTE funding was only agreed until August 2025 due to the expectation that the service would end, resulting in ongoing workforce uncertainty. In Community Primary Partnerships, workforce constraints are driven by the B8a First Contact Practitioner (FCP) budget, which has been reduced in the 2026/27 plan to align income with expenditure. Vacancy and recruitment challenges IUECs vacancies have increased to 74.57 FTE, up from 72.23 FTE in the previous month. Several services are based in hard-to-recruit locations, limiting the available candidate pool. The Trust faces continued competition from neighbouring organisations, particularly Nottinghamshire and Cambridgeshire, for skilled staff. The current Vacancy Control Measure (VCM) restricts external advertising, resulting in staff movement between UTCs rather than attracting new recruits. UTC roles require specialist skillsets, further constraining recruitment options.

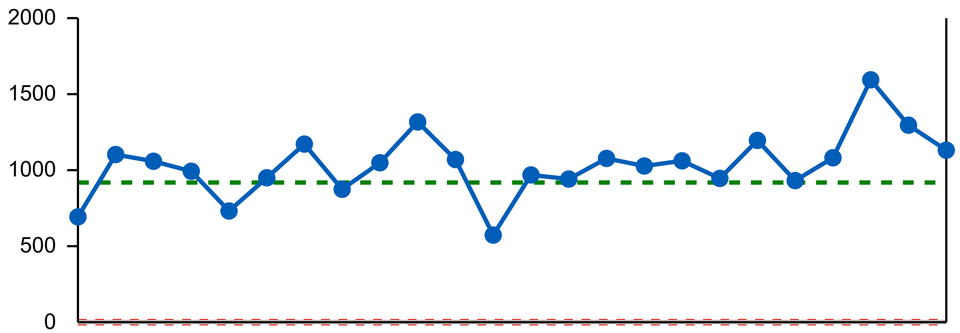
Targeted recruitment to address SAIS vacancies A significant reduction in the SAIS vacancy rate is expected by June 2026. 2.1 WTE Band 2 SAIS vacancies have been recruited to and are progressing through onboarding. 0.85 WTE Band 5 is due to commence in post on 27 April 2026. Workforce planning corrections Funding gaps identified in Central Planned Care have been addressed through inclusion of the Head of Service role in the 2026/27 budget. CYP workforce plans are being managed in line with the anticipated service trajectory. Recruitment innovation Developmental roles are being introduced within unplanned care to support recruitment, grow internal capability, and widen access to the workforce pipeline. Financial alignment Adjustments to the B8a FCP budget in Community Primary Partnerships ensure income and expenditure are better matched, reducing longer-term financial risk.



Acute - >12hr Trolley Waits

United Lincolnshire Teaching Hospitals **Target: 0**

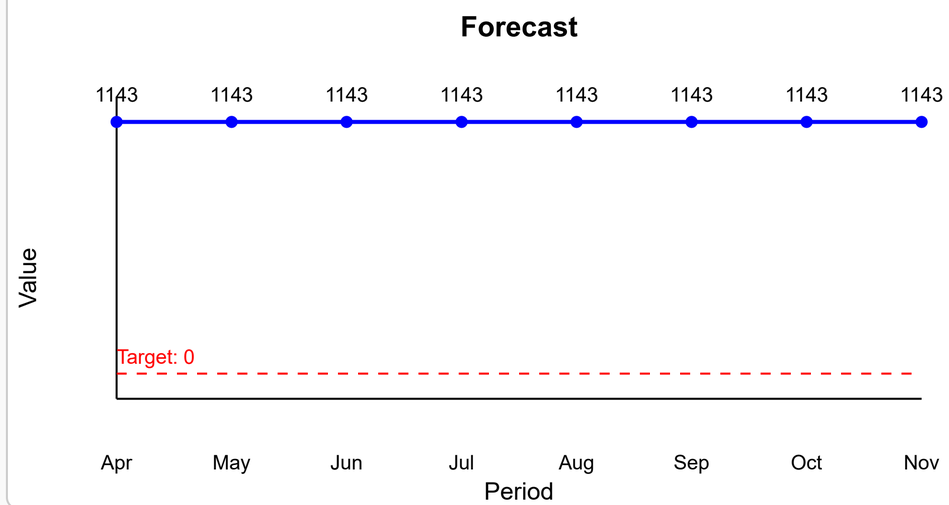
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
0	0	0	0	0	0	0	0	0	0	0	0

March experienced 1,132 breaches, an improvement from 1,296 in February, marking a variance of 12.65% (164 less patients). The 1,132 breaches accounted for 6.08% of all type 1 attendances. Additionally, the chart did not capture the adhoc internal decisions made to prioritise total time in the Emergency Department, aimed at minimising exposure risk and mortality rate. Sub-optimal discharges to meet the known emergency demand. All reportable 12hr trolleys were either associated with no available beds, patient deterioration or delays in transfer to other care settings.

The Trust continues to work closely with national regulators in reviewing and reporting these breaches. Due to the number of 12hrs trolley waits breaches currently, harm reviews are completed by the UEC team, DATIX are completed and escalations to the CCG and NHSE/I are in place. A daily review of all potential 12hr trolley waits is in place and escalated to all key strategic tactical and operational leads and divisional triumvirates. System Partners and Regulators remain actively engaged and offer practical support in situational escalations. A substantial programme of work out of hospital is in place with system partners to reduce delayed discharges which are upwards of 15% of all beds at times. A System agreement remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support. A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team. An additional consultant shift was funded by winter monies to review all DTAs every day to ensure that they still require admission Rapid Assessment and Treatment consultant shifts are in place at both ED front doors to assist with length of stay in department and appropriateness of referrals/navigation.



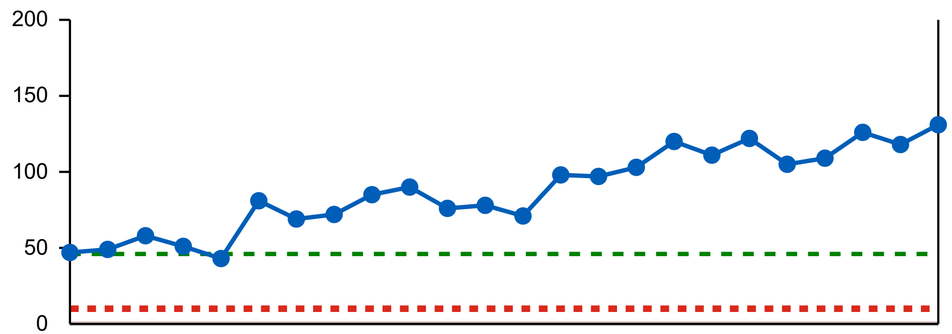
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - 104+ Day Waiters

United Lincolnshire Teaching Hospitals **Target: 10**

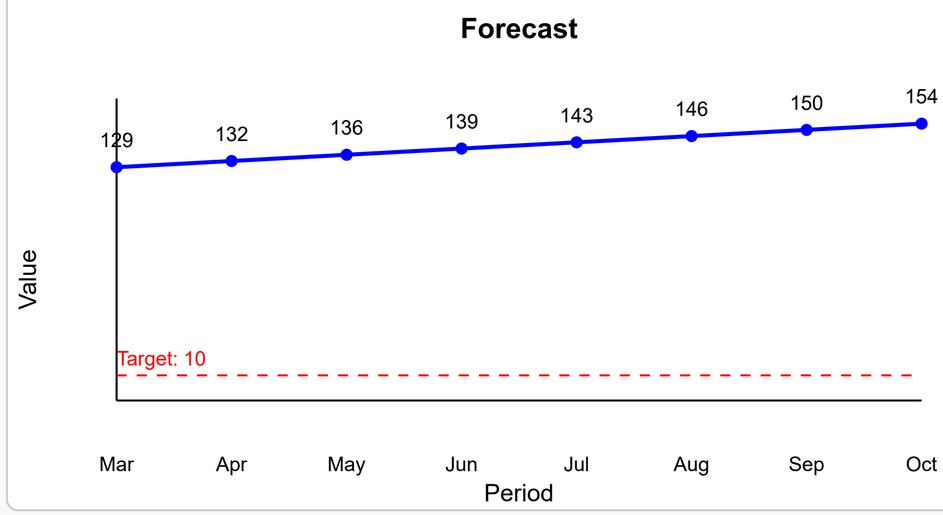
Activity Volume



Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
10	10	10	10	10	10	10	10	10	10	10	10

As of 15th April 2026 the 104 Day backlog is at 131 patients. There are 4 main tumour sites of concern:- Colorectal 37 Lung 25 Head and Neck 22 Urology 18 The impact of ongoing pathway, staffing and capacity challenges. Patients not willing to travel to where our service and / or capacity is available. Reduced OP, diagnostic and theatre capacity across the Trust, all Specialties vying for additional sessions. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Head & Neck, Gynaecology, and Lung. Approximately 12.21% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

Intensive Support Meetings in place to support Colorectal, Urology, Head & Neck, Lung, Upper GI, Skin, Gynae and Breast recovery.



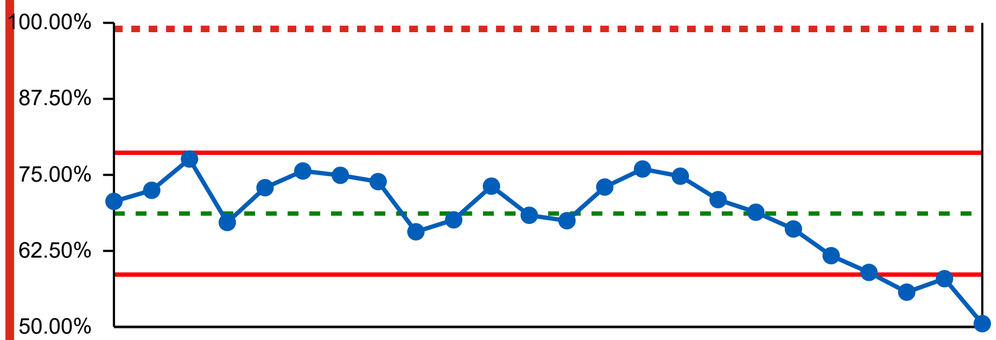
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - Diagnostics achieved

United Lincolnshire Teaching Hospitals **Target: 99.00%**

Activity Volume

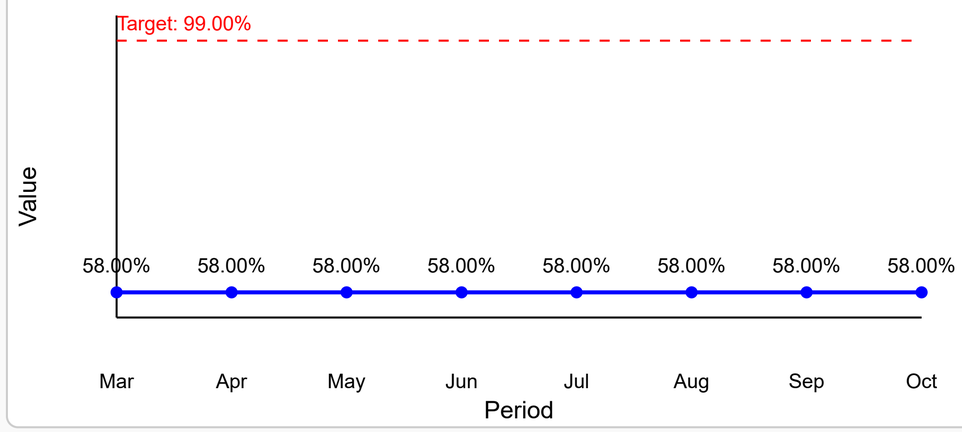


Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%

DM01 for March was 50.55%, against 99.00% target. Reduction in performance • Most diagnostic breaches sit in Audiology. Ultrasound and MRI. • Ultrasound / MRI has seen increase in demand due to the AQP contract come to an end. And the lack of admin staff to book patients. Ultrasound staffing is a national issue.

Ultrasound are using agency where possible and additional shifts, reduced capacity from clinical and no admin staff. Audiology are working on to an ambitious recovery trajectory. Patients are being seen in clinical priority.

Forecast



LCHG Scoring

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

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

Lincolnshire Community and Hospitals NHS Group

Risk Reporting to the Group Board

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*5 May 2026*
Agenda item number	*13.1*
Report title	*Risk Reporting to the Group Board*
Report purpose: • Discussion • Approval • Assurance • Information • 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* *Jeremy Daws, Associate Director Compliance and Risk*
Assurance rating: • Substantial assurance • Reasonable assurance • 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:* • *Review the content of the report. There are no further escalations at this time.*

Assurance Rating Key:

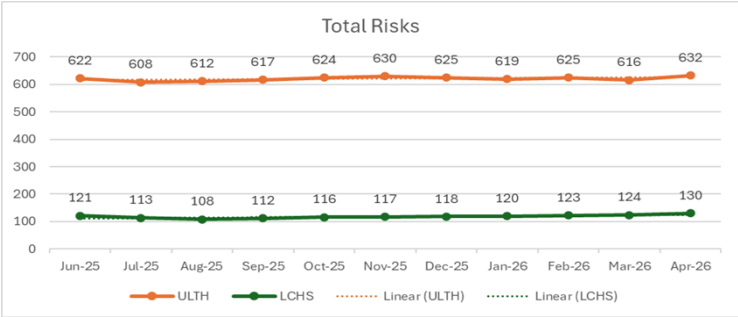
Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are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

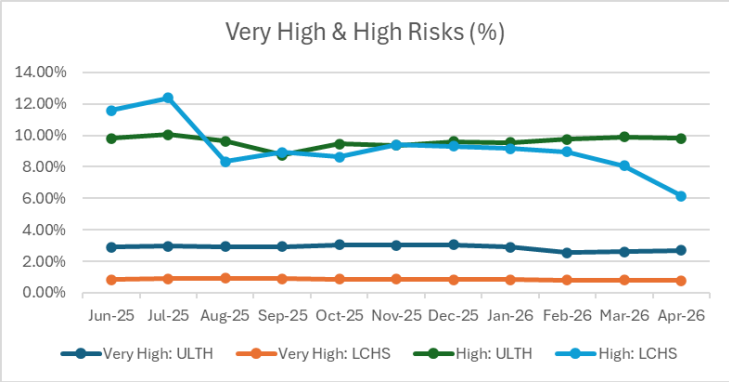
Risk movement over time:

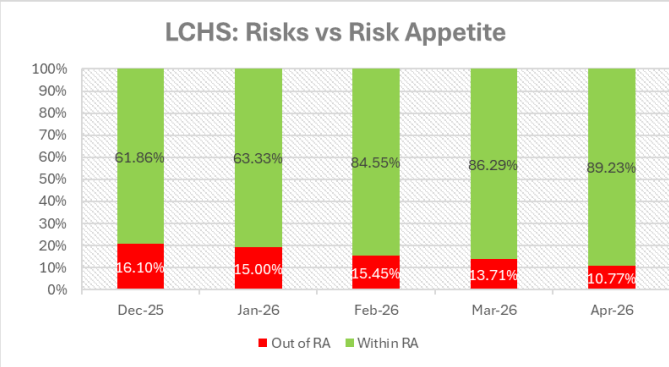
- As of 14 April 2026, there are 762 (LCHS 130 and ULTH 632) risks in total.
- This is an increase of 14 since last the last report.
- The chart demonstrates the split between ULTH and LCHS



Very high / High risk movement:

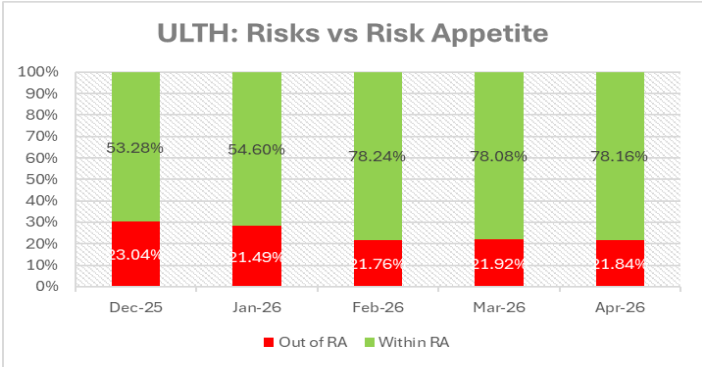
- There are 18 (9%) risks considered to be **very high** (20-25) (see appendix A for full detail)
  - LCHS: 1 (0.7%)
  - ULTH: 17 (3%)
  - The chart demonstrates an increase of 1 **very high** risk since the previous report
- There are 70 (9%) risks considered to be **high** (15-20) (see appendix B for full detail)
  - LCHS: 8 (6%)
  - ULTH: 62 (10%)
  - The chart demonstrates a decrease of LCHS high risks from 9% in November 2025 to 6% (a decrease of 2 **high** risks).





Risks vs Risk Appetite[1]:

- The proportion of risks reported that **exceed** the risk appetite established for LCHS is lower than ULTH:
  - LCHS: 11%
  - ULTH: 22%



[1] See page 6 for further details relating to the risk appetite set for risks.

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 April 2026, 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 14 April 2026, there are 762 (LCHS 130 and ULTH 632) risks in total.
- This is **an increase of 14** since the March 2026 report.
- Of the 762 risks, there are 88 (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):**
    - **New** 849 - Risk of school aged children & young people not receiving speech and language support – ***risk presented at RRC&C on 18/03/2025 confirmed score 5x4:20 Very High Risk***

    Following Risk Confirm & Challenge meetings in February and March 2026, the following risk level reductions were approved:

        - 403 - Children SLT Therapy Treatment Delays – **Very High Risk was agreed for closure** - following successful mitigation for pre-school children under the new SLT model. The remaining issues have been split into two new risks to reflect the different residual positions: a low residual risk for pre-school children and a very high residual risk for school-age and specialist referrals (new Risk IDs **849** and **850**).
- **ULTH:** Very high (20-25): 17 (an increase of 1 since 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=5; increase of +1 since 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)
    - **New** 5761 – Risk to IBD service ***risk presented at RRC&C on 18/03/2025 confirmed score 5x4:20 Very High Risk.***

    - **Finance and Performance Committee:** (n=3; same as previous report):
    - 4664 - Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
    - 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care
    - 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 130 risks, 14 are out of the risk appetite set (a decrease of 5 since Mar-26).
- **ULTH:** Of the 632 risks, 138 are out of the risk appetite set (an increase of 2 since Mar-26).

Strategic Objective:	Defined Risk Appetite[2]:	LCHS		ULTH	
		Within	Out of	Within	Out of
1a (i): Patient Safety, patient experience and deliver clinically effective care	**Cautious:** Prepared to accept risks up to 10	37	9	147	92
1a (ii): Patient Experience	**Open:** Prepared to accept risks up to 12	8	0	35	4
1a (iii): Clinically Effective Care	**Open:** Prepared to accept risks up to 12	9	0	17	1
1b: Reduce waiting times for our patients	**Open/Cautious:** Prepared to accept risks rated to 10-12	4	0	18	3
1c: Improve productivity and deliver financial sustainability	**Open:** Prepared to accept risks rated to 12	14	1	64	5
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	5	2	13	10
2b: Empower our people to continuously improve and innovate	**Hungry:** Prepared to accept risks rated as 15/16	3	0	11	4
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	7
3b: Move from prescription to prevention, through a population health management & health inequalities approach	**Hungry:** Prepared to accept risks rated as 15/16	4	0	0	0
3c: Enhance our digital, research and innovation capability	**Hungry:** Prepared to accept risks rated as 15/16	9	0	78	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

[2] 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).**

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)
Apr – 2026	130	5 (4%)	**37** (28%)	**79** (61%)	**8** (6%)	**1** (1%)
Feb – 2026	123	**5** (4%)	**36** (29%)	**70** (57%)	**11** (9%)	**1** (1%)

- The number of risks has increased by 7 compared to the previous report.
- 1 risk is scored 'Very High'. There is no change from the previous report.
- 8 risks are scored as 'High'. This is a decrease of 3 from the previous report.

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	0	1	0	**3**
	Quite likely (4) 71-90% chance	1	4	11	7	0	**23**
	Reasonably likely (3) 31-70% chance	2	6	22	15	1	**46**
	Quite unlikely (2) 10-30% chance	0	6	23	19	4	**52**
	Extremely unlikely (1) <10% chance	0	0	3	1	2	**6**
	Total	**3**	**18**	**59**	**43**	**7**	**130**

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)
Apr – 2026	632	**43** (7%)	**159** (25%)	**351** (55%)	**62** (10%)	**17** (3%)
Feb – 2026	625	**45** (7%)	**158** (25%)	**345** (55%)	**61** (10%)	**16** (3%)

- The number of risks has increased by 7 compared to the previous report.
- 17 risks are scored as 'Very High'. This is an increase of 1 from the previous report.
- 62 risks are scored as 'High'. This is an increase of 1 from the previous report.

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	15	13	15	0	**44**
	Quite likely (4) 71-90% chance	2	31	72	46	2	**153**
	Reasonably likely (3) 31-70% chance	2	44	102	72	3	**223**
	Quite unlikely (2) 10-30% chance	18	24	73	48	11	**174**
	Extremely unlikely (1) <10% chance	7	9	7	9	6	**38**
	Total	**30**	**123**	**267**	**190**	**22**	**632**

4. Risks by Strategic Objective:

4.1: Strategic objective 1a (i) Patient Safety

The Group's Risk Appetite is described as: 'Cautious' (accept risks up to 10)

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
Apr – 2026	**Cautious** Accept up to 10	37 (80%)	9 (20%)
		46	
Feb – 2026		25 (66%)	12 (34%)
		37	

Number of risks 15-25	High (15-16)	Very high (20-25)
3	2 (67%)	1 (33%)
4	3 (77%)	1 (23%)

- 80% of LCHS risks (37) are within the '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
Apr – 2026	**Cautious** Accept up to 10	147 (62%)	92 (38%)
		239	
Feb – 2026		148 (62%)	90 (38%)
		238	

Number of risks 15-25	High (15-16)	Very high (20-25)
27	21 (78%)	6 (22%)
26	20 (77%)	6 (23%)

- 62% of ULTH risks (147) are within the 'Cautious' risk appetite.
- There are 6 'Very High' risks.

Summary of the risks outside of the Risk Appetite:

LCHS: n=9

ID	Title	Rating (current)
402	Medicines Management Trust wide - includes Pharmacy Staffing	12
681	Children in Care - unable to meet IHA and RHA timescales	16
710	There is a risk of a failure to safely prescribe medication within the Community Hospitals	12
714	Delivery of pressure ulcer care in the community	16
750	ADOS Assessments for CYP	12

ID	Title	Rating (current)
789	Prescribing Governance	12
793	Contracted Pharmacy Service - Co-op Agreed KPIs	12
822	Consultant not recording eye drops given	12
849	**New** Speech and Language Therapy for School-Aged Children and Young People ***risk presented at RRC&C on 18/03/2025 confirmed score 5x4:20 Very High Risk. Risk 403 (Children's SLT Therapy Assessment and Treatment Delays) is replaced to reflect the impact of a new model of working, which has reduced the risk for pre-school children.***	20

ULTH: n=92

ID	Title	Rating (current)
5668	Increased demand within the Pre-diagnosis Team	12
4770	Ageing medical and diagnostic equipment throughout the Trust is overdue for replacement	12
5448	Anaesthetic input for Paediatric Emergency Cases at Grantham UTC	12
5200	Backlog of Paediatric Cardiology clinics	20
4952	Branston ward escalation to assist with Gynaecology emergency admissions	12
4727	Capacity gaps within individual hubs and within Outpatients	12
4700	Children and young people treated in clinical areas external to the Family Health division	12
5558	Clinical imaging software - lack of availability-Dermatology	12
5005	Compliance with GDPR / Data Protection Act in Specialist Palliative Care	12
4623	CQC inspection outcome	12
4855	Delayed diagnosis of breast cancer and increased waits to treat confirmed cancers	16
4928	Delays in Cardiology Outpatient Appointments	12
4779	Delays in Stroke Services	12
5520	Delays to mechanical Thrombectomy for patients presenting with large vessel occlusion/acute stroke	16
5101	Delivery of paediatric epilepsy pathways-Acute Paediatrics & Community	20
5651	East Midlands Cancer Alliance Centre for Psycho Social Health withdrawal of funding	16
5533	Failure of adherence to NICE Guidelines – risk of life changing disability	16
5504	Failure of Call Bell System at Louth Site – Risk to Patient Safety and JAG Accreditation	15
4989	Failure to read or act on radiology reports	12
4891	Following termination of AQP - Ultrasound capacity not meeting demand	12
4741	Fragility of Oncology services	16

ID	Title	Rating (current)
5228	Non-Compliance with Cauda Equina Service	12
4975	Non-compliance with all elements of the Paediatric Oncology Shared Care Unit measures	12
5768	Non-Compliance with Ionising Radiations Regulations 2017 Consent Requirements Impacting Critical Services	12
5165	Non-compliance with Local and National policy and NPSA 20 on the safe prescribing of injectable medicines	12
5196	Non-compliance with medicines storage audits	15
5414	OAU - Lincoln - do not complete EDD's	12
4746	Overdue patients on Ophthalmology PBWL	20
5614	Paediatric Audiology Service not meeting the Paediatrics Quality Standards	16
5002	Patient access to specialist palliative care	16
4624	Patient falls resulting in serious harm	12
5016	Patient Flow Through Emergency Departments.	20
5387	Patient safety delays in clinical assessment by experienced practitioner, due to demands on medical teams out of hours	12
5688	PHB Waiting Room-shared ED and Outpatients waiting room risk.	12
5095	PICC Line Service Delays	16
4878	Planned care non-admitted pathway (outpatients)	12
4877	Planned care pathway delays	12
5658	Poor condition of Ward 1B	12
4955	Processes for the repackaging and over labelling of medicines	12
4789	Processing of Echocardiograms	16
4646	Provision of NIV treatment	16
4879	Recovery of planned care cancer pathways	20

ID	Title	Rating (current)
5536	Funding for AHP Provision for Neonatal Care	12
4978	Gynaecology cancer metrics	12
5610	Inadequate Administration staffing in Haematology	12
5306	Inadequate Specialist Microbiologist input for patient care	16
4868	Inappropriate preparation of c-section medication	16
4782	Increasing backlog of planned care activity across the Cardiovascular CBU	12
5271	Increasing demand on capacity of children's area of ED	12
5731	Insufficient capacity to undertake timely fractured neck of femur surgery	12
5433	Insufficient EPAU scan capacity	15
5683	Insufficient maternity triage processes	12
5617	Insufficient maternity triage system	16
5525	Insufficient midwifery staffing for antenatal triage	12
5557	Insufficient number of Level 1 enhanced care trained nursing staff on surgical wards	12
5663	Insufficient number of Tier 1 and Tier 2 paediatric doctors overnight at Pilgrim	12
4769	Insufficient staffing and ultrasound equipment within the Vascular Lab at Pilgrim	16
5744	Lack of a Patient Supplies Administrative Coordinator	12
5515	Lack of capacity to meet demand for Elective Caesarean Section	12
4750	Lack of emergency alarm bell system/phones/call system within Theatres	12
5289	Lack of Emergency Buzzers on Day Case Ward Pilgrim	12
5741	Lack of robotic theatre availability for colorectal cancer surgery	12
4843	Lack of Senior Immunology expertise within Lincolnshire & resulting impact on Patient Safety and ULTH practice	16
4765	Lack of therapies provision for the Head & Neck Cancer service	12

ID	Title	Rating (current)
5538	Reduced senior nursing staff and insufficient skill mix on Ward 4a	12
5508	Reputational and Patient Safety Risk due to failure to meet NatPSA/2023/010/MHRA deadline	12
5099	Risk of a delay in haematology and oncology patients receiving specialist review / input	12
5491	Risk of Clinical treatments being carried out in rooms that do not have the appropriate ventilation levels.	16
5450	Risk of Gastro service not being viable due to current fragility of Consultant workforce	20
5713	Risk of inability to run Cardio-Diabetes service	12
4625	Risk of Outbreak of serious infectious disease	12
5542	Risk of Pleural Service	12
4626	Risk of pressure ulcers	12
5429	Risk of service disruption due to Current Cath Labs coming to end of life	12
5762	Risk of Service Disruption During Transition to In-House/Philips Sleep Service Model	12
5205	Risk of using less reliable and old equipment - Radiotherapy Treatment Equipment	12
5493	Risk to delivery of Paediatric Dietitian service due to workforce gaps	12
5181	SACT capacity does not meet demand	15
5333	Shortage of Adult Acute Dietetic Staffing Across Inpatient Wards	12
5320	Shortage of ARSAC Practitioner Licence holders	12
5654	Staffing shortages within Dietetics Oncology Team	12
5665	Stroke service – delay in receiving abnormal blood test results.	12
5146	Termination of pregnancy service currently unable to meet RCOG standards	15
4724	Therapies & Rehabilitation Medicine service provision	12
5737	Therapy Admin Team Workforce Shortfall Impacting Service Delivery	12
5393	Trust failing to provide x-ray imaging referrers (within and outside the Trust) with referral guidelines	12

ID	Title	Rating (current)
5621	Lack of Trustwide orthogeriatric cover	12
5724	Lack of vitreoretinal consultant to deal with retinal detachment emergencies	12
5708	No allocated Occupational Therapy resource for Prehab Cancer provisions	12

ID	Title	Rating (current)
5449	ULHT ERCP Service	12
5770	Unactioned Radiology Alerts Due to Staffing Shortages	12
5647	Workforce required to safely manage and maintain the e-PMA system for Systemic Anti-Cancer Therapy (SACT) (Varian-Aria)	12

Summary of the 'Very High' risks (n=7):

LCHS: (n=1):

Risk ID	Title	Risk level (current)	Care Group	Progress Update	Date of latest review
849	Risk of School-Aged Children and Young People Not Receiving Timely Speech and Language Therapy Support	Very high risk (20-25)	Family Health	Risk presented at RRC&C on 18/03/2026 confirmed score 5x4:20 Very High Risk. Risk 403 (Children's SLT Therapy Assessment and Treatment Delays) is replaced to reflect the impact of a new model of working, which has reduced the risk for pre-school children.	18/03/2026

ULTH: (n=6)

ID	Title	Risk level (current)	Care Group	Progress update	Date of latest review
4746	Overdue patients on Ophthalmology PBWL	Very high risk (20-25)	Surgery	Reviewed at Specialty Governance meeting on 11th March – backlog ha reduced by approx. 700 patients over past month which represents significant improvement.	11/03/2026
4879	Recovery of planned care cancer pathways	Very high risk (20-25)	Corporate	Performance across the cancer standards remains fragile, with no sustained improvement in 28-Day FDS, 62-Day, or 31-Day delivery. Number of 62+ day patients remains significantly above national expectations, despite the recovery trajectory targeting a reduction to 245 by March 2026. The backlog continues to be driven by diagnostic constraints, particularly in radiology and endoscopy, as well as ongoing pressures in surgical capacity. Weekly Care Group Intensive Support Meetings are now fully embedded and have strengthened tumour-specific oversight, enabling targeted issues to be identified earlier. However, several tumour sites remain off-trajectory, and long waits continue to pose a persistent patient safety concern. Recent governance changes, including the Cancer Centre's shift to a corporate structure and appointment of a Head of Cancer, have improved coordination and performance management, but operational issues affecting flow and capacity continue to limit progress.	02/03/2026
5016	Patient Flow Through Emergency Departments.	Very high risk (20-25)	Medicine	From the 16th March new non-elective model implemented which provides additional clinical space at Lincoln & expansion of both CDU's at Lincoln & Boston to enable flow. In Jan 2026, Lincoln ED rolled out their new front door joint streaming model which is designed so that patients are streamed to their most appropriate place of care avoiding ED where possible.	10/03/2026

ID	Title	Risk level (current)	Care Group	Progress update	Date of latest review
5101	Delivery of paediatric epilepsy pathways-Acute Paediatrics & Community	Very high risk (20-25)	Family Health	Service remains fragile. An increase in the neurology MDT staffing forms part of the business case, suggesting doubling the current specialist nursing capacity and the need for an EEG technician to provide neurophysiology support for timely management of these patients. The project work on transition to adult services has not yet commenced with Epilepsy and further discussion is needed in relation to the SLA with tertiary neurology services to equitably reflect local caseloads. The risk remains Very High due to several critical and unresolved issues affecting service resilience, patient safety, and operational sustainability.	19/03/2026
5200	Backlog of Paediatric Cardiology clinics	Very high risk (20-25)	Family Health	Minimal backlog at Boston but not significant enough for this risk to remain open. Risk to be presented at RRC&C in April for closure.	10/03/2026
5450	Risk of Gastro service not being viable due to current fragility of Consultant workforce	Very high risk (20-25)	Medicine	New starter expected later in year at PHB, leaving 1 post filled by general physician and 1 non-scopist. LCH have 1x12PA role for recruitment. Recruitment into the roles will not address loss of capacity due to retire/returns and workforce case still needs to progress.	03/03/2026

4.2: Strategic objective 1a (ii) Patient Experience

The Group's Risk Appetite is described as: '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)
Apr – 2026	**Open** Accept up to 12	8 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		8				
Feb – 2026		8 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		8				

- 100% of LCHS risks (8) are within the 'Open' risk appetite.
- There are no 'Very High' 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Open** Accept up to 12	35 (89%)	4 (11%)	4	3 (75%)	1 (25%)
		39				
Feb – 2026		31 (86%)	5 (14%)	4	3 (75%)	1 (25%)
		36				

- 89% of ULTH risks (35) are within the 'Open' risk appetite.
- There is 1 'Very High' risk.

Summary of the risks outside of the Risk Appetite (n=4):

ULTH

ID	Title	Rating (current)
4731	Reliance on paper medical records	20
5003	Workforce deficit for Specialist Palliative Care	16
5216	Radiotherapy Staffing levels	16
5495	Bereavement care provision in Obstetrics	16

Summary of the 'Very High' risk (n=1):

ULTH

ID	Title	Risk level (current)	Division	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.	04/03/2026

4.3: Strategic objective 1a (iii) Clinically Effective Care

The Group's Risk Appetite is described as: '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)
Apr – 2026	**Open** Accept up to 12	9 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		9				
Feb – 2026		7 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		7				

- 100% of LCHS risks (9) are within the 'Open' risk appetite.
- There are no 'Very High' 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Open** Accept up to 12	17 (94%)	1 (6%)	1	1 (100%)	0 (0%)
		18				
Feb – 2026		15 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		15				

- 94% of ULTH risks (17) are within the 'Open' risk appetite.
- There are no 'Very High' risks.

Summary of the risks outside of the Risk Appetite (n=1):

ULTH

ID	Title	Rating (current)
5747	Lack of available cardiac lab space for both PCI and device lists	15

4.4: 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Open/ Cautious** Accept up to 12	4 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		4				
Feb – 2026		4 (80%)	1 (20%)	1	1 (100%)	0 (0%)
		5				

- 100% of LCHS risks (4) are within the 'Open/Cautious' risk appetite
- There are no 'Very High' 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Open/ Cautious** Accept up to 12	18 (86%)	3 (14%)	3	3 (100%)	0 (0%)
		21				
Feb – 2026		13 (76%)	4 (24%)	4	4 (100%)	0 (0%)
		17				

- 86% of ULTH risks (18) are within the 'Open/Cautious' risk appetite.
- There are no 'Very High' risks.

Summary of the risks outside of the Risk Appetite (n=3):

ULTH:

ID	Title	Rating (current)
5267	Delay in processing cardiac MRIs	16
5447	Cancellation of elective lists due to lack of theatre staff	16
5715	Reduction in staffing levels within CT, ultrasound and MRI administration teams	15

4.5: 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Open** Accept risks up to12	14 (93%)	1 (7%)	1	1 (100%)	0 (0%)
		15				
Feb – 2026		13 (93%)	1 (7%)	1	1 (100%)	0 (0%)
		14				

- 93% of LCHS risks (14) are within the 'Open' risk appetite
- There are no '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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Open** Accept risks up to12	64 (93%)	5 (7%)	5	2 (29%)	3 (71%)
		69				
Feb – 2026		67 (93%)	5 (7%)	5	2 (29%)	3 (71%)
		72				

- 93% of ULTH risks (64) are within the 'Open' risk appetite
- There are 3 'Very High' ULTH risks.

Summary of the risks outside of the Risk Appetite (n=6):

LCHS:

ID	Title	Rating (current)
805	CIP (Efficiency) requirement 2025/26	16

ULTH:

ID	Title	Rating (current)
4664	Exceeding the agency cap due to the cost of reliance upon temporary clinical staff	20
4658	Failure to meet national standards and best practice for record management	16
5020	Reliance on agency / locum medical staff in Urgent & Emergency Care	20
5389	Risk of overspend due to current service provision being unfunded hospital at Night	16
5672	Risk of failure to deliver the CIP target in full for 2025/2026	20

Summary of the 'Very High' risks (n=3):
ULTH:

Trust:	Risk ID	Risk Title	Risk score	Division	Progress Update	Date of latest review:
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. 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. 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. 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. Medical and dental agency expenditure is thus a key area of focus in our efficiency discussions and an area for further improvements.	05/03/2026
ULTH	5020	Reliance on agency / locum medical staff in Urgent & Emergency Care	Very high risk (20)	Medicine	Robust recruitment plan International recruitment Medical Workforce Management Project	10/03/2026
ULTH	5672	Risk of failure to deliver the CIP target in full for 2025/2026	Very high risk (20)	Corporate	An assessment was made of the best, likely and worst case forecast for each month in Q4 for ULTH. Based on information available at month 10, £5.7m CIP delivery was expected in month 11 however actuals of £8.1m have been delivered in month 11 – this is an improvement of £2.5m mainly relating to technical release and a review of the Alliance care group CIP savings delivered YTD. -Delivery in the final weeks of the financial year of planned schemes is critical to support the delivery of the overall financial position. -A best, likely and worst CIP forecast has been undertaken again at month 11 alongside the care group forecast reported. The best case is £5.9m deficit from plan (without any further external income received) but has some risks to delivery -Further work continues on discussions around additional external funding support as the Trust aims for a breakeven financial position to meet it's plan.	27/03/2026

4.6: 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr - 2026	OPEN Accept up to 12	14 (88%)	2 (12%)	2	2 (100%)	0 (0%)
		16				
Feb - 2026		14 (88%)	2 (12%)	2	2 (100%)	0 (0%)
		16				

- 88% of LCHS risks (14) are within the 'Open' risk appetite
- There are no '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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr - 2026	OPEN Accept up to 12	90 (88%)	12 (12%)	12	12 (100%)	0 (0%)
		102				
Feb - 2026		91 (88%)	12 (12%)	12	12 (100%)	0 (0%)
		103				

- 88% of ULTH risks (90) are within the 'Open' risk appetite
- There are no 'Very High' ULTH risks.

Summary of the risks outside of the Risk Appetite (n=14):

LCHS:

ID	Title	Rating (current)
799	Potential for a major fire	16
649	Fire Safety Core Risk	15

ULTH:

ID	Title	Rating (current)
4648	Potential for a major fire	16
4701	Hospital environment and facilities in Maternity services	15
4725	Prolonged Estates and infrastructure issues in Therapy & Rehab department	16
4830	Pharmacy Estates at Pilgrim Hospital	15
5136	Nitrous Oxide Risk	16
5234	No clinic space at Pilgrim affecting Neurophysiology testing	16
5272	Risk of Cath Labs coming to end of life	16
5334	Lack of second theatre available to use on Pilgrim Labour Ward	16

ID	Title	Rating (current)
5383	Treatment room not compliant with HBN 00-03 due to poor ventilation	15
5471	Risk of lifts failure due to exceeding mechanical life expectancy following Risk Confirm & Challenge in December, risk validated for **increase in score from 4x3:12 Moderate Risk to 5x3:15 High Risk –** due to frequent lift failures and lack of availability of parts.	15
5498	Risk of patient delays and potential risk of accidents from Trust Helipad due to location, quality and security	15
5695	Risk of maintenance of specialist equipment was not being followed	16

Summary of the 'Very High' risks (n=0):

- There are none.

4.7: 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
Apr – 2026	**OPEN** Accept up to 12	5 (71%)	2 (29%)
		7	
Feb – 2026		6 (75%)	2 (25%)
		8	

Number of risks 15-25	High (15-16)	Very high (20-25)
2	2 (100%)	0 (0%)
2	2 (100%)	0 (0%)

- 71% of LCHS risks are within the 'Open' risk appetite.
- There are no '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
Apr – 2026	**Open** Accept up to 12	13 (57%)	10 (43%)
		23	
Feb – 2026		14 (65%)	10 (35%)
		24	

Number of risks 15-25	High (15-16)	Very high (20-25)
10	9 (90%)	1 (10%)
10	9 (90%)	1 (10%)

- 57% 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=12):

LCHS:

ID	Title	Rating (current)
715	Community nursing lacking capacity and skill set to meet community demand	16
754	Moving and Handling – poor compliance	16

ULTH:

ID	Title	Rating (current)
4780	Significant deficit in Stroke consultant staffing	16
4862	Consultant staffing capacity within Respiratory Medicine	16
4996	Consultant workforce capacity & increasing demand – Haematology	20
5142	Continued high footfall at LCH/PHB ED overnight	16
5427	Student training discrepancy between LCH/PHB	16
5467	Respiratory teaching gaps at LCH	16
5469	Failure to meet contractual requirements in Pharmacy teaching	16
5480	Risk of depleted workforce in Diabetes – DSN	15
5564	Risk of operational pressures to Hospital Out of Hours due to staffing and increase of wards	16
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: 1. Lymphoma tumour site cover 2. Haemostasis/haemophilia (single consultant Trust wide) 3. Pilgrim Consultant cover 4. Clinical governance lead 5. HoS/clinical lead	Very high risk (20)	Service review undertaken – progressing left shift to GP Surgeries for low grade CLL and MGUS. Awaiting CRIG to re-open in new financial year to submit new business case.	**Date added to the Trust Register:** 22/08/2022 **Date of latest review:** 17/03/2026

4.8: 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Hungry** Accept risks of 15/16	3 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		3				
Feb – 2026		4 (100%)	0 (0%)	1	1 (100%)	0 (0%)
		4				

- All LCHS risks are within the risk appetite established.
- There are no '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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Hungry** Accept risks of 15/16	11 (73%)	4 (27%)	6	2 (33%)	4 (67%)
		15				
Feb – 2026		12 (80%)	3 (20%)	5	2 (40%)	3 (60%)
		15				

- 73% of ULTH risks (11) are within the 'Hungry' risk appetite.
- There are 4 'Very High' ULTH risks.

Summary of the risks outside of the Risk Appetite (n=4):

ULTH:

ID	Title	Rating (current)
4844	Staffing levels requiring an increase in Pharmacy to be able to provide 7-day dispensing service	20
4997	Service configuration – Haematology	20
5093	Procurement service staffing levels	20
5761	Risk to IBD Service	20

Summary of the 'Very High' risks (n=4):
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 the current Pharmacy service provision operating limited hours (9–5 Monday–Friday and reduced or no weekend cover across sites), combined with workload cut-off times for supplies and a pharmacy establishment that is 84 WTE below national benchmarks, there is a risk that patients requiring critical medicines, discharge supplies, or pharmacy medication review outside these hours do not receive timely pharmacy input, resulting in delayed or omitted medications, delayed discharges due to inadequate discharge planning, increased readmissions, potential patient harm, and additional financial pressures from the use of FP10s, alongside reduced provision of safe and timely care owing to the lack of dedicated out-of-hours pharmacy support in clinical and admissions areas when compared with peer Acute Trusts.	Very high risk (20)	Weekend working change awaiting presentation to GLT. QIA in development on impact of covering ED. New risk being developed which will replace this risk to ensure clarity on staffing risk in relation to establishment. Ongoing discussions with finance re staffing resources	**Date added to the Trust Register:** 19/01/2022 **Date of latest review:** 09/03/2026
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)	Substantive posts advertised which will stabilise the service. Rota monitored for compliance.	**Date added to the Trust Register:** 22/08/2022 **Date of latest review:** 18/03/2026
ULTH:	5093	As a result of vacancies and long-term absence within the invoicing, purchasing, and pharmacy stores teams, there is a risk that further staff shortages will exceed available capacity to maintain medicines ordering and invoice processing across all sites, resulting in negative impacts on staff wellbeing, disruption to the supply of medicines (including IV fluids, medical gases and chemotherapy), delays in invoice payment leading to financial penalties or supplier account holds, and failure to deliver biosimilar switches and CIP targets (£1.4m).	Very high risk (20)	Storekeeper has started in post. Staff gaps and vacancies increasing. Additional staff required to mitigate the risk. Additional actions such as reducing ordering and invoicing will be implemented to manage workload and safety. Procurement staffing review has been sent to Senior Pharmacy Management Team – awaiting further update. QIA for 0.4 Band 3 on hold due to lack of funding (risk on Mondays & Tuesdays). Band 4 vacancy approved and going out to advert.	**Date added to the Trust Register:** 16/02/2023 **Date of latest review:** 25/02/2026
ULTH:	5761	As a result of establishment vacancies, absences and the gap in establishment versus GIRFT recommended WTE workforce, within the IBD Clinical Nurse Specialist team there is a risk of delays to medications management, increased non-elective admissions and delays to follow up appointments for patients with confirmed IBD. This will negatively impact patient outcomes and may result in incidences of causing harm to patients – there is an increased risk of morbidity and mortality when patients with disease that has significant impact on quality of life have delays in being seen/accessing care, primarily due to developing surgical and medical complications.		Recruitment of the vacant IBD CNS post to be expedited. Business Unit supporting with managing the IBD MDT including the agenda and capturing outcomes. Discussions are underway with Team and IT to try and manage advice line demand more automatically. IBD Nurse led clinics currently on hold with patients seen in consultant clinics when necessary. IBD Nurse in-reach service currently on hold with issues to be picked up via the gastroenterology team. Process for prescribing repeat medications, including review of the bloods, will need to be absorbed by consultant body. This will constitute a change of practice for the consultants and is not sustainable long term. Consultant identified to provide enhanced level of mentorship to the IBD CNSs whilst there is an increased level of training required and provide an enhanced patient safety aspect. This will come at the loss of 1x weekly cons clinic.	**Date added to the Trust Register:** 03/03/2026 **Date of latest review:** 18/03/2026

4.9: 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
Apr – 2026	**OPEN** Accept up to 12	1 (100%)	0 (0%)
		1	
Feb – 2026		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 no '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
Apr – 2026	**OPEN** Accept up to 12	8 (100%)	0 (0%)
		8	
Feb – 2026		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 no '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.

4.10: 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Hungry** Accept risks of 15/16	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				
Feb – 2026		0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				

- All LCHS risks are within the risk appetite established.
- There are no '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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Hungry** Accept risks of 15/16	1 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		1				
Feb – 2026		1 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		1				

- All ULTH risks are within the risk appetite established.
- There are no '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.

4.11: 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**OPEN** Accept up to 12	5 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		5				
Feb – 2026		4 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		4				

- All LCHS risks are within the risk appetite established.
- There are no '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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Open** Accept up to 12	10 (59%)	7 (41%)	7	5 (71%)	2 (29%)
		17				
Feb – 2026		10 (50%)	10 (50%)	7	5 (71%)	2 (29%)
		20				

- 59% of ULTH risks (10) are within the 'Open' risk appetite.
- There are 2 'Very High' ULTH risks.

Summary of the risks outside of the Risk Appetite (n=7):

ULTH:

ID	Title	Rating (current)
4778	Risk of failure to meet best practice standards for stroke patients due to lack of access to community rehabilitation service	16
5169	Stroke outlier causing delays to stroke rehabilitation therapy	15
5535	No Stroke Patient access to Clinical Psychology in line with current guidelines	15
5563	Neurology – Service sustainability	20
5598	Risk of HASU overspill	16
5710	Risk of unsuccessful delivery of transformation programme	16
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	Service largely achieving elective care targets using insourcing. Awaiting confirmation of YMS funding for 2026/27. 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 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.	**Date of latest review:** 03/03/2026
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: -BLET -LLG -System exec to exec -ICB Board (include partner chief execs -Group Board - weekly chief executive meetings - target operated model board (TOM) - Executive one to one's Given the pace of change and the current vagueness of the ICB cluster operating model it is difficult to quantify the future controls possible until the cluster executive team is in place.	04/03/2026

4.12: 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Hungry** Accept risks up to15/16	4 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		4				
Feb – 2026		4 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		4				

- All LCHS risks are within the risk appetite established.
- There are no '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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**Hungry** Accept risks up to 15/16	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				
Feb – 2026		0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				

- There are no 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.

4.13: 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**HUNGRY** Accept up to 15/16	9 (100%)	0 (0%)	1	1 (10%)	0 (0%)
		9				
Feb – 2026		11 (100%)	0 (0%)	1	1 (10%)	0 (0%)
		11				

- All LCHS risks are within the risk appetite established.
- There are no '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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**HUNGRY** Accept up to 15/16	78 (100%)	0 (0%)	4	4 (5%)	0 (0%)
		78				
Feb – 2026		77 (100%)	0 (0%)	4	4 (5%)	0 (0%)
		77				

- All ULTH risks are within the risk appetite established.
- There are no '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.

4.14: 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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**OPEN** Accept up to 12	3 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		3				
Feb – 2026		3 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		3				

- All LCHS risks are within the risk appetite established.
- There are no '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	Number of risks 15-25	High (15-16)	Very high (20-25)
Apr – 2026	**OPEN** Accept up to 12	2 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		2				
Feb – 2026		2 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		2				

- All ULTH risks are within the risk appetite established.
- There are no '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.

Appendices

- Appendix A – LCHS Very High and High Risks May 2026.
- Appendix B – ULTH Very High and High Risks May 2026.
- Appendix C – Further detail of the risk appetite agreed by the Group.

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Unit	Service	Risk Description	Additional/Supportive Information	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	Risk level (acceptable)	Review date
Quality Committee																					
Strategic Objective						**1a (i) Improve patient safety**															
681	Regulatory Compliance	Group Chief Operating Officer	Keeling, Kerry-Jane	Quality Committee (Lead assurance committee, Patient Safety Group (Accountable for)	05/02/2024	20	Planned Care Group	Children & Young People CBU	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. 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.	Measured by monitoring the percentage of CYP receiving IHAs and RHAs within statutory timescales.	06/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	1) Recruitment of dedicated medical time, via community paediatrics 2) Work with Local Authority and ULTH to bring CiC service and Adoption/Fostering medicals together operationally to maximise efficiency and improve recruitment opportunities 3) Seek commissioning review from ICB.	Very Low Risk (1-3)	02/04/2026

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Unit	Service	Risk Description	Additional/Supportive Information	Controls in Place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (current)	Risk level (current)	Rating (current)	Risk reduction plan	Risk level (acceptable)	Review date
714	Physical or Psychological Harm	Group Chief Operating Officer	Eustace, Abbi	Quality Committee (Lead assurance Committee), Patient Safety Group (Accountable for)	16/05/2024	16	Planned Care Group	Neighbourhood Health - District Nursing and Therapy	Tissue Viability	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 Service action plan to improve pressure ulcer care implemented ICB oversight Educational training plan for all community clinicians initiated Assurance programme commenced Monthly thematic review of pressure ulcers highlighting themes and risks in care	Incident reporting Steering groups Monthly audits for SIG	03/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	Workforce transformation plan reducing size of teams. Pressure ulcer improvement plan being reviewed and relaunched.	Moderate Risk (8-12)	03/06/2026
Strategic Objective						1a (iii) Delivery clinically effective care															

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Unit	Service	Risk Description	Additional/Supportive Information	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	Risk level (acceptable)	Review date
849	Physical or Psychological Harm	Group Chief Operating Officer	Keeling, Kerry-Jane	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)	03/03/2026	20	Planned Care Group	Children & Young People CBU	Children's SaLT (Speech and Language Therapy)	As a result of an increase in demand nationally & regionally for SLT support there is a risk that school aged 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.	•Demand has increased nationally & regionally for SLT support overwhelming commissioned capacity. Referrals 188% higher in 2023/24 than in 2019. •Waiting times breaching the 18 week wait requirement – follow up and therapy waits over a year. •Service working in OPEL 4 since Sep'23 and activating BCP, with no plans to reinstate lower level referrals •Oct'23 50+% lower-level needs CYP on the caseload not eligible for a service under the OPEL 4 threshold •Unable to meet EHCP requirements for provision of follow ups and therapy leading to increased complaints and tribunals •Increase in concerns and complaints (from 2.1 monthly to 11.5 monthly, increase of 360% post OPEL 4 implementation) Reputational damage from increased complaints & appeals to MPs & press •67% surveyed stakeholders feeling that the decision to cease early intervention services will impact	1. Advice and activities are given the patient's family and/or educational setting, ensuring they are safe to wait. 2. An appropriate skill mix is used, for example assessments are carried out by SLT and most therapy blocks completed by SLTAs. 3. Mix of face to face and virtual sessions 4. Increased the referral acceptance criteria: focused on highly complex patients only	-Waiting Time breaches -EHCP requirements -Complaints received	18/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very High Risk (20-25)	20	Action 1. Recognising that the service has exhausted internal controls to reduce the risk, the service will work with the Local Authority, ICB and Schools within Lincolnshire to review commissioning arrangements and deployment of resources across the System to develop a system proposal for changes to support improved outcomes for CYP with Speech Language and Communication Needs. Lead: Kerry-Jane Keeling Completion date: August 2026 Action 2. Following the development of a system led proposal for commissioning and joint working arrangements across the system. Seek agreement and/or funding for proposed changes. Lead: Kerry-Jane Keeling Completion date: March 2027 Action 3. Adjust working practises and/or workforce to new system model	Moderate Risk (8-12)	18/04/2026
Finance & Performance Committee																					
Strategic Objective					**1c: Improve productivity and deliver financial sustainability**																
805	Finances	Group Chief Finance Officer	Phoenix, Kat		08/08/2025	20	Corporate	Finance and Performance	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. 2. Financial control systems in place 3. Executive oversight at ELT with Executive owned targets for efficiency delivery. Cost improvement planning process overseen by ELT, PITOF and Finance Committee. 4. Benchmarking actively used in identifying opportunities across clinical and corporate areas including estates.	1. % of unidentified CIP schemes 2. RAG rating of identified schemes.	12/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	1. Working with Corporate and Operational colleagues to clearly identify the CIP schemes and review them monthly to mitigate any potential areas of concern.	Moderate Risk (8-12)	12/06/2026
Strategic Objective					**1d: Provide modern, clean and fit for purpose care settings**																

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Unit	Service	Risk Description	Additional/Supportive Information	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	Risk level (acceptable)	Review date
799	Regulatory Compliance	Group Chief Estates & Facilities	Davey, Keiron		04/07/2025	25	Corporate	Estates & Facilities	Fire & Security	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 National Guidance including HTM, HBN, British standards, ACOP Trust Protocols and Policies Fire Safety Training including managerial role. compliance rates Fire wardens Fire drills Governance committees, FEG, FSG, HS Committee FPC. Annual Fire Safety declaration including PEEP awareness reporting of unwanted Fire alarm activations reports of Fire Regulator from audits conducted Fire risk Assessments		13/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16		Moderate Risk (8-12)	13/05/2026
649	Regulatory Compliance	Group Chief Estates & Facilities	Thomas, Simon		12/09/2023	15	Corporate	Estates & Facilities	Fire & Security	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 2. Planned Preventative Maintenance PPM 3. Fire Risk Assessments 4. Fire Safety Training 5. Fire protection system tests 5. Fire Emergency Plans 6. Yearly Fire audit 7. Appointed Authorising Engineer (AE) for Fire 8. Inpatient Fire evacuation plans and tests 9. Test Fire drills. 10. National Policy via HTM, HBN and Guidance 11. Policy and Protocols 12. Governance via FEG, FSG and trust HS Committee		13/02/2026	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15		Low Risk (4-6)	15/05/2026

People Committee	
Strategic Objective	**2a: Enable our people to fulfil their potential through training, development and education**

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Unit	Service	Risk Description	Additional/Supportive Information	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	Risk level (acceptable)	Review date
754	Physical or Psychological Harm	Group Chief Estates & Facilities	Kidger, Leanne	(Accountable for)	09/10/2024	15	Corporate	Estates & Facilities	Estates	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.		1.Mutual support request to ULHT. 2.Internal sources of alternate training support being identified. 3. Reviewing training schedule and package. 4.Action plan in place to increase attendance when training is reinstated. 5.Engagement with operational colleagues to confirm appropriate staff requiring training. Training for new staff continues.	Through compliance data through Power BI	14/04/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	Action 1 - Ongoing delivery of quality M&H training. Action 2 - Monthly induction sessions for new starters. Between 3 and 6 refresher sessions being delivered each week. Action 3 -LCHS Facebook page being used to fill gaps in registers. Action 4 - L&D regularly contacting people on waiting lists to fill vacant spots as well.	Very Low Risk (1-3)	14/07/2026
715	Physical or Psychological Harm	Group Chief People Officer	Wills, Zoe	People Committee (Lead assurance committee)	16/05/2024	16	Planned Care Group	Neighbourhood Health - District Nursing and Therapy		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 Twice daily matron led safety huddles Re allocation of senior resource to at risk areas Operational oversight of risk daily Service evaluation of DNSPQ role Support from UCR and CYPSS services to aid meeting unplanned demand when required	Quality assurance audits Incident reporting Staff experience/staff survey results Patient experience	03/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	Workforce transformation plan Releasing time to care project	Low Risk (4-6)	03/06/2026
Integration Committee																					
Strategic Objective				**3c. Enhance our digital, research and innovation capability**																	

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Unit	Service	Risk Description	Additional/Supportive Information	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	Risk level (acceptable)	Review date
815	Regulatory Compliance	Group Chief Integration Officer	Scott, Ian		14/10/2025	20	Corporate	Digital Services (ICT)	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: •Previously no defined lead for digital clinical safety established in the Trust. The CNIO has voluntarily taken the lead on Digital Clinical Safety (Trained CSO) within their substantive role, although clinical safety responsibility not outlined in job description / role and responsibilities. However, no resource for non-project/non funded DCSO work = risk •Chief Digital Clinical Information Officer in post for LCHS •Clinical Safety Officer training has been completed by 9 other staff in LCHS •Digital Clinical Champions in place and agreed to be funded within community from operational budgets 1 day per week •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 EPR, this is not an adequate resource. •Digital Clinical Safety Policy now in the		29/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16		Moderate Risk (8-12)	29/04/2026

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Quality Committee																										
Strategic Objective								**1a (i) Improve patient safety**																		
5200	283	Physical or psychological harm	Caroline Landon	Coghill, Piper	Murphy, Joanne	Children & Young Persons Oversight Group	30/06/2023	8	Family Health	Children and Young Persons CBU	Paediatric Cardiology		As a result of a backlog Paediatric Cardiology clinic appointments patients are at risk of undiagnosed cardiac conditions, lack of follow up within appropriate timeframes and subsequent delay in treatment, which could lead to life limiting outcomes or death.	RTT Target is 18 weeks, best practice is to be seen within 6-8 weeks to ensure the risk of life limiting conditions and death is significantly reduced and treatment can be undertaken when necessary by appropriate clinician.	-All new referrals are triaged by the non-substantive consultant to prioritise patients on clinical need. -Regular monthly reporting to CYP oversight group to support organisational management awareness. -Continuing to support Paediatric Consultant undertaking PEC training to gain Cardiology experience.	-Number of patients awaiting an appointment -Audits -Staff feedback -Next of kin feedback -Incidents -Complaints/PALS	10/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Development of a business case for recruitment of a substantive consultant following the end of the current fixed term appointment - this is currently awaiting seals of approval before submission to CRIG.	8	30/06/2024	30/06/2025	10/04/2026
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; 2. Two epilepsy nursers have been recruited to support the consultant 3. Wider consultant body supporting the care of children who are prescribed 2 antiepileptics in the absence of a consultant paediatrician with expertise in epilepsy; 4.Single Consultant Paediatrician is developing individualized care plans for each patient to optimise management of condition; 5. 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;	19/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	1. Business case is being produced to enable establishment of fully funded epilepsy service 2. Consultant Paediatrician is undertaking SPIN training - completion date for this module has not yet been confirmed. 3. Ongoing multi-professional working group tasked with delivering improvements that will support achievement of audit compliance.	8	14/03/2024	16/02/2024	19/04/2026
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 & Orthopaedics, and Ophthalmology CBU	Ophthalmology		As a result of a backlog of patients on the Trust-wide Ophthalmology Partial Booking Waiting List, patients are waiting longer for follow up than timescale specified by clinician. There is a risk of undetected deterioration of their eye condition whilst waiting to be seen which may result in permanent sight loss.		Ophthalmology / Surgery Division clinical governance arrangements Outpatient / PBWL management processes The e-Outcomes Out-Patient clinic system has had an additional field added to record these required appointments which will be greater than 6 weeks. Both clinical and non-clinical validation undertaken to prioritise according to urgency and verify that patients are accurately recorded and still require an appointment. Ophthalmology pathway prioritisation project plan led by project management team following peer review visit to Exeter.	Monitoring Ophthalmology PBWL Clinical harm reviews / reported incidents due to appointment delays	11/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Need to ensure future sustainability once recovered.	4	31/07/2021	30/06/2022	11/04/2026

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5016	22	Physical or psychological harm	Caroline Landon	Hamer, Fiona	Hamer, Fiona		02/09/2022	25	Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	As a result of demand outstripping capacity and insufficient availability of beds within the hospitals, there is a risk that there is not sufficient flow through the Trust's Emergency Departments, leading to overcrowding. This would result in increased likelihood of long waits for patients, delays in care, potential patient harm, poor patient and staff experience, and a negative impact on the reputation of the Trust.		Medical SDEC currently working 08:00 - 20:00 24 hour UTC co-located with ED at Pilgrim and Lincoln 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's Introduction of "Pit stop" model. The development of a CDU in October 2024 will enable some flow from the emergency department to home for patients requiring treatment to discharge. This will be monitored through UEC improvement work to ensure area is fit for purpose. If CDU is utilised to enable ambulances to offload before 2 hours this will effect the flow through CDU.	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	10/03/2026	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Ongoing work in place for long lengths of stay. There is a discharge work progress team in place. 78% performance project currently in place which is supported by the improvement team. Safer Programme in place and SOP is being delivered for Operational meetings in the aim to process discharges and improve flow. Ongoing Care and Comfort project in place to mitigate both harm and risks.	10	02/09/2023	31/03/2024	10/04/2026
4879	28	Physical or psychological harm	Caroline Landon	Carter, Mr Damian	Hobson, Louise		28/03/2022	20	Corporate	Chief Operating Officer	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: - NHS standards for planned care (cancer) ULHT policy: - Cancer care pathway & booking systems / processes - Clinical Harm Review (CHR) processes ULHT governance: - Lincolnshire System Elective Recovery meeting – Monthly - Lincolnshire system RTT Cancer and Diagnostic- Weekly - ULHT Cancer Recovery and Delivery – Weekly - ULHT Clinical Business unit meetings – Weekly - Integrated Performance Report (IPR) to Trust Board - Monthly - Divisional Performance Review Meeting (PRM) process - Clinical Harm Oversight Group Intensive support meetings in association with the ICB - 2/52 Cancer Delivery and recovery - 2/52 Cancer Board - Monthly	-% of patients breaching cancer standards (FDS, 62-Day, 31-Day, 104-Day) -Median wait times for diagnostics and surgery -Number of patients waiting >62 days without a treatment plan -Clinical harm reviews linked to delays	02/03/2026	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 -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 -Trust-wide and tumour-specific trajectories have been set for FDS, 62-Day and 31-Day standards, aligned with national expectations and local targets -Local targets established to reduce the number of patients breaching 62 days with prioritisation of high-risk patients	8	31/03/2026	31/03/2023	02/04/2026

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5450	659	Physical or psychological harm	Caroline Landon	Hamer, Fiona	Highfield, Kimmi		05/06/2024	12	Medicine	Specialty Medicine CBU	Gastroenterology	Trust-wide	As a result of a reduction in Gastroenterology Consultant workforce capacity due to resignations, retirements, or reduced job plans,there is a risk that the service will be unable to maintain adequate inpatient and on-call coverage which would lead to an inability to sustain two-site Gastroenterology inpatient cover, outpatient and cancer performance, and the Upper GI Bleed On-Call service.	The capacity of the Gastroenterology Consultant workforce is reducing due to individuals wishing to take resign, retire or partially retire and return with reduce job planned activity. This is impacting the inpatient and outpatient activities of the service. However, as the drive to resign/retire/reduce job planned activity focuses on removal of all inpatient and on-call activity as a 'must' the primary impact is being felt in these area's. If the Consultant Medical workforce for Gastroenterology depletes further and/or does not recruit to vacancies within the workforce, the service will not be able to maintain a two site Gastroenterology inpatient cover, outpatient/ cancer performance and Upper GI Bleed On Call service.	-Recruitment - full time Gastroenterology gaps are out with Agency and on TRAC for NHS Locums. The Business Unit manage the gaps proactively and will put out a variation of gaps (for example, ward cover only) to seek cover for the gaps in the service. -When on-call bleed rota not covered at one site calls are diverted to the other, however this mitigation provides a lower level of service. -Management of UGI Guidelines policy. -Guidelines on Management of Upper Gastro-Intestinal Bleeding (UGIB)	Workforce gaps Capacity of the service Cover of rota's (inpatient ward cover and on-call bleed cover)	03/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Explore recruiting to Hepatology specialist posts with ERCP and EUS included. -Robust recruitment plan to cover establishment gaps, including non substantive workforce. -Single site on-call cover in place-currently covering both sites to mitigate for gaps. -Development of clinical service strategy for Gastroenterology by end of 2024/25 financial year. -Paper to go to executive detailing short fall and asking for support with further mitigation-by close of play September 2024.	8	05/06/2025		13/04/2026
4855	207	Physical or psychological harm	Caroline Landon	Chantry, Chris	Marshall, Lisa		10/02/2022	16	Family Health	Women's Health and Breast CBU	Breast Services		There is a risk of delayed diagnosis of breast cancer and increased waits for treatment of confirmed cancers as a result of insufficient staffing and clinic capacity within the Breast service, Pathology and Oncology, which could lead to increased patient harm. This could also lead to staff fatigue through the provision of additional clinics to reduce delays.		Service level agreement with Path Links Cancer MDT Weekly Breast capacity meetings New Cancer Remote Monitoring Administrator and tracking spreadsheet in place Escalation process for converting unused oncology appointments allocated to other specialties into Breast oncology appointments where possible.	Volume of referrals and clinic capacity. 2ww performance / average wait time for first appointments. 62 day performance. MDT staffing levels / absence rates.	24/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Exploration of creating additional capacity through redesign of clinic facilities, etc. Business case to be re-reviewed and resubmitted for investment round 2026/27.	4	31/12/2021	29/12/2023	24/05/2026

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5520	753	Physical or psychological harm	Caroline Landon	Marsh, David	Constantin, Dr Carmen		11/10/2024	16	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of ULHT not having a Thrombectomy centre, we have to transport patients to Nottingham. There is a risk of transfer delays for patients with acute neurological presentation suspected to be a stroke having access to a designated thrombectomy centre for consideration of mechanical Thrombectomy. This could lead to more brain cell death, increase risk to life and ultimately poor functional outcomes/severe disability. On occasions delays have been so long the offer of intervention has been withdrawn.		Attempts to streamline pathway to hold crew bring patient to Lincoln for further transfer to Nottingham however not often successful due to pathway delays. [current acute pathway QI project] Escalating to operation centre as soon as Ambulance requested for transfer if original crew already stood down/handed over. Explored option of increasing category allocated to Stroke transfers [Currently CAT2] so far despite regional engagement Ambulance service unable to re-categorise.	Regional meetings - Integrated Stroke Delivery Network M&M meetings [local & regional] Datix incidents reported.	12/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Continue to work to streamline pathway to avoid transfer delays. Consultant Stroke Practitioner & Stroke ACP lead responsible for streamlined internal pathway – current QI project till December [Code thrombolysis/Stroke] Action 2. Develop internal processes to escalate transfer delays more quickly. Stroke CBU/Acute team to liaise with Operations department for clear escalation process. Action 3. Ongoing communications/meetings with Ambulance service. Consultant stroke Practitioner liaising with ISDN & Ambulance service [Claire] ongoing Action 4. Look to the future to develop local thrombectomy centre to ensure fair access to emergency stroke treatments for the people of Lincolnshire, reducing long-term disability, dependence of health & social services, overall reducing the socio-economic burden of stroke. – Executive responsibility for service allocation?	8	11/10/2025		12/05/2026
5651	871	Physical or psychological harm	Caroline Landon	Chester-Buckley, Sarah	Rigby, Lauren		07/05/2025	16	Alliance	Cancer Services CBU	Oncology	Trust-wide	As a result of the withdrawal of funding for the East Midlands Cancer Alliance Centre for Psychosocial Health, the service will cease on 31st March 2026. There is a risk that the LPFT Macmillan Level 4 Psychological service may not be able to manage the increase in referrals with the addition of a waiting list of 66 patients coming from EMCA CPH to their service. This may result in their own waiting lists increasing substantially. There is no current plan for Level 2 psychological support training or supervision or plan for the FLO app which provides interim support for patients. This could lead to increased psychological distress and potential physical harm for cancer patients across Lincolnshire, alongside increased pressure on ULTH specialist staff to work beyond their scope of practice, resulting in moral injury, burnout, and a negative impact on patient safety and staff wellbeing. This means we will not be working in accordance to East		Level 4 referrals are being directed to Macmillan LPFT There is a strategic and tactical working group that is feeding into the clinical care Directorate who is reviewing next steps. Communication has been shared. Monthly clinical supervision for Level 2 trained cancer workforce staff has been established and is being delivered by the LPFT Macmillan Psychology team.	Datix Complaints Cancer Performance targets	12/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ICB are completing a end to end service review for Level 4 Psychological support - Sam Lewis = December 2026	4	07/05/2026		12/06/2026

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5533	754	Physical or psychological harm	Caroline Landon	Hamer, Fiona	Constantin, Dr Carmen		07/11/2024	16	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of being unable to provide specialist assessment and investigation to people whom have had a suspected TIA within 24 hours [in line with guidelines] this may result in subsequent stroke due to a delay in intervention/treatment. Stroke may cause lifelong disability or death.		Reviewing patients as soon as we can in clinic and arranging investigations to coincide with clinic appointment [limited to imaging slots allocated per day] We convey ambulance referrals to have patients reviewed in ED by ACP team, if adequate space was provided for rapid TIA review there could be hospital avoidance [better patient experience/reduce cost and better patient flow]	Audit delays from referral to physical review in TIA clinic – Stroke Co-ordinator/service manager Recent data provided by Vascular team reports delays to carotid Doppler scans being performed, creating less benefit from surgical intervention which may result in no intervention being completed Datix review of hospital admissions with stroke symptoms post TIA clinic referral and not yet seen	12/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Allocate appropriate facilities for rapid TIA clinic – recommend similar set up to NOTTINGHAM or alternative – SOP attached. Area to assess patients perform clinic plus access to imaging [carotid dopplers & Head imaging in a timely manner-SDEC approach] Responsible divisional/service managers	8	07/11/2025		12/05/2026
4741	42	Service disruption	Caroline Landon	Lynch, Diane	Chester-Buckley, Sarah		13/01/2022	20	Alliance	Cancer Services CBU	Oncology	Trust-wide	As a result of longstanding under-investment, consultant vacancies, reliance on agency staff, and unsustainable workloads across the Oncology workforce, there is a risk that the service will be unable to meet demand or maintain safe, timely care across multiple tumour sites, resulting in patient harm, service instability, and increased pressure on neighbouring Trusts to absorb displaced oncology activity.	As a result of lack of investment for Oncology workforce historically there is insufficient workforce to meet demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave. We are heavily reliant on high cost agency covering vacant posts due to the national shortage of Oncologists. If the service was to stop for specific tumour sites this would lead to significant patient harm whereby patients would have to travel following referral to neighbouring Trusts for radiotherapy and chemotherapy treatment, which in turn would put further pressure on other Trusts who could potentially collapse. Oncology is considered to be a fragile service due to consultant oncologist gaps. Demand vastly exceeds the capacity, requiring an increase in establishment. Oncology Consultants do not have capacity to review patients as required for their treatment which has a knock on	Medical staff recruitment processes Agency / locum arrangements Extra clinics offered Unable to cover sarcoma due to no capacity/specialisation so this is now picked up by NUH Job plans continuing to be reviewed Recruited at risk over and above budget to support service Support offered through on-call consultant, this is not adequate due to their workload.	Monitoring tumour site performance data Datix incidents Complaints and PALS Outcome from Staff Survey results Financial constraints of group	18/03/2026	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	4	31/03/2023	31/03/2023	18/06/2026

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5306	713	Physical or psychological harm	Caroline Landon	Cooper, Mrs Anita	Rambani, Reena	Patient Safety Group	28/08/2024	20	Alliance	Path Links (Pathology)	Microbiology (Pathology)	Trust-wide	As a result of the inadequate resource of Microbiologists provided via the service contracted from NLAG, there is inadequate specialist input to ULH for complex cases or reviews on the correct use of high risk treatments used. This would lead to patient care being unsafe and can result in harm including death. It would also lead to extended hospital stays, readmissions, poor bed flow affecting access to Acute NHS care, increased morbidity and increases risk of antimicrobial resistance as a Public Health threat which harms our patients further. There are severe restrictions to prescribers accessing Microbiologist Specialist advice as it is now limited to Registrars, Consultants, Advanced Nurse Practitioners and GP level only that can access. This is resulting in patients being managed without the specialist required input, including for complex cases. Due to lack of Microbiologist capacity there is no		Currently being directed through Consultant Antimicrobial Pharmacist within own working hours and remit as and when they are able to do so. Being flagged at various forums. Regular communication and reminders about availability of Antimicrobial team and guidelines and any resources available. Draft Business case for Microbiologist Consultant currently in progress.	Through antimicrobial consumption and surveillance Audit results Specialist time input from Antimicrobial Team Survey Pending Infection prevention & control surveillance and audits	23/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Trust to review Microbiologist contracting - as a matter of urgency – Ian Fulloway – December 2025 Antimicrobial Guidelines being revised to for both ULTH and NLAG – Balwinder Bolla – March 2026	4	30/11/2025	01/06/2025	23/04/2026
4868	64	Physical or psychological harm	Caroline Landon	Bassi, Sangeeta	Martinez, Francisca	Maternity & Neonatal Oversight Group	01/03/2022	16	Corporate	Group Chief Medical Officer - Pharmacy CBU	Pharmacy		As a result of LSCS drugs being prepared in advance and left unattended, contrary to Medicines Act requirements and national governance guidance, there is a risk that medicines may be tampered with, contaminated, or administered incorrectly, resulting in potential patient harm and non-compliance with legal, safety and injectable-medicine standards.	Preparation of Drugs for Lower Segment Caesarean Section (LSCS). 1. Medicines at risk of tampering as prepared in advance and left unattended. 2. Risk of microbiological contamination of the preparations. 3. Risk of wrong dose/drug/patient errors. Breach of Medicines Act: Regulation 3 of the Human Medicines Regulations 2021 permits doctors to prepare medicines for administration. The expectation would be that preparation would be in compliance with current best practice and governance expectations. Regulation 214 permits parenteral administration of medicines by or in accordance with the directions of and appropriate practitioner. This practice would constitute a risk to the patient and falls outside of expected governance arrangements detailed in Advice Note for Chief	No current processes in place to minimise risk Policies do not support this practice	Incidents involving advance preparation of intravenous medication in clinical areas. Audits of compliance with standards / policy - The current labelling does not comply with national recommendation. Not all labels include the recommend identity (no dose/strength as per pictures). Also, no preparation date/time always included. There is no documented procedure stating the process to follow to ensure that the medicines prepared are discarded.	09/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Use of tamper proof boxes/trays being purchased - April 2026 2. Risk assessment reviewing practice - LMM Feb 2026 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 4. Safer medicines audits to be completed Dec 2025 Lisa H	4	30/09/2022	31/03/2023	08/05/2026

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5617	854	Physical or psychological harm	Caroline Landon	Upjohn, Emma	Rayner, Gemma		24/03/2025	20	Family Health	Women's Health and Breast CBU	Obstetrics		As a result of insufficiencies within the current maternity services triage system, there is a risk that not all pregnant individuals will be able to access safe and timely care, which could lead to harm to the mother and baby. A recent MNSI Escalation of Concern notification highlighted 'insufficient triage processes in place to support safe care for mothers' and 'evidence of the Trust gate keeping access to acute care'. The trust is in the process of looking to adopt the BSOTS model for triage which is the nationally recognised standard for an individualised, 24 hour service. Despite an agreed temporary uplift in staff of 2.52 wte B6 for LCH and 2.73 wte for PHB, there is still insufficient midwifery and medical staff to fully implement BSOTS. In addition to patient harm, there is also a financial risk to delivery of		• Lead midwife for triage appointed September 2024 to lead the implementation of BSOTS, action plan has already been developed to support this. Initially fixed term for 12 months due to complete in September 2025, within the Business case this has been asked to extend to a substantive position. • Uplift of staff on both sites for a designated triage midwife to provide a 24 hours service. 2.75 WTE for PHB and 2.25 WTE for LCH. • Maternity specific triage training is being delivered to core triage midwives and HCSW in line with BSOTS methodology to help improve the safety for women and babies. This training will then be rolled out to all maternity staff during the role out of the BSOTS pathway. • Communications issued to all staff outlining a clear directive to all maternity staff emphasising that women should not be discouraged from attending triage based on criteria such as membrane rupture or the number of prior telephone calls. We are moving to Badgernet maternity IT system late Spring 2025 which has a BSOTS specific triage to be followed improving compliance. • A business case has been submitted to consider a staffing uplift in line with 2024 Birthrate Plus (BR+) establishment review data which equates to 12.1 WTE midwives.	MNSI reporting Audit Currently women are seen in a timely manner by a midwife but the medical review is often delayed due to not having dedicated 24 hour medical cover for triage.	06/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Conducting a full audit of triage cases from the past three months to identify trends and assess the impact of our interventions. Implementing a patient feedback system to evaluate the effectiveness of the changes and enhance the overall maternity experience. Continuing our collaboration with MNSI, ensuring that insights from the final investigation report are integrated into our maternity care strategy. Progress with the triage action plan is monitored through the Maternity and Neonatal Safety Improvement Plan (MatNeoSIP) and reported through to the Maternity and Neonatal Oversight Group (MNOG) with upward reporting to the Group Quality Committee.	4	30/06/2025		06/06/2026
4769	759	Physical or psychological harm	Caroline Landon	Rojas, Mrs Wendy	Arya, Nityanand	WORK	14/01/2022	15	Surgery	General Surgery, Vascular, Head & Neck 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. 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. Occupational Health and EAP support available to staff in post.	Staffing levels / vacancies for Vascular Scientists Incident reporting	04/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business case developed for the purchase of a 3rd ultrasound machine.	8	31/08/2021	30/04/2023	04/06/2026

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4843	57	Physical or psychological harm	Colin Farquharson	Farquharson, Colin	Farquharson, Colin	Medicines Quality Group	19/01/2022	20	Corporate	Group Chief Medical Officer			As a result of the ICB's non-commissioning of Senior Medical Immunology expertise within Lincolnshire, there is a risk that medication will be prescribed, supplied and administered by ULTH healthcare staff without clear senior medical input for clinical review, monitoring, and escalation, for the IVIG patients that reside within Lincolnshire. This could lead to patient harm (inappropriate treatment and risk of adverse drug reactions including when switching molecules, inappropriate treatment duration), reputational damage, and is a professional, and regulatory risk. There is also a financial risk as ULTH will be unable to switch patients in accordance with the national NHSE IVIG framework by September 2025 because the is no expert clinical review of the patients.		NHSE Immunoglobulin clinical commissioning policy Local Immunoglobulin Panel (IAP) and Sub regional Immunoglobulin Panel (SRIAP)	Patient incidents and complaints reported through Datix National framework switch being completed/not completed in time by September 2025 Financial enabler scheme/CIP targets being met/not met by December 2025 Monthly contract challenges from NHSE (challenge value and non-payment accrued) Monthly KPIs monitored by sub regional IVIg panel (SRIAP) Monthly KPIs monitored by local IVIg panel (ULTH IAP)	30/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Work with ICB to either employ an immunologist or have a local agreement with a neighbouring Trust to access senior immunologist input - Sunil Hindocha/Colin Farquharson - August 2025 Shared Care arrangements and prescribing accountabilities to be reviewed - Sunil Hindocha/Colin Farquharson - August 2025	4	01/10/2021	31/07/2023	30/04/2026
5614	825	Service disruption	Caroline Landon	Fulloway, Mr Ian	Woods, Mr Michael		04/03/2025	16	Alliance	Diagnostics CBU	Audiology	Trust-wide	As a result of Increasing demand on referrals to the service, the Paediatric Audiology Service not meeting the Paediatrics Quality Standards and the consequence of the requirement to attain UKAS IQIPS accreditation, due to insufficient staffing, capacity and lack of soundproofing rooms (the room at Boston has recently been condemned after IQUIPS benchmarking visit which has reduced capacity further) there is a risk of 1) an increase in waiting times which is a causing a delay in patients being seen and a delay in treatment which could lead to long term patient harm and risk of litigation and 2) the risk of the Trust not attaining accreditation which could lead to Audiology losing the contract for Paediatric Services in Lincolnshire.		Audiology team are undertaking work to bring the service up to this standard by updating or developing new policies, operating procedures and work instructions to meet the new Paediatric Quality Standard requirements. This is causing capacity pressures as staff are having to be taken out of clinical time due to the work involved in revising the required documents. Team is working to review IQUIPS standards and match requirements to policies and procedures currently in place within the department and to develop the new working practices and quality monitoring processes required. Work will then be undertaken to produce an action plan to put into place any policies, procedures or processes that are not currently embedded in service. Once action plan is complete and revised systems suitably embedded then an application will be placed to UKAS for initial assessment for department's compliance with IQUIPS standards. Clinics are pausing during testing while noise levels abate. Clinic dates have been amended to quieter clinic days. Insert earphones used for greater attenuation of	Standards met Waiting times report Action plan review and UKAS initial assessment report. (This is relating to IQUIPS) Environmental sound levels measured between patients and at times of testing. Recent training identified reverberation risks which cannot be measured Facility will not meet stage C calibration standard for freefield testing hence test stopped. Monitor numbers of patients being transferred and action plan for impact as data is recorded.	18/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Audiologists to take time out of clinical work to review, revise and complete the required documentation. Locum Audiologist in place to reduce backlogs of clinics - Michael Woods - December 2028 Development of Case of Need / Business Case to increase staffing and improve facilities to Gold Standard at all sites - Michael Woods - August 2025 Action planning from the UKAS Benchmarking visit is underway - Michael Woods - August 2025 Review of waiting list currently underway - Michael Woods + Victoria Biddulph - August 2025 Reviewing with Procurement options around temporary booth hire as an interim resolve for the CoN for refurbishment – this is not possible without significant investment in enabling works - Michael Woods + Clare Wright – September 2025	4	31/03/2026		18/05/2026

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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	Alliance	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 Daily palliative huddle with key partners to support demand Working as one team across sites to provide pan trust cover Senior leadership for direct support to PEOL at ULHT by addition of deputy lead nurse for PEOL Workforce plan to identify gaps in alignment with national policy and guidance completed Service improvement gap analysis Internal and external ask for multi disciplinary support to the SPC team. Working with Clinical Education to deliver the training PEOL Champions in place across the Trust and undertaken a training event with them Involvement in systemwide PEOL Operational meeting to promote improvements across services NACEL action plan completed	Frequency of referrals outside SPC referral criteria Frequency of referrals that require more information for triage Datix incident / HPF's Complaints/concerns Frequency of patients died/discharged before seen Frequency of patients dying outside Preferred place of death Frequency of first assessment (over 24hrs) from service KPI's. SPC workforce review including staffing deficits and skills gap analysis Daily OPEL level Frequency of support needed by teams from SPC	06/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business Case written and awaiting CRIG invitation - Sarah Chester-Buckley - April 2026 Development of SPC SOP, job plan for CNS & business continuity plan - Jill Edwards - March 2026	4	30/12/2024		05/06/2026
5095	59	Physical or psychological harm	Caroline Landon	Capon, Mrs Catherine	Chamberlain, Liz (Elizabeth)		24/02/2023	16	Surgery	General Surgery, Vascular, Head & Neck CBU	Vascular Surgery	Pilgrim Hospital, Boston	Due to increased demand for PICC services there is a risk that within the current establishment there is a significant delay to patients. This can delay treatment, hinder flow and cause poorer outcomes for patients. 8 years ago, venous access within the Trust was classed as central lines (internal jugular insertion) and cannulas. Peripheral central catheters (PICC) were undertaken occasionally for oncology patients and portacaths and Hickman lines were done in theatre, as they still are. The vascular ACPs started to learn how to insert picc PICC lines starting from one morning clinic on a Tuesday (supported by the Consultants). The needs for PICC increased and we went to two full day clinics in a week. They were only inserting in pilgrim at that time. It was then determined that Total Parental Nutrition (TPN) needed to be given centrally and not peripherally, and the work load increased two fold. A business case		At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	04/03/2026	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 Give consideration to training of a wider network of clinicians associated with their individual service needs	1	01/06/2023		04/06/2026

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4789	32	Service disruption	Caroline Landon	Marsh, David	Venugopal, Mr Vinod		16/01/2022	20	Medicine	Cardiovascular CBU	Cardiology		As a result of ongoing pressures to clinical staffing shortages this has led to a 40% reduction in the DMO1 performance. Clinical staffing shortages have been impacted by maternity leave and lack of agency staff being available for eight months. The Trust is currently unable to fund seven day echo despite this being an NHS England requirement. The Recruitment and Retention package has not been renewed which impacts ability to recruit staff. We have been unable to staff complex Echo Lists as cardiology staff are excluded from recent band 3 uplift. Length of stay for patients is increasing due to lack of cover. In addition we have recruited four new admin posts, however it will take around 3 months until fully trained which leads to delays in processing internal and external requests. Skegness CDC opened in November, however this can only be covered by admin 5 days a week which limits		Weekly review and monitoring of OP activity /utilisation data Monthly data provided throughout CBU to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell All referrals are triaged to ensure appropriate	DMO1 activity - monthly review Backlog consistently increasing. Booking Team are now part of the Cardiovascular Division.	21/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Continued recruitment process, which included current recruitment and retention package. Due to be completed April 2025 -Lincoln CDC is online and is staffed for seven day working -Business Case is currently in process, this was submitted in November in the Investment Planning Round-this will now go through Trust Process. -Review of Band 2/3 uplift job description currently with HR-cardiac physiology assistant currently unwilling to support Specialist Echos due to skill required being above band 2 pay band. Currently backfilling with trained nurses at additional cost	4		01/02/2024	21/04/2026
4646	66	Physical or psychological harm	Caroline Landon	Smith, Charles	Gibbins, Donna	Patient Safety Group	14/12/2021	20	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	As a result of the Trust not being consistently compliant with NICE Guidelines and BTS/GIRFT standards for the recognition of type 2 respiratory failure, there is a risk of delays in initiating treatment using Non-Invasive Ventilation (NIV). This would lead to serious and potentially life-threatening patient harm.		National policy: - NICE Guideline NG115 - COPD in Over-16s: diagnosis and management - NICE Quality Standard QS10 - COPD in Adults - British Thoracic Society (BTS) / Get It Right First Time (GIRFT) standards for NIV ULHT policy: - Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting - NIV-trained clinical staff - Dedicated NIV beds (Respiratory wards) ULHT governance: - Medicine Division clinical governance arrangements / Specialty Medicine CBU / Respiratory Medicine - Trust Board assurance through Quality Governance Committee (QGC) / lead Patient Safety Group (PSG) / NIV Group and Integrated Improvement Plan (IIP) / Improving Respiratory Services Programme	- Frequency and severity of patient safety incidents involving delayed NIV - recent history of rare but serious harm incidents - Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins - Start time for NIV <60mins from Arterial Blood Gas (ABG) - NIV progress for all patients to be reviewed (once NIV commenced) < 4hours update: There is a NIV audit captured monthly which determines both trust wide compliance and site specific- this is shared through PRM and available for cabinet and CBU governance meetings	02/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	4		31/12/2024	30/03/2026

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5491	701	Physical or psychological harm	Mike Parkhill	Parkhill, Michael	Bailey, Karen	Health and Safety Group, Infection Prevention and Control Group, Patient Safety 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 patient harm and patients contracting Hospital acquired infections.		Change of Use Policy Space Management Policy-this was approved by H&S Committee IPC Action Plan to review all current areas that are being used inappropriately.	IPC Action Plan. Datix incidents raised.	15/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	IPC Action Plan has been developed and carried out identifying all areas where treatment rooms are being used with inadequate ventilation. Estates Actions: •Estates to progress a ventilation compliance review upon Trust approved Capital Funding. •If mechanical ventilation is present – discuss / request Estates feasibility to increase air changes for treatment rooms found to have less than 10 air changes. •Estates to progress environmental infrastructure remedial work upon Trust approved funding. Clinical Division Actions •Where treatments rooms are not up to standard, the relevant Clinicians to be informed by the Divisions so that they can perform their own assessment of risk / responsibility. IPC will support risk assessments. •Red rated treatment rooms to be a	8	18/07/2025		15/04/2026
5504	716	Regulatory compliance	Caroline Landon	Fulloway, Mr Ian	Belk, Carolann	Estates Infrastructure and Environment Group	02/09/2024	9	Alliance	Diagnostics CBU	Endoscopy	County Hospital, Louth	As a result of the absence of a functioning patient call bell system at the Louth site (current system cannot be repaired as replacement parts are unavailable because of its age), there is a significant risk of non-compliance with JAG standards, potentially leading to loss of accreditation. This also creates a clinical safety risk, as delays in summoning assistance during a medical emergency could occur, increasing the likelihood of patient harm. Additionally, patients who have received sedation are at heightened risk of falls due to the lack of a nurse call system		Patients are chaperoned by two members of staff within procedure room over and above Endoscopist. Recovery areas are staffed by registered nurses as per JAG requirements. Bed rails in situ to help prevent falls.	Datix incidents JAG visit / outcome	23/02/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Property Services at Louth are sourcing a supplier and looking to install a new call bell system - Pete Kerman (Property Services) is leading on this - February 2026	3	02/09/2025		22/05/2026

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5433	646	Physical or psychological harm	Caroline Landon	Upjohn, Emma	Marshall, Lisa		08/05/2024	8	Family Health	Women's Health and Breast CBU	Gynaecology		As a result of insufficient EPAU scan capacity to meet the demand, there is a risk that patients may not be offered an appointment in a timely manner. National and local recommendation is that patients should be seen within 24 hours but patients are currently waiting up to 2 weeks. This increased waiting time may cause psychological harm during a very emotional and worrying time for a patient but can also result in physical harm as not all treatment options may not be open to the patient by the time they are seen.		24 hour emergency service is available via GAU. Patients offered scan at either site to maximise use of available scan capacity. Weekend scanning undertaken at a cost pressure where possible. EPAU nurse has completed sonography training but remains in a preceptorship period currently so limited impact on scan availability at the moment.	Complaint data PALS enquiries Patient and staff feedback	24/02/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Explore options for increasing to a 7 day service at each site, with a phased increase in capacity starting with one additional day at first. Explore utilisation of CDCs to support scan delivery - this will also assist with the separate risk of patients who are potentially losing their baby from having to access care in Maternity areas where there are heavily pregnant women and babies.	4	31/05/2025		24/05/2026
5196	309	Regulatory compliance	Caroline Landon	Bassi, Sangeeta	Moore, Lisa-Marie		20/06/2023	15	Corporate	Group Chief Medical Officer - Pharmacy CBU	Pharmacy		As a result of Pharmacy staffing shortages preventing completion of required medicines-storage and temperature-monitoring audits, there is a risk that standards for safe and secure medicines storage will fall below legal and regulatory requirements, including controlled drugs governance, resulting in patient safety risks, continued CQC 'must do' non-compliance, and the potential for enforcement actions such as improvement notices.	As a result of regular audits not being completed, the standards for medicines storage are likely to fall below the required standards. Medicines storage and temperature monitoring was raised by CQC during the last inspection, as 'must do' actions. Some of these audits have legal implications such as the controlled drugs audits and safe and secure medicines storage. As we have had the same 'must do' action since 2018 with no improvement, there is possibility without full assurance they could impose improvement notices. Due to a shortage in staffing, Pharmacy department are unable to complete the annual medicines management and temperature monitoring audits for all clinical areas that store medication. The organisation is required to be compliant with both the RPS Guidance for the safe and secure handling of medicines and the Health Building Note (HBN 14-02)	The matrons and quality matrons complete ward assurance audits that include some medicines management questions.	Review of incomplete audits, highlights that there are ongoing issues with timely completion of medicines management audits due to the lack available staff to complete these. Datix incidents reported indicate ongoing issues with medicines management.	15/01/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Action plan to be approved by SMIG Jan 2026 SB	4	20/06/2024		15/04/2026

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5181	358	Physical or psychological harm	Caroline Landon	Lynch, Diane	Rigby, Lauren		23/05/2023	16	Alliance	Cancer Services CBU	Oncology	Trust-wide	As a result of chemotherapy units at PHB and LCH consistently operating below the recommended nurse staffing levels set by EMCA—requiring 14 nurses per day at PHB and 17 per day at LCH, but typically having only 8 and 9 respectively and inadequate space and an increase in available treatments particularly oral treatments, SACT capacity does not meet the demand required which would lead to the Trust being unable to meet our 31 and 62 day cancer targets, psychological distress to patients due to waiting time and staff burn out due to working conditions. Pilgrim does not have a medical day unit (MDU), our SACT services therefore have to run differently to Lincoln. Chemotherapy Suite at PHB has 18 Chairs which could all be utilised for SACT delivery however, as we do not have an MDU these are used for transfusions, picc flushes etc.		OAU used in appropriately at times, patients admitted to wards if time critical. Staff work extended hours Patients waiting 3 weeks or more are escalated to Matron	Datix incidents Complaints / PALS Staff concerns Sickness absence Retention figures 31 & 62 day targets	19/03/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	SACT Pathway to be reviewed - Kate Taft - July 2026 Chemotherapy Case of need for staffing written and awaiting CRIG invitation - Sarah Chester-Buckley - April 2026 Oncology / Haematology Right Sizing paper written and awaiting CRIG invitation - Sarah Chester-Buckley - April 2026	6	23/05/2024		19/06/2026
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.		The Home termination of pregnancy service has been implemented but further work is required to fully implement telemedicine support for this. Additional weekend clinic capacity used for TOP scans where possible.	Monitoring number of patients unable to receive service at the trust and have to be referred elsewhere. Undertaking patient feedback requests and questionnaires to ascertain patient's voice to improve service.	24/02/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Full implementation of telemedicine service, including development of a SOP, as this will enable some patients to have a termination without the requirement for a scan. General Manager working with the ICB to ensure that they have accurate and correctly coded activity data to support their commissioning decisions.	3	29/02/2024		24/05/2026
Strategic Objective								**1a (ii) Improve patient experience**																		

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Handler	Reportable to	Opened	Rating (initial)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Additional/ Supportive Information	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	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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	As a result of lack of adequate provision for appropriate clinical care of bereaved families within Obstetrics at Lincoln County Hospital, there is a risk of psychological harm due to hearing labouring women and crying babies, and having to share facilities with mothers and their new-borns.		Have allocated a room on labour ward to care for the women, which is not within the centre of the labour ward and has its own en-suite facilities. Women not to be moved to Nettleham ward at any point during their admission.	Incident reports PMRT reviews Patient complaints	22/01/2026	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.	4	07/08/2025		22/04/2026
4731	33	Physical or psychological harm	Daren Fradgley	Humber, Michael	Humber, Michael	Patient Safety Group	13/01/2022	20	Corporate	Finance and Performance	Digital Services (ICT)		If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.		- Clinical Records Management Policy (approved June 2021, due for review December 2023) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Clinical Records Group - Now led by Deputy Medical Director.	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	04/03/2026	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.	4	30/06/2018	31/03/2025	02/04/2026

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Handler	Reportable to	Opened	Rating (initial)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Additional/ Supportive Information	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	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5216	362	Physical or psychological harm	Caroline Landon	Cooper, Mrs Anita	Brown, Paula		14/07/2023	12	Alliance	Cancer Services CBU	Radiotherapy	Trust-wide	As a result of various staffing issues including: Lack of engineer staff for equipment maintenance; Lack of radiotherapy physics staff for weekday and bank holiday run-ups; Lack of radiotherapy physics staff for on-call run-ups; Reduced radiographer numbers; Key staff members leaving the Trust; Increased workload in radiotherapy and radiotherapy physics. There are risks of delivering the necessary patient workload and not always being able to start treatment on time, Increased cancellations. poor morale, long term sick leave and staff leaving their post which could lead to an inability to meet cancer waiting times target, increasing waiting lists, poorer patient experience, poorer patient outcomes and impact commissioning of new equipment.		1) Continue to pro-actively manage activity and capacity to mitigate workload; delaying patients where necessary 2) Review possible breaches to avoid 3) Train additional staff to help with pressured parts of the service where possible 4) Maximise use of existing technologies	Cancer Waiting Time targets Datix Incidents Staff sickness Staff Survey Cancellation of appointments Activity reporting	28/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	We will seek funding for some supernumerary salary support for radiation engineers in the coming years – Patrick Downes – April 2026 Business Cases will be developed to meet service needs – Patrick Downes – April 2026 Review duties and service needs to balance staffing against service needs. This could lead to a business to recognise the need for more staff due to service demand - Patrick Downes – 30 November 2025 Recruit to vacant posts as soon as possible - Patrick Downes - December 2025 Staffing review - Patrick Downes - November 2025	4	30/09/2025		28/04/2026
5003	342	Physical or psychological harm	Caroline Landon	Farquharson, Colin	Edwards, Mrs Jill	Patient Safety Group	23/08/2022	16	Alliance	Cancer Services CBU	Specialist Palliative Care	Trust-wide	As a result of the lack of staffing resource for Specialist palliative care, the Trust is not able to meet the NHS England Service specifications for specialist palliative care. Resulting in lack of skilled professionals to provide specialist palliative care and negative impact on staff wellbeing. Specialist Palliative currently has absence data way above national average with a risk of poor staff retention, recruitment and impacting sustainability. Staffing deficit results in increase for Senior lead to work operationally decreasing the ability to influence, improve and innovate across the Group and partners.		Daily huddle with senior support present OPEL reporting measures with sitrep for escalation of risks daily Working as one team across sites increasing team support to improve wellbeing Senior leadership visibility increased Internal and external ask for multi disciplinary support to the SPC team as required. Education training needs analysis for team completed Workforce plan to identify gaps in alignment with national policy and guidance completed Service improvement gap analysis completed Prioritised 1:1 meetings with individuals and protected time for essential education. Daily check in/out with team. Clear escalation route developed for concerns/risks Absence management policy followed	Gap analysis for staff education Daily escalation reports with staffing levels and patient caseload numbers Number of referrals to service Number of referrals to assessment outside KPI target Figures for nurse recruitment/retention SPC absence rates Staff feedback on NACEL reports Staff vacancy rates and appraisal rates 1:1 supervision feedback on staff wellbeing	06/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business Case written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026	8	30/12/2024		05/06/2026
Strategic Objective								**1a (iii) Deliver clinically effective care**																		

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Handler	Reportable to	Opened	Rating (initial)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Additional/ Supportive Information	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	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5747	944	Physical or psychological harm	Caroline Landon	Hamer, Fiona	Venugopal, Mr Vinod	Patient Safety Group	23/01/2026	20	Medicine	Cardiovascular CBU	Cardiology	Trust-wide	As a result of the sustained lack of available cardiac catheter lab space for both PCI and device procedures—driven by rising inpatient flow pressures, emergency admissions, and the displacement of elective activity—there is a risk that elective PCI and device waiting lists will continue to grow, leading to increasing P2 and P3 breaches, an inability to maintain safe balance between inpatient and elective demand, prolonged delays in clinically time-sensitive procedures, and failure to meet NICE/MINAP standards resulting in avoidable patient harm, further increases in acute admissions and inpatient length of stay, service destabilisation, and serious regulatory exposure for the Trust, including the potential for a Regulation 28 "Action to Prevent Future Deaths" notice should a patient die while awaiting PCI or device implantation.	Inpatient flow pressures and unpredictable emergency admissions continue to displace elective activity, severely limiting our ability to reduce waiting times. This is leading to a further rise in acute admissions, and potentially creating a feedback loop that further destabilises the service. There is also a serious regulatory exposure for the Trust. Should a patient die while awaiting PCI or device implantation under a consultant, the organisation is at real risk of receiving a Regulation 28 "Action to Prevent Future Deaths" notice from the coroner. These pressures not only create new risks but compound multiple existing high severity risks, including: •Prolonged delays in elective device procedures, currently reaching six months, which exceeds acceptable clinical thresholds. •An ongoing inability to safely balance inpatient device and PCI demand, a situation that has already	Some PCI patients are being medically managed but the delay in waiting for procedures can affect their condition and can result in admissions through the emergency route while they wait for elective treatment. Electives are being cancelled as needed to accommodate IP demand.	Outpatient waiting list Inpatient length of stay MINAP data-latest data shows we are only completing 60% of inpatient PCI within the NICE recommended target of 72 hours.	18/02/2026	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Action 1. No mitigation is possible without the availability of "separate" elective and urgent/hot lists. Until then cases are risk stratified and listed in order or clinical urgency. Action 2. Development of a business case for a third lab timed in with the replacement of the existing labs which is overdue. This will ensure minimum disruption during refurbishment and future proofing the service Completion date: Jan 2027	8	23/01/2027		29/04/2026
Finance & Performance Committee																										
Strategic Objective								**1b: Reduce waiting times for our patients**																		
5447	691	Service disruption	Caroline Landon	Rojas, Mrs Wendy	Daniels, Mrs Samantha	Workforce Strategy Group	05/06/2024	16	Surgery	Theatres, Anaesthesia and Critical Care CBU	Theatres		Nurse staffing in theatres does not support current activity, resulting in patient cancellations and delays. There is a risk of elective lists being cancelled due to lack of theatre staff. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill.		AFPP guidelines for staffing in perioperative setting in place. Daily review of staffing/lists and prioritisation of patients within available capacity. Use of agency staff where required to avoid cancellations where possible.	Incident reporting Review of cancellations	20/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business case to be submitted for increase in nursing establishment. Project group at Lincoln to introduce activity manager to try to support planning and management of deficits.	8	30/06/2025		20/05/2026

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5267	485	Physical or psychological harm	Caroline Landon	Hamer, Fiona	Marsh, David		26/09/2023	16	Medicine	Cardiovascular CBU	Cardiology		As a result of workforce limitations and an existing backlog of cardiac MRI scans, there is of risk of a continued delay in processing cardiac MRIs. This would lead to delayed assessment and treatment for patients, resulting in potential for serious harm, poor patient experience, and poor clinical outcomes.		1.Paper for outsourcing option submitted to exec team for consideration for sign off (more economical than paying substantive consultants extra contractual rates) to clear backlog. 2. Locally agreed KPI's to outline number of scans to be reported within allocated PAs. 3.Undertaking additional reporting sessions - this will help significantly with the reporting backlog but not solve causal factors. At cost. 4. We now have a Radiographer that can report Cardiac MRI's independently which is approx 8 a week. 5. Additional imaging consultant recruited (starts September 2025)-joint funding from CDC/radiology 6.Backlog monitored weekly and escalated through Divisional Governance structure.	Size of reporting backlog (number/time required) Average time for reporting of scans from date of imaging Locally agreed KPI's to outline number of scans to be reported within allocated PAs-This is being monitored.	21/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Work with imaging colleagues to develop/review need for additional imaging consultant with CMR included in Skill-set. 2. Continue to mitigate proactively at cost via current controls. 3. planned job planning changes to give us more capacity, this will take place October 2025 (additional device consultant starting in October 25 will enable one of our part time imaging consultants to reduce ward commitments and provide more reporting capacity) 4. There is a possibility of mutual aid from Sherwood Forest, ongoing negotiations are taking place. 6. Submitted paper to the Exec Team for £35,000 for an external company to clear 200 scans from the backlog.	3	01/07/2024		21/04/2026
5715	919	Physical or psychological harm	Caroline Landon	Fulloway, Mr Ian	Clapham, Mrs Sarah	Patient Safety Group	21/10/2025	12	Alliance	Diagnostics CBU	Radiology	Trust-wide	As a result of the reduction in staffing levels within CT, ultrasound, and MRI administration teams due to MARS, retirements, maternity leave, long term sickness, unfilled vacancies and the recent Patient Services Hub consultation, there is a risk that patients will experience delays in appointments, diagnosis, and treatment, and staff will experience increased workload and stress, which could lead to harm to patients through missed or delayed care and harm to staff through burnout and sickness absence.	Patient Safety & Experience • Delays in booking appointments and answering calls lead to prolonged waiting times. • Delays in diagnostic tests resulting in delayed diagnosis and delays in treatment • Increased likelihood of DNAs due to reduced patient contact and longer notice periods for letters. • Failure to meet national diagnostic targets (DM01 and cancer targets) compromises timely diagnosis and treatment. • Increased patient complaints and dissatisfaction. Staff Wellbeing • Remaining staff face increased workload and pressure. • Higher risk of booking errors and reduced service quality. • Increased sickness absence and burnout due to stress. Operational Performance • Diminished efficiency in appointment scheduling and communication. • Reduced ability to manage patient	Offer overtime to staff where appropriate to increase capacity and reduce backlog. Provide wellbeing support to staff to mitigate stress and prevent burnout. Prioritise clinically urgent and cancer-related workload to minimise disruption and reduce risk of clinical harm to patients.	Datix Patient complaints Patient experience Waiting list Staff absence Patient attendance for appointments	10/03/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Recruit into the vacant posts that have not been affected by MARS - Sarah Clapham - March 2026	3	31/10/2026		10/06/2026
Strategic Objective								**1c: Improve productivity and deliver financial sustainability**																		

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4664	5	Finances	Paul Antunes Goncalves	Antunes Goncalves, Paul	Picken, David		11/01/2022	20	Corporate	Finance and Performance	Operational Finance	Trust-wide	The Trust is overly reliant upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services.		ULHT policy: - Financial plan set out the Trust limits in respect of temporary staffing spend - Financial plan for agency expenditure is based upon developed savings plans in relation to agency staffing; acknowledges the progress made in 2023/24 in relation to real reductions in actual agency expenditure - Monthly financial management & FRP monitoring arrangements are in place to identify variation; agency expenditure reduction is a major part of the FRP and as such is heavily monitored. - Key financial controls for the use of the break glass agency usage are in place. - Specific staff group temporary staff spend is provided to dedicated Medical and Nursing workforce oversight groups. - Financial review meetings held monthly with each Division to understand and challenge usage of temporary staffing. - Plan for every post information has been embedded to support temporary staff usage forecasts ULHT governance: - The establishment of the Improvement Steering Group will provide general oversight of Trust wide agency reduction schemes	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Finance, People & Activity Meeting (FPAM)	05/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Financial Recovery Plan schemes: - recruitment improvement; - medical job planning; - agency cost reduction; - workforce alignment	8	31/03/2023	31/03/2024	05/04/2026
5020	6	Finances	Caroline Landon	Hamer, Fiona	Steadman, Nathaniel	WORK	02/09/2022	20	Medicine	Urgent and Emergency Care CBU			As a result of continued reliance on bank and agency staff for the medical workforce in Urgent & Emergency Care, there is a risk that medical rotas, including ward/department cover and on-call shifts, are not sufficiently filled. This would lead to risks to patient safety and have a negative impact on the CBU budget.		Robust medical plan for every post meetings Close working with temporary medical staffing team Daily management of any gaps to support minimum staffing levels Fundamental overview of tier 1 and tier 2 docs in medicine and ED based on RCP safer staffing levels. Introduction of BMA rate cards This will reduce once output on medical workforce plan is in place, not due to come online in this review period.	Plan for every post meetings Budget reports	10/03/2026	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	10	02/09/2023		10/04/2026

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5672	883	Finances	Paul Antunes Goncalves	Antunes Goncalves, Paul	Sargeant, Paula		17/06/2025	25	Corporate	Finance and Performance	Operational Finance	Trust-wide	The Trust has a £69.8m Financial improvement target for 25/26. If the Trust fails to deliver the CIP Plan, this will have a significant adverse impact on the ability of the Trust and the Lincolnshire ICS to deliver its breakeven financial plan for the year. This represents a 6% target of £48m plus the impact from systemwide schemes of £21.8m, totalling £69.8m to breakeven. This is greater than any financial improvement the trust has delivered in previous years. This requires delivery at the same time that the organisation is going through vast amounts of transformation, both as a Group and as part of the Lincolnshire system. This target represents a significant reduction in headcount, and needs to be delivered either without invest to save options or with additional CIP delivered over and above target to		National policy: - NHS annual budget setting and monitoring processes - Breakeven Plan - Acute to Community, Analogue to digital. ULHT policy: - Detailed Financial plan inclusive of the headcount reductions has been submitted and ownership is in place for delivery. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial recovery plan aligned to CIP. - Development of Care Group level Schemes assured through PRM's and GLT (Transactional) - Establishment of future looking programme to develop schemes for a sustainable cost improvement programme for the future. This incorporates Acute to Community pathways across the group (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Group Improvement Strategy supported by the transformational team resource. (Targeted) - Divisional CIP targets allocated as part of the budget setting process and removed from budgets. ULHT governance:	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE and through ICB. For 2025/26 the Trust continues to be monitored weekly on the status of the CIP programmes and their level of maturity. The Trust monitors internally against its CIP targets inclusive of specific Care Group and Transformational scheme targets through the PRM's, GLT and PITOF. Scrutiny & oversight is increased as all committees now meet as a group and allows confirm & challenge across the group. Monthly Reports into Integration Committee and Finance Committee.	27/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	- Support offered to all Care Groups. - Increased CIP governance & monitoring arrangements introduced through PRM's to ensure oversight (including additional one off detailed executive review sessions with care groups). Business cases submitted to NHSE for Delivery support in key areas where capacity & expertise require. - Alignment with the Group Strategy for Acute to Community, Digital To Analogue. - CIP is embedded across the group and resources shared and is not seen as a separate annual work stream. - Development of future programme of cost improvement. - Continual exploration of new opportunities. - SRO's assigned	4	01/04/2026		27/04/2026
4658	17	Reputation	Jayne Warner	Warner, Jayne	Willey, Karen	Digital Hospital Group	10/01/2022	20	Corporate	Trust Headquarters	Corporate Secretary	Trust-wide	If the Trust does not have a defined records management framework/ strategy it runs the risk of not meeting national best practice and not making informed decisions in relation to Digital programmes of work. This could result in a breach of regulations and ULHT finding it difficult to meet national enquires that could lead to regulatory action and financial penalties. This risk has increased due to ongoing national enquiries and the move to a more digital way of records mgmt which whilst positive heightens the need to manage legacy and ensure expert RM support for future decision making.		The Trust has policies in place. Trust DPIA template included aspects on records mgmt and retention.	FOI compliance gives an indication of the Trusts position as compliance is linked to good records management. Reports of unmanaged records found in Trust locations.	18/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments. Needs to link into 365, ePR and EDMS Programme. 365 cannot be delivered with dedicated Records SME resource.	4	28/06/2024	31/12/2025	18/05/2026

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5389	559	Finances	Caroline Landon	Landon, Caroline	Anderton, Kerry		19/02/2024	20	Corporate		HOSPN		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.	20/01/2026	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.	6	19/02/2025		20/04/2026
Strategic Objective								**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 on the labour ward at Pilgrim Hospital within which to undertake any theatre based procedures when Theatre 8 is already in use. As a result, there is a risk that, in time critical scenarios, the additional time taken to transfer a to Theatre 1 on ground floor and commence surgical management may impact on the health and wellbeing of the mother and baby. This would lead to physical harm as well as poor patient experience due to a lack of privacy and dignity for women when transferring to ground floor theatres through public corridors. There is also a potential for an increase in Caesarean Section rate as clinicians attempt to avoid late labour transfers.		Multi-professional discussions in relation to plans of care. Out of hours – on call maternity manager available for support. Dedicated theatre available in ground floor theatre. Close monitoring of labour ward activity. Publication of Standard Operating Procedure (SoP) Labour Ward Manager / Matron / Labour Ward Obstetric Lead to have an awareness of all theatre cases. Visible management and Leadership/active on call support to teams PMA support	Closely monitor all cases where woman transferred to theatre before or following birth – daily Medway report for scrutiny. Regular review of Incident reporting system.	22/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To inform teams of the risk controls in place. Coordinate Estates to undertake the works on Theatre 8a to minimise disruption as soon as practicably possible.	6	01/01/2025		22/04/2026

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Handler	Reportable to	Opened	Rating (initial)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Additional/ Supportive Information	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	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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)).		Following notification the following actions were undertaken: Pilgrim Hospital – Labour Ward: Estates staff checked the supply ventilation from the Air Handling Unit (AHU) to the Supply Grilles within the labour rooms. At the time of inspection, the Estates staff identified the dampers restricting airflow were not adjusted correctly. This was addressed and airflow checks were undertaken. Typical air change rates were around 6 air changes per hour (ACH) – current guidance is a minimum of 10 ACH, however the ventilation systems are circa. 1960 and the guidance is not retrospective. Following the actions undertaken, resampling commenced 15th March (15 sample tubes), 13 were within WEL limits, but 2 sample results were recorded at 255 and 407 ppm (8 h TWA) in Rooms 2/2a and Room 3, respectively and exceeded WEL limits. Estates are reviewing the current system to look at increasing air changes by upgrading the supply fans / changing pulleys / upgrading filter media or a combination of factors. Further works to increase ventilation has been completed and whilst not HTM03 compliant by design - supply ventilation has been increased to reduce the risk of WEL exceedance. Lincoln Hospital - Labour Ward: Estates staff found the ventilation system had been isolated (approximately 10 years ago). Following discussions with Estates members, the ventilation system had	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	17/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training	10	28/03/2024		17/05/2026
5234	510	Service disruption	Caroline Landon	Lynch, Diane	Biddulph, Victoria		25/08/2023	15	Alliance	Diagnostics CBU	Neurophysiology	Pilgrim Hospital, Boston	As a result of the Emergency Department new build project, Pilgrim (PHB) H block was demolished and therefore clinical space was taken from Neurophysiology. No EEG or EMG service is provided at PHB currently. No Inpatient provision for testing at PHB. Inpatients requiring tests have to be transferred by hospital transport to Lincoln County for testing therefore there is a delay in treatment which would lead to patient harm and additional stress caused to patients having to travel to another location.		Adhoc bookings of space available within Outpatients at PHB. Booked where and when possible. Inpatient being transferred to Lincoln (although this is taking staff off wards in Pilgrim)	Waiting times Travel times Patient Feedback Datix Incident	11/02/2026	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	4	26/08/2024		11/05/2026

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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. Low level of attendance/completion of fire safety training also contributes to this risk as there there may be significant non-adherence to fire safety policy and procedures which could lead to potential of a major fire.		National policy: - Regulatory Reform (Fire Safety) Order 2005 - NHS Fire safety Health Technical Memoranda (HTM 05-01 / 05-02 / 05-03) LCHG policy: - Fire Policy (approved by FEG / FSG Aug 25) # Personal Emergency Evacuation Plans (PEEPs), reviewed 2025 - 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 - Major Incident Plan - Estates Planned Preventative Maintenance (PPM) programme LCHG governance: - Trust Board assurance through Finance, Performance & Estates Committee (FPC) / lead Fire Safety Group (including divisional clinical representation & regulator attendance) / Fire Engineering Group - 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	Results of fire safety audits & risk assessments, currently indicate: - Fire Risk assessments within Maternity Tower block Lincoln indicating substantial breaches of compartmentation requirements - Fire risk assessments indicate lack of compartmentation within some sleeping risk areas - Age of fire alarm systems across Group (beyond industry recommendations) - No compartmentation reviews undertaken to provide assurance of existing compliance (across Group) - Concerns with networking of fire alarm system at Pilgrim (to notify Site Duty Manager / Switchboard of alarm activation) Reported fire safety incidents (including unwanted fire signals / false alarms). Fire safety mandatory training compliance rates. Internal audit review of fire safety	12/02/2026	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 - Group-wide replacement programme for fire detectors. - Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection. - Fire safety protocols development and publication. - Fire drills and evacuation training for staff. - Fire Risk assessments being undertaken on basis of inherent risk priority; areas of increased residual risk to be added to the risk register for specific action required - Local weekly fire safety checks undertaken with reporting for FEG and FSG. Areas not providing assurance receive Fire safety snapshot audit. - Staff training including bespoke training for higher risk areas - Planned preventative maintenance programme by Estates	10	31/03/2026	31/03/2025	12/05/2026
4725	466	Reputation	Caroline Landon	Taylor, Ruth	Taylor, Ruth	Health and Safety Group	13/01/2022	20	Alliance	Therapies and Rehabilitation CBU		Lincoln County Hospital	As a result of prolonged and unresolved estates related issues, including temporary relocation of Occupational Therapy staff into Physiotherapy Department and the decanting of the Rehabilitation Medicine Team into reduced and unsuitable space at Lincoln County Hospital, staff and patients continue to be affected by environmental and infrastructure shortcomings. These include overcrowding, poor temperature control and ventilation, inadequate clinical and patient facilities, and general deterioration of furnishings and building systems. Despite being approved as a temporary measure, the situation has remained unresolved for over 12 months. There is a risk that the ongoing substandard working and treatment environment will result in reputational damage to the organisation, stemming from negative staff and patient experiences and perceptions.		Legislation: - Health & Safety at Work Act 1974 -Management of Health & Safety at Work Regulations 1992 associated guidance. ULH policy: - Health & Safety Policy & related guidance - Health & safety training (Induction, Core Learning, Core Plus Learning and CPD) - Estates Planned Preventative Maintenance (PPM) / testing - Occupational Health services ULH governance: - Health & Safety Committee / site-based H&S Forums; accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) Frequent escalations to Estates Team for repairs Increased use of flexible working policy Site visits by senior Exec Team members Frequent escalations through Governance processes Ongoing review of space Curtains in place in the clinical area which will increase clinical space, which will also reduce noise levels. Staff who want to come to work in their uniform are doing so Hot desking room created in the department	IPC flo scores / Monthly audits Datix incidents Staff surveys / leavers feedback Staff concerns / complaints Complaints / PALS H&S audits Walkaround with Estates and log jobs	06/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Work with Estates to identify better facilities – Ruth Taylor – April 2026 Business Case is required to implement any service move to another space – Rebecca Johnson – April 2026	4	31/03/2022	31/03/2023	05/06/2026

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5695	906	Physical or psychological harm	Colin Farquharson	Bardan, Ela	Bardan, Ela		19/08/2025	20	Corporate	Group Chief Medical Officer		Trust-wide	As a result of an internal audit identifying that the Trust policy on maintenance of specialist equipment was not being followed and needed to be addressed, work has been undertaken and identified that a significant proportion of devices are beyond their stated manufacturer lifespan and require removal and replacement. There is a risk that ageing and inadequately maintained equipment may fail or malfunction which could lead to harm to patients, disruption to clinical services, and operational delays. In addition, this poses a risk of regulatory action in response to the Trust not meeting statutory requirements in respect of regulation 12 and 15 from the Health and Social Care Act 2008 and Medical Device Regulation (MDR 2017/745) which would also lead to a reputational risk. There is a financial risk in that unplanned use of resource will likely be needed to mitigate the risks to		1.Devices deemed to be unsafe have been removed from use at audit point and portable suction devices were made available for clinical areas use, if needed. Some filters that were not fit for use were replaced then and there. This supports operational efficiency 2.24/07 Placed urgent compliant orders to support the replacement of devices at Pilgrim Hospital, Boston. 3.17/07/2025-24/07/2025 – Negotiated discount to have a cost avoidance of £48,964.76 +VAT against NHS Supply Chain, with an annual CIP saving for the next 7 years of £13,859,34 + VAT per year, giving a total of £97,015.41 saved over this period, to address the future finance risk. 4.Engagement with key stakeholders to accelerate actions while ensuring safety and considering financial implications.	Audit Datix incidents Patient complaints / PALs Review of all equipment	16/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1: Financial resource has been identified to purchase replacement medical devices for Boston only. This should lead to replacement of all affected devices by the w/c 25 August 2025.Completion Date – August 2025 Action 2: Work is underway to raise finances needed to take mitigating action following receipt of the Lincoln audit findings. This remains a work in progress.Completion Date -March 26 Action 3: Place an order for replacement devices at Lincoln and roll-out removal and replacement of deficient devices at Lincoln –Completion date- September 2025. Action 4: Clinical Engineering to submit a Quality Impact Analysis (QIA) to the Vacancy Control Panel (VCP) to secure approval for the recruitment of four Band 3 and two Band 4 Clinical Engineering	4	19/08/2026		16/06/2026
5272	455	Physical or psychological harm	Caroline Landon	Hamer, Fiona	Miller, Mrs Sally		06/10/2023	12	Medicine	Cardiovascular CBU	Cardiology	Lincoln County Hospital	As a result of the current Cath Labs coming to end of life and Lincoln Cardiac catheter lab not being connected to the emergency power supply at Lincoln County Hospital, power cuts and faults due to breakage may occur. This would lead to potentially being unable to offer a PPCI service (primary percutaneous cardiac intervention) and possible risk of patient harm, death or possible implications around infection if a patient is undergoing a procedure at a time of a power cut. Parts not being able to be sourced may put inpatients for angioplasty and pacing procedures at risk and cause significant disruption across the service In addition, Cardiology is trying to build a case for a 3rd lab due to lack and ability and being able to maintain emergencies and piece of work is being undertaken on lab efficiency to help inform the case for. Currently there is nowhere currently on the		Temporary electrical fix via Estates-UPS-however there have been mechanical failures which has required Estates to manually to change it over. Estates had a third party assess the UPS switch-this needs to be re-wired but are currently awaiting a date for this to be carried out. Both of the Cath Labs will need re-wiring. Estates have stated they cannot provide power in the event of national grid power outage. Business Continuity Plan Cath Lab-short term power cut would look at utilising Thrombolysis. Prolonged power outage we would need to request mutual aid from those that offer PPI in neighbouring organisations. -Maintenance of labs done by Siemens, however contract comes to an end 2027. -Monthly testing carried out by estates on generators. -Risk of Cath Labs has been escalated to board level. -Project group for new Cath Lab now in place	Monthly audit internally (Cath Lab) Incidents of power outage raised on Datix. Log of jobs raised to Siemens recorded. Financial efficiency project in progress.	21/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	-Estates reviewing Lincoln site space. Job has been raised around electrics with Estates-this may be tied in with Lab replacement. Request to Estates to provide sufficient power to Cath Lab during a power outage has been made. Estates are currently working on solutions for this. -Efficiency Project -Case being developed for replacement of existing labs alongside options appraisal for the possibility of attaining a third lab.	1	31/12/2023		21/04/2026

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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 - Corporate oversight through Estates Investment & Environment Group / Finance, Performance & Estates Committee (FPEC)	Patient & staff feedback on the environment in Maternity services. Audits of infection prevention & control compliance. Reported health & safety and IPC incidents.	22/01/2026	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Plans for refurbishment of Maternity units on both sites, estimated timescales 3-5 years for LCH, PHB to be confirmed. Full Business Case required. Maternity shared decision council looking at simple solutions for improving working lives of staff.	6	31/03/2025	31/03/2025	22/04/2026
4830	11	Service disruption	Mike Parkhill	Parkhill, Michael	Savill, Allen	Estates Infrastructure and Environment Group, Medicines Quality Group	17/01/2022	15	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	As a result of estates plant and pipes that are prone to blockage and overflow being located above the pharmacy at Pilgrim Hospital Boston, there is a risk that if there were to be a flood his could lead to extensive damage to medicines; computer equipment and aseptic facilities that disrupts service continuity and has serious financial implications.		ULHT policy: - Estates maintenance / repair arrangements - Business continuity plans ULHT governance: - Trust Board assurance via Quality Governance Committee (QGC) / Medicines Quality Group (MQG) / Pharmacy CBU / CSS Division Contingency plan in place - medicines and equipment are moved to a temporary location in the event of overflow into Pharmacy.	Reported incidents of service disruption	18/02/2026	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	6	30/09/2021	31/03/2022	16/04/2026

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5471	676	Service disruption	Mike Parkhill	Parkhill, Michael	Whitehead, Mr Stuart	Lift Safety Group	26/06/2024	12	Corporate	Estates and Facilities	Estates	Trust-wide	Risk of failure of lifts due to exceeding mechanical life expectancy, leading to possible service disruption across ULHT sites. LCH have 19 lifts age range 1984 to 2002 mixture of hydraulic, traction and platform GDH have 5 lifts age range 1960 to 2008 mixture of hydraulic, traction and platform PHB have 17 lifts age range 1967 to 2000 mixture of hydraulic, traction and platform The oldest lifts being 60 years old and the newest being 12 years old. The Chartered Institute of Building Services Engineers (CIBSE) Guide D for Transportation systems in buildings advise the typical life of a lift for electrical traction type is 20 to 25 years and 15 years for hydraulic lifts. The age of the sites lifts in the most part far exceeds the expected life in accordance with CIBSE Guidance.		To manage the current risks of these Lifts, a robust service and maintenance contract is in place and is well established, not only is this a requirement to have but is significant for the resilience of the lifts. Recent contract reviews have now implemented more frequent service visits and full critical spares parts requests to be stocked on the sites to reduce impact and down time when lifts fail to operate. However, this is not possible for all lifts, many lifts are beyond stock item ability and retrofit parts are required on many aspects.	Incidents reported via Datix Estates Job requests.	20/03/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	A capital development plan has been implemented to replace all lifts over a period of years, starting with an initial 6-year replacement plan, reviewed annually for financial allocation and risk profile. As part of the risk management of lifts the Trust employs the services of an Authorising Engineer (AE) who undertakes an annual review of lifts and associated maintenance and procedures.	6	26/06/2025		19/06/2026
5498	726	Regulatory compliance	Mike Parkhill	Parkhill, Michael	Purdy, David	Health and Safety Group	19/08/2024	15	Corporate	Estates and Facilities	Estates	Trust-wide	As a result of the poor condition of the PHB and LCH helipads they pose a risk to arriving crews (they cannot see it due to poor lighting and no demarcation) but also carry risk where they are accessible for anyone to get onto the helipad during landing. The helipads fail against the CAP1264 Civil Aviation standard for NHS Helipads due to the above concerns, design and fabric. There is a severe risk of harm or death to persons in the vicinity of the helipads (up to 50m) from the downwash. Issues at other NHS sites with downwash have resulted in a visitor death. LCH has also incurred incidents with people accessing the pad during landing and at other times.		Estates maintain the pads as best resources allow. Security attend the pads during landings when aware and able.	Datix, ED arrival mode data, data from the air ambulance service and anecdotal information from the Lincs & Notts Air Ambulance Unit Chief Pilot	03/03/2026	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Action 1. Estates and Facilities take immediate action when notified of issues. Action 2. Working with the Hospital Emergency Landing Pad (HELP) appeal and Green Deck Operations, obtaining surveys for options and developing a business case to improve conditions and become compliant. Green Deck appeal have offered to fund the works required to existing pads once the plan is developed. Currently we need to review options available at Lincoln & Boston. Action 3. Once investment in place, Ops to work on Governance compliance for CAP1264 Civil Aviation standard. Action 4. Meeting to be had with Lee Taylor as we need to have an accurate recorded data process for recording when a helipad lands.	3	31/03/2026		03/06/2026

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5383	615	Regulatory compliance	Caroline Landon	Cooper, Mrs Anita	Rigby, Lauren	Estates Strategy Group, Health and Safety Group	13/02/2024	15	Alliance	Cancer Services CBU	Haematology (Cancer Services)	Pilgrim Hospital, Boston	As a result of the treatment room not being compliant with HBN 00-03 procedures are being performed in an area that is not compliant, Adhoc and urgent bone marrow biopsies and intrathecal chemotherapy will still be performed in this room which would lead to an infection risk to patients.		Room is being decluttered Estates have reviewed, still awaiting if they can increase the air exchanges and how much this would cost. Larger organisation piece of work being undertaken Regular bone marrow biopsy clinics have been moved to outpatient department Venesections have been confirmed by the lead Estates Nurse can continue Risk assessment and precautions have been circulated to staff to adhere to for adhoc and urgent bone marrow biopsies and intrathecal chemo.	Datix incidents Complaints / PALS Assessment against regulations	19/03/2026	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 - April 2026 Wider organisational piece of work - Karen Bailey - April 2026	3	13/02/2025	13/02/2025	19/06/2026
People Committee																										
Strategic Objective								**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	Alliance	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	As a result of lack of investment for Haematology workforce historically there is insufficient workforce and to meet increasing demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave and the service to collapse which would also lead to significant patient harm. Patients would need to be referred to other neighbouring Trusts which in turn would cause other Trusts to collapse. Particular areas of concern are Clinical Governance Lead and Head of Service for Haematology.		CG lead duties shared between consultants but no one wishes to take on role (Clinical Governance Lead to commence post in April 2025) Introduction of nurse-led clinics to manage demand. Fixed term Locum Consultants / High cost agency above budget to support service. Ad-hoc additional clinics outside of consultant job plan Workforce review completed Refresher of Fragile Services Paper completed (NB there is a National shortage of Haematology consultants) Additional unfunded ST3+ for Haematologist started in August 2022	New referrals and PBWL show ongoing capacity issues. RTT and cancer performance below target. Increased PA's for substantive consultants. Outcome from Staff Survey results Financial constraints of group Monitoring of outpatient appointments Datix incidents / Clinical Harm reviews / Complaints / PALS	17/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Recruitment of further substantive consultants - Sarah Chester-Buckley April 2026 Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026	8	30/09/2023	01/04/2025	17/04/2026

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4862	44	Service disruption	Caroline Landon	Hamer, Fiona	Smith, Charles	WORK	22/02/2022	16	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	As a result of insufficient consultant staffing within Respiratory Medicine at Lincoln, Boston, and Grantham hospitals, an uncertain event may occur where the service cannot provide the recommended level of specialist input. This would lead to increased risk for high-acuity inpatients without specialist care, delays in outpatient pathways including 2-week wait referrals, and delays in commencing treatments such as chemotherapy. The inability to cross-cover between sites due to skillset and list requirements places Grantham at particular risk. Currently, there are only 9 substantive consultants and 3 locum/agency staff against the GIRFT recommendation of 15, leaving a significant workforce gap.		Due to the severity of the risk: Currently: x 5 Consultant Gaps in Resp The impact this is having on the current workforce is stretching the team and leading to added pressure on the workforce. We are working with agency teams to work 'differently' for example Locum consultants supporting with on call work / remote clinics to release the burden on the current clinical team in respiratory. OD support in place also, along with weekly catch up meetings with the teams to explain the current state of play. The CBU continue to proactively manage workforce. Rotas are stable but continue to be challenged with gaps.	Staff Survey Results. Data Analysis through HR around recruitment and retention. Measured through Performance for patients (although this is not directly attributed towards the recruitment and retention, the longer wait times cause anxiety and unwarranted stress for the consultants in post)	04/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Close working with Agency to try and recruit agency locums to temporarily fill gaps. Working with Advanta / Medical Resourcing to recruit long term and improve retention of current staff. Additional funding applied for from Cancer alliance/ICB for Gastro and Resp to allow for additional Gen Med Locum to reduce burden on current workforce. Remote working in place to support outpatients where possible. Agency spend supporting out of hours workload - for example, covering the substantive consultants on calls to allow them to focus on Cancer work instead of on call - supporting patient care.	4	30/12/2022	03/06/2024	04/05/2026
5142	65	Physical or psychological harm	Caroline Landon	Hamer, Fiona	Steadman, Nathaniel		12/04/2023	20	Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	As a result of increased demand and footfall within Lincoln and Pilgrim Emergency Departments, there is a risk that the current overnight staffing template for middle grade doctors is insufficient to maintain patient safety. This would lead to a risk of compromised patient care, delays in treatment and potential harm.		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.	10/03/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades. New rota templates signed off by finance, to be implemented Q3 2023. Recruitment ongoing.	9	31/08/2023	01/11/2023	10/06/2026
5469	697	Service disruption	Colin Farquharson	Rinaldi, Dr Ciro	Chablani, Manish		21/06/2024	16	Corporate	Group Chief Medical Officer	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.	17/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	8	21/06/2025		17/05/2026

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5691	905	Service disruption	Caroline Landon	Fulloway, Mr Ian	Clapham, Mrs Sarah		19/08/2025	16	Alliance	Diagnostics CBU	Radiology	Trust-wide	As a result of reduction in staffing levels within PACS team attributable to MARS which was 1WTE 8A (with 20+ years of experience), and unfilled vacancies. This will have a significant adverse impact on service delivery across the Trust, affecting the delivery of safe patient care caused by the inability to deliver on vital projects such as Boston CDC, PACS / Web V and CRIS upgrades, importation of images to and from external parties, irefer, Phillips ROCC project, EPR, and the inability to produce data supporting monitoring of diagnostic Waiting times, inability to produce billing reports resulting in loss of income. (this list is a small representation and not exhaustive of the current PACS team workload) Due to staffing issues and unsustainable workload there has not been the capacity to be able to cross train appropriately. Requiring the team to function on the basis of		All posts that are unaffected by MARS will be advertised as the QIA system allows. (No controls are in for the posts that have been approved by MARS as unable to replace).	Datix Patient complaints Patient experience Waiting list Staff absence Patient attendance for appointments	18/02/2026	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	4	31/08/2026		18/05/2026
5467	695	Service disruption	Paul Antunes Goncalves	Babu, Suresh	Chablani, Manish		21/06/2024	16	Corporate	Group Chief Medical Officer	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	29/01/2026	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	8	21/06/2025		29/04/2026

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5564	783	Physical or psychological harm	Claire Low	Capon, Mrs Catherine	Anderton, Kerry		19/12/2024	16	Corporate	Chief Operating Officer		Trust-wide	As a result of staffing not being uplifted for Hospital Out of Hours along with gaining more wards this has resulted in an increase in patients along with an increase in acuity. This has led to patients waiting for longer than they should do to be reviewed and for essential medications and fluids to be prescribed. This could result into an increase in patient mortality leading to increase length of stay, a reduction in bed flow and a negative effect of patient experience. This risk also has an effect on staff with reduced morale and increased levels of stress due to pressures.		-All clinical task requests are triaged by Hospital Out of Hours clinical coordinator who can advise the nurses on interim measures while they are waiting for their patient to be reviewed and give safety netting advice. -Tasks are then triaged again by the clinician receiving them. -Any tasks left at the end of shift are handed back to day staff. - Staffing levels currently have at both Lincoln & Boston: 1 ACP, 1 Clinical Coordinator and 1 Clinical Support Worker. -Medical staffing at Lincoln: 1 dedicated Hospital Out Of Hours F1 Doctor -Medical staffing Boston: 1 Trauma and Ortho Doctor, 1 Surgical Doctor, 1 Medical Doctor-these are not however dedicated to Out Of Hours so may not be readily available-these also clerk on Admissions Units and A&E.	-Datix Incidents -Audit Nerve Centre -Regional Hospital Out of Hours Network KPI's	22/01/2026	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.	8	19/12/2025		22/04/2026
4780	74	Service disruption	Claire Low	Hamer, Fiona	Constantin, Dr Carmen		16/01/2022	20	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of a significant deficit in stroke consultants levels due to staff leaving/ retiring and stroke service struggling to recruit substantive consultants there is a risk of not being able to maintain effective stroke provision across ULTH. From April 2025 the stroke service will have only one Substantive Consultant, upcoming retirement could result in no substantive Consultant Stroke Physicians in 2028-2029 if continue to not recruit. Reliance on Locum consultants is costly and causes instability in the rota. Locum/Agency/Bank reliance results in limited medical training & supervision for resident doctors, Registrars, ACPs and students – limiting staffing pool for the future & reduces staff experience/satisfaction.		•Utilising a regular pool of locum consultants •Consultant advert out •Attended recruitment drive at medical conference November 2024 •Consultant ACP post •Liaising with Integrated stroke delivery network [ISDN] for possible regional solutions	Datix/incidents/SJR/SI Rota Gaps Budget/costing	12/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Convert locum contacts to Bank where possible Action 2. Continue to advertise for consultant stroke physicians Action 3. Continue to liaise with Integrated stroke delivery network [ISDN] for possible regional solutions ?regional rota Action 4. Further consultant stroke practitioner post & support Stroke registrars to become stroke consultants. Action 5. Redesigned stroke pathway.	8	31/03/2022	01/07/2024	12/05/2026

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5427	699	Service disruption	Colin Farquharson	Babu, Suresh	Chablani, Manish		30/04/2024	16	Corporate	Group Chief Medical Officer	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	09/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	4	30/04/2025	30/04/2025	09/05/2026
5480	683	Service disruption	Claire Low	Marsh, David	Bursey, Sarah		05/07/2024	12	Medicine	Cardiovascular CBU	Endocrinology/Diabetes	Trust-wide	As a result of a depleting workforce in diabetes this is leading to withdrawal of ward work which is impacting on the quality of care that patients are receiving. Currently pan Trust Trust there should be eleven DSN nurses WTE and there is currently only two in post. Out of these two in post one is due to retire. There is currently three members of staff on maternity leave. Care is having to be withdrawn from ICU, DSN reviews and referrals. For Navenby Ward they are having to rely on junior medic workforce. Active in reach for ED is now limited due to lack of resources. This leads to the potential of missing patients. Staff education has stopped, if its not on ESR or online but no face to face is not currently possible due to work pressures.There is an impact of outpatient referrals, unless it is life threatening these are delayed till further notice which would lead to an increase in waiting lists. Unless patients are pregnant PUMP cannot		-2x secondments approved and 1x secondment to be advertised -Working with Patient Safety Team looking at DKA within the ward and education. -Working with cost efficiency manager for department but yet to hear feedback.	staffing levels and service provision Datix incidents-list of Datix with insulin provided by Medical Safety Lead. Themes remain the same.	27/01/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Action 1: Escalated through clinical cabinet and commissioners. 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. Action 3: Managing workload as best a possible with input from consultant team and existing specialist nurse staff.	2	05/07/2025		27/04/2026
Strategic Objective								**2b: Empower our people to continuously improve and innovate**																		

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5093	40	Service disruption	Caroline Landon	Bassi, Sangeeta	Baines, Andrew	Workforce Strategy Group	16/02/2023	20	Corporate	Group Chief Medical Officer - 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		Currently no controls in place	Staff Survey Staff Feedback Staff sickness Finance performance on invoice payment Workload CIP tracking Biosimilar switching targets	25/02/2026	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) Staff trained and competent to fulfil roles - Colin Bell - March 2026 Staff skill mix review and time and motion study to ensure that staff managing workload Andrew Baines - Feb 2026 Training of new store keeper post - Andrew Baines March 2026 Procurement staffing review - Fran Martinez March 2026	4	16/02/2024	16/02/2024	25/03/2026
5761	967	Physical or psychological harm	Caroline Landon	Hamer, Fiona	Smith, Charles		03/03/2026	25	Medicine	Specialty Medicine CBU	Gastroenterology	Trust-wide	As a result of establishment vacancies, absences and the gap in establishment versus GIRFT recommended WTE workforce, within the IBD Clinical Nurse Specialist team there is a risk of delays to medications management, increased non-elective admissions and delays to follow up appointments for patients with confirmed IBD. This will negatively impact patient outcomes and may result in incidences of causing harm to patients – there is an increased risk of morbidity and mortality when patients with disease that has significant impact on quality of life have delays in being seen/accessing care, primarily due to developing surgical and medical complications. This position has worsen in the coming months as the lead ACP for the service is leaving.		•Patients will be booked into Gastroenterology Consultant clinics for their follow-up appointments as soon as possible – there significant follow-up backlogs in gastroenterology consultant clinics so delays in IBD FU's are still a likely occurrence. •Nurses will focus their resources on managing the nurse-led advice line to reduce the volume of patients who present to emergency departments with a flare of their condition. •Patients advised to attend an emergency department if very unwell.	•Non-elective admissions for patients with IBD •Datix Incidents involving patients with confirmed IBD •Patients who are overdue their follow up appointment. •Complaints received involving patients with confirmed IBD.	18/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Action 1: Expedite the recruitment of the vacant IBD CNS post. Lead: Donna Gibbins Completion date: TBC Action 2: Business Unit supporting with managing the IBD MDT including the agenda and capturing outcomes. Lead: Donna Gibbins Completion date: Ongoing Action 3: Discussions are underway with Team and IT to try and manage advice line demand more automatically. Lead: Kimmi Highfield Completion date: Ongoing Action 4: IBD Nurse led clinics currently on hold with patients seen in consultant clinics when necessary. Lead: Kimmi Highfield Completion date: Ongoing Action 5: IBD Nurse in-reach service currently on hold with issues to be picked up via the gastroenterology team. Lead: Kimmi Highfield Completion date: Ongoing	8	03/03/2027		18/04/2026

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4997	41	Service disruption	Caroline Landon	Lynch, Diane	Chester-Buckley, Sarah	Patient Safety Group	22/08/2022	16	Alliance	Cancer Services CBU	Haematology (Cancer Services)	Trust-wide	Haematology still remains a fragile service with a non-compliant rota for the Speciality Doctors / ACP's. Following a regional audit by EMCA it is clear that the number of Haematology Consultants should be increased to ensure that the capacity can meet the demands of the service. Following recent investment in the workforce by recruiting one Specialty Doctor and four Consultants, the overall workforce has expanded; however, the on-call arrangement has not increased in line with this growth and remains a single consultant covering both sites during weekends. This creates a risk of insufficient consultant availability if critically unwell patients are present on both sites at the same time, which could lead to delays in care, delayed discharge decisions, and potential patient harm. To rectify this further investment will be required.		VC ward rounds are taking place if face to face ward rounds are not possible.	Datix incidents Complaints and PALS Outcome from Staff Survey results	17/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	The risk reduction plan now the monies are in the CBU budget posts are advertised substantively to stabilise the service further. The rota is monitored for compliance - Sarah Chester-Buckley - June 2026	4	01/04/2023	01/04/2023	17/04/2026
4844	38	Service disruption	Caroline Landon	Bassi, Sangeeta	Saddick, Ahtisham	Medicines Quality Group	19/01/2022	20	Corporate	Group Chief Medical Officer - Pharmacy CBU	Pharmacy	Trust-wide	As a result of the current service provision from Pharmacy operating a 9-5 Monday-Friday and 9.30-13.15 Saturday and Sunday (except Grantham which only opens Saturday and Louth does not open on weekends). The current working model has seen introductions of cut off times for supplies (including Blister packs and discharges) to ensure that the workload can be managed safely and effectively, whilst also supporting ward/pharmacy staff, and patient flow. (It is key to note that, from national benchmarking, the Pharmacy establishment is 84wte lower than comparable peers, Pharmacy Review, Phase One, 2025). There is a risk of harm for patients requiring critical medication, discharge supplies, or a pharmacy medication review outside of these times (note emergency stock items are available via the emergency cupboards on LCH, Pilgrim, and Grantham sites).		Provision of an emergency supply only service on weekends between 9am and 12:30 On call pharmacy service outside of pharmacy working hours Quarterly comms to staff to remind them that that weekend service is for urgent items only and what the cut off time is and that we cannot do MDS.	Staffing levels / budget benchmarked against other similar trusts. Reported medication incidents occurring out of hours. Monitor sickness rates following weekend working Staff Survey results Staff exit interviews	09/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	QIA to be developed - LMM (Chelsea Andrews) - April 2026 eDD pilot - AS May 2026 and QIA following the outcomes of the pilot.	4	29/10/2021	21/06/2023	09/04/2026

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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. Staff are being offered paid in TOIL for any additional sessions undertaken in order to minimise additional budgetary impact. Escalation to Divisional Triumvirate to request agency cover when gaps cannot be filled by existing staff. Escalations are made to the medical director re payment agreements in accordance with NHSE/I policy. Business Continuity Plans are in place for both sites.	Monitoring of gaps in rotas Agency spend reporting Datix incidents recorded	20/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruitment to vacant posts.	4	31/10/2022		20/05/2026
4905	48	Physical or psychological harm	Caroline Landon	Cooper, Mrs Anita	Taylor, Ruth		22/04/2022	12	Alliance	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. Comprehensive review and optimization of therapies and rehabilitation services, including CIPP and CON. Strengthened collaboration with LCHS and system partners, including creation of joint system posts. Defined therapies and rehabilitation strategy aligned with system priorities. Collaboration with finance to review establishment and nominal roles. Established plan for a sustainable medical workforce in rehabilitation medicine. Development team established for therapies. Neuropsychology posts successfully recruited.Substantive funding secured for therapies at front-door services. Active management and review of waiting lists, including RAG rating, telephone/video consultations (TC/VC), patient-initiated follow-up (PIFU), and timely discharge. Case-of-need strategy established and aligned with wider system initiatives. Competency frameworks and preceptorship processes implemented. Comprehensive strategy covering capacity and demand management, workforce planning, and development.	Patient complaints. Monitoring of flow at front and back door. Site escalation. Vacancy rate monitoring. Roster fill rates. Waiting list numbers of frequency of follow ups. Staff absence. Staff survey and feedback.	06/03/2026	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	9	30/09/2023	18/12/2023	05/06/2026
Integration Committee																										
Strategic Objective							**3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services**																			

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5563	782	Physical or psychological harm	Caroline Landon	Hamer, Fiona Smith, Charles			19/12/2024	16	Medicine	Specialty Medicine CBU	Neurology	Trust-wide	As a result of the retirement of 50% of the substantive workforce in Apr 2025 and a challenging national recruitment environment; there is a risk that the trust's Neurology service will cease to function sustainably. This would lead to a risk of harm to patients via delayed outpatient appointments, delayed inpatient reviews and an inability of the service to meet it's demands. Prior to the impending retirement, the Neurology service is already in a situation whereby substantive capacity does not meet recurrent demands on the service At present Neurology has 5900 overdue patients on its PBWL, 44% of which (2415) are overdue by more than 1 year. At this time there is no clinical capacity (for all the reasons highlighted in this report) for any clinical validation of this backlog and no available administrative resource for a data cleanse. It may be some of		Agency workforce already in place to supplement establishment that is not right-sized to service demands 1x new consultant starting 01/09/25 One of retiring consultants has agreed to do x2 monthly weekend clinics for 6mo to support Botox FUs who have no alternative treatment provider.	-Substantive workforce against establishment -Size of PBWL -NEW backlog/Booking timeframes	03/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Action 1. Working group convened to discuss plans for service as current model not appropriate. Have met twice as of 19/12. Action 2. Discussions to take place with contracting team/ICB re: discussion of service model for Lincolnshire. Action 3. Meetings taken place with NUH to discuss interim measures for balancing workload/pt cohorts. Action 4-Multiple papers drafted for GLT updating on situation. Most recent has requested permission for insourcing.	8	19/12/2025		13/04/2026
5711	915	Finances	Daren Fradgley	Rich-Mahadkar, Sameedha	Rich-Mahadkar, Sameedha		03/10/2025	20	Corporate	Integration and Improvement		Trust-wide	As a result of the ICB's reorganisation into a three county cluster, with fewer senior leaders covering a bigger area there is a risk for the Group that a loss of corporate memory and diluted focus disrupts our ability to deliver our strategy. This could lead to failed delivery of our 25/26 operational plan and loss of progress or regression in our strategic partnerships		The current position is monitored and mitigated through the following strategic and leadership engagement forums: -BLET -LLG -System exec to exec -ICB Board (include partner chief execs -Group Board - weekly chief executive meetings - target operated model board (TOM) - Executive one to one's Given the pace of change and the current vagueness of the ICB cluster operating model it is difficult to quantify the future controls possible until the cluster executive team is in place. It is anticipated the announcement will be made during October on these roles and then formalised next steps planning can take place.	1)The system boards including the ICB Board, the Group Board and the formal joint committees at a system level. 2)Measuring progress and impact at exec to exec monthly meetings.	04/03/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Action 1. Map critical relationships and dependencies to ensure they are actively maintained and not lost during leadership changes. Lead: Director of Strategy, Improvement & Redesign Completion date: 3 months Action 2. Ensure new cluster executives are quickly brought up to speed with local context, priorities, and strategic goals. Lead:Chief Integration Officer Completion date: 3 months Action 3. Enhance joint system governance reporting through improved visibility and alignment across forums such as BLET, LLG, TOM, and the Group Board. Lead: Chief Integration Officer Completion date: 3 months Action 4. Oversee continuity and coordination during the reorganisation period to maintain strategic momentum Lead: Chief Integration Officer Completion date:3 months	12	31/03/2026		04/04/2026

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4778	94	Physical or psychological harm	Caroline Landon	Hamer, Fiona	Marsh, David	Patient Safety Group	16/01/2022	15	Medicine	Cardiovascular CBU	Stroke		As a result of a lack of timely access to community rehabilitation services for stroke patients, there is a risk that best practice standards for stroke care are not met. This would lead to extended lengths of stay beyond the 10-working-day target, delays in rehabilitation, potential patient harm, service inefficiencies, and staff burnout. Additionally, this negatively impacts staff morale and performance as they feel unable to deliver the expected standard of care.		LCHS provides Lincolnshire Community Stroke Services with a broadened access criteria post 100 day challenge. This is offering some increased access to stroke rehab in the community. One year seconded band 6 OT is currently covering Lincoln Stroke Unit 2 days. Her remit is to identify and facilitate timely discharge from acute to community. This service has KPI's to measure this. -Teams Groups with LCH to facilitate handover. -Joint email to narrow where referrals are directed and sent. -Reviewing prioritise lists everyday to decide appropriate pathways for patients. This is carried out every morning at 08:30. -Joint assessment with OT and PT to increase effectiveness and reduce time to decide which pathway is best for the patient. -Pathways currently in place are HomeFirst, ABI referral pathway --Working with CHC to create meeting of discussion for patients to trust each other within our	SNNAP data scores . Service provision not in top quartile	12/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Stroke pathway development project on place. Close partnership working within community to expedite discharges into the community	6	31/03/2025	28/02/2023	12/05/2026
5598	853	Physical or psychological harm	Caroline Landon	Marsh, David	Constantin, Dr Carmen		19/02/2025	20	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	As a result of the consolidation of stroke services and acute service demands there has been occasions when patients requiring admission to the hyperacute stroke unit [HASU] have not had access due to capacity issues. The HASU is often full and patients are stepped down when stable enough to enable new admissions. There have been occasions when no patient is suitable to step down therefore acute patients have been admitted to the ward area resulting in non-hyperacute monitoring due to differing staff levels and skill-mix/competences. This has been identified as a risk to patients as deterioration may be missed resulting in death or further disability.		•When HASU overspill happens, acute patients are cohorted in a bay area within the stroke unit, additional staffing is requested for increased patient acuity and monitoring requirements, staff with the most appropriate skills will be allocated to the additional acute cohorted patients. •Medical staffing is reviewing and supporting to attempt the new admissions. •Consultant on-call and/or ACP to ensure patients most at risk of deterioration/needing HASU treatments are allocated to HASU, and less acute/at risk patients will be allocated to the 2nd Bay for cohorted acute admissions unable to be cared for in HASU. •If additional nursing staff cannot be allocated this will reduce the ability to mitigate risk.	Patient incidents Datix Staff reports/concerns voiced	21/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Improve capacity Increase HASU capacity – ASR plans to increase 5 HASU beds to 7 – plan to be completed 2026 Action 2. Risk reduction Ward co-ordinator/ward manager to liaise with site manager and CBU [lead nurse] to help support with additional staffing in line with acute patient acuity. Increase staffing levels to ensure appropriate monitoring/treatments for acute patients admitted to the ward but not into HASU, attempting to assign those individuals with the most appropriate skills. Ensure middle grade doctor support if staffing capacity allows. Extra staffing to be sort for upcoming shifts/up-lift nursing numbers whilst 2nd acute bay open – ward manager/ward co-ordinator to contact staff members Action 3. Risk reduction On-call Consultant and/or Stroke ACP to risk stratify patients liaising with ward co-ordinator/ward manager to ensure those most at risk of deterioration are moved	8	31/03/2026		21/04/2026

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Handler	Reportable to	Opened	Rating (initial)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Additional/ Supportive Information	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	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5710	916	Finances	Daren Fradgley	Fradgley, Daren	Fradgley, Daren		01/10/2025	20	Corporate	Integration and Improvement		Trust-wide	As a result of the size and complexity of our transformation programme there is a risk that we cant mitigate against unplanned delays or complexities which will result in a potential impact on multiple transformation programmes.		1)Internal resources are coordinated by the Strategy, improvement and redesign Directorate and overseen by the productivity improvement and transformation oversight forum, which reports into and Finance and Performance and the Integration Committee. 2)Each transformation programme has a senior responsible officer who is accountable to the governance in item 1. 3)External resources are coordinated by executive sponsors (SRO) and report into the governance in item 1. 4)None transformation cost improvements or quality improvement programmes are monitored through the same governance in item 1, however if they relate specifically to care group actions they fall under the oversight of the performance review meetings.	1)Each programme and associated projects have a delivery plan and benefits map. 2)The larger scale programmes have defined key performance indicators which relate to the expected progress and are monitored monthly. 3)Smaller change programmes including those that have cost improvement benefits are monitored through the performance review meetings.	28/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Review and strengthen governance structures to ensure consistent oversight and escalation Lead:Chief Integration Officer Completion date: 3 months (Dec 2025) Action 2. Standardise programme reporting templates to improve consistency and clarity Lead: Director of Strategy, Improvement & Redesign Completion date: 3 months (Dec 25) Action 3. Align outputs from performance review meetings with strategic governance processes Lead: Chief Integration Officer Completion date: 3 months (Dec 25) Action 4. Conduct bi-annual data quality audits on delivery plans and KPIs Lead:Chief Integration Officer Completion date: 3 months (Dec 25)	8	31/03/2026		28/04/2026
5169	60	Physical or psychological harm	Caroline Landon	Marsh, David	Constantin, Dr Carmen		09/05/2023	15	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	As a result of consolidating the acute stroke services at one site without appropriate stroke therapy staffing & bed base, many stroke inpatients reside outside the stroke unit as outliers and do not receiving the adequate level of therapy input in line with guidelines and patient-centred care, the effect is increased risk of mortality and long term disability, as well as low staff morale and poor staff retention. There is a risk of an increase of delays to patient care, causing harm and reduced functional outcomes/recovery for stroke patients. Current mitigations mean patients on the Stroke Unit may also receive less therapy input in an attempt to deliver some input to outliers.		Stroke Therapy Team review all outliers at the cost of not seeing the Stroke ward patients as much. Stroke team will advise general ward based therapy team. Minimal basic Stroke assessment and treatment skills for general ward therapy staff. Proposal to implement Trusted Assessor Stroke Assessment. Cohort some outlier A Consultant AHP has been recruited to provide leadership and stroke pathway oversight needed across the group	SSNAP data Datix Complaints Staff retention & post vacancy	12/02/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1) Recruit stroke therapists [PT/OT/SALT/Dietician] consistent with current service demands in line with guidelines - Ruth Taylor - December 2025 2) 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 - June 2027-due to building work. 3) Refurbishment and workforce development – business case to be submitted - Rebecca Johnson - March 2026	3	13/05/2024		12/05/2026

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Handler	Reportable to	Opened	Rating (initial)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Additional/ Supportive Information	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	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5535	784	Physical or psychological harm	Caroline Landon	Hamer, Fiona	Constantin, Dr Carmen		07/11/2024	15	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	As a result of the lack of access to clinical psychology services for acute stroke patients, there is a risk that psychological care is not provided in line with the National Clinical Guideline for Stroke 2023. This would lead to patients being unable to fully engage with therapy, resulting in longer rehabilitation periods and increased lengths of stay. Additionally, staff may be adversely affected by challenging behaviours from patients due to cognitive impairment.	National Clinical Guideline for Stroke 2023 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.	There is currently no commissioned post for this service within the acute service there is limited provision in the community.	SSNAP data & Datix	12/02/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Commission post and recruit to post, currently lies with CBU Proposal for additional ward space	6	07/11/2025		12/05/2026
Strategic Objective								**3c. Enhance our digital, research and innovation capability**																		
4641	18	Service disruption	Daren Fradgley	Fradgley, Daren	Gay, Nigel	Emergency Planning Group	23/11/2021	16	Corporate	Integration and Improvement	Digital Services (ICT)	Trust-wide	If the Trust's digital infrastructure or systems experience an unplanned outage then the availability of essential information for multiple clinical and corporate services may be disrupted for a prolonged period of time, resulting in a significant impact on patient care, productivity and costs		National policy: - NHS Digital Data Security Protection Toolkit (DSPT) and Guidance ULHT policy: - Telecoms infrastructure maintenance arrangements - ICT hardware & software upgrade programme - Corporate and local business continuity plans for loss of access to ICT systems & system recovery ULHT governance: - Digital Hospital Group / Information Governance Group (IGG), accountable to the Finance, Performance & Estates Committee (FPEC) - 5 year capital plan -	- Network performance monitoring - Digital Services reported issues / incidents - Monitoring delivery of digital capital programme - Horizon scanning across the global digital market / supply chain to identify availability issues	14/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Prioritisation of available capital and revenue resources to essential projects through the business case approval process. - Working with suppliers and application vendors to understand upgrade and support roadmaps. - Assurance mechanisms in place with key suppliers for business continuity purposes - Comprehensive risk assessments to be completed for local service / site specific vulnerabilities so that appropriate action can be taken to manage those risks. - Contingency plans - data centres protected from overheating, fire and flood / water damage risks: Portable air con units kept on site for when needed. Estates work has addressed some leakage issues at Pilgrim. Fire retardant systems in all data centre rooms, routinely serviced by Estates.	4	31/03/2023	31/03/2023	14/04/2026

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Handler	Reportable to	Opened	Rating (initial)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Additional/ Supportive Information	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	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5245	19	Service disruption	Daren Fradgley	Fradgley, Daren	Humber, Michael		30/08/2023	20	Corporate	Integration and Improvement	Digital Services (ICT)	Trust-wide	The Trusts disaster recovery capabilities are limited. In the event of a major incident affecting the primary data centre/site the ability to restore services elsewhere is limited. This would affect the availability and data integrity of tier 1 clinical and corporate systems, leading to extended unavailability and reliance on Business Continuity Plans. In addition there is a risk of significant data loss in the event that recent backups are unavailable or compromised.		-Business Continuity Plans which the Trust is planning to exercise of a regular basis via Emergency Response. -Annual SIRO approved incident response exercise. -Protections that reduce the likelihood of various disasters, including environmental and technical controls: A number of improvements have been made in this area. We now have a dedicated ""stretched"" Metro cluster between Lincoln and Boston. We also have Standard clusters at each site which have increased capacity. -Immutable Backup system introduced to ensure organisational data is held securely and available for recovery, this includes off site cloud storage for critical data	-Annual SIRO approved incident response exercise. -Incidents reported via Datix these are backed up via an RCA and lessons learned.	14/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Whilst some systems still need to transition fully with VLAN/IP changes we do have new systems and system upgrades migrating to the new solution. Enabling Tech programme in place to improve the Trust Foundations from which the Digital Services will run. This requires completion prior to remobilisation of EPR. Trajectory for this is 2025/26.	10	30/08/2024		14/04/2026
5648	870	Physical or psychological harm	Daren Fradgley	Fradgley, Daren	Humber, Michael		25/04/2025	20	Corporate	Integration and Improvement		Trust-wide	The Trust is currently carrying a significant number of risks associated with the reliance on paper-based health records (covered by Datix risk ID 4731) and legacy stand-alone digital systems. There is currently an inability to deliver the required level of patient safety that is enabled by technology and innovation, via more robust and consistent clinician decision making and access to the right information in the right place at the right time. Without an integrated Electronic Patient Record (EPR) and Electronic Document Management System (EDMS) the Trust risks not achieving the key benefits outlined in the EPR Full Business Case (FBC). There is clear evidence in the FBC that an EPR can deliver significant benefits to an organisation which may be unrealistic to deliver with (paper-based systems and) stand-alone digital health systems. These include:		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.	22/01/2026	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.	8	25/04/2026		22/04/2026

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Handler	Reportable to	Opened	Rating (initial)	Division	Clinical Business Unit	Specialty	Hospital	What is the risk?	Additional/ Supportive Information	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	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5519	739	Regulatory compliance	Daren Fradgley	Fradgley, Daren	Evans, Thomas		08/10/2024	16	Corporate	Integration and Improvement	Digital Services (ICT)	Trust-wide	As a result of the lack of an established Digital Clinical Risk Management system (Health IT system), processes and resource resulting in non-compliance with the Digital Clinical Safety Standards DCB0129 and DCB0160 (the Standards mandated by NHSE to ensure the safe manufacture, development, deployment, and use of Health IT Systems) this could lead to patient safety incidents involving digital systems, resulting in or contributing to patient harm or death. An informal 'best endeavours' approach has previously been taken and digital clinical systems have been deployed that have not fully met the Standards. The Standards also mandate an approach to Clinical Risk Management which continues for the entire lifecycle of the Health IT system, not just prior to initial deployment. Under the standards, the CRMS must have proactive and		•Previously no defined lead for digital clinical safety established in the Trust. The CNIO has voluntarily taken the lead on Digital Clinical Safety (Trained CSO) within their substantive role, although clinical safety responsibility not outlined in job description / role and responsibilities. However, no resource for non-project/non funded DCSO work = risk •Digital Clinical Safety Officer (DCSO) post recruited into May 2024, as part of EPR programme (not revenue funded = risk). 1 further DCSO post has been included in the resource model for EPR implementation (>2025 funding) however, given the large volume of current in-flight Health IT System projects and legacy systems outside of EPR, this is not an adequate resource. •Digital Clinical Safety Policy now in the organisation (approved at DHG and Corp Gov – awaiting publication on the intranet) •Draft Clinical Risk Management System developed by new DCSO and awaiting Clinical Governance review before formal approval at DHG •Further development of required structures and governance standards to meet/comply with National standards and strengthen our position underway. •Digital Clinical Safety processes / awareness will require significant 'socialisation' to ensure they are effectively embedded. This will include clinical safety	•Number of digital systems without full compliance with the Standards i.e Clinical Risk Management File, Clinical Risk Management Plan, Clinical Safety Case Report, Hazard Logs etc. •Lack of digital clinical safety resource and no policy or standard within the Trust prior to recently created and published policy. •Known new and upcoming digital projects are tracked, and activities aligned to new policy and the National standards. •Previous deployments will require review and a post deployment safety assessment and remain subject to further clinical safety activities under the National standards and guidance	02/02/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Develop and strengthen Digital Clinical Safety Function - will require funding for permanent staff including administrative resource to administer / manage the CRMS. Action 2. Continue to work towards meeting the National standards, all new projects will have the Digital Clinical Safety Standards applied. Action 3. Further development of the new CRMS, embedding of associated processes and improved digital clinical safety literacy among digital, clinical, and operational teams. Action 4. Review of previous projects and live systems, deployed under previous arrangements to ensure a clinical safety review is applied under the new standards. Action 5. Ensure effective application of Digital Clinical Risk Management activities through regular audits	12	08/10/2025		02/05/2026

Appendix C

Risk Appetite Statement 2025/26

Introduction:

LCHG recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, LCHG will not accept risks that materially impact on patient safety. However, LCHG has an appetite to take considered risks in terms of their impact on the Group and its reputation. LCHG has the utmost appetite for innovation that will challenge current working practices where positive improvements can be anticipated, acknowledging the limits within regulation. The Group has adapted definitions for Risk Appetite and Risk Tolerance for the 'Orange Book – Risk Appetite guidance note August 2021.

Definitions:

'Risk appetite' is the level of risk within which LCHG aims to operate, informed by the Group's strategic objectives while ensuring we provide safe and effective patient outcomes.

'Risk Tolerance' is the level of risk within which LCHG is willing to operate, given current constraints.

Risk Appetite and Tolerance Levels:

Table 1 shows the risk appetite levels agreed by the Group Board, with the associated upper risk tolerance levels.

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

Table 2 details each strategic objective, along with associated risk appetite level and risk appetite statement. The upper tolerance level shown represents the maximum risk tolerance for each objective and provides guidance for risk owners to use in managing their risks.

Strategic Objective	Risk Appetite Level	Risk Statement	Upper Tolerance Level
1a (i) Patient Safety	**Cautious**	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny.	**10**
1a (ii) Patient Experience	**Open**	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients	**12**

		resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny.	
1a (iii) Clinically Effective Care	**Open**	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny.	**12**
1b	**Open / Cautious**	If we do not improve the efficiency and effectiveness of our services then we will not improve **access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes, and increased risk of clinical harm.	**10-12**
1c	**Open**	If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not return to **financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients	**12**
1d	**Open**	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny.	**12**
2a	**Open**	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable, less efficient services and the inability to attract and retain staff.	**12**
2b	**Hungry**	If we do not **empower our people to continuously improve and innovate**, they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience.	**15-16**
2c	**Open**	If we do not nurture **compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement.	**12**
2d	**Hungry**	If we do not continue to **recognise people through thanks and celebration**, then we will be unable to attract staff of the required calibre and experience resulting in services becoming unsustainable / fragile.	**15-16**

3a	**Open**	If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience.	**12**
3b	**Hungry**	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners, then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes.	**15-16**
3c	**Hungry**	If we do not enhance our **digital, research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale.	**15-16**
3d	**Open**	If we do not drive forward our Green Plan, we will be unable to effectively transform key clinical pathways and reduce our **carbon footprint** resulting in services becoming unsustainable.	**12**

Risk Appetite Management:

Below Appetite - Risks which have a residual risk score below an agreed risk tolerance are deemed to be being actively managed. If the risk remains within tolerance for six months, the risk should be subject to review and if satisfied that the scoring reflects the control environment and assurances remain positive then the risk should be considered for closure, via the normal governance processes, giving a clear rationale in the closing comment box.

Exceeding Appetite - Where a risk exceeds the Group's agreed risk tolerance, an action plan should be developed that mitigates the residual risk down to the agreed tolerance level. Until the residual risk score meets the agreed risk tolerance it requires ongoing monitoring and reporting. Where a risk exceeds its risk tolerance and has done so for more than six months a deep dive review of the risk and its control environment should be undertaken to ensure that all appropriate mitigation actions have been put in place. Deep dives should be undertaken every six months until such times as the risk reduces to the agreed risk tolerance. All risks that exceed risk tolerance should be reported and discussed with line management with onward reporting to the relevant Committee's of the Group Board as per the Risk Management Policy.

NHS
Lincolnshire Community and Hospitals NHS Group

Group Board Assurance Framework (BAF)

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*5 May 2026*
Agenda item number	
Report title	*Group Board Assurance Framework*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Assurance* • *Approval*
Accountable Director	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial assurance*
Prior approval process, if applicable	*Considered through Board Committees*
Financial implications, if applicable	*N/A*
Action / decision required	*The board is asked to:* • *approve the proposed changes to assurance ratings for objectives 3a, 3b and 3d, moving from amber to green* • *approve the proposed change to the risk rating for objective 3a from 12 to 6* • *note the year end position of 2025/26 framework* • *note the substantial assurance provided through the Internal Audit review* • *approve the proposed changes to the Strategic Objectives and Strategic Risks for the 2026/27 year*

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.

Each of the board committees 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.

Summary of the Report

This report provides the BAF for the 2025/26 year.

The BAF has been reviewed by all Committees, including the Audit Committee during March and April and narrative updates provided. All assurance Committees have now undertaken development sessions in respect of the BAF, and feedback now requires capturing within the document from the People and Finance and Performance Committee workshops.

During April 2026, the Integration Committee reviewed the BAF and has recommended to the Board changes to the assurance ratings for 3a, 3b and 3d from amber to green and for the risk rating for objective 3a to decrease from a score of 12 to 6.

In April 2026 the Internal Auditors provided the final report in respect of the BAF and Risk Management audit that had been undertaken during the year, offering substantial assurance to both LCHS and ULTH in respect of these areas. The findings noted that there were no significant weaknesses noted during the course of the review with no management actions identified.

2026/27 Board Assurance Framework

In March 2026 a Board Development Session was held to discuss the BAF one year on and to further develop the format of this with the inclusion of the 'heat map'. As part of the work of the Board consideration was given to the Strategic Aims, Objectives and Strategic Risks with development of the BAF to support the revised detail the objectives and risks as identified by the Board.

The revised objectives and risks are appended to the report for Board approval. Agreement of the refreshed objectives will allow the next step of development work on the framework to be completed ahead of submission into the May round of Committee meetings.

Group Board Action Required

The Group Board is asked to:

- note progress with the development of the new group BAF;
- approve the proposed changes to assurance ratings for objectives 3a, 3b and 3d, moving from amber to green
- approve the proposed change to the risk rating for objective 3a from 12 to 6
- note the substantial assurance provided through the Internal Audit report
- approve the proposed changes to the Strategic Objectives and Strategic Risks for the 2026/27 year

Lincolnshire Community & Hospitals NHS Group (LCHG)

Group Board Assurance Framework (BAF)

As at March 2026

The LCHG BAF

Background & Introduction

An effective BAF should guide the agenda setting for a board and its committees and, in turn, should be used as the framework for the committees to report assurance and / or escalate gaps in assurance to the board in respect of delivery of the group's strategic aims & objectives.

In order to reflect the move to group and to provide a more high-level and concise view of the risks to the achievement of the group's strategic aims & objectives, the LCHG Group Board has agreed to the introduction of a revised BAF format. This report provides the first iteration. Work to further refine the new style BAF and embed its use within the board and committee cycle will continue over the coming months. Each of the board committees, in turn, will continue to review, challenge and seek assurance in respect of the areas of the BAF for which they have oversight.

Scoring the BAF

Risk Scores

The scoring methodology for BAF risks reflect the group's existing risk scoring matrix (as shown in Table 1 below) calculating the impact / severity of the identified risk should it occur by the likelihood of the risk occurring.

Table 1:

	Impact / Severity score & descriptor (with examples)				
Risk type	**1 Minimal**	**2 Noticeable**	**3 Moderate**	**4 Severe**	**5 Extreme**
Physical or psychological harm	**Low level of temporary harm (no clinical attention required) affecting individual patients, staff or visitors**	**Relatively low level of harm (requiring first aid or psychological support) affecting multiple patients, staff or visitors**	**Significant, temporary harm (requiring clinical treatment but expected to make a full recovery) affecting one or more patients, staff or visitors**	**Significant long-term or permanent harm affecting individual patients, staff or visitors**	**Significant long-term or permanent harm affecting multiple patients, staff or visitors**
Reputation	**Small number of individual concerns raised**	**Small number of individual complaints raised**	**Multiple complaints received; negative local media / social media attention**	**Direct intervention from a regulator; serious complaint from one or more partner organisation; sustained negative national media / social media attention**	**Fundamental loss of confidence amongst the public, partner organisations and regulators**
Service disruption	**Manageable, temporary disruption to peripheral aspects of service provision affecting one or more service**	**Manageable, prolonged disruption to essential aspects of service provision reducing the efficiency & effectiveness of one or more service**	**Temporary, unplanned service closure affecting one or more service or significant disruption to efficiency & effectiveness across multiple services**	**Extended, unplanned service closure affecting one or more service; prolonged disruption to services across multiple services**	**Indefinite, unplanned general hospital or site closure**
Regulatory compliance	**Technical non-compliance with reasonable justification; no regulator attention**	**Recommendations for improvement for one or more service**	**Improvement / warning notice for one or more service; recommendation for independent review; legal action for regulatory / contract breach**	**Special measures; prohibition notice for one or more service; prosecution**	**Suspension of CQC registration; Parliamentary intervention**
Finances	**Some adverse financial impact (unplanned cost / reduced income / loss) but not sufficient to affect the ability of the service / department to operate within its annual budget**	**Noticeable adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more services / departments to operate within their annual budget**	**Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more business units to operate within their annual budget**	**Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of the organisation to achieve its annual financial control total**	**Significant aggregated financial impact (unplanned cost / reduced income / loss) affecting the long-term financial sustainability of the organisation**

Likelihood score & descriptor (with examples)				
1 Extremely Unlikely	2 Quite Unlikely	3 Reasonably Likely	4 Quite Likely	5 Extremely Likely
Unlikely to happen except in rare circumstances Less than 10% chance	Unlikely to happen except in specific circumstances Between 10-30% chance	Likely to happen in a significant number of circumstances Between 31-70% chance	Likely to happen in the majority of circumstances Between 71-90% chance	Almost certain to happen Greater than 90% chance

Risk Scoring Matrix						
Impact / Severity	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	2	3	4	5
		Likelihood				

Risk Rating	Very Low (1 – 3)	Low (4 – 6)	Moderate (8 – 12)	High (15 – 16)	Very High (20 – 25)

Risk Appetite

How much risk is the Trust prepared to accept for each level of appetite?

Table 2 below provides the group's risk appetite statement and tolerance levels.

Hungry	• This would mean we are willing to take risks such as being innovative or using new technologies	15/16
Open	• Open is when we are willing to consider all potential options and recognises that there will be risk exposure	12
Cautious	• Preference of cautious is to always be safe but we accept there may be some risk exposure	10
Minimal	• Minimal is when we will accept the safest options only	8
Averse	• We will avoid all risk exposure and cease activity	6

Assurance Rating

For each strategic risk, the BAF identifies a number of controls (the actions that are already being taken to manage the risk) and outlines the sources of assurance against these (how it can be determined that the controls are working) and any gaps. For each strategic risk an overall assurance rating is provided using the assurance level definitions set out in Table 3 below. This is intended to assist the LCHG Group Board to assess the level of confidence it can have that appropriate controls are in place and that they are working effectively, that any material gaps in control have been identified and that clear actions, leads and timescales have been agreed to address them.

Table 3:

Assurance Rating Key	
Strength	**Description**
Red	**Effective controls are not in place or are insufficient to manage the risk and / or appropriate assurances are not available to the board**
Amber	**Effective controls are mostly in place and actions have been agreed to implement the remaining controls and / or assurances are uncertain or possibly insufficient**
Green	**Effective controls are definitely in place and the board is satisfied that appropriate assurances are in place**

Action Plan Progress: RAG Rating

Progress with delivery of actions to address gaps in controls and / or assurances will be rated in accordance with the matrix shown in Table 4 below.

Table 4:

Action Plan Progress RAG Rating	
Blue	**Completed & embedded and added to controls or assurances**
Green	**Completed & ongoing and / or not yet fully embedded**
Amber	**In progress & on track**
Red	**Not yet completed / significantly behind agreed timescales**

Group BAF Overview: Strategic Risks

Strategic Aim	Strategic Objective	Strategic Risk
Patients: Better Care – Timely, affordable, high quality care in the right place	1a: Improve patient safety, patient experience and deliver clinically effective care	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny
	1b: Reduce waiting times for our patients	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm
	1c: Improve productivity and deliver financial sustainability	If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients
	1d: Provide modern, clean and fit for purpose care settings	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny
People: Better Opportunities – Develop, empower and retain great people	2a: Enable our people to fulfil their potential through training, development and education	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable, less efficient services and the inability to attract and retain staff
	2b: Empower our people to continuously improve and innovate	If we do not **empower our people to continuously improve and innovate** they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience
	2c: Nurture compassionate and diverse leadership	If we do not **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement
	2d: Recognising our people through thanks and celebration	If we do not continue to **recognise our people through thanks and celebration** then we will be unable to attract and retain staff of the required caliber and experience resulting in services becoming unsustainable / fragile
Population: Better Health – Improve population health	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience
	3b: Move from prescription to prevention, through a population health management & health inequalities approach	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes
	3c: Enhance our digital, research and innovation capability	If we do not **enhance our digital, research and innovation** capability then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale
	3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable

Group BAF: Position Overview as at March 2026

Strategic Aim	Strategic Objective	Strategic Risk	Executive Lead(s)	Board Committee Oversight	Current Risk Score (as at March 2026)	Target Risk Score (March 2026)	Assurance Rating (as at March 2026)	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~~ 8 (Moderate)**	**8 (Moderate)**	**~~Amber~~Green**	**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 /	Group Director of Estates & Facilities	Finance & Performance Committee	**16 (High)**	**16 (High)**	**Amber**	**Amber**

		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 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~~6 (~~Moderate~~Low)**	**8 (Moderate)**	**Green ~~Amber~~**	**Green**
	3b: Move from prescription to prevention, through a population health management & health	If we do not change to a more innovative approach to tackling health inequalities in collaboration	Group Chief Integration Officer	Integration Committee	**~~9~~6 (~~Moderate~~Low)**	**8 (Moderate)**	**Green ~~Amber~~**	**Green**

	inequalities approach	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	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~~6 (~~Moderate~~Low)**	**8 (Moderate)**	**Amber**	**Green**

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (i): **Improve patient safety**, patient experience and deliver clinically effective care
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

8 (Moderate)

Last Review Date:	March 2026
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	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	Amber	Amber	Amber

Identified Controls *(What are we already doing to manage the risk?)*	
1	Quality & safety priorities and KPIs agreed but continually under review as new areas of concern are identified
2	Safety culture approach established with an action plan agreed which is being rolled out.
3	Patient Safety Partners appointed and human factors guidance & training in place.
4	Clinical Governance teams & structures in place and refined to reflect the move to group
5	Strong PSIRF process in place & learning from incidents processes well embedded.
6	Strong focus on maternity & neonatal safety reported through MNOG
7	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
8	Ward / service accreditation process in place
9	IPC team and governance framework in place across the group
10	Safeguarding team and governance framework in place across the group
11	Robust Patient Safety Alert System with oversight and reporting in place
12	Triangulation of learning
13	Governance structure under Quality Committee is in place and operating
14	Robust Care Group Governance arrangements
15	Datix system and process
16	Robust oversight and escalation processes for policies, procedures and guideline development

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	~~No gap~~
4	~~Ongoing vacancies due to current vacancy process in place.~~
5	
6	
7	
8	Ward / service accreditation programme not fully embedded in community and reporting – see actions below – if there now is one then surely this is no longer a gap
9	NHSE and other external reviews of the group's IPC arrangements have identified gaps
10	Low uptake of mandatory safeguarding training by operational teams
11	~~None identified~~
12	Learning approach ~~not fully~~ developed and is being rolled out across ~~embedded across~~ the Group.
13	Work continues with Groups reporting to Quality Committee sub groups to strengthen upward reporting~~Groups beneath Committee not fully functioning~~
14	~~Gaps present during restructure~~
15	~~Currently running 2 Datix systems across the Group~~
16	Overdue policy and guideline position requires strengthening.

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
2	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. 08/01/26 – Safety Culture process established, and pilot area identified to be reviewed in Jan 26. Plan to have full roll out by Q4 25/26.
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.
16	Aligned policy agreed on the development of policies, procedures & guidelines. Improvement trajectories to be agreed as a priority for bringing all out of date documents into compliance. Performance to be monitored through monthly PRMs with escalation to ELT / GLT as required	Group Director of Corporate Affairs	Deputy Trust Secretary	30 September 2025 (Agreement of Improvement Trajectory) 31 March 2026 (Improvement Performance)	Underway – paper being submitted to ELT on Thursday, 31 July 2025. Performance also being monitored from an assurance perspective through the Audit Committee
4	Weekly pressure ulcer assurance meetings being held with the community nursing teams with safeguarding support. Improvement Trajectory agreed	Group Chief Nurse	Deputy Chief Nurse	31 December 2025	Underway Monthly pressure ulcer assurance meetings continue outcome themes reported to SIG. Oversight also through QA dashboards. Review of data/reporting processes in progress through task and finish group. Improvement plan has been reviewed and updated. ~~in progress.~~ In addition, ongoing work to restructure pressure ulcer governance and develop data dashboard.
5	Full review of pharmacy and medicines management to be undertaken across the group / system (key priority for incoming Chief Pharmacist)	Group Chief Medical Officer	Chief Pharmacist	30 September 2025	Underway
6	Ward / service accreditation programme to be fully established in community	Group Chief Nurse	Deputy Chief Nurse	31 March 2026	Underway Programme established for community hospitals and community nursing with monthly quality dashboards in place Unannounced peer review visit programme commenced. Work is underway to continue to expand and rollout to additional services during Q4/1. A number of community hospital wards will be in a position to commence preparation for Diamond Award application during Q1/2. UTCs have started to pilot a quality assurance tool.

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	NHSE Action Plan updated and due to over trajectory C. difficile position enhanced IPC interventions and KPIs approved at March IPG
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
13	Implement Clinical Governance restructure	Group Chief Clinical Governance Officer	Deputy Chief Clinical Governance Officer		Closed – consultation closed, and structure implemented.

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of quality & safety agenda and key risks by the Quality Committee and reporting sub-groups (e.g. Patient Safety Group, Maternity & Neonatal Oversight Group, Safeguarding & Vulnerabilities Group), with escalation to the Group Board as required
2	Reporting on quality & safety KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	QIAs reviewed by care groups and executives with Quality Committee oversight
4	Learning from incidents reported to the Patient Safety Group and disseminated across the group
5	Incident themes & trends monitored through the Patient Safety Group
6	Delivery of quality & safety KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
7	Local level and Group Board Maternity & Neonatal Safety Champions in place with reporting to the Group Board
8	Internal & external audit, external reviews and visits provide independent assurance of the robustness of the group's quality governance arrangements
9	Internal audit review of ULTH's management of medical devices undertaken during 2024 / 25 has provided 'reasonable assurance'. Medical Devices Group in place reporting to Patient Safety Group
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 *(What are we going to do, by when, to ensure the required assurances are in place?)*		**Executive Lead**	**Operational Lead**	**Due Date**	**Progress**
12	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. 08/01/26 – Completed PSII learning summaries now being shared through PSG and Quality Committee – appointed into the Band 8a Clinical Governance and learning lead post. Update 13/04/26 - New post within the Clinical Governance Directorate is supporting take a lead role on learning. Learning framework agreed via ELT, to go to GLT during May 2026 and through to committee with roll out planned during Q1 26-27.
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 08/01/26 – Training commenced led by the PMO team. Robust reporting into the Quality Committee including pre and post risk mitigation scoring and actions taken.
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	Underway Update 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	849~~403~~	20	Risk of school aged children not receiving timely SLT~~Children's SLT treatment delays~~

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (ii): **Improve** patient safety, **patient experience** and deliver clinically effective care
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

9 (Moderate)

Last Review Date:	March 2026
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	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	Amber	Amber	Amber

Identified Controls *(What are we already doing to manage the risk?)*	
1	Quality & safety and patient experience priorities and KPIs agreed
2	Patient Experience & Involvement Team in place to deliver controls
3	Established complaints & PALS teams to deliver controls
4	Group Complaints & PALS Policy agreed to embed learning
5	Improvement Plans developed in response to national patient experience surveys
6	PLACE reviews completed and improvement plans developed
7	Systems for reporting for patient experience and volunteer statistics
8	Ward / service accreditation process in place

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Review and Refresh KPI
2	• Group approach to Patient Panels agreed and being implemented • Current vacancies/Longterm sickness in patient experience and Voluntary Services • No routine reporting of patient experience at service level or divisionally
3	Lack of data comparison report between Complaints/PALS and Patient Feedback
4	Lack of feedback mechanism from learning
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
7	Lack of capturing of diversity information from patient feedback and volunteer service
8	Ward / service accreditation programme not fully embedded in community and reporting

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and refresh KPI	Group Chief Nurse	Head of Patient Experience	31 August 2026	
2	Group approach to Patient Panels to be implemented from April 2025 routine reporting of Pals, complaints and compliments at group and at service level	Group Chief Nurse	Head of Patient Experience	1 April 2025	Completed
3 / 4	Develop a report that allows comparison of data between Complaints/PALS and Patient Feedback allowing for learning to be identified and shared	Group Chief Nurse	Head of Patient Experience	31 July 2026	
7	Increase engagement with local groups	Group Chief Nurse	Head of Patient Experience	31 August 2026	

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of patient experience and key risks by the Quality Committee and its reporting sub-group: the Patient Experience & Involvement Group, with escalation to the Group Board as required
2	Reporting on quality & safety and patient experience KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	Patient Stories 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	None Identified~~Reporting sub-groups not yet aligned~~
2	~~IPR not yet aligned~~
3	
4	Triangulation of patient experience data with other sources of information e.g. complaints, PALS etc. requires strengthening to routinely embed data
5	
6	

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Board and board committees have been aligned and executive governance structures agreed. Some final work to complete to align the committee reporting sub-groups. **Proposed revised deadline 31 August 2025**

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:	1a (iii): Improve patient safety, patient experience and **deliver clinically effective care**
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

8 (Moderate)

Last Review Date:	March 2026
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	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	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 with escalation processes for non compliance agreed
3	NICE Policy and process in place with escalation processes for non-compliance agreed
4	Medical Examiner Service in operation
5	Mortality review process in place and learning from deaths process well established with escalation processes for non compliance agreed
6	Getting It Right First Time (GIRFT) Programs of work
7	Care Group reporting
8	Clinical Effectiveness Group reporting groups (e.g. HTA / MOG / Care Groups etc.)
9	~~System Oversight - ICB~~
10	Policies and processes in place
11	Ward / service accreditation process in place

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	~~Overdue Baseline Assessments and overdue actions.~~
4	~~Non-compliance with completion of MCCD within 5 days~~
5	~~Not achieving required compliance for SJR's completion.~~
6	Governance not in place for GIRFT programs of work
7	~~Variation of assurance and understanding of issues~~
8	~~Reporting groups into Clinical Effectiveness Group aligned however maturity of some of these groups needs further development.~~
9	~~Feedback lacking due to challenges~~
10	There are a significant number of policies across the group which are out of date
11	Ward / service accreditation programme not fully embedded in community and reporting

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
4	Medical Examiner – Additional workforce being recruited	Group Chief Clinical Governance Officer	Associate Director of Clinical Effectiveness and Complaints	31 March 2026	Recruitment underway 08/12/25 - Additional workforce now recruited – awaiting start dates. Compliance improved and currently achieving MCCD within 5 days. Update 02/02/26 proposed closure of this action as team recruited to and all reporting has reverted into BAU.
6	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
7	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. Update 04/02/26 – proposed closure of this action as reporting reviewed and new templates to be used from Q1 26/27. Update 13/04/26 – Upward report template updated and implemented – plan to trial through Q1 -action to be closed.
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.
2	Meeting with Audit Leads to review roles and responsibilities	Group Chief Clinical Governance Officer	Associate Director of Clinical Effectiveness and Complaints	31 March 2026	

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of clinical effectiveness and key risks by the Quality Committee and its reporting sub-group: the Clinical Effectiveness Group, with escalation to the Group Board as required
2	Reporting on quality & safety and clinical effectiveness KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	Learning from deaths reported to the Clinical Effectiveness Group and disseminated across the group
4	There is oversight of delivery of the clinical audit programme through the Clinical Effectiveness Group with reporting to the Quality Committee as required including areas where an outlier status is received.
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
8	System Oversight

Gaps in Assurance	
1	~~Reporting sub-groups aligned.~~
2	~~IPR not yet aligned~~
3	
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.~~
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Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
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** **Jan26: Revised performance dashboards have gone through 2 cycles for each of the Board Committees, and 1 cycle for Board itself. These have been reviewed and feedback given to Performance leads. Each dashboard contains guidance on how metric performance is escalated.** **CLOSE**

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1b (i): Reduce waiting times for our patients **(Unplanned Care)**
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm

Current Risk Score & Movement since last review:

15 (High)

Last Review Date:	March 2026
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	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	Amber	Amber	Amber

Identified Controls *(What are we already doing to manage the risk?)*	
1	Daily internal capacity meetings in place to improve discharge and flow and troubleshoot operational issues at the front door
2	Daily ICB UEC calls occur to escalate issues across the system and provide support to unblock pressure areas with the aim of reducing bed blocking and delayed discharges
3	Group Discharge Board in place with a focus on discharge & flow, SAFER principles and criterial-led discharge
4	Unplanned Care Group established to drive delivery of agreed performance & improvements
5	System Unplanned Care Partnership Board in place to have oversight of system issues and challenges and to drive delivery of agreed improvements
6	OPEL escalation triggers and actions in place
7	Winter Plan (2025)
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 *(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 to be embedded
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 *(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
4	Escalation Policy & Full Capacity Protocol to be reviewed and aligned	Group Chief Operating Officer	Group Deputy Chief Operating Officer	31 July 2025	Underway **Proposed revised deadline of 30 November 2025**
9	Requirement remains for focus on community data to ensure clarity of service delivery and meeting patient outcomes. All community performance data scrutinized through community PRM and reported through to monthly F&P committee. Next step is sharing of data from Optica	Group Chief Integration Officer	Group Deputy Integration Officer	31 October 2025	Ongoing – ~~data needs to be consistently available~~ Live push of the dashboard transfer of care supported delays through care flow with plans to merge with Optica live feed end of April 2026

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	OPEL triggers regularly used and activated
2	ED activity, flow and LoS regularly reviewed by site teams and issues escalated through the #daily capacity meetings
3	Improvement trajectories in respect of ED performance and expectations agreed for all specialties
4	Suite of metrics in place to measure improvements and focus Care Group leadership teams on discharge target
5	ED performance monitored through the Unplanned Care Group and System Unplanned Care Partnership Board
6	Delivery of ED performance and improvements reviewed through the Care Group PRMs
7	Reporting on ED performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board as required
8	Sustained improvements seen across the UEC pathway: standard currently being delivered

Gaps in Assurance	
1	Dedicated discharge programme
2	Assurance re daily drumbeat being embedded
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Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Newtons work will support improved flow across all group capacity discharge ~~– with proposed daily target for each ward and specialty~~. First 3 months of mobilisation will focus on daily operational grip and oversight of flow across the group and into	Group Chief Integration	Group deputy chief	Delayed till May 2026	Awaiting regional sign off

	the wider system Daily ED assurance meetings to discuss previous days and overnight activity and performance	Officer	integration officer		
2	Group senior supported flow team in place reporting through the unplanned care group. Oversight of all performance metrics within community PRMs and flow and TOC steering group through to ASG	Group Chief Integration Officer	Group deputy chief integration officer		Completed
2	Optica discharge tool now implemented across the acute sites. Improvement team targeted at improving utilization across all areas with all system partners now using Optica to manage their transfer of care pathways. Optica reporting will allow production of a weekly audit if all delays using national discharge codes to understand capacity constraints and explore mitigations	Group Chief Integration Officer	Group deputy chief integration officer	May 2026	Awaiting data warehouse updates
9	Committee dashboards and F&P out of hospital update paper will include key group flow metrics linked to days lost due to TOC delays across acute wards, community wards (pathway 2) and the group pathway 1 offer	Group chief integration officer	Group deputy chief integration officer	30th April	
9	Capacity redesign building on the winter mitigation schemes to be scoped for full delivery across 26/27 including use of CAS as safety net to all patients discharged on a supported pathway	Group chief Integration officer	Group deputy chief integration officer	June 2026	The transformation of Intermediate care services funded via the BCF and delivered by the group to be key workstream of Newton

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1b (ii): Reduce waiting times for our patients **(Planned Care)**
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm

Current Risk Score & Movement since last review:

15 (High)

Last Review Date:	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	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	Amber	Amber	Amber

Identified Controls *(What are we already doing to manage the risk?)*	
1	Clinic template project initiated
2	Weekly PTL / activity meetings in place
3	Weekly 6/4/2 meetings held to support theatre utilization
4	Booking 'protocol' being developed
5	Planned Care Group established to driver delivery of agreed planned care performance & improvements
6	Forecast performance in place and used to monitor delivery
7	List brokering commenced
8	Power BI dashboard and RTT audit in place for community 52 ww.

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Lack of standardised and centralised scheduling and booking
2	Inconsistent approach to validation / validation not comprehensive. Internal validation team recruited. National validation initiative commenced
3	Opportunities exist to maximise theatre productivity & utilisation - theatre timetable not refreshed
4	Gaps in job planned and delivered activity for admitted and non-admitted
5	Workforce gaps
6	Time to first appointment delivery is high risk for 2025 / 26
7	Delivery of cancer 62 day performance remains a risk
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 *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Maximise theatres & out-patient improvements (scheduling / booking / cancellations). EY commissioned to support elective producivity improvements. PWC commissioned to support scheduling / booking efficiencies	Group Chief Operating Officer	Deputy Group Chief Operating Officer	31 October 2025	Underway

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	RTT and cancer improvement trajectories agreed for all specialties
2	Theatre dashboard in place and monitored through the Planned Care Group
3	RTT & cancer performance monitored through the Planned Care Group
4	Delivery of RTT and cancer performance and improvements reviewed through the Care Group PRMs
5	Reporting on RTT and cancer performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board, as required
6	Improved performance: sustained backlog reduction
7	Internal audit review of RTT pathways within ULTH during 2025 / 26 provided 'reasonable assurance)

Gaps in Assurance	
1	IPR is not comprehensive
2	Reports to committee and ELT require improvement
3	
4	
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Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	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** 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.
4	Ongoing discussion with commissioners around commissioning support for Community Management Partnership Board	Group Chief Integration Officer	Group Deputy Chief Integration Officer	31 October 2025	Position now agreed with the new director of commissioning. Support will be provided for the first part of the neighbourhood board

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1c: Improve productivity and deliver financial sustainability
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not manage costs effectively, optimise productivity and deliver our efficiency / cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unsustainable services for patients

Current Risk Score & Movement since last review:

~~12~~8 (Moderate)

Last Review Date:	March 2026
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~~2	~~12~~8 (Moderate)	~~Amber~~, Green
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

~~Amber~~ Green

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate	Moderate	Moderate	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	Amber	Amber	Green

Identified Controls *(What are we already doing to manage the risk?)*	
1	Finance teams & structures, policies & processes in place including Standing Financial Instructions and Scheme of Delegation
2	Financial planning & budget setting processes across the group harmonised and single budget holder manual developed and implemented
3	Single operational & financial plan, planned deficit and CIP / efficiency target for the group agreed
4	Processes in place for holding Care Groups / Corporate Directors to account for budgetary control & adherence, the delivery of financial plans & activity and efficiency / cost improvements
5	Productivity, Improvement & Transformation Group in place, reporting to the Group Leadership Team, to oversee delivery of the group's financial plan (including specific deep dive sessions as required)
6	Capital, Revenue & Investment Group in place, reporting to the Group Leadership Team, to oversee the development and delivery of the group's capital, revenue and investment plan (also introduced post-investment evaluation process)
7	Pay controls in place (VCP) to support delivery of the financial and workforce plan
8	Non-pay discretionary spend controls in place to reduce spend whilst transformational plans are developed (and reviewed / amendments proposed to Audit Committee in June)

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Current financial policies are up to date but some have yet to be aligned across the group
2	Financial literacy of the organisation not fully developed
3	Finance Strategy for the group to be agreed
4	Forward assurance on efficiency delivery and activity position being developed
5	The delivery of workforce / headcount reduction, adherence to workforce controls (e.g. bank and agency spend) and activity levels are key risks.
6	Business Case development, review and approval process not yet fully harmonised - this has now been complete. Will be removed, included to show completed
7	
8	

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
5	Deliver the financial plan and maximise CIP opportunities with a focus on key high impact areas Comprehensive review on current CIPs completed in early January / Revised forecast out-turn range in progress Continue to explore and work up income generation opportunities	Group Chief Financial Officer	Care Groups / Corporate Directorates	31 March 2026	Underway

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of finance and key risks by the Finance & Performance Committee and reporting sub-groups with escalation to the Group Board as required
2	Reporting on finance KPIs to the Finance & Performance Committee and Group Board through the Integrated Performance Report (IPR)
3	Internal & external audit arrangements in place
4	Internal audit review of performance management and data quality within ULTH during 2024 / 25 provided 'reasonable assurance'
5	Assessment of 'grip and control' undertaken by external parties including through ICB and regulator challenge

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	Internal audit arrangements have been aligned across the group but work remains ongoing to develop a single report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability
4	Internal audit review of overseas and contracts within ULTH provided 'limited assurance'
5	None identified

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
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) 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**

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**
ULTH	4664	20	Exceeding the agency cap – temporary staff
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**

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1d: Provide modern, clean and fit for purpose care settings
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

16 (High)

Last Review Date:	March 2026
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-25	4	4	16 (High)	Amber
Target	Mar-26	4	4	16 (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	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
	Red	Red	Red	Red	Red	Amber	Amber	Amber	Amber	Amber	Amber	Amber

Identified Controls *(What are we already doing to manage the risk?)*	
1	Estates & Facilities Management (EFM) leadership & professional structures in place (including Authorising Engineers (AEs), Authorised Persons (APs) and Competent Persons (CPs). The Director of Estates & Facilities is the 'Designated Person' for EFM for the Group and this is now a board role
2	EFM governance structure and safety groups in place reflecting Health Technical Memorandums (HTMs), Health & Safety legislation and other statutory requirements
3	Estates Strategy, Green Plans and EFM Transformation & Improvement Plans in place
4	EFM policies, processes, work plans and risk assessments in place covering HTMs, Health & Safety legislation and other statutory requirements.
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 *(What are the gaps in control that are required to manage the risk)*	
1	Lack of EFM capacity due to the limited resource within LCHS around CP and AP appointments. Work is on-going to try and make group wide appointments. Work remains ongoing to bring together the Fire Safety, Health & Safety and Emergency Planning & Business Continuity Teams
2	The external audit provides Limited Assurance over the adequacy and effectiveness of the Group's PPM management system.
3	Estates Strategy and Green Plans not yet aligned for group, reports to the 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
6	The backlog maintenance programme for ULTH of £123m remains a significant risk. The lack of space and the need to decompress the acute site also remains a key area of focus
7	Inability to address critical infrastructure risks with limited capital

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
4	In response to the recommendations identified through the external audit, a comprehensive PPM and Asset Improvement Plan has been established. This includes defined workstreams and dedicated task groups focused on delivering targeted improvements and ensuring sustained compliance ~~Draft Report has been received and under-going accuracy and factual review. PPM and Asset improvement plan put into place to address recommendations from the external audit with set workstreams and focused task groups.~~	Group Chief Estates & Facilities Officer	Group Chief Estates & Facilities Officer	1 April 2026	**Proposed revised deadline 31 March 2027**
7	Once the EFM risks in respect of LCHS are clear following the AE audits, service mapping exercise, PAM, review of leases and licenses 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	~~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	Ongoing ~~Underway~~ ~~**Proposed revised deadline of April 2026**~~
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.	Group Chief Estates & Facilities Officer	Group Chief Estates & Facilities Officer	30 June 2025	~~Underway Proposed revised deadline of April 2026~~
10	Align and update the group business continuity plans to reflect the group infrastructure risks and challenges Update: • All Estates & Facilities BCP's for the acute site are in place. • Fire & Security BCP's for the community sites are in place. • LCHS Estates BCP's to be progressed.	Group Chief Estates & Facilities Officer	EPRR Lead	31 December 2025	Underway **Proposed revised deadline of 31 May 2026**
11	Continue to explore alternative sources of capital funding – A list of schemes are being identified in the Estates Safety Fund 2025/26 addressing critical infrastructure and safety risks.	Group Chief Estates & Facilities Officer	Group Chief Estates & Facilities Officer	Ongoing	Ongoing

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Increased levels of compliance with EFM statutory compliance requirements as demonstrated through internal audits, external condition surveys, AE audits etc.
2	External / independent review processes in place including AE annual audits and quarterly reviews across all HTMs (ULTH) with monitoring of improvement actions through the EFM Cabinet and reporting to the Finance & Performance Committee in the monthly EFM report
3	Premises Assurance Model (PAM) utilised annually to evaluate the effectiveness of premises performance against a set of common domains / SAQs with assurance and / or key risks reported to the Finance & Performance Committee and the Group Board. Comparison of the 2023/24 & 20224/25 PAM evaluation submissions for ULTH show a year-on-year improvement in compliance across most domains. (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	Capacity to complete actions and undertake internal audits. Deficiencies in document management and control.
2	Outstanding actions continue to be progressed.
3	• Comparison of the 2023/24 & 2024/25 PAM evaluation submissions for LCHS show an improvement in compliance across the majority of domains although with good levels of compliance in the patient experience domain. The requirement for risk assessed, costed action plans for SAQs rated 'inadequate' or requiring 'moderate or minor improvements' was rated 'Inadequate' across all domains • Areas for focus from the PAM evaluation for both trusts, albeit to differing degrees, include Group alignment of policies, procedures & availability of documentation, risk assessment, maintenance, training & development and resilience, emergency & business continuity • Single central document repository required to support smooth document retrieval and proof of compliance when called upon. Current documentation is stored on multiple shared locations and is heavily reliant on local knowledge to retrieve.
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 and the recent AECOM report provided 'limited assurance'
8	Asbestos, Water and Lift Reports received, awaiting further reports for ventilation pressure systems, med gas, confined space, LV. Pressure systems and LV Report received, requiring review for sign off.

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Align the EFM compliance dashboards across the group as part of the review and strengthening of the EFM governance arrangements. Document Management Control to be put in place establishing a clear process, standardisation and responsibilities for document lifecycle management and on-going practices.	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	30 September 2025	Underway **Proposed revised deadline May 2026**
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

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2a: Enable our people to fulfil their potential through training, development and education
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable harm, less efficient services and the inability to attract and retain staff

Current Risk Score & Movement since last review:

Moderate (9)

Last Review Date:	February 2026
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	Moderate	Moderate	Moderate

Identified Controls *(What are we already doing to manage the risk?)*	
1	Education, Learning & Organisational Development Team working with Care Groups to improve statutory and mandatory training compliance to 90% by 31 March 2026, with a focus on areas where compliance is <50%. ESR Hierarchy reviews planned twice per year to support accurate reporting and management of non-compliance.
2	Education, Learning & Organisational Development Team working with Care Groups to ensure that staff have the correct training and support available to fulfil their roles as leaders through upskilling, strengthening and awareness of responsibilities through active engagement with leadership and development training
3	Further opportunities being developed for improving productivity and integration through a 'grow our own' approach and use of apprenticeship levy being maximised
4	Education Oversight Group in place
5	Processes in place for holding Care Groups/Corporate Directors to account for the delivery of people KPIs and improvements to support ownership at local level
6	Lincolnshire (system) People Plan in place. Continued focus on ensuring that the People Promise themes are embedded across the group in line with the wider Lincolnshire System People Plan objectives
7	Implementation of Resident Doctor 10 Point Plan. To improve the working lives of resident doctors for example improving rest areas, access to food, exception reporting, rota compliance

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Divisional/Clinical Care Group Leadership Teams awareness of areas of non-compliance to support local improvement interventions
2	Divisional/Clinical Care Group uptake of leadership and development training
3	Limited oversight of apprenticeship levy use at Clinical Care Group level
4	There is no Education Oversight Group KPI dashboard in place and assurance that Education Oversight Group agenda is in line with assurance required within People Committee, and that KPI Dashboard is in place to monitor progress against key deliverables
5	FPAM monthly reports are not aligned to the refreshed PRM packs. Divisional Leadership Teams not able to / unclear on how to access the standard reports to support oversight
6	None identified
7	Await NHS England guidance in relation to Lead Employer model expansion

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	Green	Green	Green

	Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*	**Executive Lead**	**Operational Lead**	**Due Date**	**Progress**
1	People Systems Team are undertaking a review of ESR hierarchy structures to ensure reporting lines are validated / accurate to support leaders to access statutory / mandatory training and appraisal compliance, and support accurate recording of appraisals. Additionally, monitoring of workforce metrics / compliance rates through monthly performance meetings such as PRM There is a plan in place to now send out ESR Hierarchy Reports twice per year to the Care Groups across the Group (planned to take place March in line with readiness for new financial year, and August (post Dr rotation) for mid-year review). Monthly reporting in place for Key Performance Indicators for the regular oversight of training, appraisal and workforce metrics to support compliance monitoring – this reports via a dashboard to Workforce Strategy Group and People Committee.	Group Chief People Officer	Group Associate Director of Workforce/ 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	PRM data includes an update on workforce by Care Group with SPC charts identifying areas of focus against target. FPAM meetings were replaced by PRM meetings with progress being made on the development of reporting to further support Care Group oversight of workforce data. Progress has moved to 'completed – embedded and added to controls and assurances' as the PRMs are fully embedded with Care Groups able to access their workforce reports via 'drop box areas' and contact the Workforce Planning & Reporting Teams. Active engagement with Care groups throughout both the annual planning process, Plan for Every Post meetings and Workforce Strategy Group continue monthly.	Group Chief People Officer	Deputy Group Chief People Officer / Group Associate Director of Workforce	30 June 2025	Completed – embedded and added to controls and assurances
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	Completed – continues to be embedded
7	Act upon guidance as issued by NHS England. Task and Finish group meeting regularly to monitor progress and to support accurate reporting back to NHSE. Regular reporting to People Committee/ELT/Board	Group Chief Medical Officer	Director of Medical Education	30 September 2026	On hold – guidance yet to be released

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of the people agenda and key risks by the People Committee and reporting sub-groups with escalation to the group board as required. Forward reporting schedule shared with People Directorate annually to able to pro-actively list agenda items in sub-groups.
2	Reporting on People KPIs to the People Committee and Group Board through the Integrated Performance Report (IPR). Mandatory training compliance continues to improve
3	Reporting on medical and non-medical education and medical revalidation to the People Committee
4	Reporting on safer staffing (including training and knowledge gaps) to the People Committee
5	Monthly PRM meetings take place which review KPIs against targets, and this is reported at overall Trust level at People Committee within the scorecard. Active engagement with Care Groups throughout both the annual planning process, Plan for Every Post meetings and Workforce Strategy Group continue monthly
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
9	Performance against Resident Doctor 10 Point Plan reported to People 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. None identified since PRM packs are now aligned to the overall KPIs for workforce that are monitored through People Committee and relevant ELT confirm and challenge able to be undertaken via PRM in relation to these.
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
9	None identified

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year. This is now in place with enhanced communication by way of agenda sharing and workplan being accessible from Trust Board papers which sets out workplan.	Group Chief People Officer	Deputy Group Chief People Officer / Group Associate Director of Workforce	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 / Group Associate Director of Workforce	30 June 2025	Completed – embedded and added to controls and assurances -
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) Working closely with Business Manager to the Group Medical Officer to ensure that the reporting into Workforce Strategy Group is enhanced further as currently this includes an update only from the Medical Workforce Team. This will enhance oversight,	Group Chief Medical Officer / Group Chief People Officer	Business Manager to the Group Chief Medical Officer /Group Associate	30 September 2025	Completed – continues to be embedded

	monitoring and engagement with Care groups and key Corporate support functions.		Director of Workforce /		
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 / Group Associate Director of Workforce /	30 September 2025	Completed – continues to be embedded
5	Review of standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms Once People Directorate restructure has been fully transacted this will provide capacity to further support Care Groups to have oversight of their workforce data and provide regular training to their leadership teams on how to interpret their data.	Group Chief People Officer	Group Deputy Director of People / Group Associate Director of Workforce /	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	Group Associate Director of Workforce	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 Workforce Committee has been 'stood down' during Q3 of 2025/26 and is under review in terms of future meeting structures. However, continued reporting developments will be a priority within the People Directorate and will be able to support Workforce Committee should this be reinstated.	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: (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:	February 2026
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	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	Amber	Amber	Amber

Identified Controls *(What are we already doing to manage the risk?)*	
1	Education, learning and development programmes and KPIs in place
2	Engagement 'Tube Map' – 'Better Together' Programme in place and ongoing including OD support
3	Improved job planning compliance rate to 95% with supporting evidence in place, and a move towards a prospective cycle.
4	Improved Medical & Dental middle tier vacancy rate with a focus on stabilisation and succession planning through fully embedding a revised 'Plan for Every Post' process
5	Quality Improvement (QI) strategy/Quality Management System (QMS) being developed as a key enabler to support innovation/delivery of the group improvement/transformation agenda
6	Creating a culture of research and innovation recognised as a group priority
7	Workforce Planning

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Delivery of action plans and improvements at operational level needs to be incorporated into the Performance Management & Accountability and PRM process
2	Staff awareness at all levels of group strategy, values and approach to innovation and continuous improvement remains ongoing
3	2023 / 24 and 2024 / 25 job plans are still being finalised although significant improvements have been made
4	Division/Clinical Care Groups not yet fully owning the 'Plan for Every Post' process
5	Capacity of staff to engage with improvement agenda to be determined
6	Culture of research and innovation not yet embedded
7	Adverse to plan (M06) within Acute as a result of temporary staffing use, and approved substantive staff levels not included within plan

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review the way in which Staff Survey action plans are monitored and reported through standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms	Group Chief People Officer	Education & Learning Manager / Group Associate Director of Workforce	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. This has been embedded into the Quality Fundamentals Rounds and will continue to evolve.	Group Chief People Officer	Education & Learning Managers	31 March 2026	Completed – continues to be embedded
3 4	IPR metrics have been reviewed within People Directorate and shared, with alignment across LCHS and ULTH in line with Workforce Plans for 2025/26. People Committee Scorecard to be refreshed to ensure inclusion of current job planning and medical & dental middle tier rates for assurance purposes Plan for Every Post standardised framework in development to support ownership at Divisional Care Group level with clarity on roles and responsibilities and core enablers.	Group Chief People Officer	Deputy Group Chief People Officer / Group Associate Director of Workforce	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 Vacancy Control and weekly reporting to ELT on Workforce Plan position has been embedded as Business As Usual (BAU) within the People Directorate.	Group Chief People Officer	Deputy Group Chief People Officer / Group Associate Director of Workforce	31 March 2026	Completed & embedded and added to controls or assurances

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1 2	Upward Reporting: Pulse Survey and NHS Staff Survey results are reported to the Executive Leadership Team, People Committee and Group Board and action plans are monitored through the People Committee with escalation to the Group Board as required.
3 4	Oversight of the people agenda and key risks by the People Committee and reporting sub-groups with escalation to the group board as required. Reporting on people KPIs to the People Committee and Group Board through the Integrated Performance Report (IPR)
5	Oversight of research & innovation has transferred to the Integration Committee

Gaps in Assurance	
1 2	Monitoring of action plan progress not fully embedded within sub-groups and relevant upward reporting, with priority focus being on the Divisional Clinical Care Groups monitored via PRM so that leaders are accountable and undertaking their actions
3 4	Sub-Groups ensuring that agenda items and upward reports are in line with People Committee annual plan. IPR metrics currently being refreshed
5	Regular reporting to be established

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year.	Group Chief People Officer	Deputy Group Chief People Officer / Group Associate Director of Workforce	30 June 2025	Completed & embedded and added to controls or assurances

2	Review and alignment of the ~~PMAF~~ FPAM 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) People Committee Scorecard has been reporting throughout 2025/26 on LCHS and ULTH metrics and these are now aligned for ability to have oversight at each Provider level. Group People restructure will further support the function of harmonising reporting across the Group as the Workforce & Reporting Team will be Group roles.	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
3 4	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year.	Group Chief People Officer	Deputy Group Chief People Officer / Group Associate Director of Workforce	30 June 2025	Completed – continues to be embedded
5	Reporting requirements to be agreed as part of the refresh of the board committee terms of reference and work plans	Group Director of Corporate Affairs	Deputy Trust Secretary	30 June 2025	Completed – continues to be embedded

Related risks on Risk Register – ULTH

Trust	Datix ID	Score	Summary Risk Description
ULTH	4997	20	Service configuration (Haematology)
ULTH	5093	20	Procurement service staffing levels (Pharmacy)
ULTH	4844	20	Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service

Related risks on Risk Register – LCHS

Trust	Datix ID	Score	Summary Risk description

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2c: Nurture compassionate and diverse leadership
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then out staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement

Current Risk Score & Movement since last review:

Moderate (9)

Last Review Date:	February 2026
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	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	Amber	Amber	Amber

Identified Controls *(What are we already doing to manage the risk?)*	
1	Group values agreed by the Group Board – Compassionate, Collaborative & Innovative
2	HR policies and T&Cs are being harmonised across the group supported by staff side
3	Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) submissions are completed and signed off by the Group Board
4	Results from Pulse surveys and NHS staff survey are systematically reviewed and action plans developed in response to findings
5	Culture and Leadership Programmes are in place across the group: Equality, Diversity & Inclusion (EDI), Civility & Respect, Compassionate Leadership and Just Culture 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 *(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.
6	None identified
7	None identified
8	There is currently insufficient funding for the development of the menopause service

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		**Executive Lead**	**Operational Lead**	**Due Date**	**Progress**
1	Education, Learning & Organisational Development Team are actively developing ways of communicating across LCHG, including the 'Better Together Forum' relating specifically to values, and this will include how we embed as part of our business as usual cycles.	Group Chief People Officer	Education & Learning Managers	31 March 2026	Completed – continues to be embedded
2	LCHG Policy Group has commenced and is working collaboratively to review policies at pace. Policies have been prioritised to focus on contractual policies as the priority 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. 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	Completed – will continue to evolve. -
4	People Directorate Teams (Education, Learning & OD and People, Planning & Transformation) are working together to identify improved reporting within 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. 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	Completed

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Feedback on the adherence to the group values and expected standards of behaviours is gathered through a variety of sources including engagement roadshows, surveys, exit interviews, staff networks, and union engagement
2	There is monitoring of progress with the review and alignment of HR policies and T&Cs through engagement with staff side colleagues and through JCNC/JNF
3	WRES and WDES 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 *(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 This is now accessed through the published Policy reports on the Intranet (Corporate Governance site) and reported via People Committee Scorecard. Updated from Group Policy committee are shared where required into 'Any Other Business' or the Workforce Hub report into Workforce Strategy Group.	Group Chief People Officer	Deputy Group Chief People Officer / ~~Head of Workforce Planning & Reporting~~ Group Associate Director of Workforce	30 September 2025	Completed & embedded and added to controls or assurances
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	
4	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. Discussions taking place to include and monitor engagement action plans through PRMs.	Group Chief People Officer	Education & Learning Managers	31 March 2026	

5	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year	Group Chief People Officer / Group Director of Corporate Affairs	Deputy Group Chief People Officer / Group Associate Director of Workforce	30 June 2025	Completed – continues to be embedded

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2d: Recognising our people through thanks and celebration
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not continue to **recognise our people through thanks and celebration** then we will be unable to attract and retain staff of the required caliber and experience resulting in services becoming unsustainable / fragile

Current Risk Score & Movement since last review:

Low (6)

Last Review Date:	February 2026
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	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	Amber	Amber	Amber

Identified Controls *(What are we already doing to manage the risk?)*	
1	Reward and Recognition arrangements harmonised across the group including the development of a group Reward and Recognition Policy
2	Reward, Recognition and Engagement Manager in post to support ongoing work streams from 'People Promise' themes
3	ELT visibility and recognition of staff and teams through established communication and engagement channels
4	Annual staff awards ceremony held to recognise the contribution of individuals and teams
5	Robust review processes in place including appraisal, 1:1 meetings and feedback

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Policy approved but needs embedding
2	Role is in place within ULTH workforce but needs expanding to work across the group with an ability to utilise insights from this role to support wider reporting and identification of trends and development of action plans
3	None identified
4	None identified
5	Concept of group appraisals and appraisal lite process to be considered as part of review and alignment of HR policies

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Embed Group reward & Recognition Policy	Group Chief People Officer	Group Deputy Chief People Officer	31 March 2026	Completed – continues to be embedded
2	Review how the Reward, Recognition and Engagement Manager role aligns to wider LCHG work streams and how the role can bring insights to wider work streams, including reporting into PRM 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) (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 *(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 There is a dashboard that has been developed and is now used to report into the Culture & Leadership Group and upwardly into People Committee.	Group Chief People Officer	Group Associate Director of Workforce	31 March 2026	Completed & embedded and added to controls or assurances
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. New approach introduced to both local and organisational staff survey action plan monitoring, via GLT and also Culture & Leadership Group reporting. Discussions taking place to include and monitor engagement action plans through PRMs.	Group Chief People Officer	Associate Director of Culture & Wellbeing	31 March 2026	Completed – will continue to evolve.
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: (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~~6 (~~Moderate~~Low)

Last Review Date:	March 2026
Lead Executive:	Group Chief Integration Office/Group Chief Estates and Facilities Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Mar-26	~~4~~3	~~3~~2	~~12~~6 (Low~~Moderate~~)	~~Amber~~Green
Target	Mar-26	4	2	8 (Moderate)	Amber~~Green~~

Assurance Rating & Movement since last review:

Green~~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	Moderate	Moderate	Low~~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	Amber	Amber	~~Amber~~Green

Identified Controls *(What are we already doing to manage the risk?)*	
1	Left Shift Transformation Plan with oversight of delivery by the Alliance Steering Group. We have an agreed draft blueprint to move specialties between care groups (e.g. from Medicine to Alliance) and BI dashboard.
2	Transformation of planned and unplanned pathways to be managed through a sub-group of the Alliance Steering Group.
3	Governance structures and QIA processes in support of the transformation programme in place. 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 sub-group of the Alliance Steering Group
5	Partnership Strategy in place to support transformation
6	Neighbourhood Board established to oversee and support delivery which includes external partners and will support delivery of the left shift programme and INW transformation schemes
7	Health Inequalities Working Group established to identify and address health inequalities, focusing on the use of the Health Inequalities Maturity Matrix to drive improvement
8	Estates strategy being developed, Space Group set up to support rationalisation and specific service transformation request

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Pace of change and cultural mindset of working collaboratively needs to be embedded
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)
5	Partnership Strategy is updated now ~~requires updating~~ in line with new national and local guidance ~~will be refreshed in line with the Group Strategy and Alliance Model for Board sign off end March 2026~~
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 *(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 agreed in January 2026 which will include proposals for any external stakeholder attendance. Neighbourhood Health Board established with external leaders – this will support the identification of the appropriate external partners to join the alliance steering sub-groups	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign / Deputy Chief Integration Officer	31 July 2025	**Complete**
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	Group Director Strategy, Improvement and Redesign / 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	Group Director Strategy, Improvement and Redesign	12 May 2025	Complete & ongoing
3.	Draft blueprint for specialty moves reviewed by ASG and Integration Committee – detailed plan developed with care groups to support moves by end March 2026 and left shift programme board established and meeting fortnightly to drive pace and provide support..	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign	End Dec 2025	Complete and ongoing~~Underway~~
5	Partnership Strategy to be refreshed with sign off by the Integration Committee. Update paper to IC in December proposed a more substantial rewrite to the current 2024-27 Strategy, with a new Plan for 2027-30 to be developed during Q4 aligned to the LCHG 5-year strategy and NHS 10-year plan to ensure it is fit for the future.	Group Chief Integration Officer	Deputy Director of Strategic Partnership	30 June 2025	Ongoing – New Partnership Plan to be tabled at April IC Ongoing ~~**Proposed revised timescale 1 April 2026**~~
8	Work with EFM to contribute to developing the Estates Strategy. Process to identify external delivery partner run in December 2025. 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
7	Health Inequalities plans for Care groups have been completed and will be finalised as part of their 26/27 operational plans. ~~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. Care Group narrative plans being supported by new SIRT Strategic Business Partners.~~	Group Chief Integration Officer	Deputy Director of Strategic Partnership	December 2025	~~Underway~~ ~~**Proposed revised timescale end March 2026**~~**Complete**

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of transformation work streams by the Integration Committee with escalation to the Group Board as required
2	Alliance Steering Group upward reporting into PITOF, Integration Committee and Neighbourhood Board. ~~External assurance will be provided through the Alliance Steering Group updates to Lincolnshire Leaders Group. Neighbourhood Board and partner provider boards~~
3	PITOF upward reports including reporting on delivery of key KPIs and milestones to the Integration Committee – 26/27 PITOF Programme approved by SRO's
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 Health Board now established

Gaps in Assurance	
1	Consistent representation at ASG by key operation and corporate leads. Consistent communication and engagement with left shift specialties to have a collective view on transformation programme.
2	None identified
3	~~Work streams, KPIs and timelines still being worked up with a digital dashboard being created, to be finalised in Q4~~26/27 PITOF programmes to be finalised on new Monday.com software – will roll over into 26/27 BAF
4	None identified
5	No formal Partnership Agreement in place. Currently the 'managerial' and operational boundaries differ across LCHG, LCC, LPFT and PCNA although it has been agreed that this can remain flexible in order to support organisational efficiency.

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Integration Committee work plan and reporting sub-groups to be established including external partners where appropriate (with support from Newton's for INW)	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign / Deputy Chief Integration Officer	31 May 2025	Complete – evolving but no gaps in governance
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	Group Director Strategy, Improvement and Redesign / Deputy Chief Integration Officer	January 2026	Complete
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	Group Director Strategy, Improvement and Redesign / Deputy Chief Integration Officer	31 May 2025	Complete
2	The Neighborhood Health Board (established October 2025) will be a forum for system partner discussions and collective resolution of 'wicked issues' supported be a partnership agreement (in development).	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign / Deputy Chief Integration Officer	Review March 2026	Compete and ongoing~~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	Group Director Strategy, Improvement and Redesign	31 May 2025	Complete
3	26/27 programmes will need to be added to Monday.com software to support reporting processes	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign	End April 2026	Underway – to roll over into 26/27
5	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	Group Director Strategy, Improvement and Redesign	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. Working example on the NH Board January meeting agenda.	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign	January 2026	~~Underway- to roll over into 26/27~~On-going to be tabled at IC
5	Work proactively to engage with system partners across the Alliance Portfolio to support governance processes and specific initiatives such as Newton work programme.	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign	Review March 2026	Complete and ongoing~~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:

96 (~~Moderate~~Low)

Last Review Date:	March 2026
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Mar-26	4~~3~~	3~~2~~	96 (~~Moderate~~Low)	~~Amber~~Green
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

~~Amber~~Green

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Low~~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	Amber	Amber	~~Amber~~Green

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 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
2	None identified
3	Embedding the data in decision making in local delivery plan and best long term approach to oversee HI and Personalisation.
4	None identified
5	Methodology for developing data packs in place, initially for key left shift transformation priorities e.g. Respiratory (shared with IC in June 25) but suitable for all services, and a programme to address skills / knowledge gaps. 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

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Monthly Alliance Steering Group established (complete) ASG arrangements are subject to the outcome of a Board discussion on a proposed system Neighbourhood Board. Representation by PCNA on LCHG governance groups has been confirmed. Neighborhood established now to close the gaps	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign / Deputy Chief Integration Officer	31 July 2025	Complete
3	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). Agreement by NH Board in November 2025 that its core business is Planned and Unplanned Care, and it is a key stakeholder in Resilient Communities. Board members also agreed that the PCNs are the 'lowest common denominator of neighbourhood', and that there is a key difference between 'managerial' and 'operational' boundaries set by partner organisations. While there may be some variation in 'managerial' boundaries, consistency will be attempted as far as possible but operational alignment is key. Discussions ongoing re: future of Lincs Linked dataset (optum tool).	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign / Deputy Chief Integration Officer	Review March 2026	Complete and ongoing~~Underway~~
5 / 6	Population Health data packs/intelligence embedded in the improvement methodology approach for left shift and wider transformation activities.	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign / Deputy Chief Integration Officer	31 July 2025	Complete and ongoing

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Health Inequalities Working Group upward report into the new Alliance Steering Group and Integration Committee and Group Board
2	Development of a LCHG Co-production Strategy to support the health inequalities and personalisation agenda and reduce health inequalities – being owned by Chief Nurse/Group Head of Patient Experience and Volunteer Services
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	TIAA HI audit results demonstrates reasonable assurance
5	Care group level HI & Personalisation Plans embedded in Operational Plans
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~~
2	Lack of clarity in the role of health providers in the ~~Ongoing discussion re: role of health providers in~~ Resilient Communities part of the Neighbourhood Operating Model e.g. stakeholder vs lead.
2	No LCHG Co-production Strategy in place ~~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	None
4	None
5	
6	

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Alliance Steering Group meeting with external partners to be held in September 2025 (ASG stood down in August due to availability of key members) ASG arrangements are subject to the outcome of a Board discussion on a proposed system Alliance Board. Representation by PCNA on LCHG governance groups has been confirmed.	Group Chief Integration Officer	Deputy Director of Strategic Partnerships	31 August 2025	Complete
2	Health Inequalities Action Plan completed and was provided to the Alliance Steering group/Integration Committee in July/August2025. Care group plans to be signed off as part of operational plans. ~~and corporate area plans required and are in development~~.	Group Chief Integration Officer	Associate Director of Partnership	31 July 2025	~~Underway~~Complete
2	Neighbourhood Health Board Plan and 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	Group Director Strategy, Improvement and Redesign	Review March 2026	Underway – to roll over into 2026/'27
2	LCHG Coproduction Strategy to be developed, led by Corporate Nursing Team with support from SIRT	Group Chief Nurse	Group Head of Patient Experience and Volunteer Services	Q2 2026/27	Underway – to be rolled over into 2026/27
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
2	New LCHG Strategy being deployed via Roadshow and in communications cascade	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign	30 June 2025	Complete
3	TIAA audit. Action Plan completed, approved by ASG and Integration Committee. Audit team agreed on actions articulated and final reports received. Actions will be incorporated into the RAID log for the working group	Group Chief Integration Officer	Deputy Director of Strategic Partnerships	31 December 2025	Complete

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3c: Enhance our digital, research and innovation capability
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **enhance our digital, research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale

Current Risk Score & Movement since last review:

12 (Moderate)

Last Review Date:	March 2026
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Mar-26	4	2	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	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	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
9	Monthy oversight of 150 day performance via R&D Operations Group
10	Active dataset validation to correct the Group's reported position
11	Targeted communications & engagement plan for PIs and support departments (60 day set up, 30 day first patient)
12	Lessons learned process to classify internal/Group/external delays for each breach
13	Standing RIGG agenda item for 150 day performance

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
9	Limited capacity across Research Delivery and Clinical Trials Pharmacy delaying activation and compliance
10	Inconsistent PI protected time and variable responsiveness in support services (Radiology, Medical Physics, Estates, Digital)
11	National data quality and local validation issues limiting reliable monitoring.

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Implementation Partner to be procured to provide capacity for EPR and other in scope initiatives as part of EMAP DDC collaborative.	Group Chief Integration Officer	Group Director of Digital Services	TBC to alignment with EMAP	Tactical implementation partner procured up to end August 2026 whilst 2026 whilst looking to extend this to end of programme. EMAP Implementation Partner also in place. Also using resource via UHL
7	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**
4	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 key/senior roles now filled for implementation Stage. Some change etc. roles still to be filled
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
11	Complete validation of national 150 day dataset to enable accurate internal performance reporting and trend analysis	Chief Medical Officer	Head of Research and Innovation	30 Apr 2026	In progress – data cleanse underway
10	Implement communications & engagement plan for all PIs and support services	Chief Medical Officer	Head of Research and Innovation	31 May 2026	Draft Plan in Development
9	Map recurrent internal delays (capacity, contracts, pharmacy) and escalate systemic issues to Integration Committee (quarterly)	Chief Medical Officer	Head of Research and Innovation	Quarterly	Lessons learned process established
9	Develop a capacity recovery plan for Research Delivery and Clinical Trials Pharmacy to reduce backlog and enable compliance	Chief Medical Officer	Head of Research and Innovation	30 Jun 2026	Constraints identified; options being scoped

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of digital strategy, digital transformation and key risks by the Integration Committee
2	Digital Maturity Assessment completed
3	Digital Innovations Group established to assess and accelerate safe use of AI technologies
4	Oversight of AGEM IT service transition to LCHG via upward reporting to Integration Committee to manage risk, including agreement of structures.
5	Digital led business continuity exercise to identify improvement and learning, with departments providing assurance to Emergency Planning Group.
6	Monthly R&D Operations Group review of studies withing the 150 day window
7	Upward reporting to Integration committee once dataset validation completes

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
6	No validated, routine reporting yet available to provide full Board assurance on 150 day compliance
7	Limited assurance that supporting services have capacity/prioritization aligned to research timelines

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
4	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
5	Report and recommendations from Exercise Subaqua to Digital Oversight Group (Digital Response) in October 2025 and to Emergency Planning Group (Operational Resilience)	Group Chief Integration Officer	Group Director of Digital Services	30 June 2025 (Report) 31 August 2025 (Digital Oversight Group)	Completed
6	Integrate 150-day performance into existing corporate oversight cycles (RIGG, Integration Committee) to provide multi line assurance once validated data is available.	Group Chief Integration Officer	Head of Research & Innovation	May 2026	150 day metric already a standing item at RIGG; upward reporting planned post validation.
7	Develop cross service assurance framework to evidence Radiology, Pharmacy, Medical Physics, Estates and Digital readiness for 150 day set up timelines.	Group Chief Integration Officer	Relevant Service Leads / Group Director of Digital Services	30 June 2026	Dependencies mapped through lessons learned work; assurance framework in planning.

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~~6 (~~Moderate~~Low)

Last Review Date:	February 2026
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	Mar-26	~~4~~3	~~3~~2	~~12~~6 (~~Low~~Moderate)	~~Green~~Amber
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

~~Amber~~Green

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	~~Moderate~~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	Amber	Amber	~~Amber~~Green

	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 to drive the green agenda
6	Refreshed ULTH and LCHS Green Strategy documents signed off by Board
7	Sustainability agenda embedded in new Group Strategy
8	The Group Chief Estates & Facilities Officer is the SRO for the sustainability agenda
9	LCHG Green Group established, reviewed ToRs submitted to Integration Committee 29/01/26 - awaiting sign off. Group to meet quarterly.
10	The Green Plans committed each organisation in the Group to undertake a Clean Air Hospital Baseline Review

	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	Embedding Green agenda in refreshed Group
8	None identified
9	Lack of resource identified to support full programme delivery
10	No identified resource to undertake the reviews.

	Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*	**Executive Lead**	**Operational Lead**	**Due Date**	**Progress**
1	Extraordinary Care Group, GLT and ELT meetings taking place to identify 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** **Proposed revised timescale 30 September 2025**
3	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 Procurement process completed on 28/01/26 for long term solution. Now in contract negotiation and finance discussions. Work to commence thereafter on system configuration with key stakeholders to deliver a PMO framework and reporting function in readiness for 26/27 Programme delivery from 1st April 2026	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	30 April 2025	**Underway** ~~**Proposed revised timescale end December 2025**~~**New software in situ and training on going**
4	Green Plans for LCHS and ULTH approved by Board to be published and shared with NHSE	Group Director of Estates &	Group Head of Sustainability	31 July 2025	**Complete** **Green Plans**

		Facilities			Published and shared with NHSE

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of productivity, improvement & transformation by the PITOF, Finance Committee and Integration Committee
2	Sustainability report to the Green Group for oversight and assurance. Upward reporting to the Integration Committee and Group Board
3	Green Plan for LCHS and ULTH approved by Board in September 2025
4	Regular updates on PMO solution being provided at Group Leadership Team Meeting

Gaps in Assurance	
1	
2	None identified
3	Embedding green plan through Care Group annual plans
4	None identified

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	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
2	Green Programme resource (people and budget) plan to be developed to mobilise delivery action key actions within the Green Plans	Group Director of Estates & Facilities	Group Head of Sustainability	31/03/2026	No plan

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Group BAF: Position Overview as at February 2026

Strategic Aim	Strategic Objective	Strategic Risk	Executive Lead(s)	Board Committee Oversight	Current Risk Score (as at February 2026)	Target Risk Score (March 2026)	Assurance Rating (as at February 2026)	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 in all care settings	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**
	1b (iii): Reduce waiting times for our patients **(Out of hospital)**							
	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 whilst addressing our requirements for sustainability and our Green agenda	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 /	Group Director of Estates & Facilities	Finance & Performance Committee	**16 (High)**	**16 (High)**	**Amber**	**Amber**

		system scrutiny. 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						
People: Better Opportunities – Develop, empower and retain great people	2a: Enable our people to fulfil their potential through high-quality training, development and education, underpinned by a positive and inclusive culture	If we do not foster a positive and inclusive culture that supports high-quality training, development and education, our people will be unable to fulfil their potential or support the delivery of new models of care, leading to reduced quality, increased risk of avoidable harm, inefficiency and challenges in attracting and retaining staff.	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Green**	**Green**
	2b Create a culture that empowers our people to deliver change through continuous improvement and innovation	If we do not foster a strong, inclusive and enabling culture that empowers our people to continuously improve and innovate, they will feel unable to perform their roles effectively and take ownership of change. This will limit our ability to deliver the required transformation in the quality, efficiency and effectiveness of our services, resulting in a disengaged and disenfranchised workforce, poorer clinical outcomes and diminished 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 population health** resulting in less equitable access to services and poorer clinical outcomes	Group Chief Integration Officer	Integration Committee	**9 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	3c (i) Enhance our digital capability through innovation delivering the 10 year health plan	If we do not **enhance our digital, Innovation** 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**
	3c (ii) Enhance our digital capability through delivery of our EPR in 26/27/28	If we do not **enhance our digital care models through EPR** 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				
	3c (iii) Enhance our research and innovation capability linked to our population health needs	If we do not **enhance our 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 Medical Officer	Integration Committee				
	3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	If we do not listen to the needs and wants for our communities and deliver an aligned approach in collaboration with our partners, we will continue to duplicate care and deliver inefficient outcomes	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**

NHS
Lincolnshire Community and Hospitals NHS Group

Audit and Risk Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*5 May 2026*
Agenda item number	*13.3*

Audit and Risk Committee Upward Report of the meeting held on 27 April 2026

Accountable Director	*Paul Antunes Goncalves, Group Chief Finance Officer*
Presented by	*Neil Herbert, Audit Committee Chair*
Author(s)	*Jayne Warner, Group Director of Corporate Affairs*
Recommendations / decision required	*The Board is asked to:* • *Note the discussions and assurance received by the Audit and Risk Committee;*

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

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	5 May 2026
Report from:	Audit and Risk Committee
Report from meeting held on:	27 April 2026
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Audit and Risk Committee at its meeting held on 27 April 2026 including assurances received and those matters which the committee wish to escalate to the Group Board.

2.0 Matters considered by the committee

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

a) External Audit Progress Report
b) Internal Audit Progress Report
c) Local Counter Fraud Progress Report
d) Internal Audit Close Down Report 2025/26
e) Internal Audit Plan 2026/27
f) Compliance Report
g) Board Assurance Framework
h) Risk Report and External Risk Review
i) Policies and Procedures

The External Audit provider offered assurance to the Committee that there were no identified issues in terms of progress with the year end work. There had been no changes to the audit team and resources were in place. The Committee were advised that there had been changes to the risk profiles for the two organisations in respect of financial reporting.

The ULTH risk in respect of capital expenditure had been downgraded to standard. The LCHS risk in relation to Property Plan, Land and Buildings had also been downgraded on the basis that the value was only just above the materiality threshold and 70% was within 4 assets meaning that a full audit review could be completed.

The materiality threshold for both organisations had been set at 3% of overall materiality.

The Committee were assured that all year end work was on track.

The outgoing Internal Audit provider offered the year end progress report and Internal Audit Annual Report and Draft Head of Internal Audit Opinion. Since the last Committee meeting four reports had been issued for LCHS (2 substantial assurance and 2 reasonable) and seven reports had been issued for ULTH (5 reasonable assurance, one limited and one substantial assurance). The Committee were alerted to a theme arising in respect of data quality and noted that this area had been recommended for further review in the internal audit plan for 2026/27.

The outgoing Internal Audit provider advised that the draft Head of Internal Audit Opinion offered Reasonable Assurance for both organisations.

The Committee noted the position with outstanding audit recommendations and sought assurance that these were still subject to the rigorous follow up processes to ensure they were closed down. Audit Recommendations remain subject to assurance committee review and follow up.

The Committee welcomed the incoming Internal Audit provider and received the draft internal audit plan. The Committee recognised that this had been turned around at pace and would be subject to further review in year. Engagement form all Chief Officers had been sought. The Committee agreed the Quarter One plan and the reset of relationship with new provider.

The Committee received the LCFS Progress Report and Operational Plan which had been agreed with the Chief Finance Officer. The Committee continued it's review of oversight of the organisations arrangements for the recent Failure to Prevent Fraud Regulations.

The Committee received assurance in respect of the compliance with governance arrangements in the form of the quarterly compliance report and approved for publication the Group Debt Management Policy.

The Committee considered the annual self-certifications in relation to governance arrangements against the NHS provider licence and recommended these to Board.

The Committee considered the Board Assurance Framework and Risk Management Report. Substantial assurance was received from an Internal Audit Review of the two areas, with no management recommendations. The Committee were assured by the continued strength of reporting in this area. The Committee continued to receive updates on progress in respect of the NHS providers review of Risk.

The Committee received a report on the actions being taken to address the level of overdue policies. Resource had been redirected from within the Clinical and Corporate Governance teams to support improvement and the Committee noted the 10% improvement in policies in date since the last meeting. The Committee were assured on next steps and the trajectory to achieve 90% of policies in date by quarter 4.

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

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

a) The position in respect of overdue internal audit actions remained a focus for the Committee.

4.0 Matters for reporting / escalation to the Group Board

4.1 There were no matters for reporting / escalation to the Group Board

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

5.1 The committee considered the BAF and Risk Register and following the well led actions agreed to give increased oversight to movement by month of assurance ratings and risks outside of risk appetite.

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- Note the matters considered and assurances received from the Audit Committee;

Neil Herbert, Audit Committee Chair

27 April 2026

Audit and Risk Committee
Terms of Reference

1. Authority

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

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

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

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

2. Purpose of the Committee

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

3. Membership

The members of the Committee are:

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

The following roles will be routine attendees at the Committee:

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

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

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

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

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

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

4. Attendance and Quorum

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

5. Frequency

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

6. Specific Duties

The Audit and Risk Committee will:

Integrated governance, risk management and internal control:

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

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and self-certifications including the NHS Code of Governance and NHS Provider Licence

- Review the adequacy and effectiveness of the policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA

Internal Audit:

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

External Audit:

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

Other Assurance Functions:

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

Counter Fraud:

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

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

Management:

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

Financial Reporting:

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

Raising Concerns:

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

Governance Regulatory Compliance

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

7. Administrative support

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

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

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

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

8. Accountability and Reporting Arrangements

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

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

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

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

9. Monitoring effectiveness and Compliance with Terms of Reference

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

10. Review of Terms of Reference

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

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

Approved:
Approved by:
Next Review Date:

DRAFT

United Lincolnshire Teaching Hospitals NHS Trust/ Lincolnshire Community Healthcare Services NHS Group Audit Committee Forward Reporting Schedule 2026/27

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

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

NHS
Lincolnshire Community and Hospitals NHS Group

NHS Provider Licence Self Certification

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*5 May 2026*
Agenda item number	*13.5*
Report title	*NHS Provider Licence Self Certification*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Approval*
Accountable Director	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Jayne Warner, Group Director of Corporate Affairs*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial*
Prior approval process, if applicable	*Audit Committee – 27th April 2026*
Financial implications, if applicable	*Not applicable*
Action / decision required	*The Board is asked to:* • *Approve the self-certification for both ULTH and LCHS as recommended by the Audit Committee*

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

Executive Summary

This report provides assurance to the Board that the Trust is compliant with the conditions of its NHS provider licence. Whilst the Trust is not required to submit self-certifications to NHS England (NHSE), it may be required to provide evidence of its compliance with licence conditions, specifically that the Trust has:

- effective systems in place to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G5 formerly G6);
- complied with governance arrangements (condition NHS2, formerly FT4)

Condition G5
The condition requires NHS providers to have processes and systems that:
- identify risks to compliance with the licence, NHS acts and the NHS Constitution
- guard against those risks occurring.

Providers must assess whether their processes and systems were implemented in the previous financial year and were effective. A self-certification has been completed using the recommended template which confirms that processes and systems were implemented in the previous financial year and were effective. On the basis that ULTH and LCHS are not subject to any imposed requirements under the NHS Acts, has regard to the NHS Constitution in delivering NHS services and has received positive assurance on its processes and systems from internal auditors, it is reasonable for the Trust to confirm it is compliance with Condition G5 in its self-certification this year.

Condition NHS2
This condition requires NHS providers to apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. The relevant template has been compiled in line with the Annual Governance Statement for 2025-26, which will be subject to review by the Trust's External Auditors.

Evidence of Compliance

In making the above declarations, the following assurances can be provided to the Board for both organisations;

- The Trusts have Standing Orders, Standing Financial Instructions, a Scheme of Delegation and an Accountability Framework, which together describe how the Trust Boards discharge their duties through the Trust's governance structure.
- The Organisations have well established Joint Assurance Committees chaired by Non Executive Directors. Committees complete annual self assessments and have been subject to additional review and oversight as part of the NHS providers Well Led Review

- A risk management strategy which sets the standards for staff regarding the management and responsibility for risk for both Trusts, describes the risk appetite and defines the framework and structure for risk management.

- There is a Risk Register in place for both organisations**.** The Audit and Risk Committee, and assurance committees provide assurance regarding the management of risk to the Trust Board via the monthly risk reports.
- A risk based Internal Audit programme has been delivered that includes audits of risk management, key financial systems and governance arrangements.

- An Annual Governance Statement is produced which reflects each Trust's governance structures and internal control arrangements.

- An Integrated Performance Report is received by the Board at each meeting which details performance against operational, quality and financial targets and offers opportunity for challenge.

The Board is asked to:

- Approve the self-certification

Worksheet G5"

Financial Year to which self-certification relates **2025/26** Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. **Confirmed** OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity		**Capacity**	
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Worksheet "NHS2 declaration"

Financial Year to which self-certification relates **2025/26** Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust has well developed systesm of corporate governance which have been continually reviewed in year as part of Group Model Programme Plan. This is evidenced by Annual Governance Statement, Head of Internal Audit Opinion, internal and external reports and regular review of risk by Board and Committees and external review against well led criteria.
2	The Board has regard to such guidance on good corporate governance	Confirmed	The Board reviews and takes account of all guidance issued by NHS E and other regulatory bodies
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board has conducted a review of its committee structures and terms of reference and ensured that committee responsibilities are aligned to a revised BAF. The Board has engaged external support in a review of governance arrangements and has implemented a new Operating Model. Responsibilities are clearly defined in a Trust Governance Manual.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Trust has sound systems of governance in place which are underpinned by programmes of internal, external and clinical audit. All statutory audits and reporting requirements are fulfilled. B. A monthly performance report is produced, and is scruinised by the Quality Commitee, People Committee and the Finance & Performance Commitee and the Trust Board. C. Board approved financial plans are in place and Internal Audit has provided assurance that the organisation is delivering a sound system of financial control. The Standing Financial Instructions govern financial decision making and financial performance is scrutinised by the Finance & Performance Committee. The 2025/26 accounts have been prepared on an on-going concern basis. D. The Board and its committees work to pre-agreed work plans and are serviced by the Corporate Affairs Team which assists with agenda setting, paper circulation, minute taking, and action follow-up. Directors take responsibility for ensuring that accurate, comprehensive and up-to-date information is presented for consideration. E. An established embedded Risk Register identifies key strategic risks. It is presented to each Board meeting ; risks are also subject to detailed review and scrutiny by the commitees. F. The Trust's Strategic plan is refreshed each year G. The Trust's regularly seeks advice on legal compliance and a compliance report is considered quarterly at Audit Committee.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	A. Robust appraisal and performance review arrangements are in place at Board level (and throughout the organisation) B. The Quality Committee, on behalf of the Group Board , receives assurance on issues of patient safety and quality of care, patient experience and patient outcomes, and promotes the involvement of service users, carers and the public. In addition focussed reviews of any indicators or areas of concern are commissioned by and shared with the QualityCommittee as they arise. C. The Quality Committee receives information on the quality of care, and relevant information and metrics relating to quality performance . D/E. A patient story or service overview is presented at the start of each Board Meeting. Board members undertake service visits. The Board receives a range of quality related reports, including reports on Serious Incidents, CQC regulatory compliance . F. There is clear accountability for quality of care throughout the Trust and systems of governance allow for appropriate escalation to Board .
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Recruitment has been made to all Group Board positions. All Board mebers meet the Fit and Proper Person requirements.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name **Name**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Lincolnshire Community and Hospitals NHS Group
Board Work Programme 2026/27

Agenda Item	Lead	Person Responsible	Committee Oversight	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		
Ward Accreditation	Group Chief Nurse		N/A	X	X	X	X	X	X		Assurance
Declarations of Interest	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	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						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	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	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	To brief the boards on local and national topical matters, risk issues & mitigations and good news & communication updates	
Celebrating Group Success	Group Director of Corporate Affairs	Deputy Trust Secretary	N/A		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		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	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	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	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	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	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	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	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	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	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	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	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						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	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		